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Tracking Queer Kinships: Assisted Reproduction, Family Law and the Infertility Trap

Stewart Donnell Marvel

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Tracking Queer Kinships: Assisted Reproduction, Family Law and the Infertility Trap

Stewart Marvel

A Dissertation submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements for the
Degree of
Doctor of Philosophy

Osgoode Hall Law School
York University
Toronto, Ontario
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ABSTRACT

The global advent of assisted human reproduction has brought with it an upheaval in social, cultural and legal norms of the family. The centrality of biological reproduction to the traditional heterosexual family has been challenged by reproductive intervention, further destabilizing nuclear family norms already unmoored by same-sex marriage, single mothers, unwed fathers, and increased access to divorce, contraceptives and abortion. As these challenges have shifted EuroAmerican social norms of family, the law has increasingly been called upon to preside over the re-organization of intimate life, operating as a central vehicle to reframe the relationship of the family to the state. This relationship remains critical, as the family remains the preeminent social institution and the conduit through which both biological and social reproduction are performed. The traditional family has thus become the site of considerable anxiety, and perhaps nowhere more so than in regard to assisted human reproduction (AHR).

This dissertation argues that the complex outcomes of blood, genetics, sociality and affiliation created through reproductive technology, and the legal struggles they engender, cannot be understood as mere deviations from the heterosexually reproductive family. Instead, it invites exploration of the sociality and legal bonds created by the *inherently* non-reproductive family as a locus to understand the decoupling of sex from reproduction that is being produced through AHR. It draws from more than 1200 pages of interview transcripts with lesbian, gay, bisexual, trans, two-spirit and queer [LGBTQ] Canadians who have used or considered using reproductive assistance, and reflects upon this data to examine the assumptions of law, nature, technology and kinship that drive the conceptual vocabularies of AHR. Its central contention is for the utility of a queer perspective on reproductive law and technology, as a way to pry open cognate issues around kinship, biology, sociality and the order of family. By placing LGBTQ participant voices at the fore, this dissertation offers a fresh analysis on complex questions of parentage, child-rearing and the legal regulation of intimacy.

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TABLE OF CONTENTS

ABSTRACT II

ACKNOWLEDGEMENTS..... III

SECTION I

CHAPTER ONE: INTRODUCTION 1

Introduction..... 1

Outline of Dissertation..... 8

CHAPTER TWO: CHANGING MODELS OF FAMILY AND KINSHIP..... 13

The New Reproductive Family 13

Finding Fathers for the Traditional Family 17

Seeking Parental Rights Outside the Traditional Family Form 20

C.(P.) v. L.(S.) and the Patriarchal Double-Bind 21

Analyzing Biological Facts and Social Relations 27

CHAPTER THREE: NATURE AND CULTURE IN CRITICAL THEORY..... 31

Introduction..... 31

Feminist Critiques of the Nature/Culture Divide 33

Biological Determinism 33

Role of Marxist Thought 34

Nature/Culture; Sex/Gender 37

Michel Foucault on the Sexed Body..... 37

Judith Butler on the Sex/Gender Divide 39

Science and Technology Studies and the Natural World 41

Materiality of Western Binaries 43

Corporeal Feminism..... 44

The New Kinship Theory 46

Questioning of 'Nature' 47

Kinship and New Reproductive Technologies..... 48

Interface between Science and Technology Studies and New Kinship Studies 49

Queer Theory..... 51

A Brief History 51

Heterosexuality and Heteronormativity 53

The Heterosexual Imaginary 55

Production of Heteronormativity in Social Life and Family 56

Queer Scholarship on Biological Reproduction	59
Classic Gay and Lesbian Writings on Reproductive Bodies.....	59
Recent Queer Scholarship on Reproduction.....	63
Queer Theory and Reproductive Kinship	65
Homonormativity and Neoliberalism	69
Law and the Recognition of Family	71
Constructive Relationality of Law	71
Toward a Queer Legal Theory.....	75
Conclusion	77
Material Realities of Queer Parents.....	77
A Techno-Marxist-Feminist Analysis of the Queer Reproductive Family?.....	80

SECTION II

CHAPTER FOUR: AN EMPIRICAL APPROACH TO AHR IN CANADA.....	84
The Creating Our Families Research Project.....	84
Research Methodology.....	85
Written Consent Forms – Concerns and Considerations	86
Methodological Precautions.....	88
Legal Strategy.....	90
Data Gathering and Analysis.....	93
Making Sense of the Data	95
Conclusion	97
CHAPTER FIVE: LAWS OF CONCEPTION	98
Introduction.....	98
Anxieties Over New Technology	99
International Radical Feminist Movement	101
Feminist Movements in Canada	104
Steps Toward Regulation in Canada.....	110
Policy Development around AHR.....	110
Public Consultations by RCNRT	114
Representation by National Action Committee on the Status of Women at RCNRT.....	115
Representation by Infertility Groups at RCNRT	118
Representation of Gays and Lesbians at RCNRT	120
Representation of Anti-Gay Positions at RCNRT.....	122
Public Polls Undertaken by RCNRT	123
Feminist Position on Gay and Lesbian Reproduction	125
Feminist Criticisms of Baird and the RCNRT	127

Publication of Proceed with Care	129
Feminist Positions and Concerns Addressed by the Report	129
Increased Regulation of Lesbians and Donor Insemination.....	131
Nature/Culture Binary and Heterosexist Logic	133
Feminist Critiques of the Report	133
CHAPTER SIX: AFTER THE RCNRT	136
Next Phase of Development	136
Next Steps Toward Legislation.....	137
Analysis of Radical Feminist Position	138
Queer Analysis of RCNRT	142
Supreme Court Reference Case	143
LGBTQ Issues in the Reference Case.....	146
Next Steps for the Regulation of AHR in Canada.....	149

SECTION III

CHAPTER SEVEN: INTERROGATING MEDICAL INFERTILITY	152
Introduction	152
The Natural Order of Family	154
History of Infertility	155
Defining Infertility	157
Unpacking Infertility	164
Reproductive Trauma and the Infertility Trap	170
Defining Reproductive Trauma	172
Reproductive Trauma in Canadian Fertility Clinics	174
Queer Health and Subfertility.....	177
CHAPTER EIGHT: THE INFERTILITY TRAP AND LGBTQ EXPERIENCE	180
Introduction	180
Barriers Faced by LGBTQ People in the Clinic.....	180
The Medicalization of Queer Bodies	183
Discourses of Failure and Pathology	187
Treatments of the Clinic.....	189
Queer Response to Clinical Bedrock	194
Standard Clinical Regime	196
Potential Benefits of Testing.....	201
Other Models for Treatment	207
Heterosexual Reiterations of the Clinic	210

Heterosexual Bureaucracies	211
“Congratulations, you’re pregnant. Oh my God, let’s be careful.”	217
Conclusion.....	220
CHAPTER NINE: REJECTING INFERTILITY AND DEVELOPING NEW MODELS	223
Introduction.....	223
Beyond the Infertility Trap.....	224
Current Understanding of Infertility	224
Heterosexual Gold Standard of the Clinic.....	226
Distinguishing Between Two Categories of Parents	227
Intra-reproductive Parents	228
Extra-reproductive Parents.....	229
Intra-reproductive Family Formation	232
Intra-reproductive Families in Law	235
Extra-reproductive Family Formation	237
Extra-Reproductive Families in Law.....	240
Extra-Reproductive Families Outside the Heterosexual Dyad	244
Politics of Queer Recognition.....	246
CHAPTER TEN: CREATING NEW CONCEPTUAL CATEGORIES	252
Introduction.....	252
Orthofertility: Interrogating Reproductive Supremacy	252
Parafertility: Intra-reproductive Family.....	259
Introducing Synfertility	267
Unplanned Synfertility	268
Intentional Synfertility	272
Queer Agents of Intentional Synfertility	273
Post-Menopausal Women and Reproduction	274
Clinical Pressures on the Intentionally Synfertile	280
Synfertility in Family Law	286
Conclusion	295
CHAPTER ELEVEN: FINANCING REPRODUCTIVE ASSISTANCE.....	298
Introduction.....	298
Fertility Inc.	298
Increased Chance of Multiple Births.....	302
Clinical Success Rates.....	305

IVF and Multiple Births in Canada.....	306
Heterosexual Focus on IVF.....	310
Impact of Quebec Legislation.....	312
AHR Funding By Other Provinces.....	317
<i>Cameron v. Nova Scotia</i>	319
Terry Buffett v. Canadian Forces.....	326
Toronto (City) v. Toronto Professional Fire Fighters’ Association	329
Queer Folks and Access to Reproductive Funding.....	335
CHAPTER TWELVE: FAMILY, CONTRACT AND QUEER PARENTHOOD	343
New Models for New Times.....	343
Privileged Families of Law.....	346
Intentional Parenthood and the Law of Contracts	350
Contextual Purposive Intent of the Synfertile Parent.....	356
Contextual Purposive Intent in Canada	363
Wrapping Up	368
Importance of Developing New Models	372
Future Landscapes	373
APPENDIX A: SELECTED DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS	376
APPENDIX B: INTERVIEW GUIDE.	380
APPENDIX C: SOCIO-DEMOGRAPHIC QUESTIONNAIRE.	383
APPENDIX D: WRITTEN CONSENT FORM	385
ATTACHMENT ONE: QUEER PERSPECTIVES ON REPRODUCTIVE LAW IN CANADA	388
ATTACHMENT TWO: SEMEN DONATION AND LESBIAN MOTHERHOOD	418

SECTION I

Chapter One: Introduction

Introduction

The global advent of assisted human reproduction has brought with it an upheaval in social, cultural and legal norms of the family. Innovations in reproductive technology have emerged in step with other popular and scholarly developments in late modernity, unsettling the foundational binaries in EuroAmerican thought and working to destabilize an Enlightenment worldview fixed upon the Cartesian separation of mind and body. The epistemologically certain dualities of nature/culture, biological/social, male/female, local/global, human/nonhuman have been blurred, diversified and denaturalized in recent decades, with these changes perhaps most powerfully evident in the constellation of effects that cluster around assisted reproduction. Such developments strike at the heart of multiple scholarly and disciplinary fields, encompassing concerns of gender, the body, technology, science, kinship, marriage, the family, religion, ethics, law, justice and biomedicine.

Assisted reproduction thus provides a critical lens into rapid social and cultural change, and a useful avenue through which feminist scholars might explore the shifting terrain of foundational epistemic and ontological concerns. For feminist *legal* scholarship in particular, assisted reproduction offers an unparalleled window through which to view the regulation of intimacy and the gendered forms of sex, family, intimacy and kinship that may emerge, dissolve and be reformulated. This involves a process of reiteration and the reinstatement of old norms upon fractured or reshaped modes of family, an often ambivalent process that both unsettles and stabilizes existing kinship relations. As medical anthropologist Marcia Inhorn suggests, in discussing the rapid proliferation of scholarship on reproductive technology in the past two

decades the widespread application of technologies of reproduction “have diversified, globalized, and denaturalized the taken-for-granted divisions between, inter alia, sex-procreation, nature-culture, gift-commodity, informal-formal labor, biology-sociality, heterosexuality-homosexuality, local-global, secular-sacred, and human-nonhuman.”¹ Thus, as she rightfully concludes, there is much to consider in thinking through what is “new” about the so-called new reproductive technologies.²

The Canadian setting offers an instructive perspective on the history and application of assisted human reproduction [AHR]³ in the Western world, and in particular the feminist struggle to legislate emerging forms of biotechnology. The genesis of Canada’s federal attempt to regulate all forms of assisted reproduction and related research – the *Assisted Human Reproduction Act* [AHRA]⁴ – has been deeply marked by feminist conflict over proper modes of intervention and ideological commitments, reflecting the need for updated responses to the dispersed kinship forms created through reproductive technology.⁵

In the wake of the December 2010 Supreme Court decision on the constitutional legitimacy of the AHRA,⁶ Canada finds itself facing continued regulatory uncertainty in the area

¹ Marcia C. Inhorn & Daphna Birenbaum-Carmeli, "Assisted Reproductive Technologies and Culture Change" (2008) 37 Annual Review of Anthropology 177 at 178.

² *Ibid.*

³ While the abbreviation of ‘ART’ for assisted reproductive technology is more common in international scholarship, this definition is more limited. In general, ART describes procedures that involve surgically removing eggs from a woman’s ovaries, combining them with sperm in the laboratory, and returning them to the woman’s body or donating them to another woman. They generally do not include treatments in which only sperm are handled (i.e., intrauterine—or artificial—insemination) or procedures in which a woman takes medicine only to stimulate egg production without the intention of having eggs retrieved. I am interested in all forms of technological mediation of human reproduction, and therefore prefer the more inclusive AHR. However when reproducing original quotations that make reference to ART, I will use the form selected by the author. For a standard definition of AHR see: *The Fertility Clinic Success Rate and Certification Act of 1992* (Pub. L. 102-493, 42 U.S.C. 263a-1 et seq.)

⁴ *Assisted Human Reproduction Act, SC 2004, c 2* [AHRA]. This conflict over feminist goals forms the bulk of Chapter Five.

⁵ There are a handful of cases from Ontario in particular which reflect this creative approach. The language of “dispersed kinship” is inherited from Marilyn Strathern, whose shadow over the field of ART research and analysis looms large. Strathern, *infra* note 131.

⁶ *Reference re Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 SCR 457 [AHRA Reference].

of assisted reproduction. For those who have followed the history of the *AHRA*, this will perhaps come as little surprise; the long and tortuous journey of this piece of legislation is a story which continues to be written. While many have weighed in on the merits and failures of the *AHRA* over its more than twenty-year history, few have looked at its impact upon a specific sector of the population: lesbian, gay, bisexual, trans, two-spirit and queer [LGBTQ] people.⁷

This dissertation aims to address this scholarly gap, and explore the ways in which LGBTQ people are and have been using the technologies of assisted human reproduction [AHR] in Canada.⁸ It draws from more than 1200 pages of interview transcripts with LGBTQ Canadians

⁷ *Lesbian* is a term for a female whose primary sexual orientation is to other women. *Gay* is a term for a male whose primary sexual orientation is to other men. This term is sometimes used by lesbians (i.e., gay woman). *Bisexual* is a term for a person whose sexual orientation is directed towards individuals of more than one sex or gender, though not necessarily at the same time. *Trans* is an umbrella term referring to people who do not embrace traditional binary gender norms of masculine and feminine and/or whose gender identity or expression does not fit with the one they were assigned at birth; it can refer to transgender, transitioned, transsexual, and genderqueer people, as well as some two-spirit people. *Transgender* is a term used by individuals who falls outside of traditional gender categories or norms. It literally means “across gender,” and conveys the idea of transcending the boundaries of the gender binary system. It however is not necessarily a desire to be of the “opposite” sex. A *transsexual* is someone who feels their gender identity does not match the sex that they were assigned at birth. Many transsexual people choose to go through sex reassignment, including hormone treatment and surgeries, so that their sex and gender identity match. *Transition* refers to the process of changing from the sex one was assigned at birth to one’s self-perceived gender. It may involve dressing in the manner of the self-perceived gender, changing one’s name and identification, and undergoing hormone therapy and/or sex reassignment surgeries to change one’s secondary sex characteristics to reflect the self-perceived gender. *Two-Spirit* is an English language term used to reflect specific cultural words used by First Nations people who have both a masculine and a feminine spirit or to describe their sexual, gender and/or spiritual identity. *Queer* is a term that has traditionally been used as a derogatory and offensive word for LGBTQ people. Many have reclaimed this word and use it proudly to describe their identity and/or as an umbrella term for LGBTQ people or communities. Some people use ‘queer’ as a way of identifying their non-heterosexual orientation yet avoiding the sometimes strict boundaries that surround lesbian, gay, bisexual and trans identities. ‘Queer’ can also signify one’s rejection of heteronormative sexual identities, normative gender constructions, or essentialist identity politics. Please note that because ideas and attitudes are constantly changing within LGBTQ communities and among society at-large, these definitions may be used differently by different people and in different regions. See: datejie green, Lesley A. Tarasoff & Rachel Epstein, “Meeting the Assisted Human Reproduction (AHR) Needs of Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ) People in Canada: A Fact Sheet for AHR Service Providers” LGBTQ Parenting Network, (Toronto: Sherbourne Health Centre, 2012).

⁸ While the abbreviation of ‘ART’ for assisted reproductive technology is more common in international scholarship, this definition is more limited. In general, ART describes procedures that involve surgically removing eggs from a woman’s ovaries, combining them with sperm in the laboratory, and returning them to the woman’s body or donating them to another woman. They do not include treatments in which only sperm are handled (i.e., intrauterine insemination) or procedures in which a woman takes medicine to stimulate egg production without the intention of having eggs retrieved. I am interested in all forms of technological mediation of human reproduction, and therefore prefer the more inclusive AHR. (For a standard definition of ART see: *The Fertility Clinic Success Rate and Certification Act of 1992*, Pub. L. 102-493, 42 U.S.C. 263a-1 et seq., which defines the term as “all treatments or procedures which include the handling of human oocytes or embryos, including in vitro fertilization, gamete

who have used or considered using reproductive assistance, and reflects upon this data to examine the assumptions of law, nature, technology and kinship that drive the conceptual vocabularies of AHR. Its central theoretical contention is for the utility of a queer lens on reproductive law and technology, as a way to pry open cognate issues around kinship, biology, sociality and the order of family. This argument will be fleshed out in the chapters to follow, but in a nutshell: AHR, for the first time in human history, has decoupled sex from reproduction, allowing a child to be produced without the need for sexual intercourse. Same-sex relations, for their part, are *inherently* non-reproductive, and when procreation happens it is actively and intentionally decoupled from sexual intercourse. LGBTQ families thus offer a tremendously useful vantage on the workings of ART, representing in some ways the ideal client for an industry built upon baby-making without sex (although this is not the case in practice, as will be seen). Queer families offer a fascinating combination of sociality and biology; traditional and disruptive; conventional and strange – that, I think, provide useful passage for scholars interested in the workings of technology and kinship.

This theoretical project also carries a normative weight, as reflected in the empirical components of this dissertation and the urgency of participant voices that inform the analysis. In step with the conceptual rethinking of AHR, then, is argued a need for the greater incorporation of LGBTQ people in policy-making and judicial reasoning around AHR. Yet rather than enfolding queer folks into existing models of heterosexual family, as has been the overwhelming response to techno-mediated kinships, I argue instead for a revamped perspective on the medical and juridical frames which advance AHR family projects. By placing queer voices at the fore, I believe that a refreshed analysis may be gained on thorny questions of parentage, child-rearing and the legal regulation of intimacy.

intrafallopian transfer, zygote intrafallopian transfer, and such other specific technologies.”)

As will be explored over the coming chapters, this contention puts two main theses in play. The first is fairly straightforward, and will be demonstrated through an examination of empirical data, federal regulations and recent case law. This dissertation argues that current Canadian legal and clinical models are failing LGBTQ people seeking reproductive assistance, and this represents a grave matter requiring immediate remedy. This is queer as a *politic* and a tool for justice.

The current medico-juridical system of assisted human reproduction is profoundly heteronormative, and remains geared toward ameliorating the infertility experienced by ever-larger numbers of heterosexual couples.⁹ LGBTQ families are either shoehorned into the same model as their heterosexual counterparts, or are simply not being adequately served by a system unable to recognize their specific needs (this is particularly the case with trans* people).¹⁰ The chapters on the ‘infertility trap’ as well as the history and law of reproductive technology in Canada set the stage for first-person accounts of study participants, and their experiences with a system ill-designed to meet their needs. All too often queer families pose an exceptional case in the clinic and in law, and one that serves to highlight the larger failings of a for-profit industry constructed around the business of human reproduction.

This leads to the second main thesis of this dissertation, which contends that queer

⁹ There are a variety of reasons why infertility is on the rise among heterosexuals, both in Canada and internationally. These will be explored in detail in Chapter Seven with the discussion of medical infertility and the natural order of family.

¹⁰ The term “cisgender” marks congruence between the gender one is assigned at birth, one’s body, and one’s lived experience of that gender; cisgendered people experience a match with societal expectations around their physical and mental expressions of gender identity. A person who is transgendered experiences a gender identity that does not match up with the gender assigned at birth. Recent usage has favored the term “trans*” to describe the broadest range of identities that fall outside the cisgender norm. This includes people who identify as transgender, transsexual, transvestite, genderqueer, genderless, two-spirit, and others. Usage without the asterisk generally refers explicitly to transgender men and women. The struggle for self-definition has been an important part of the trans* movement, with focus placed on the use of proper terminology as a symbol of respect and inclusivity. Being trans* does not imply any specific sexual orientation, and may involve identification as straight, gay, lesbian, or bisexual (or something else entirely). See: Stu Marvel & Martha Ertman, “Sexual Orientation and the Law” in N. J. Smelser & P. B. Baltes, eds., *International encyclopedia of the social & behavioral sciences*, 2ed. (Oxford, United Kingdom: Elsevier Science, 2014).

families and their experiences are not a mere aberration from the heterosexual norm, but offer a distinct theoretical frame through which to examine the complexities of AHR for all manner of families. This is queer as a *theoretical* tool. Again, for most of human history, reproduction has been dependent on sexual coupling to produce offspring. The social norms and family ties that bound resultant children to their caretakers would, of course, vary according to each culture's kinship structure and legal code. The meanings ascribed to this act of 'nature' also shifted according to context and interpretation, even as the mechanics of reproductive alignment remained a necessary proposition.¹¹ This is no longer the case, with children regularly created via AHR without reliance upon sexual intercourse or a biological tie between parent and child. Despite this seismic shift in reproductive modes, the law and culture of reproduction has remained strangely fixed on the need to replicate the workings of 'nature'. As Sarah Franklin has termed it, AHR is often framed as simply there to "give a helping hand" to Nature and allow each heterosexual couple to fulfill their biological destiny.¹²

At the same time, legal scholars such as Janet Dolgin have mapped the convoluted routes that law has taken to assign the value of 'natural' parenthood to children produced through surrogacy arrangements. Dolgin has shown how courts use *both* traditional notions of biological kinship and intended social parentage to recreate a vision of the idealized 'natural' family for the purposes of parentage and custody determination.¹³ While Dolgin does not frame her analysis in precisely these terms, what the courts actually mean by 'natural' in these cases is 'as close to a

¹¹ This is not to minimize the complex ways in which kinships have been produced, or call into being a pre-cultural 'nature' which has been practiced since time immemorial. As will be argued, the use of AHR actually draws attention to the cultural fiction of unassisted reproduction and the legal family as a naturalized model of ideal kinship construction. Dion Farquhar has written provocatively about this process at *infra* note 426.

¹² Sarah Franklin has remarked upon the tendency of clinics to produce promotional material that represents IVF as a simple, natural procedure through the use of phrases such as "giving Nature a helping hand". Franklin, Sarah (1997) *Embodied Progress: A Cultural Account of Assisted Conception* (London: Routledge) at 103.

¹³ Janet L. Dolgin, *Defining the Family: Law, Technology, and Reproduction in an Uneasy Age* (New York: New York University Press, 1997). See also *infra* notes 680 to 687.

heterosexual reproductive ideal as possible.’

Indeed, despite the oceans of ink spilled on the social and legal ramifications of new reproductive technologies, few scholars have incorporated the robust language of heteronormativity and queer critique in their analysis. Fewer still have read the workings of the clinic through a queer lens. However I believe the *inherently* non-reproductive modalities of queer sexuality have much to tell us about children produced without sex.

This dissertation takes AHR’s variations from ‘the natural’ not as an aberration, but as a starting point. It seeks to use this queer terrain as a launching pad to ask the following questions: What might happen to our understanding of AHR if gay, lesbian, bisexual and trans* parents were placed at the fore? Can a queer perspective help us destabilize ‘the natural’? And how can it help us think more carefully about the ways in which reproductive power and privilege are distributed to some and not others? How might the legal landscape cant differently when the presumed male-female link between genetic and social parenting was never in play? Does the same-sex family resist assignment under the ‘natural’ model of heterosexual blood kin? What role does technology play in producing social and legal outcomes of family in the midst of all this shifting terrain? In sum, might queer uses of AHR, and the families which result, allow us to think through problems such as infertility, filiation and fertility law from a fresh perspective?

With the queer family, we start from a location wherein it is assumed that a child will *not* have biological ties to both her parents.¹⁴ Nor must it be assumed that only two parents will constitute the family. Reliance upon AHR to create one’s family is not viewed as a failed mode of heterosexual infertility, but a mandatory intervention due to the inherent non-reproductivity of

¹⁴ An evident exception to this would be a lesbian couple in which a transwoman is partnered with a cisgendered woman who intends to gestate their biological child. Exactly such partnership arrangement is chronicled in later chapters. While the gamete contributions might match heterosexual expectations for biological reproduction, the couple describes how their social reality was in fact very much at odds with clinical norms.

same-sex relationships.

From the seat of such queer vantage, therefore, this dissertation seeks to explore the conceptual narrowing effected by a specific set of normative presumptions about reproduction. It consciously places the queer user of assisted reproduction at the forefront with the aim of opening new conceptual vistas on AHR. It relies upon critical theory as well as first-person narratives to evaluate the medico-juridical frame of reproductive technology and family law in Canada, and outlines the heterosexist presumptions that continue to undergird both clinic and courtroom. While other scholars have of course written a great deal on reproductive technology from each of these disciplinary locations, this dissertation aims to use an interdisciplinary approach to bring previously siloed perspectives into conversation. This project will reflect on the structural underpinnings of family law, using a lens of queer legal theory, feminist science studies and new kinship theory to understand the exclusions produced by heteronormative models of reproduction. In this way, it is hoped, the queerly reproductive family may open access to explanatory power for all manner of reproductive projects conducted beyond sexual intercourse.

Outline of Dissertation

The dissertation is structured into three main sections. Section One aims to ‘set the scene’ and lay out the foundational discourses required to understand the unique ways in which queer people approach AHR. Following this introductory chapter, Chapter Two outlines the changing models of family and kinship upon which the ‘new reproductive family’ is located. It looks to jurisprudence that has sought to find parental rights outside the traditional family form, and analyzes the relationship between biological facts and social relations as played out in a recent appellate decision from Saskatchewan. After this broad framing of the themes of the dissertation,

Chapter Three provides the theoretical frameworks upon which the rest of the project are constructed. It offers a range of feminist critiques of the nature/culture divide as a foundational binary in supporting both biological determinism and the systems of medico-juridical regulation in play around AHR. It draws from Foucauldian analysis, science and technology studies and corporeal feminism to explore this binary, before looking to the new kinship theory and its questioning of 'nature' in the alignment of human intimacy. Chapter Three then offers an overview of queer theory, and moves to explore the ways in which queer scholarship has talked about futurity and reproduction. It suggests a queer legal analytic through which we can engage the complexities of reproductive technology use by queer subjects, and concludes with an application of queer legal theory toward a techno-marxist-feminist analysis of the queerly reproductive family. Parts of Chapter Three have been published in a special two-part collection of the *Jindal Global Law Review* on the topic 'Rethinking Queer Sexualities, Law, and Cultural Economies of Desire'.¹⁵

Section Two then moves to foreground the queer subject and analyze the experience of LGBTQ people seeking AHR in Canada. It explores the history and present of fertility law in Canada with an eye to how this is experienced by queer people with a reproductive plan. Chapter Four outlines the research methodology used by the empirical aspects of this project, and describes the Creating Our Families study carried out in Ontario, on which the author was a co-investigator. Parts of Chapter Four have been published in the *Journal of Obstetrics and Gynaecology Canada* and were co-authored by the Creating Our Families research team.¹⁶

Chapter Five develops the historical background to the project, and lays out a queer genealogy of

¹⁵ Stu Marvel, "Polymorphous Reproductivity and the Critique of Futurity: Toward a Queer Legal Analytic for Fertility Law" (2013) 4(2) *Jindal Global Law Review* 294.

¹⁶ Lori E. Ross, Lesley A. Tarasoff, Scott Anderson, Datejie Green, Rachel Epstein, Stu Marvel, & Leah S. Steele. "Sexual and gender minority peoples' recommendations for assisted human reproduction services." (2014) 36:2 *Journal of Obstetrics and Gynaecology Canada* 146-153.

the *Assisted Human Reproduction Act*. As the guiding piece of legislation around reproductive technology and research in Canada, the *AHRA* has seen a fraught history that will be traced through to the present day. This chapter traces the competing ideologies in play in Canadian feminist movements as they grappled with AHR and state regulation, spanning from the early 1980s to the release of the report of the Royal Commission on New Reproductive Technologies. Chapter Six then picks up after the publication of the report, and looks to the passing of the *AHRA* and the related Supreme Court reference case in 2010. The particular impact of this discourse on queer people will inform this chapter, as it explores how the legislation that emerged over decades of public consultations, government-sponsored commissions and explicit feminist intervention has led to today's legal order. This frames the discussion in the two attachments to this dissertation, both of which have been published elsewhere. Attachment One is being published within an anthology on Assisted Human Reproduction Law by the University of Toronto, and has been co-authored with the Creating Our Families research team.¹⁷ It looks at how LGBTQ access to reproductive material, services and facilities has been constrained by the *AHRA* and supportive legislation, and incorporates empirical data and the specific concerns expressed by LGBTQ Canadians.

Attachment Two extends this empirical analysis with a case study of a lesbian couple using an anonymous sperm donor. The experience of these women frames the investigation of semen regulations, lateral kinships, 'donor sibs,' and the particular concerns of queer people of colour as they create families from known and anonymous donor sperm in Canada and abroad. Attachment Two ends with a postscript from one of the women in the case study, describing the

¹⁷ Stu Marvel, Lesley A. Tarasoff, Rachel Epstein, datejie green, Leah S. Steele & Lori E. Ross¹⁷ Stu Marvel *et al* (forthcoming), "Listening to LGBTQ People on Assisted Human Reproduction: Access to Reproductive Material, Services, and Facilities" in Trudo Lemmens, Cheryl Milne & Ian Lee, eds, (Toronto: University of Toronto Press: 2015).

new forms of kinship their family has created with other lesbian couples who used the same anonymous donor. This Attachment exists in a slightly varied form in a volume of the *Canadian Journal of Women and the Law*.¹⁸

The dissertation continues with Section Three, which takes up the notion of ‘infertility’ as a central rubric. It unpacks this term as a structuring discourse of the fertility industry and (increasingly) a distinct legal category demanding state response. This section uses ‘infertility’ to demonstrate the ways in which narrow conceptions of nature, technology and kinship explored in the previous chapters are enacted in the space of the reproductive clinic. It overviews the history and definition of infertility, and unpacks the heterosexist and gendered presumptions which are foundational to its pathology. Section Three then argues that these normative presumptions lay an ‘infertility trap’ for prospective parents, queer and otherwise, who encounter a conceptually narrow set of reproductive ideals upon entering the space of the clinic. Such ideals hinge upon a misleading characterization of reproductive potential and a privileging of biology above other forms of kinship. This dissertation will argue powerfully against the “infertility trap” as a cluster of normalizing regimes which people seeking out AHR must inevitably encounter.

As will be explored in Chapter Seven, the infertility trap is laid by antiquated categories which embrace medieval concepts of sexuality, place an undue burden on female bodies, foster stigma by promoting blunt polarities of normalcy and failure, presume a high degree of sexual availability, and ignore the lived realities of single people and queers. It is also created by the definitional inconsistencies of the term infertility itself, which has drastically limited the ways in which clinical and demographic researchers can think about adult procreation. The infertility trap is based upon a misleading characterization of reproductive potential and a privileging of biology

¹⁸ Stu Marvel, “Tony Danza is my Sperm Donor?: Queer Kinship and the Impact of Canadian Regulations Around Sperm Donation” (2013) 25(2) *Canadian Journal of Women and the Law* 221.

above all other forms of kinship.

The prism of infertility is thus used in the text to critically examine a range of diagnostic assumptions about gender, sexuality, genetics, pathology and regimes of the normal. This in turn illuminates a series of cognate legal issues, laying bare a medico-juridical order that is broadly unable to account for all manner of bodies beyond the realms of ‘natural’ reproduction. Chapter Eight will particularly explore this relationship between medicalization, failure, reproductive trauma, infertility and queer subjectivity.

Chapter Nine develops a response to the infertility trap, suggesting the creation of new models that reject the wounded heterosexuality of the fertility clinic. It distinguishes between two forms of kinship structures: intra-reproductive (where the biological tie is contained within the parenting dyad); and extra-reproductive (where the biological tie is not contained with the parenting dyad). It then tracks their location in both medicine and law, and considers the role of the heterosexual dyad in closing down broader frameworks for family formation. This exploration is pushed into the fresh neologisms and conceptual frames of Chapter Ten, which offer a range of novel categories to think through the rupture of ‘traditional’ family frames that has occurred through AHR. Finally, the substantive explorations of the dissertation are concluded in Chapter Eleven, which uses these new conceptual frames to think through intentional parenthood, contracts, the bioethical implications of state funding for AHR and legal challenges to infertility as a category of disability. Using the frame of queer legal theory developed across the dissertation, this chapter offers suggestions to emerge from the infertility trap and offers new models for family law and reproductive justice able to account for the subjectivity of LGBTQ parents and other families being created outside the heterosexual norm. Chapter Twelve offers a review and conclusion to the dissertation.

Chapter Two: Changing Models of Family and Kinship

The New Reproductive Family

It is not difficult to grasp why LGBTQ people may find themselves uniquely dependent on assisted human reproduction to create their families. While an earlier generation of gays and lesbians might have had children in heterosexual relationships before ‘coming out,’ the increasing acceptance of LGBTQ identities in Canada has made this social trajectory less common. Certainly some queer people may choose to engage in potentially reproductive sex, either for pleasure or for the aim of pregnancy, although this is not the norm – popular media representations notwithstanding.¹⁹ Instead, most people in same-sex relationships will look either to adoption or to reproductive assistance to create their families. The institution of civil rights and constitutional protections for same-sex relationships has meant that more queer people than ever are seeking clinical assistance to have children. The layering of a possibility for genetic connection atop historic queer modes of social kinship has led to an explosion of interest in AHR; indeed, recent estimates from Toronto suggest that LGBTQ people may represent up to 15-25% of clientele at urban fertility clinics.²⁰ Lesbians, bisexuals and transpeople are also the largest consumers of donor sperm in Canada, as indicated by a 2010 study which estimated that same-sex couples represent 55% of demand for donor insemination.²¹ The study estimated a

¹⁹ For example in the Showtime series ‘The L Word’ about a group of lesbians living in Los Angeles, two of the main characters – Bette and Tina - seduce a straight man with the intention of getting Tina pregnant. When they coyly suggest not using a condom during intercourse, the would-be sperm donor reacts with anger and recognition of their lesbian pregnancy scheme. This ‘sexy pregnancy threesome’ has become something of a cliché in popular culture, but represents male sexual anxiety and phallogentric sexual fantasies far more than it showcases actual reproductive strategies devised by lesbian women. This is also, evidently, not a strategy open to gay men.

²⁰ Rachel Epstein, *The Assisted Human Reproduction Act and LGBTQ Communities* (Toronto: LGBTQ Parenting Network, 2008).

²¹ The “same-sex couples” described in the study may include not only lesbian couples, but bisexual women partnered in a same-sex relationship as well as transwomen in lesbian relationships and partnered transmen seeking donor sperm. It is important to note that these estimates came not from empirical research conducted in Canada, but by triangulating Canadian census data from 2006 with a five-year research study on donor sperm conducted in Belgium. The model used in the Canadian report assumed that the demand in Canada would follow a similar ratio of request. JM Bowen *et al*, “Altruistic Sperm Donation in Canada: an Iterative Population-based Analysis” Submitted

further 23% of demand from single women (without orientation specified) and just 22% on the part of heterosexual couples.

Yet these changes come in step with an overall transformation in the understanding and recognition of family. Feminist legal scholars have offered sweeping analyses of family law in recent decades, tracking the ways in which intimate recognition has become an increasingly complex matter.²² As Naomi Cahn writes:

The future of the family is one of the central cultural and legal obsessions of our time. As the courts struggle with the rights to be accorded to same-sex and transgendered couples, as potential parents hire surrogates to carry their children, as divorcing couples fight over 'their' embryos, and as cohabitants successfully claim rights against each other, traditional constructions of the family have become increasingly subject to challenge.²³

The growing presence of same-sex couples bearing children, the widespread use of assisted reproductive technology and demographic shifts toward 'non-traditional' families have reshaped the landscape of family. Canadian census data from the past fifty years has tracked a dramatic shift from the end of the baby-boom period (1946 to 1965), when heterosexual couples still married young and had relatively large families.²⁴ In 1961, married heterosexual couples accounted for 91.6% of census families; by 2011, this proportion had declined to 66.2%.²⁵ Even within this married majority of Canadians, the norm is no longer the biologically-related nuclear

to Assisted Human Reproduction Canada (AHRC). Programs for Assessment of Technology in Health (PATH) Research Institute. Hamilton, ON. [20 May 2010].

²² For a small sampling of this literature, see for example: Mary Ann Glendon, *Abortion and Divorce in Western Law* (Cambridge, MA: Harvard University Press, 1987); Gary S. Becker, *Treatise on the Family* (Cambridge, MA: Harvard University Press, 1991); Martha Fineman, *The Illusion of Equality* (Chicago, IL: The University of Chicago Press, 1991); June Carbone, *From Partners to Parents: The Second Revolution in Family Law* (New York: Columbia University Press, 2000); Linda Waite & Maggie Gallagher (eds.) *The Ties that Bind: Perspectives on Marriage and Cohabitation* (New York: Aldine de Gruyter, 2000).

²³ Naomi Cahn, "The New Kinship" (2012) *Georgetown Law Journal* 100(2) at 368.

²⁴ Statistics Canada, *Fifty years of families in Canada: 1961 to 2011* (Ottawa: Minister of Industry, 2012), online Statistics Canada http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/2011003/fig/desc/desc3_1-2-eng.cfm

²⁵ *Ibid.* Note this percentage does not include same-sex married couples.

family. Instead we have families structured by re-marriage, stepchildren, and multiple generations living under one roof, as well as growing numbers of gay and lesbian couples. Between 2006 and 2011 the number of married same-sex couples nearly tripled, soaring by 181.5%.²⁶ During the same period the number of common-law couples of all sexes rose 13.9%, more than four times the 3.1% increase for married couples.²⁷

These social phenomena have directed important changes in the legal understanding of family, and to parentage in particular. A major turn has been away from the primacy of genetic affiliation in determining parentage and toward a child-focused approach to the concept of “parent” that incorporates a concern for social and psychological ties.²⁸ Of course law’s attempt to locate an appropriate child-parent relationship has never been a simple matter of tracking biology; in fact the primary relationship between parent and child was hardly an issue of legal concern until relatively modern times. Legal historian Jamil Zainaldin has traced this history in the English-speaking world, exploring the emergence in the 19th century of childrearing as the primary concern of the family, and, by extension, a concern of the courts.²⁹ Zainaldin explains how the recognition of ‘childhood’ as a distinct phase in human development, and specifically as a period of vulnerability and dependence, created a matching requirement for caretakers to guide such children into adulthood. For example, one of the central gendered presumptions in this

²⁶ Statistics Canada, *Portrait of families and living arrangements in Canada* (Ottawa: Minister of Industry, 2012), online Statistics Canada <http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-312-x/2011001/tbl/tbl1-eng.cfm>

²⁷ *Ibid.*

²⁸ Nicholas Bala and Christine Ashbourne, “The Widening Concept of Parent in Canada: Step-Parents, Same-Sex Partners, & Parents by ART” (2012) *American University Journal of Gender Social Policy and Law* 20(3).

²⁹ Jamil Zainaldin, “The Emergence of a Modern American Family Law: Child Custody, Adoption and the Courts, 1796-1851” (1979) *Northwestern University Law Review* 73.

history of American family law – the ‘tender years’ doctrine – was reliant both upon notions of vulnerable children as well as an idealized vision of mothers as natural caregivers.³⁰

Economic concerns about the cost of child-rearing, as well as naturalized presumptions about the care-taking roles of mothers and fathers, have long been critical for both legislators and courts. To this end, Chapter Three will involve a lengthy exploration of the “facts of life” as the seemingly natural conduit to kinships forged through sex, birth and genetic connection.³¹ However law and society have also recognized non-biological kinship ties when necessary, with adoption being perhaps the most evident example of kinship formation that depends on intentional social affiliation and a concern for the welfare of children. There have historically been a number of ways to achieve legal parenthood, based on genetics as well as intent, social relationships, and the best interests of the child.³² As Roxanne Mykitiuk rightly argues, “law does not always mirror nature and often it is more representative of the societal values (ie social and cultural imperatives) it is employed to protect.”³³ Despite these multiple roads to family, legal constructs of parentage and filiation have nevertheless tended to shape themselves powerfully around the basic “facts of life” in which a mother and father is required to produce a child.

³⁰ For contrasting views on the modern utility of the tender years doctrine, see Allen Roth and Ramsay Laing Klaff. Roth locates the doctrine as it stood following the feminist revolutions of the 1970s, making an argument for father’s rights and the error in judicial presumptions toward maternal custody. Klaff, on the other hand, offers a spirited defense of mother’s rights and the continued importance of the tender years doctrine based on the actual caretaking labour being performed by women. Allen Roth, “The Tender Years Presumption in Child Custody Disputes” (1977) 15 J. Family L. 423; Ramsay Laing Klaff, “The Tender Years Doctrine: A Defense” (1982) 70 Cal. L. Rev. 335. See also Martha Fineman, “The Neutered Mother” (1992) 46 U. Miami L. Rev. 653, for an evaluation of the consequences for mothers of the de-gendering of family law, particularly in the context of child custody.

³¹ Strathern, *infra* note 133.

³² Angela Campbell, “Conceiving Parents through Law” (2007) 21 International Journal of Law, Policy and the Family 242.

³³ Roxanne Mykitiuk, “Beyond Conception: Legal Determinations of Filiation in the Context of Assisted Reproductive Technologies” (2002) Osgoode Hall Law Journal 39(4) at 776.

Finding Fathers for the Traditional Family

Until recently, for example, it was presumed that “the act of giving birth necessarily resulted in motherhood.”³⁴ Thus, the main challenge facing courts and legislatures has been how to determine *paternity*, amidst either competing or absent claims to the role. The default assumption has been to presume the husband of the natural mother as the father of any children to the marriage. English common law shares this presumption of ‘*pater est quem nuptia demonstrant*’ with the world’s major legal traditions, including Sharia law and the Napoleonic Code, stemming from the very practical matter of indeterminate biological paternity (as compared to the physical certainty of childbirth).³⁵ The paternal presumption was rooted in the legal bond between husband and wife, ensuring that any resultant children would be legitimated by the marriage regardless of actual biological inheritance. This presumption functioned not only to avoid conflict between potential male progenitors, but, importantly, awarded legal status to all children born into wedlock. Only a legal father could bestow upon his son the patrilineal rights claim to inheritance and intergenerational wealth transfer.³⁶ As Lois Harder and Michelle Thomarar have explained, “While mothers could create bare life, only husband-fathers could confer full humanity and full entry into the social realm.”³⁷

This patriarchal and resolutely heterosexual model for biological reproduction and social identity has functioned as the baseline model for family across centuries and diverse legal orders.

As Roxanne Mykitiuk has argued:

What has been construed within our understanding of kinship as "natural," then, is a normatively essentialist position having direct bearing upon the way we understand

³⁴ *Ibid* at 778.

³⁵ There have of course been cases where the maternity of a child was concealed or denied after birth. The certainty here attends the physical process of gestating and delivering a child. See also *ibid* at 779.

³⁶ *Ibid* at 782.

³⁷ Lois Harder and Michelle Thomarar, “Parentage Law in Canada: The Numbers Game of Standing and Status” (2012) *International Journal of Law, Policy and the Family* 26(1).

gender and sexuality within the reproductive context. "Natural" procreation, in this sense, occurs only between two heterosexual individuals, without the assistance of technology.³⁸

Such a paternal presumption is now easy to refute not only in light of the technology of AHR, but thanks to the prevalence and convenience of DNA paternity testing kits.³⁹ Yet its power endures. An ancient legal convention aimed at conferring social legitimacy continues to operate, taking contemporary form less to uphold the rules of primogeniture and more as a method to ensure the privatization of care. Whilst presumptive paternity has always been a 'legal fiction' unconnected to biological ties, its resilience in the face of contemporary genetic testing methods demonstrates the deeply rooted tenets upon which it rests. Fiona Kelly correctly identified the foundations of this fiction when she argues that "the law has historically been more committed to protecting the traditional patriarchal family than to accurately representing biological fact,"⁴⁰ although one might also wish to question the idea of 'biological fact' as a socially unconstructed modality.

Nevertheless, in more recent cases where paternity has been contested due to DNA testing, courts have applied traditionalist reasoning to replicate an exclusive, two-parent model of heterosexual parentage.⁴¹ As Janet Dolgin has argued, even in cases with complex biological and social kinship ties at work, the legal protections awarded to fathers "will follow unreservedly only to protect traditional family structures."⁴² This was famously illustrated in *Michael H. v. Gerald D.*, a 1989 United States Supreme Court case in which plaintiff Michael H. was not

³⁸ Mykitiuk, *supra* note 33 at 774.

³⁹ As an advertisement for a popular home test kit - Identigene - proclaims, "DNA Paternity Testing kits are discrete, accurate & found at your local pharmacy." Online at: <http://www.dnatesting.com/>

⁴⁰ Fiona Kelly, "Producing Paternity: The Role of Legal Fatherhood in Maintaining the Traditional Family" (2009) *Canadian Journal of Women and the Law* 21(2) at 316.

⁴¹ As Martha Fineman explains: "A traditional family is typically imagined: a husband and wife – formally married and living together – with their biological children. The husband performs as the head of household, providing economic support and discipline for the dependent wife and children, who correspondingly owe him duties of obedience and respect." Martha Fineman, "Why Marriage?" (2001) 9 *Virginia Journal of Social Policy* 239 at 247.

⁴² Dolgin, *supra* note 13 at 78.

married to the mother of his biological child. Instead the paternal presumption had favoured the woman's husband Gerald, who despite a lack of biological relation, refused to relinquish his claim to legal fatherhood. In Justice Scalia's majority ruling, which dismissed Michael H.'s suit, a defense of patriarchal tradition and the prevailing social order trumped any claims to 'biological fact'. As Scalia thundered stentoriously: "Our traditions have protected the marital family...against the sort of claim Michael asserts."⁴³

Buoyed by the reproductive complexities of AHR, the past few decades have brought ever thornier issues of paternity and parentage to the courtroom. As the law has been obliged to struggle with complex and conflicting parentage claims it has increasingly recognized multiple forms of fatherhood, even as the presumption of paternity has held fast. Kelly describes this apparently contradictory phenomenon:

A review of both statute and case law suggests that the law is open to multiple constructions of fatherhood, some based in biology, some in the man's relationship to the child's mother (which is linked to presumptions about biological paternity), and others grounded solely in a social relationship with the child. In fact, at the same time that rights and responsibilities associated with biological fatherhood remain deeply entrenched in the law (and may even be experiencing a resurgence), there appears to be a simultaneous rise in the recognition of social fatherhood.⁴⁴

Kelly argues that undergirding these diverse responses is a commitment to the privatized nuclear family, and a resistance to families without fathers. She identifies these multiple modes of paternity recognition as emerging from the desire of courts to reinforce the primacy and centrality of fatherhood, thereby ensuring that each family properly has a father at the head. As Kelly suggests, "the law does not favour either biological or social paternity" but rather seeks to

⁴³ *Michael H. v. Gerald D.* [1989] 491 U.S. 110, 109 S. Ct. 2333, 105 L. Ed. 2d 91 at 124. Quoted in Dolgin *ibid.*

⁴⁴ Kelly, *supra* note 40 at 316.

increase the circumstances under which fatherhood may be assigned, strategically adapting the facts of the case to meet the patriarchal goals of dominant ideology.⁴⁵

In recent decades the fragmentation of kinship has been effected through the critical and material formations of AHR, and law has moved awkwardly in addressing these cultural shifts. As Judith Butler has argued in relation to queer sociality, kinship has now been irreversibly opened to “a set of community ties that are irreducible to family.”⁴⁶ But what happens when these fragmented forms actively seek out legibility as ‘a family’ within law? Does this irreducibility, in Butler’s words, actually *depend* on the inability of legal authority to read these dispersed kinships *as* family? What if they *were* brought into legal recognition? Would they remain irreducible? Posed another way: Is the family a strictly legal concept, and one which only finds culturally legible form through the categorizations of law? If so, might the queer family represent not only the breakdown of the symbolic heterosexual order, but also a rupture in the ways in which ‘family’ has assumed a coherent legal form? Might the queer family, in its material form and inherent non-reproductivity, represent an oxymoron with which the law cannot grapple? And ultimately, is it possible for law to adapt, or must it seek to reinstate existing heterosexual modes of nature/culture upon the palimpsest of the queer family?

Seeking Parental Rights Outside the Traditional Family Form

Scholars such as Fiona Kelly have argued that the adaptation of law to the queer (or at least, lesbian) family is structured through the project of ‘finding fathers’. Family law has historically wrestled with non-biological kinship almost exclusively in relationship to fatherhood, and she is correct that many lesbian families have had to face the presumption of

⁴⁵ *Ibid* at 317.

⁴⁶ Judith Butler, “Is Kinship always already Heterosexual?” (2002) *Differences: A Journal of Feminist Cultural Studies* 13: 14–44 .

paternity in arguing for the legitimacy of co-motherhood. However this dissertation will argue that such operations of family law are clustered far more closely around normative heterosexuality than simply a patriarchal interest in ‘finding fathers.’ The multiple strategies that courts have applied in carving out space and potential for paternity claims have dominated the legal landscape and set the circumstances under which parental rights may be assigned. This has dramatically impacted those parents seeking rights outside of the traditional family form, with claimants encouraged to operate under patriarchal forms. As Kelly has correctly noted – these are diverse strategies, and biological and social tropes have both been liberally applied in the service of the patriarchal order.⁴⁷

Thus, the lesbian partners of biological mothers have often been compelled to analogize themselves to the presumptive paternal rights enjoyed by male heterosexual partners of biological mothers. In order to have their parental rights recognized, lesbian co-mothers are obliged to wedge themselves into a heterosexual model of kinship that – *even when it recognizes social and affective bonds* – still struggles to place these ties within the framework of biological reproduction. Both social *and* genetic relations come into play as viable juridical strategies when courts seek to defend the heterosexual model of family, a patriarchal double-bind that is exemplified in the 2005 Saskatchewan case of *C.(P.) v. L.(S.)*.⁴⁸

C.(P.) v. L.(S.) and the Patriarchal Double-Bind

In this matter, a lesbian couple had been in a five-year spousal relationship, over the course of which one of the women had conceived a child through sexual relations with a male

⁴⁷ Kelly, *supra* note 40 at 317.

⁴⁸ 2005 SKQB 502. [*C.(P.) v. L.(S.)*]

friend.⁴⁹ After the end of the relationship, disagreement arose as to whether the child's conception and birth was a deliberate result of the women's intention to have a child together (as the petitioner alleged), or the unplanned outcome of casual intimacy (as the respondent contended). The case arose when the non-biological mother petitioned for access to the child under the same presumptive parental rights that a male cohabiting with the mother would have enjoyed.⁵⁰

The petitioner's primary request was that the paternity presumption in s.45(1)(a) of the *Children's Law Act* of Saskatchewan be similarly extended to a woman cohabiting with the mother at the time of the child's birth or conception.⁵¹ The relevant provision holds that:

“s.45(1). Unless the contrary is proven on a balance of probabilities, there is a presumption that a *man* is, and that a *man* is to be recognized in law to be, the *father* of a child in any one of the following circumstances:

(a) *at the time of the child's birth or conception the man was cohabiting with the mother, whether or not they were married to each other;*⁵²

The petitioner challenged this section of the *Act* as being inconsistent with s. 15 of the *Canadian Charter of Rights and Freedoms*, as well as the language of s. 2 of the *Act*, which defined the two possible parents of a child in strictly gendered terms as consisting of a male “father” and female “mother”.⁵³ Thus, the petitioner argued that this section of the *Act* was

⁴⁹ Note that while this case does not involve assisted reproductive technologies but conception through sexual relations, the fractured legacies of AHR and their ability to complicate the traditional family nevertheless haunt the ruling. The mere presence of a same-sex couple and a lesbian claim to ‘fatherhood’ disrupts the analytical frame of heterosexuality, obliging the judge to cast this matter in the language of assisted reproduction even where none is present.

⁵⁰ *C.(P.) v. L.(S.)*, *supra* note 48

⁵¹ *Ibid.*

⁵² *The Children's Law Act*, 1997, S.S. 1997, c. C-8.2, emphasis mine. Although this is a rebuttable presumption unless there was evidence to the contrary - namely upon failure to establish, on a balance of probabilities, that there is a biological connection between the presumed parent and the child, or that a parental relationship exists with the child – the instant case had not been rebutted at the time of the child's birth. Thus the lesbian co-mother would have been presumed to be the legal father of the child *if she had only been a man*.

⁵³ Quoted in *C.(P.) v. L.(S.)*, *supra* note 48 at Appendix A:

In this Act:

discriminatory under equal protection grounds on the basis of sex or sexual orientation, because a male cohabiting with the mother would be presumed in law to be the father of the child, while a same-sex partner is not entitled to the benefit of the same presumption.⁵⁴

Justice Wilkinson's ruling first wound its way through provincial case law involving matters of parental recognition, wherein same-sex lesbian partners had requested to be named a "mother" in addition to, but not in substitution for, the biological mother. The analytical frame Wilkinson J. drew from these cases involved whether the use of the definite article ("the" mother) in provincial family law statutes, rather than the indefinite article ("a" mother), indicated a legislative intention that there could only be one mother of a child.⁵⁵ The courts in the cases surveyed had found it unnecessary to decide the point, but Wilkinson J. took the 'definite article' issue as determinative for the present analysis.⁵⁶

The court then moved to review the facts of the instant case, acknowledging that "a final and binding determination regarding the status of 'parent' is not simply an issue of biological

"father" means the father of a child and includes:

- (a) a man declared to be the father pursuant to section 43 or 44; and
- (b) a man recognized as the father pursuant to section 50, 51, 55 or 56;

"mother" means the mother of a child and includes:

- (a) a woman declared to be the mother pursuant to section 43 or 44; and
- (b) a woman recognized as the mother pursuant to section 50, 51, 55 or 56;

"parent" means:

- (a) the father or mother of a child, whether born within or outside marriage; or
- (b) the father or mother of a child by adoption.

⁵⁴ *Ibid* at para 4.

⁵⁵ This logic operates as follows: if legislators had planned to allow for the presence of more than one mother, they would have crafted a statute that reads "a" mother rather than "the" mother. To solve the 'definite article issue,' it is analogized to concerns over multiple fathers and the intention of legislators not to allow more than one paternity claim to succeed. This logic maintains a patriarchal frame, wherein the presence of multiple mothers can only be read through the guiding analogy of competing fatherhood claims and (presumably) resultant issues of confusion over proper patrilineal succession. This issue was addressed in *Buist v. Greaves*, [1997] O.J. No. 2646 (Ont. Gen. Div.), where the Court was asked to declare that the mother's same-sex partner was a "mother" under similar provisions in the Ontario *Children's Law Reform Act*. The applicant relied on the argument that a child can have two mothers in the case of a same-sex adoption. The case *JK v. LH and GH*, [2002] O.J. 3998 (Ont. S.C.J.) also addressed the question of two mothers for the purpose of gestational surrogacy. Neither of these courts found it necessary to decide upon the issue of legislative intent in use of the definite article.

⁵⁶ *Ibid*.

connection”⁵⁷ and recognized the importance of acknowledging affective ties – not least because of the “extraordinary social issues involved” with advances in reproductive technology.⁵⁸ Wilkinson J. drew from the U.S. court ruling *Lehr v. Robertson* to quote approvingly that: “Parental rights do not spring full-blown from the biological connection between parent and child. They require relationships more enduring.”⁵⁹ This balance between biology and sociality is spread clearly across the court’s ruminations, as Wilkinson J. recognized the “emotional attachments that derive from the intimacy of daily association” even as he gives weight to “the fact of blood relationship”.⁶⁰

After recognizing the validity of claims to social and intentional parenting, however, the court ultimately sides with the Attorney General’s defense, agreeing that a presumption of parentage cannot extend to a woman, quite “simply because a woman could not have provided the seed.”⁶¹ Thus Wilkerson J. frames his dismissal of the petitioner’s *Charter* claim as resting upon the primacy of biological ‘truth’ – viewed as a natural realm that exists distinct from the social stereotypes deemed impermissible under s.15:

...the presumption of paternity is not based on societal stereotypes in the ordinary sense. Historically, like other rebuttable presumptions, it made certain assumptions about ordinary human behaviour in circumstances where direct proof was difficult. It assumed that a man and woman cohabiting at a child’s conception or birth were engaging in sexual intercourse from which procreation might inevitably result... *The Court cannot aspire to affect the fundamentals of biology that underlie the presumption purely in the interests of equal treatment before the law.*⁶²

⁵⁷ *C.(P.) v. L.(S.)*, *supra* note 48 at para 21.

⁵⁸ *Ibid* at para 22. See also *supra* note 49.

⁵⁹ Quoted in *ibid* at para 21. Original cite: *Lehr v. Robertson* 463 U.S. 248 at 260 103 S. Ct. 2985 at 2992.

⁶⁰ *Ibid*.

⁶¹ *Ibid* at para 17.

⁶² *Ibid* at para 20. My emphasis. This form of biological determinism has a long history in English common law. The duality of nature and culture and the helplessness of legal norms in the face of biological truths dates back at least from the 1889 writings of Sir Patrick Geddes and John Arthur Thomson, who argued for the withholding of political rights from women based on their evident biological inferiority. As they explained, in defending the ban of women

Wilkinson J. also found the petitioner’s *Charter* claim flawed because it failed to take into account the ‘definite article’ issue raised by courts in Ontario, instead basing its weight merely upon the “alleged discriminatory effect of the presumption of paternity arising from cohabitation.”⁶³ By the court’s reasoning, then, because the petitioner did not challenge the statutory assumption that precludes recognition of more than one mother or one father, she relied upon a flawed analysis of available status and parentage declarations under the *Act*. As such the issue was not one of impermissible discrimination, because a woman can never be a male progenitor, and social ties are no substitute for ‘biological truth’. Rather, for the court, the issue depended not on whether a co-mother can enjoy a parental presumption (she has no ‘seed’ and evidently cannot), but whether a finding of more than one female parent is *even possible*.

According to the court, a proper constitutional challenge should have been framed in relation to “the prohibition against making declaratory orders in favour of *multiple* parents (whether mothers or fathers), rather than the narrower objection to the presumption of paternity in favour of male cohabitants”.⁶⁴ It is irrelevant that this matter was in fact *not* about the petition of multiple parents, but the recognition of a cohabiting lesbian relationship with the same presumptions that a heterosexual union would have enjoyed. Instead the court’s reasoning maintains the ghostly presence of a father at all costs and *despite the presence of an existing co-parent*, by refusing to foreclose the possibility of a biological progenitor one day emerging to claim his natural rights.

from enfranchisement to vote: “what was decided among the prehistoric Protozoa cannot be annulled by Act of Parliament.” One hundred and sixteen years later, this phrase is quite remarkably echoed by the Court of Queen’s Bench of Saskatchewan. *Infra* note 85.

⁶³ *C.(P.) v. L.(S.)*, *supra* note 48 at para 24.

⁶⁴ *Ibid* at para 15.

In this ruling Wilkinson J. deploys both biological *and* social reasoning, coming to rest ultimately on the germinative authority of the male progenitor. He carefully acknowledges that biology is by no means the only determining factor in awarding parental rights, even as he rushes to reinstate the presumptions of paternity as natural fact. An elemental vision of male biology, blood and nature cements this logic, wherein the primacy of the genetic wellspring – the ‘seed’ – soundly trumps a lesbian mother’s social claims to parental relation. This is a resolutely heterosexual model of biological parentage, wherein no family is complete without the primary contribution of the patriarch; it also echoes Biblical scripture that traces family lines to the male progenitor, with women merely providing an incubator for the vital ejaculate of life.

In sum, even though the petitioner’s presumption of parentage had not been rebutted in this case, and there was no evidence of any other party’s interest in claiming parental rights, the absent figure of the patriarch won out. The fluidity of social versus genetic parenting is here strategically employed in the service of fatherhood (and used to deflect competing claims), as an operation to protect the institution of the traditional family. Yet while this ruling indeed bent over backwards to ‘find a father,’⁶⁵ such efforts were ultimately aimed at reinstating and securing a naturalized vision of the heterosexual nuclear family. Melanie Jacobs has made a similar point in the U.S. context, where, as she describes: “The commonality between the biological and social paternity approaches is preservation of the unitary, nuclear family: a family predicated on a two-parent paradigm consisting of one mother and one father.”⁶⁶

Ironically, this labour in service of a heterosexist ideal also works to reveal the machismo inherent within the paternity presumption itself. Here the presumption clearly rests not upon a

⁶⁵ Kelly, *supra* note 40 at 351.

⁶⁶ Melanie B. Jacobs, “My Two Dads: Disaggregating Biological and Social Paternity” (2006) 38 *Ariz. St. L.J.* 809 at 7.

legitimate social tie or concern for the constitutional rights of the petitioner, although both were contemplated by the court. Rather, the force of the presumption is invested wholly in patriarchal tradition, with a woman unable to assume the ideological space of fatherhood regardless of her functional family role. Had the petitioner been *male* and a non-biological parent, she would have smoothly assumed parental rights under s. 45(1)(a) of the *Act*. In the absence of a rebuttal, such as with the instant case, the presumption would have been uncontrovertibly hers. Within the singular vision of Justice Wilkinson's court, the only thing able to trump one man's seed is another man's claim to the household, a *reductio ad absurdum* wherein sociality, affective ties and care are boiled down to a manly struggle over the domestic fruits of the home.

Analyzing Biological Facts and Social Relations

In order to more productively interrogate this dynamic it may be helpful to focus on the move to privilege biological 'facts' over social ties, which in the case of *C.(P.) v. L.(S.)*, effectively reinscribed the primacy of (heterosexual) genetic affiliation in constructing the family. Legal determinations depend upon the ideology of normative constructions of family, which are themselves generated through a particularized social recognition of relationships.⁶⁷ In Canada, as has been discussed, this involves the privileging of both biology *and* adult sexual affiliation in constructing relatedness.⁶⁸ Yet despite the broadening recognition of social forms of parentage, and their regular application in the service of such ends as finding fathers for children,⁶⁹ the importance of blood runs deep. Shared genetics remains a powerful basis for awarding legal kinship, for as Angela Campbell argues, "'blood'-based connections continue to

⁶⁷ Mykitiuk, *supra* note 33 at 773.

⁶⁸ *Ibid.*

⁶⁹ Note that the *Michael M.* case discussed above opted to prioritize the marriage bond over the biological tie. The married heterosexual couple was viewed as the proper "traditional family" and the structure in need of legal and societal buttress, while Michael's claim to genetic affiliation was dismissed. In *supra* note 43.

undergird judicial analyses: the presence or absence of a biological link with a child might still wield considerable impact on whether parental status, responsibilities or rights are recognized.”⁷⁰

This dissertation is interested in the way that ‘the family’ as channeled through blood and the heterosexual order continues to hold normative sway upon law and culture, despite the dizzying multiplication of new forms of kinship and its challenge to binary ontological and epistemic formulations. It is concerned not with the patriarchal rush to find fathers at all costs, as has been explored by Kelly and others,⁷¹ but with the underlying baseline of heteronormativity upon which such an impulse depends. It seeks to explore the models of nature and ‘natural’ forms of family that continue to mark the essentialist logics of biological reproductivity, even as such mechanics take place in the very ‘unnatural’ realms of assisted reproduction.

As the lens through which to view these complex ruptures and sutures, this project focuses on the experience of queer families within a heterosexual matrix. For example in *C.(P.) v. L.(S.)* the matter was not one of assisted reproduction, but of conception achieved through male-female sexual intercourse. Yet the ruling did *not* look to competing parental claims when a child has been conceived through sex with someone other than a cohabiting spouse (of which there are many).⁷² Instead, Wilkinson J. turned to the language of AHR to frame the claims to

⁷⁰ Campbell, *supra* note 32 at 259.

⁷¹ Susan Boyd and Hester Lessard have also made very useful contributions in this area. *See*: Hester Lessard, “Mothers, Fathers, and Naming: Reflections on the Law Equality Framework and *Trociuk v. British Columbia (Attorney General)*” (2004) 16 C.J.W.L. 165; Susan B. Boyd, “Gendering Legal Parenthood: Bio-Genetic Ties, Intentionality and Responsibility” (2007) Windsor Yearbook of Access to Justice 25.

⁷² The constitutional implications of an irrebuttable presumption of paternity have already been discussed in a U.S. context in regard to *Michael H. v. Gerald D.* *supra* note 43. Similarly, in *Bodwell v. Brooks*, 141 N.H. 508 (1996), there was a contest between a mother and her husband on one hand, and the biological father on the other. The trial court ruled that the paternity of the custodial non-biological father had been terminated when the paternity of the biological father was ascertained. Upon appeal, this holding was reversed and the case remanded for further proceedings based on the best interests of the child. The court tread delicately in balancing these competing paternity rights, emphasizing that by including the custodial father in the proceedings “we do not wish to exclude the biological father from the custody determination, but merely to permit inclusion of the stepfather who has acted, in this case, as a longtime caretaker and the child's psychological parent.” At *para* 514. Within a Canadian context the balance between the responsibilities of a biological parent and custodial parent was resolved in *Chartier*, which

parentage demanded by the lesbian non-biological mother. C.(P.)’s queer claim to ‘lesbian fatherhood’ so disrupted the analytical frame of reproductive heterosexuality, that the primary context available to the court was the ‘unnatural’ couplings and triplings of assisted technology and the “extraordinary social issues involved”⁷³ – a conceptual rupture that was soon soothed by the biological certainty of the male ‘seed’.

The coming chapters will interrogate this complex and often paradoxical relationship between nature, heterosexuality, queer families and assisted reproduction, and the ways in which they are configured and reinscribed through law and culture. Queer families represent a fascinating combination of sociality and biology; nature and culture; traditional and disruptive; conventional and strange – a hybrid inherently-non-reproductive form of union that provides useful passage for the examination of many of the anxieties around reproductive technology.⁷⁴

overturned a case in which the custodial relation was not seen as legally binding (*Carignan*) and approved a decision in which it was (*Thériault*). *Chartier* found that a person could not unilaterally withdraw from a relationship in which he or she stood in place of a parent. The determination of whether or not one did, in fact, stand in place of a parent, was determined to rest on the objective nature of the relationship between the adult and the child. As Harder and Thomarat have argued, however, this determination has less to do with biological or social ties, than an orientation toward financial support obligations. As they explain, “the Supreme Court has interpreted the Divorce Act to enable more than two people to have parent-like standing. Importantly, this openness to parental pluralism is strictly limited to a post-spousal relationship and is most likely to occur when a non-custodial biological parent lacks the resources to provide adequate support to the child. Ultimately, the designation of ‘standing in place of a parent’ is centrally focused on financial support.” Harder and Thomarat *supra* note 37 at 12. See also: *Carignan v. Carignan* 1989 CanLII 180 (MB C.A.); *Thériault v. Thériault* 1994 Can LII 5255 (AB C.A.); *Chartier v. Chartier*, [1999] 1 S.C.R. 242.

⁷³ *C.(P.) v. L.(S.)*, *supra* note 58.

⁷⁴ In calling these forms of family ‘hybrid’ in function, the intention is to draw attention to the contradictory terms evoked on one hand by ‘the family,’ and on the other by ‘the queer’. The queer family is in some respects an oxymoron, resting ambivalently at the crux of theoretical and material developments in reproductive technology. The reference to hybridity is intentionally designed to call this peculiar ambivalence into relief, rather than to create a new taxonomy through the mixture of pure forms. Bruno Latour’s evaluation of critical analysis is here instructive:

“Critical explanation always began from the poles and headed toward the middle, which was first the separation point and then the conjunction point for opposing resources. . . In this way the middle was simultaneously maintained and abolished, recognised and denied, specified and silenced. . . How? . . . By conceiving every hybrid as a mixture of two pure forms.” Bruno Latour, *We Have Never Been Modern* (trans. C. Porter) (Harvester Wheatsheaf: Hemel Hempstead, 1993) at 77-78.

It may thus be helpful to begin with the overdetermined question of biology, and ask upon what precisely the natural tie depends. It appears to take form, at least in *C.(P.) v. L.(S.)*, as genetic reification, dependent upon a view of ‘nature’ that reflects a strictly heterosexual mode of coitus and reproduction. It seems to require adherence to a nature/culture divide that assumes the former is primal and universal, rooted in some pre-cultural mode upon which humans have gamely erected our civilizations. How might one then question this duality and understand the actualization of such discursive forms in Canadian case law? It proves no simple task to unravel these genealogies. As Raymond Williams has argued, “*Nature* is perhaps the most complex word in the [English] language” and “any full history of the uses of nature would be a history of a large part of human thought.”⁷⁵

Chapter Three will survey the emergence of the nature/culture critique as it developed out of Marxist analysis, and the influence it has held upon central strands of feminist thought. From these histories, and in step with the spread of postmodern insights across the humanities, a rich and complex body of literature has been generated. In order to address the complexities of assisted reproductive technologies, it will be helpful to first canvass the intersections between materialist feminist analysis, kinship studies, science and technology studies and queer theory. These are the foundational scholarships upon which the rest of this project depends.

⁷⁵ Raymond Williams, *Keywords: A Vocabulary of Culture and Society* (Oxford: Oxford University Press, 1976 at 219-221. Quoted *ibid* at 54.

Chapter Three: Nature and Culture in Critical Theory

Introduction

While the nexus between new kinship studies and science and technology studies has been well explored, as well as the relationship between materialist (or corporeal) feminism and kinship studies, the intersection of these knowledges with queer theory remains underdeveloped.⁷⁶ Critical legal theory, for its part, has occasionally looked to new kinship studies as well as various forms of feminist materialist and feminist science studies for inspiration. Yet even these projects have been seldom: feminist legal theory in Canada, for example, has often sidestepped foundational ontological questions of reproduction and affiliation in a preference for the pursuit of normative solutions.⁷⁷ When queer theory has made an appearance in analyzing reproductive technology it has been partial, although certainly queer legal scholars have taken up other questions of sexual citizenship, power and privilege within the Canadian context.⁷⁸

⁷⁶ Laura Mamo is the scholar who has most actively sought to bring queer theory into productive conversation with medical anthropology, reproductive technology and its engagement with new kinship and feminist science studies. Her work has been very influential on my own. Laura Mamo, *Queering Reproduction: Achieving Pregnancy in the Age of Technoscience*, (Durham, NC: Duke University Press, 2007).

⁷⁷ Roxanne Mykitiuk's work on AHR represents a major exception here, with its capacity to simultaneously pursue dense theoretical analysis, normative questions and concerns for social justice. For other work in this vein see also Maneesha Deckha "Legislating Respect: A Pro-Choice Feminist Analysis of Embryo Research Restrictions in Canada" (2012) McGill Law Journal 58(1) and Susan Drummond "Fruitful Diversity: Revisiting the Enforceability of Gestational Carriage Contracts" (2013) Osgoode CLPE Research Paper No. 25.

⁷⁸ For an example of queer theory brought directly to bear on questions of AHR see: Angela Cameron, "Regulating the Queer Family: The Assisted Human Reproduction Act" (2008), 24 Canadian Journal of Family Law 101. For a non-exhaustive list of Canadian scholars working in the field of queer legal theory, see for example: Brenda Cossman "Sexuality, Queer Theory, and Feminism After: Reading and Rereading the Sexual Subject" (2004) 49 McGill LJ 847; Elaine Craig "Laws of Desire: The Political Morality of Public Sex" (2009) 54 McGill Law Journal 3; Ummni Khan, *Vicarious Kinks: S/m in the Socio-Legal Imaginary* (University of Toronto Press: Toronto, 2014); Kathleen Lahey, *Are We 'Persons' Yet? Law and Sexuality in Canada* (Toronto: University of Toronto Press, 1999); Bruce MacDougall, *Queer Judgments: Homosexuality, Expression and the Courts in Canada* (Toronto: University of Toronto Press, 2000); Bruce Ryder "The Little Sisters Case, Administrative Censorship and Obscenity Law" (2001) Osgoode Hall Law Journal 39(1); Carl Stychin, *Governing Sexuality* (Hart Publishing: Oxford and Portland Oregon, 2003).

The approach offered by this dissertation, however, is novel. It draws upon well-founded theoretical relationships on AHR forged between kinship studies, materialist feminisms and science and technology studies, and weaves through queer theory insights on intimacy, heteronormativity and “regimes of the normal”.⁷⁹ It then brings this theoretical assemblage into conversation with critical legal theory in order to explore a body of empirical data gathered on the lived reality of LGBTQ families. These diverse theoretical strands are united in a concern for interrogating the Enlightenment binaries of nature/culture and biology/sociality, as well as an interest in how intimate material worlds are embedded within and shaped by the workings of power and knowledge. The framework of ‘the natural’ has profoundly shaped queer engagements with reproductive technology and law, and this chapter will spend some time exploring this discursive field.

The chapter begins with an overview of feminist critiques of the nature/culture divide and the role of Marxist thought in challenging biological determinism. It then moves to Marxist feminism and the ways in which ideas of the ‘natural’ have also worked to buttress the sex/gender divide. Science and technology studies is taken up in turn, with its deep analysis of nature and culture, before moving on to materialist feminism and the new kinship studies. There is then a sustained examination of queer theory and in particular the debates over its figuration of reproductive bodies. The chapter concludes with an examination of critical legal thought around nature and culture and the development of a queer legal theory.

⁷⁹ This term is taken from Michael Warner at *infra* note 145.

Feminist Critiques of the Nature/Culture Divide

Biological Determinism

Feminism looms large across this interdisciplinary assemblage. While critiques of the nature/culture dualism have emerged from a variety of scholarly traditions, perhaps the most sustained and rigorous critique has been developed by a succession of feminist thinkers.⁸⁰

If we look at feminist theory from Beauvoir to Butler, a diverse landscape appears. But a common denominator is the fight against biological determinism and its naturalization and normalization of essential links between biological sex, sexuality, reproductive capacities, gendered subjectivity and hierarchical gender systems. The history of feminist theorizing is in many ways shaped by the project of de-naturalizing the conceptual frameworks of biological determinism.⁸¹

A classical position on biological determinism is offered by Sir Patrick Geddes and John Arthur Thomson who, in 1889, argued that the social, psychological and behavioural traits of men and women were caused by metabolic states.⁸² According to this view, women conserve energy (being ‘anabolic’), which makes them passive, conservative, sluggish, stable and uninterested in politics; while men expend their surplus energy (being ‘katabolic’), which renders them eager, energetic, passionate, variable and, thereby, interested in political and social

⁸⁰ Critical geographers might arrive a close second in this intellectual footrace. Notable works in this disciplinary tradition include Marxist geographers such as David Harvey’s early writing, and explorations of American capitalism by William Cronon. Other influential scholarship includes the wonderful *Hybrid Geographies* by Sarah Whatmore as well as Noel Castree’s *Nature*, and Kate Soper’s classic *What is Nature?* See for example: David Harvey “Population, resources and the ideology of science” (1974) *Economic Geography* 50, 256–77; William Cronon, *Nature’s Metropolis: Chicago and the Great West* (W.W. Norton: New York, 1992); Noel Castree, *Nature: The Adventures of a Concept* (Routledge: London, 2005); Kate Soper, *What is Nature? Culture, Politics and the non-Human*. (Blackwell: London and Cambridge, 1995); Sarah Whatmore, “*Hybrid Geographies. Natures, Cultures and Spaces*” (Sage: London, 2002).

⁸¹ Nina Lykke “Are Cyborgs Queer? Biological Determinism and Feminist Theory in the Age of New Reproductive Technologies and Reprogenetics” (2000) Conference Paper. Available online at www.women.it/quarta/workshops/epistemo-logical4/ninalykke.htm at 1.

⁸² Sir Patrick Geddes and John Arthur Thomson, *The Evolution of Sex* (Walter Scott: London, 1989) quoted in Mari Mikkola (2012) “Feminist Perspectives on Sex and Gender”, *The Stanford Encyclopedia of Philosophy*, Edward N. Zalta, ed. Available online at <http://plato.stanford.edu/archives/fall2012/entries/feminism-gender/>.

matters.⁸³ These biological ‘facts’ about metabolic states were used not only to explain differences in temperament between women and men, but – importantly - to justify existing social and political arrangements.⁸⁴ More specifically, they were used to argue for withholding from women the political rights accorded to men because (according to Geddes and Thompson) “what was decided among the prehistoric Protozoa cannot be annulled by Act of Parliament.”⁸⁵

While authors like Simone de Beauvoir and Virginia Woolf vigorously questioned the subjugation of women in the decades to come,⁸⁶ it was not until the 1970s, drawing upon Marxist critiques of the human transformation of nature to meet the ideological ends of capitalism, that feminists began to challenge in earnest the role of the nature/culture divide in sustaining female oppression. Emerging in force out of Marxist labour debates regarding the nature of production, women joined in the argument that class conflict shapes the operation of technology in the workplace.⁸⁷

Role of Marxist Thought

Karl Marx provided critical insight into the process of development, arguing that technological innovation did not *produce* the engineering innovations of (for example) the Industrial Revolution; rather, it was the political and economic climate of the time that gave rise to the conditions to bring such elements into production. The division of labour and certain forms

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ *Ibid.* Quote from Toril Moi, *What is a Woman? And Other Essays* (New York: St. Martin's Press, 1999) at 18. This 1889 quotation is a neat echo of Saskatchewan Court of Queen's Bench Justice Wilkinson and the 2005 determination in *C.(P.) v. L.(S.)* that a woman's parental rights claim must wither under the biological supremacy of the male seed: “The Court cannot aspire to affect the fundamentals of biology that underlie the [paternity] presumption purely in the interests of equal treatment before the law.” What *nature* has created, *culture* cannot touch. See also *supra* note 64.

⁸⁶ For example, Simone de Beauvoir famously claimed that one is not born, but rather *becomes* a woman, and that “social discrimination produces in women moral and intellectual effects so profound that they appear to be caused by nature.” Simone de Beauvoir, *The Second Sex* (Penguin: Harmondsworth, 1972 [original 1949]) at 18.

⁸⁷ Judy Wajcman “Reflections on Gender and Technology Studies: In What State is the Art?” (2000) *Social Studies of Science* 30(3).

of commodity fetishization created a social environment in which new machines could be produced. In other words, it was not the whiz-kid visionary who dreamt the future, but an evolutionary process of capital and accumulation; not the genius of Thomas Edison and Alexander Graham Bell, but labour as the driving engine, as “Labour is, in the first place, a process in which both man and Nature participate, and in which man of his own accord starts, regulates and controls the material re-actions between himself and nature.”⁸⁸

This process was dialectical. Even as the social environment gave rise to conditions in which new technological forms could be produced, humans in turn were shaped by the presence and utilization of such machinery. These tools structured the way in which humans adapted their bodies to the mechanized world, and impacted not only the human body but the next iteration of the tools themselves. As Sarah Franklin argues, for Marx, “the evolution of technology, must be understood as both inherited equipment and as the molding conditions of human existence, constantly reshaping what the human is by what it can do, in a dialectical process that extends beyond historical time into the mists of human species emergence.”⁸⁹

The relationship of humans to Nature was therefore not simply the story of man conquering the physical world. Instead Marx suggested that nature was socially ‘produced’ or constructed in a materialist sense, and described the transformation effected by human labor in reworking the raw matter of nature into material of a second, social nature.⁹⁰ In turn this second nature impacted the ways in which human used such tools, giving rise to a complex system of production and exploitation, wherein the workings of labour and capital generated a continuous

⁸⁸ Karl Marx, *Capital: A Critique of Political Economy*. Volume I: The Process of Capitalist Production, Book 1, C 7, Section 1 [1867], quoted in Sarah Franklin, *Biological Relatives: IVF, Stem Cells, and the Future of Kinship* (Durham, NC: Duke University Press, 2013) at 13.

⁸⁹ *Ibid.*

⁹⁰ *Ibid.*

mode of human adaptation, development and re-adaptation with and through the evolution of technological forms.

Marxist scholars argued that as capitalism continuously applies new technology designed to fragment and de-skill labour, so that labour becomes cheaper and subject to greater control. Technological revolution was rightly understood to be a trait of capital accumulation processes, even as it shaped the realities of the human beings who directed and were directed by technological development. This was a complex understanding of the social order and one which has been enormously influential on a range of post-Marxist thought.⁹¹ Yet feminists questioned the notion that this control and adaptation of the labour process could operate independently of the gender of the workers who were being controlled, and sought to bring a theory of sex to bear on the social relations of production.⁹²

Feminist sociological work pointed out that the division of labour characterizing paid occupations was a sexual hierarchy, and that its gendered nature was not incidental. Both employers as employers, and men as men, were shown to have an interest in creating and sustaining occupational sex-segregation. Time and time again, gender was shown to be an important factor in shaping the organization of work that resulted from technological change.⁹³

From this early form of materialist feminist analysis came a critique of not only the technologized workplace, which would mature into feminist science and technology studies, but a concern for the economic relations of the domestic sphere as well. Feminist scholars argued that Marx's vision of labour and capital had overlooked a significant aspect of human work - the unpaid labour done by women in the home. Attention to the gendered labour of social reproduction aimed special vitriol toward the designation of male-female domestic roles as

⁹¹ See for example: Herbert Marcuse, *Reason and Revolution* (New York: Oxford University Press, 1967); Gerry A. Cohen and Will Kymlicka "Human nature and social change in the Marxist conception of history" (1988) *Journal of Philosophy* 85.

⁹² Franklin, *supra* note 88 at 13.

⁹³ *Ibid* at 448-449.

rooted in ‘nature,’ and took up the relational critique of human engagement in the natural world to interrogate the cultural expectations that flowed from women’s so-called proper place among the home and family. This rejection of the ‘natural’ place of women as mother, caregiver and angel of the household allowed for the critique and contestation of all forms of female subjugation built upon (now apparently fragile) cultural norms.⁹⁴

However an important issue raised by this cultural critique of gender roles, was how to distinguish socially constructed norms from differences of a biological nature. Early work held that *gender* might be created by culture, but that *sex* rested upon an unchanging natural world that demarcated men and women into two distinct biological creations.⁹⁵ This division was itself soon challenged by feminist scholars, drawing heavily upon the work of French theorist Michel Foucault to argue for the discursive and social construction of ‘sex’ as well.

Nature/Culture; Sex/Gender

Michel Foucault on the Sexed Body

Foucault’s legacy of work drew upon the role of human institutions in constructing and disciplining social meaning, and the ways in which medical, social, legal and political discourses – as a set of knowledges and practices – are enacted on and through the human body. For Foucault, sex had no ontological status; the body only gained cultural legibility through the

⁹⁴ This rupture of the traditional family form would have tremendous impact on the field of anthropology and kinship studies, as will be seen shortly.

⁹⁵ For example the feminist theorist Gayle Rubin used the phrase ‘sex/gender system’ in order to describe “a set of arrangements by which the biological raw material of human sex and procreation is shaped by human, social intervention.” Her seminal piece on ‘The Traffic in Women’ aimed to understand how the sex/gender system turns sexual bodies into different genders, which then shoulder differently gendered norms and burdens. The dyadic form of the sex/gender system was further complicated by Rubin herself in subsequent work, when she argued that feminist theory should reconsider *sexuality* as encompassing its own dynamics of sexual oppression to more accurately reflect the separate ways in which gender and sexuality come into social existence. Gayle Rubin, “The Traffic in Women: Notes on the ‘Political Economy’ of Sex”, in *Toward an Anthropology of Women*, R. Reiter, ed., (New York: Monthly Review Press, 1975) at 165. See also Gayle Rubin, “Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality” in *Pleasure and Danger: Exploring Female Sexuality*, Carole Vance, ed., (Boston: Routledge and Kegan Paul, 1984).

techniques of power and classification applied by clinical expertise.⁹⁶ This theory was perhaps most carefully illustrated through his close reading of a memoir by a 19th century hermaphrodite.⁹⁷ Foucault demonstrated how there was in fact no ‘pre-cultural’ knowledge of the body upon which to draw; the confounding figure of the hermaphrodite demonstrated the socially contingent nature of the production of meaning, as medical experts struggled to apply sexual boundaries and taxonomies upon a body that troubled categorization. It was by foregrounding the queer figure of the hermaphrodite that Foucault was able to draw attention to the discursive production of other, apparently settled, forms of categorization, such as the boundaries which create static ideals of ‘male’ and ‘female’.

This expert work of categorization is critical for Foucault. Given that there is no pre-cultural ontological mode from which to draw, it is through the application of medical and juridical systems of knowledge that the subject is actually *produced*. Individuals are functionally created through these technologies of power, with the juridical formation that allows one to classify (for example) ‘a woman’ representing her production through discursive effects. This is not to say that the body is ephemeral, a location with no relevance – on the contrary Foucault “positions the body as the locus of productive forces, the site where the large-scale organization of power links up with local practices.”⁹⁸ The body exists, but it has no social meaning outside of

⁹⁶ Foucault developed this line of thinking through a series of tremendously influential texts. There is not space to do justice to the complexity of his work here, but a ‘greatest hits’ compilation of his work on the medico-judicial production of social meaning must include Michel Foucault, *Birth of the Clinic* (New York: Pantheon Books, 1963); Michel Foucault, *The Order of Things: An Archaeology of the Human Sciences* (New York: Vintage Books, 1970); Michel Foucault, *The Archaeology of Knowledge and the Discourse on Language*. Trans. A. M. Sheridan Smith (New York: Pantheon Books, 1972); and Michel Foucault, *Power/Knowledge: Selected Interviews and Other Writings, 1972–1977*. ed. Colin Gordon. (New York: Pantheon Books, 1980)

⁹⁷ Michel Foucault, *Herculine Barbin: Being the Recently Discovered Memoirs of a Nineteenth century French Hermaphrodite* (New York: Pantheon Books, 1980).

⁹⁸ Karen Barad, “Posthumanist Performativity: Toward an Understanding of How Matter Comes to Matter” (2003) *Signs: Journal of Women in Culture and Society* 28(3) at 809.

regimes of knowledge and power. As Foucault explains in the final chapter of *The History of Sexuality (Vol. 1)*, his aim is certainly not to deny the physical body, but rather to:

...show how the deployments of power are directly connected to the body—to bodies, functions, physiological processes, sensations, and pleasures; far from the body having to be effaced, what is needed is to make it visible through an analysis in which the biological and the historical are not consecutive to one another . . . but are bound together in an increasingly complex fashion in accordance with the development of the modern technologies of power that take life as their objective. Hence, I do not envision a “history of mentalities” that would take account of bodies only through the manner in which they have been perceived and given meaning and value; but a “history of bodies” and the manner in which what is most material and most vital in them has been invested.⁹⁹

Judith Butler on the Sex/Gender Divide

Judith Butler has taken up these Foucauldian insights and applied them to a particular concern for the biological determinism of the sex/gender divide. Butler has famously suggested that the (hetero)sexed body does not take shape either naturally or through biology, but is performed through the iteration and repetition of gender norms.¹⁰⁰ Butler is concerned with how the body (and thereby the experience of that body) is *embodied* through its participation in society, and argues that categories such as ‘woman’ or ‘lesbian’ cannot exist prior to their specific cultural formation.¹⁰¹ She denies either sex or gender a material ‘reality’ and maintains that such taxonomies are discursively constructed according to available social categories.¹⁰² Thus for Butler, both sex *and* gender are socially constructed:

⁹⁹ Michel Foucault, *The History of Sexuality. Vol. 1. An Introduction*. Trans. Robert Hurley. (New York: Vintage Books, 1980) at 151–52.

¹⁰⁰ Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990) [*Gender Trouble*]. Butler is not arguing, of course, that the body itself does not have a material form, but that prior to the inscription of discursive norms upon the body it cannot become legible in society and therefore does not ‘exist’ in any substantial way. The natal assignment of binary sex/gender is thereby a central tool in establishing the polarities of heteronormativity; genital ambiguities are ‘corrected’ in the West because they threaten not the infant’s life but the culture the infant is born into. See also: Judith Butler, *Bodies That Matter: On the Discursive Limits of “Sex”* (New York: Routledge, 1993) [*Bodies That Matter*].

¹⁰¹ Butler, *Gender Trouble*.

¹⁰² *Ibid.*

If the immutable character of sex is contested, perhaps this construct called 'sex' is as culturally constructed as gender; indeed, perhaps it was always already gender, with the consequence that the distinction between sex and gender turns out to be no distinction at all.¹⁰³

Under this logic our sexed bodies have no ontological status before they are brought into being through the various acts which constitute their reality – the first and primary being language. For Butler, sex assignment is constituted through a Foucauldian set of disciplinary practices and the discursive power of medical expertise. When a doctor looks between the legs of a newly delivered baby and cries out, “It’s a girl!” this represents not a *descriptive* claim but a *normative* one. As Butler argues, this speech act is what, quite literally, makes infants into girls (or boys): the child’s sexual identity is immediately congealed into one of two available options, by defining and naturalizing the appropriate gender performance this child is expected to pursue over the course of her life.¹⁰⁴ As Butler describes: “The naming is at once the setting of a boundary, and also the repeated inculcation of a norm.”¹⁰⁵ Sexed bodies are not to be understood as the objective stuff of nature, but as the discursive and repetitive performance of a set of subjective social categories.

The work of Foucault and Butler has provided scholars with a set of tools to understand how the body has acquired the appearance of a natural, stable, unitary individual with a fixed form and identity. By interrogating the “disciplinary gaze” of medical and legal professionals, Foucault developed a complex understanding of medico-juridical knowledge that permits analysis of the normative work performed by social and cultural regulation. These insights have deeply impacted critical scholarship across the wide-ranging disciplines at the heart of this project: feminist theory, anthropology, science and technology studies and queer theory.

¹⁰³ *Ibid* at 10–11.

¹⁰⁴ Butler, *Bodies That Matter*.

¹⁰⁵ *Ibid* at 8.

An important strand of feminist thought has taken up this Marxist-Foucauldian-Butlerian thread to ask difficult questions of materiality and subjectivity, but more precisely in relation to technology and the operations of scientific knowledge. This feminist approach to what is broadly termed science and technology studies offers another useful perspective on the bedrock of the ‘natural’.

Science and Technology Studies and the Natural World

The tools of postmodern and post-structuralist deconstruction have proved especially adept to question the naturalized and gendered basis for culture and the social order in an era of scientific rationale. Following from Marxist analyses of the relationships between human labour, capital and technology, scholars such as Bruno Latour have explored the role of technology in creating the social order. Indeed for Latour, the fabricated world exists “not as mere retro-projection of human labour onto an object” but as a “sturdier, much more reflexive coproduction richly invested within a collective practice.”¹⁰⁶ Thus the very binary between nature and culture dissolves into a more complex entanglement between production, human labour and embodiment. Rather than thinking of nature as a location ‘out there’ from which we might break from ‘society’, frameworks such as Latour’s call attention to the ways in which nature and culture exist only in and through each other. It demands an upheaval of binary forms in order to re-think “the intimate, sensible and hectic bonds through which people and plants; devices and creatures; documents and elements take and hold their shape in relation to each other in the fabric-ations of everyday life.”¹⁰⁷

¹⁰⁶ Bruno Latour, *Pandora’s Hope: Essays on the Reality of Science Studies* (Cambridge, MA; London, UK: Harvard University Press, 1999) at 273, quoted in Whatmore, *Hybrid Geographies* at 3, *supra* note 80.

¹⁰⁷ Whatmore, *ibid.*

Feminist scholars have also sought to deconstruct the nature/culture binary, with Donna Haraway's work being perhaps the leading contribution to this field. Haraway's framework of "naturecultures" – a cultural theory that intentionally avoids privileging the side of culture in thinking through these dualities¹⁰⁸ - is exemplary in aiming to contest the oppositional framing between nature and culture, matter and mind, the human and the inhuman. Instead, it seeks to understand how these dualities are produced through action itself. As Haraway observes:

...in the West nature has been the key operator in foundational, grounding discourses for a very long time.... [N]ature is the zone of constraints, of the given, and of matter as resource; nature is the necessary raw material for human action, the field for the imposition of choice, and the corollary of mind. Nature has also served as the model for human action; nature has been a potent ground for moral discourse.¹⁰⁹

Nature as the raw stuff of matter has played a critical foundation in Western epistemologies, as the vital corollary to the civilizing work of human thought and action. Yet as Haraway goes on to explain: "If the world exists for us as "nature", this designates a kind of relationship, an achievement among many actors, not all of them human, not all of them organic, not all of them technological."¹¹⁰ Technology for Haraway, as with Marx, is not an inert set of tools to which we may apply for instrumental ends, but a relational system of constructed meaning. In her work, Haraway calls describes how technology is not a blank screen that may be unproblematically inscribed with new subjectivities and identities, but rather a value-laden arena of contestation that is constantly under negotiation and re-negotiation. As she famously pronounced: "Technology is not neutral. We're inside of what we make, and it's inside of us.

¹⁰⁸ Donna Haraway, *The Companion Species Manifesto: Dogs, People, and Significant Otherness* (Chicago: Prickly Paradigm Press, 2003).

¹⁰⁹ Donna Haraway, *Modest-Witness, Second-Millennium: Femaleman Meets Oncomouse: Feminism and Technoscience* (New York: Routledge, 1996) at 102.

¹¹⁰ Donna Haraway, "The Promises of Monsters: A Regenerative Politics for Inappropriate/d Others" in Lawrence Grossberg, Cary Nelson, Paula A. Treichler, eds., *Cultural Studies* (New York: Routledge, 1992) at 287.

We're living in a world of connections - and it matters which ones get made and unmade.”¹¹¹
Thus technologies do not simply act as robotic adjuncts to hectic modern lives; instead Haraway proposes that we live during an era in which technological expertise increasingly shapes the very possibilities for being human.¹¹²

Materiality of Western Binaries

These human forms are material, and carry deeply inscribed cultural, gendered and sexed meanings. The materialist ramifications of the conceptual dualities of Western science have been the subject of sustained feminist interrogation, both within feminist science studies and related branches of theory. For example, Sandra Harding has located pervasive discourses of masculinity and femininity in the construction of scientific reason and logic, explaining how the construction of scientific rationale coalesced around the masculine, the modern, the exceptional Western intellect aimed at achieving mastery of nature itself.¹¹³ At the same time, according to Harding, Western modernity remains “haunted by anxieties about the feminine and the primitive, both of which are associated with the traditional.”¹¹⁴

Harding’s work thus belongs to a feminist tradition that aims to theorize beyond the problematic binaries of culture/nature, mind/body, sex/gender and reason/passion, not least

¹¹¹ Donna Haraway quoted in an interview with Hari Kunzru, “You are Cyborg” (1997) *Wired*, Issue 5.02.

¹¹² A range of works on biotechnology and reproduction have drawn directly from Haraway’s thinking around hybridity and cyborg bodies to better understand the subjectivating modalities of (for example) IVF, clinically-aided reproduction and embryo creation. See for example: R. Davis-Floyd & J. Dumit, eds. *Cyborg Babies: From Techno-Sex to Techno-Tots* (New York: Routledge, 1998); Susi Geiger “On Becoming a Cyborg and Paying for It: Invocations of Motherhood in the IVF Industry,” (2006) *Advertising & Society Review*; Sarah Franklin “The Cyborg Embryo” (2006) *Theory, Culture & Society*, 23(7-8).

¹¹³ Sandra Harding, *Sciences From Below: Feminism, Postcolonialities, and Modernities*, (Chapel Hill, NC: Duke University Press, 2008) at 1.

¹¹⁴ *Ibid.*

because these binaries have historically led to the association of men with the privileged terms (culture, mind, reason) and women with the devalued (nature, body, passion).¹¹⁵

These dualities remain deeply ingrained within Western forms of knowledge, even as a suspicion of truth claims and scientific rationales of fixity and immutability have given feminist scholars room to contest the binary divide. As Haraway has suggested, in relation to feminist science studies, the theories of social construction offer a “strong tool for deconstructing the truth claims of hostile science by showing the radical historical specificity and so contestability of *every* layer of the onion of scientific and technological constructions”.¹¹⁶

Corporeal Feminism

Yet the postmodern dissolution of epistemological certainty had led to its own concerns, due to the difficulty of recovering an objective stance following the assertion that all knowledge is contingent, partial and relative. On the one hand, feminist scholars have sought to dissolve nature/culture and object/subject dualisms so as to insist that all knowledge is essentially socially situated. On the other hand, many scholars have also longed for a strong notion of objectivity on which to base their claims about the reality of women’s oppression in male-dominated societies.¹¹⁷ Haraway has referred to these conflicting desires as a variety of “epistemological electro-shock therapy, which...lays us out...with self-induced multiple personality disorder.”¹¹⁸ As a response, Harding and others have articulated a kind of neo-materialism, an attempt to give special attention to bodies as the site and locus of power and knowledge. As Rosi Braidotti has

¹¹⁵ Rick Dolphijn & Iris van der Tuin, *New Materialism: Interviews & Cartographies* (University of Michigan Library: Ann Arbor, 2012).

¹¹⁶ Donna Haraway, *Simians, Cyborgs, and Women: The Reinvention of Nature*. (New York: Routledge, 1991) at 186. Emphasis in the original.

¹¹⁷ Franklin Ginn and David Demeritt, “Nature: A Contested Concept” in Nicholas Clifford, Sarah Holloway, Stephen P. Rice, Gill Valentine, eds., *Key Concepts in Geography*. (London: Sage, 2009) at 305.

¹¹⁸ Haraway, *supra* note 116 at 186.

framed this project, it is an attempt to provide “a more radical sense of materialism” by framing it as “[r]ethinking the embodied structure of human subjectivity after Foucault”.¹¹⁹

The corporeal feminism of Elizabeth Grosz, for example, has sought to understand the sexed body as it is lived and experienced *in time*, arguing that the body is not a brute, passive, or inert object merely inscribed by social forces, but rather that it is actually created through the durational operation of social systems of representation, meaning, and signification.¹²⁰ By adopting such an approach, the body may be seen as central site for feminist inquiry – the key to understanding women’s experience in a gendered social world. As Grosz puts it, for corporeal feminists, “the body can be seen as the crucial term, the site of contestation, in a series of economic, political, sexual and intellectual struggles.”¹²¹

Such a feminist approach also materializes as methodology, and in a form that deeply influences the investigative approach of this dissertation. For example, Harding has articulated the goal of feminist science studies as seeking a variety of ends in relation to the culture of the sciences, in providing “systemic empirical accounts of gender politics, in this case in the institutions, practices and cultures of nature and the social sciences.”¹²² This dissertation seeks to apply Harding’s call for a systemic empirical account of a certain instantiation of gender politics, by understanding the interface of gender, sexuality, law and reproduction as it takes place within the technologically-mediated space of the clinic.

¹¹⁹ Rosi Braidotti, *Metamorphoses: Towards a Materialist Theory of Becoming* (Cambridge: Polity Press, 2002) at 158.

¹²⁰ Elizabeth Grosz, *Volatile Bodies: Toward a Corporeal Feminism* (Bloomington: Indiana University Press, 1994).

¹²¹ *Ibid* at 19.

¹²² To this list one might wish to add law, and an epistemic account of the ways in which gender and sexuality take both abject and normative form. Harding, *supra* note 113 at 125.

In the realm of reproductive technology in particular, the disavowal of ‘nature’ (wherein technological innovation, rational modernity and intention rule) often occurs directly alongside a conscious reinscription of the ‘natural’ links between biology and kinship (wherein ideal families are genetically and gestationally related). This contradictory double move is made possible by a fascinating multi-faceted engagement with the institutions of law, medicine and family, and its interrogation will form a central part of this dissertation. To understand the workings behind such a move, however, two more theoretical strands remain vital. The first involves kinship studies and its robust analysis of the sociological impact of new reproductive technologies.

The New Kinship Theory

The ‘multiple personality disorder’ that Haraway diagnosed has been especially pronounced in regard to kinship studies and the analysis of new reproductive technologies. As Sarah Franklin and Susan McKinnon argue, it was precisely the toppling of a universal category of ‘nature’ which led to a renewed interest in kinship studies and the critique of notions of biological relatedness.¹²³ This history is usually launched by Schneider’s critique of kinship in the field of social anthropology, which challenged the export of a naturalized version of Euro-American family onto non-Western social forms.¹²⁴ Schneider argued that the axioms that were the foundation of the study of kinship were, in fact, insupportable in the context of all cultures; he argued, therefore, that the only basis on which kinship studies could proceed was to take kinship as an empirical question, not as a universal fact.¹²⁵ Thus, Schneider’s *A Critique of the Study of Kinship* offered an approach to studying kinship that did not rely upon assumptions

¹²³ Sarah Franklin & Susan McKinnon, “Introduction” in *Relative Values: Reconfiguring Kinship Studies*, Sarah Franklin & Susan McKinnon, eds., (Durham: Duke University Press, 2001). See also Janet Carsten, *After Kinship* (Cambridge: University Press, 2004); Robert Parkin & Linda Stone, eds. *Kinship and family: an anthropological reader* (Oxford: Blackwell, 2004); and Jeanette Edwards’ *Born and Bred: Idioms of Kinship and New Reproductive Technologies in England* (Oxford: University Press, 2000) for examples of the new kinship studies.

¹²⁴ David Schneider, *A Critique of the Study of Kinship* (Ann Arbor, Michigan: University of Michigan Press, 1984)

¹²⁵ *Ibid.* see also: Katrina Hargreaves, “Constructing families and kinship through donor insemination” (2006) *Sociology of Health and Illness* 28(3): 261-283.

about appropriate gender roles, heterosexuality or the marriage bond, marking an important turning point in Euro-American kinship studies.

Questioning of 'Nature'

This questioning of the 'nature' upon which kinship was thought to be universally grounded led to deep reflection in the field upon the cultural origins of meaning, in step with similar turns towards linguistics and semiotics in the humanities. Kinship was now to be understood as uncertain, flexible, provisional and relationally sited.¹²⁶ Thus by the 1990s the idea of 'family' had developed within kinship studies into a subjective and relational concept that empirically reflected intimate connections, rather than a formalist model based solely on biological or marriage ties.¹²⁷ As Kath Weston demonstrated in her classic work on gay and lesbian kinship in San Francisco, a unitary understanding of 'family' has the effect of foreclosing (for example) queer modes of affiliation, which have long reached past biology to incorporate lovers, friends and other non-biological ties to create "families we choose."¹²⁸ Thus for Weston, as for other 'new kinship' scholars, biology operates as a cultural construct rather than a self-evident "natural fact."¹²⁹

Kinship studies has devoted substantial ink to destabilizing the ties between nature and culture in regard to the construction of human relations,¹³⁰ and exploring the ways in which biology and the social (often simultaneously) reflect, reinscribe, negate, amplify, diminish and

¹²⁶ Emily Martin, *Flexible Bodies: Tracking Immunity in American Culture* (Boston: Beacon Press, 1994).

¹²⁷ For examples of this literature on family see: Jaber F. Gubrium & James A. Holstein. *What is Family?* (Mountain View, CA: Mayfield, 1990); Elizabeth Silva & Carole Smart, eds., *The New Family?* (London: Sage, 1999); Judith Stacey, *In the Name of the Family: Rethinking Family Values in a Postmodern Age* (Boston: Beacon, 1996).

¹²⁸ Kath Weston, *Families We Choose: Lesbians, Gays, Kinship* (New York: Columbia University Press, 1991).

¹²⁹ *Ibid* at 35.

¹³⁰ See for example Carsten, *supra* note 123; Janet Edwards *et al*, eds., *Technologies of Procreation: Kinship in the Age of Assisted Conception* (London and New York: Routledge, 1999). Marilyn Strathern, *After Nature: English Kinship in the Late Twentieth Century*. (Cambridge: Cambridge University Press, 1992); Sarah Franklin, *Embodied Progress: a Cultural Account of Assisted Conception*, (London and New York: Routledge, 1997); Sarah Franklin & Helena Ragona, *Reproducing Reproduction: Kinship, Power and Technological Innovation*. (Philadelphia: University of Pennsylvania Press, 1998).

disperse each other.¹³¹

Marilyn Strathern's work has been particularly instructive in this regard, showing how ideas of kinship combine genetics, social bonds and individualism to create a complex matrix of belonging and selfhood, offering humans a theory about the relationship of society to the natural world.¹³² Her scholarship has inspired much of the recent anthropological work on kinship and AHR in EuroAmerican cultures, and canvasses the central issues at the heart of this project: the social construction of scientific knowledge; articulations of gender and sexuality; and new reproductive technologies.

Kinship and New Reproductive Technologies

Strathern has achieved great intellectual traction by using the lens of new reproductive technologies to throw the imbricated structures of biology and sociality into stark relief. As she describes in one of her earliest works on AHR, such technological interventions offered an opportunity to “ponder upon how to think about experiments being conducted in a real system that is *both* a biological *and* a social one.”¹³³ By tracking the modes of AHR, Strathern illustrated the crisis posed to normative ideals of how the simple acts of “having sex, transmitting genes, giving birth” formed the very “facts of life” and thus the basis for human social relations. When this dominant model was challenged by reproductive technologies, it opened a window onto a baffling and uncertain future where Nature needed a helping hand and human families could no longer rely upon a range of suppositions about the connection between natural facts and social

¹³¹ Strathern argues that in the context of donor-assisted conception, kinship is *dispersed*. She suggests that such a dispersed kinship formation describes the existence of a group of procreators whose relationship to one another and to the child is contained in the act of conception itself and not in the family as such. See: Marilyn Strathern, “Displacing knowledge: technology and the consequences for kinship” in Faye Ginsburg & Rayna Rapp, eds., *Conceiving the New World Order: The Global Politics of Reproduction* (Berkeley: University of California, 1995).

¹³² *Ibid.*

¹³³ Marilyn Strathern, *Reproducing the Future* (New York: Routledge, 1992) at 3.

constructions.¹³⁴ As she explains:

What is in crisis here is the symbolic order, the conceptualisation of the relationship between nature and culture such that one can talk about the one through the other. Nature as a ground for meaning can no longer be taken for granted if Nature itself is regarded as having to be protected and promoted.¹³⁵

Thus the advent of new reproductive technologies has forced critical attention onto the constructed nature of biological and social reproduction alike. Via the medical, commercial and legal practices of AHR, Strathern argues that both biology and culture are ‘assisted,’ blurring the lines of the unremediated facts of life and demanding a renewed critical engagement on the relationship between the natural and the social. As Strathern puts it: “The more facilitation is given to the biological reproduction of human persons, the harder it is to think of a domain of natural facts independent of social intervention.”¹³⁶

Interface between Science and Technology Studies and New Kinship Studies

The interface between feminist science studies and new kinship studies has produced a series of broad theoretical assumptions about the operation of reproductive technologies, guided by the understanding that “technologies are socio-technical products, which are shaped by human and nonhuman factors, including the technical features of the ARTs themselves, as well as by the economic, political, cultural, and moral environs in which they unfold.”¹³⁷ This perspective tracks the development of technology alongside existing social and cultural norms, viewing the emergence of new forms of innovation as deeply culturally embedded and inextricable from the power relations through which they are produced.

Society and technology thus co-produce each other, in a mutually constitutive

¹³⁴ *Ibid* at 5.

¹³⁵ Strathern, *supra* note 130.

¹³⁶ *Ibid* at 30.

¹³⁷ Inhorn, *supra* note 2 at 178

relationship in which the technological apparatus is both a source and a consequence of the social order.¹³⁸ Thus it is impossible to understand the development of AHR in isolation from its constitutive networks of power/knowledge, as well as the surrounding cultural and social order.

This realization has paved the way for rich and complex feminist engagements with the kinships produced by new reproductive and genetic technology. For even as the terms ‘nature’ and ‘culture’ were being problematized across the social sciences by feminist thinkers from multiple disciplinary bounds, the new genetics appeared to reintroduce the importance of genetic and blood ties in both popular and scholarly forms. For example in the context of genetic testing and risk counseling, Kaja Finkler writes:

People are compelled to recognize consanguinity even when in the lived world they define family by a sense of sameness that may be grounded in friendship or sharing of affect and interest rather than in genes.¹³⁹

So it is that even as ‘the family’ is destabilized as a construct mediated through blood, it also comes to be read anew through the centrality of genetics, creating fresh metaphors for the relationality of technology to bodies and our social webs.¹⁴⁰ It is the contention of this dissertation that these new currencies of belonging and connection take up particular resonance in the context of assisted reproductive technology, and most specifically, in regard to the queer family.

¹³⁸ Aiwha Ong & Steven Collier, *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems* (Malden, MA: Blackwell, 2005).

¹³⁹ Kaja Finkler, *Experiencing the New Genetics Family and Kinship on the Medical Frontier* (Philadelphia: University of Pennsylvania Press, 2000) at 238.

¹⁴⁰ Herzfeld has argued, for example, that ‘blood’ has not waned as a kinship signifier, but has taken on refreshed meaning in the context of the modern bureaucratic nation-state. This process has involved the “transformation of familial into national terms: infused with blood, the nation is a single enormous kin group – or ‘patriline’ – defined by its common ‘birth’”. Michael Herzfeld, *The Social Production of Indifference: Exploring the Symbolic Roots of Western Bureaucracy* (New York: Bergamon, 1991) at 42.

Queer Theory

A Brief History

The work of Judith Butler, discussed above, has been of central importance in what has come to be called ‘queer theory’ in challenging the ontology of gender as well as sexual identity categories, and in tracing how subjects are brought into being through the discursive power of social regimes. Queer theory has focused sustained inquiry on how power and sexuality operate through the foundation of normative heterosexuality, with scholars writing from within a broad range of disciplinary bounds.¹⁴¹ This section will trace a brief history of queer theory, discuss the use of ‘heteronormativity’ as an operational principle, and then turn to the ways in which reproduction and children have been discussed within queer scholarship.

Beginning in the early 1990s, inspired by developments in poststructuralism and psychoanalysis; fueled by a resistance to essentialism and identity politics; and galvanized by political mobilization around the AIDS epidemic, diverse strands of activism, scholarship and sexual practice came unsteadily together under the rubric of ‘queer’.¹⁴² Strongly influenced by the work of Foucault, as well as the distaste for binary opposition put forth by continental philosophers such as Jacques Derrida, queer theory aimed to destabilize established sexual and gender binaries while calling attention to the importance of sexuality in social analysis.¹⁴³ Queer

¹⁴¹ See for example: Kate Bedford, “Loving to Straighten Out Development: Sexuality and Ethnodevelopment in the World Bank’s Ecuadorian Lending” (2005) *Feminist Legal Studies*, 13(3): 295–322; Evelyn Blackwood, “Wedding bell blues: Marriage, missing men, and matrifocal follies” (2005) *American Ethnologist* 32(1): 3-19; A. Lind and J. Share, “Queering Development: Institutionalized Heterosexuality in Development Theory, Practice and Politics in Latin America” in K. Bhavnani, J. Foran and P. Kurian, eds., *Feminist Futures: Re-imagining Women, Culture and Development* (London: Zed Books, 2003); Martin F. Manalansan, “Queer Intersections: Sexuality and Gender in Migration Studies” (2006) *International Migration Review* 40(1): 224-249; Cindy Patton, “Stealth Bombers of Desire: the Globalization of ‘Alterity’ “ in A. Cruz-Malavé & M. Manalansan, eds., *Queer Globalizations: Citizenship and the Afterlife of Colonialism* (New York: New York University Press, 2002).

¹⁴² Teresa de Lauretis, “Queer Theory: Lesbian and Gay Sexualities. An Introduction”, (1991) *Differences: a Journal of Feminist Cultural Studies* 3(2): iii-xviii.

¹⁴³ See especially Michel Foucault, *The History of Sexuality Volume 1*, *supra* note 96; Jacques Derrida, “Geschlecht:

theorists refused the dichotomous categories of homosexual and heterosexual and insisted that such labels were not only reductive but actually imposed in the service of hegemonic heterosexuality.¹⁴⁴ Thus, ‘queer’ located itself outside and beyond the borders of the straight world if not actually in direct opposition (which would, of course, generate yet another binary).¹⁴⁵

As a body of work queer scholarship has never hoped to offer a unified whole to readers; queer theory is a discipline in permanently self-conscious flux, as “queer itself can have neither a fundamental logic, nor a consistent set of characteristics”.¹⁴⁶ This self-conscious ephemerality has led more than one scholar to declaim that “queer theory is dead!”,¹⁴⁷ even as others suggest that the playing of funeral elegies might be somewhat premature.¹⁴⁸ Amidst these disciplinary skirmishes, queer has remained a carefully indefinable set of practices and (political) positions with the potential to challenge normative knowledges and identities by working from a necessarily unfixed site of engagement and contestation.¹⁴⁹ It thus seeks to function as an anti-

Sexual Difference, Ontological Difference” in Peggy Kamuf (ed.), *A Derrida Reader: Between the Blinds*. (New York: Columbia University Press, 1991); Luce Irigaray, *This Sex Which Is Not One* (Ithaca, NY: Cornell University Press, 1985); Julia Kristeva, *The Kristeva Reader*, Toril Moi, ed., (New York: Columbia University Press, 1987); Jacques Lacan, *Ecrits: Selections*, Alan Sheridan, trans. (New York: Norton, 1977).

¹⁴⁴ Eve Kosofsky Sedgwick, *Epistemology of the Closet* (Berkeley/Los Angeles: University of California Press, 1990)

¹⁴⁵ Michael Warner, “Introduction” in Michael Warner, ed., *Fear of a Queer Planet: Queer Politics and Social Theory* (Minneapolis: U of Minnesota Press, 1993).

¹⁴⁶ Annamarie Jagose, *Queer Theory: An Introduction* (New York: NYU Press, 1996).

¹⁴⁷ In a rather infamous essay in the *Chronicle of Higher Education* in 2012, Michael Warner appeared to imply that queer theory is dead, or at the very least has spun out its productive energies into other intellectual formations. His long and nostalgic elegy to queer theory referred to other retrospective works taking critical stock a good twenty years after the ‘foundational’ texts in queer theory emerged, most notably the anthology edited by Janet Halley & Andrew Parker, “Introduction” in *After Sex? On Writing since Queer Theory* (2007) 413 *South Atlantic Quarterly*, 106(3) and a special double edition of *Social Text* published in 2005 called “What’s Queer About Queer Studies Now?”. See: Michael Warner, “Queer and Then?” (2012) *Chronicle Review*.

¹⁴⁸ There were a number of impassioned responses to Warner’s pronouncement on the field of queer theory, as one might imagine. Two representative examples, both of which use temporal metaphor to claim an ongoing relevance for queer scholarship, are: Michael O’Rourke, “The Afterlives of Queer Theory” (2011) *continent*. 1.2: 102-116; and Elahe Haschemi Yekani, Eveline Kilian, and Beatrice Michaelis, eds., *Queer Futures: Reconsidering Ethics, Activism, and the Political*, (London: Ashgate, 2013).

¹⁴⁹ Nikki Sullivan, *A Critical Introduction to Queer Theory* (Melbourne: Circa Melbourne Publishing Group, 2003).

normative signifier as well as a social category.¹⁵⁰ Queer is intentionally a provisional, contingent and partial reference that may be “necessary as a term of affiliation, but it will not fully describe those it purports to represent”.¹⁵¹ By resisting the location of a proper subject or object at the center of its critique and insisting that queer has no fixed political referent, space is (ideally) opened for a flexible and multi-sited resistance to hegemonic regimes.

Again following Foucault, this subject-less approach implicates “a wide field of normalization”¹⁵² in the production of social violence, and is able to embrace a shifting and intersectional logic to explore why some subjects are rendered ‘normal’ and ‘natural’ while others are cast as ‘deviant’ and ‘perverse’. The project of queer is thus intentionally contested terrain, for “if it is to retain its ability to abrade the ‘natural’, queer must be continuously denaturalized itself”.¹⁵³

Heterosexuality and Heteronormativity

The notion of *heteronormativity* within queer theory refers not simply to *heterosexuality*, but rather describes how a single type of kinship construction – romantic, monogamous, reproductive heterosexual union – has been naturalized as the ideal form of social organization within Euro-American and other global cultures. A series of second-wave feminists provided the intellectual ground for later queer theorists, with 1970s groups like the Furies Collective, Purple September Staff and Redstockings questioning the dominance of a singular male-dominated form of social order in which women were subordinated through the heterosexual marriage bond.¹⁵⁴ Lesbians of colour like Rita Mae Brown rejected both racial and sexual oppression as

¹⁵⁰ See Manalansan, *supra* note 141.

¹⁵¹ Butler, *Bodies that Matter*, *supra* note 100 at 230.

¹⁵² See Warner, *supra* note 145 at xxvi.

¹⁵³ Donald E. Hall, *Queer theories* (Basingstoke; New York: Palgrave Macmillan, 2003) at 88.

¹⁵⁴ Redstockings Collective, *Feminist Revolution* (New York: Random House, 1975).

instantiated through patriarchal power,¹⁵⁵ while Charlotte Bunch also drew from lesbian-feminism and lesbian separatism by refusing to see heterosexuality as 'natural' and a reflection of the biological world.¹⁵⁶

As the 1980s began, Adrienne Rich published her classic article "On Compulsory Heterosexuality and Lesbian Existence," arguing that white heterosexuality actually functioned as a patriarchal tool to assure multiple forms of dominance over women.¹⁵⁷ While the decade wore on, Western scholars of colour, gay and lesbian scholars and women writing from the Global South increasingly challenged the central concern of 'gender' as the primary axis of feminism.¹⁵⁸ A complex intersectional feminism emerged that understood a shifting mode of white classist hetero-patriarchy as the hegemonic social arrangement which operated to subordinate and exclude categories of difference.

Scholars like Monique Wittig also argued against the totalizing universality wrought by heterosexual frames of knowledge, claiming that "the straight mind cannot conceive of a culture, a society where heterosexuality would not order not only all human relationships but also its very production of concepts and all the processes which escape consciousness, as well."¹⁵⁹ Heterosexuality was thus understood not only as a model of social organization, but as an

¹⁵⁵ Rita Mae Brown, *Plain Brown Rapper* (Baltimore: Diana Press, 1976).

¹⁵⁶ Charlotte Bunch, "Forum: Learning from Lesbian Separatism." (1976) *Ms.*, November.

¹⁵⁷ Adrienne Rich, "Compulsory Heterosexuality and Lesbian Existence" (1980) *Signs* 5(Summer): 631-60.

¹⁵⁸ This is a deep and rich tradition of scholarship, of which the following are only a brief selection. Cf: Patricia Hill Collins *Black Feminist Thought* (New York: Routledge, 1991); Combahee River Collective "A Black Feminist Statement." in *This Bridge Called My Back: Writings of Radical Women of Color*, Gloria Anzaldúa & Cherrie Moraga, eds., (New York: Kitchen Table Press, 1983); Angela Davis, *Woman, Race, and Class* (New York: Random House, 1981) ; bell hooks, *Feminist Theory: From Margin to Center* (Boston: South End Press, 1984); Trinh T. Minh-Ha, *Woman, Native, Other* (Bloomington: Indiana University Press, 1989); Chandra Mohanty, "Under Western Eyes: Feminist Scholarship and Colonial Discourses." (1988) *Feminist Review* 30: 61-88.; Cherrie Moraga, "From a Long Line of Vendidas: Chicanas and Feminism" in *Feminist Studies/Critical Studies*, ed. Teresa deLauretis (Bloomington: Indiana University Press, 1986); Chela Sandoval, "U.S. Third World Feminism: The Theory and Method of Oppositional Consciousness in the Postmodern World." (1991) *Genders* 10(Spring): 1-24.

¹⁵⁹ Monique Wittig, *The Straight Mind* (Boston: Beacon, 1992) at 28.

epistemic *and* political form of oppression that supported various forms of subjugation through the production of knowledge from the ‘straight mind’.

The Heterosexual Imaginary

In an early and influential piece on the “heterosexual imaginary,” Chrys Ingraham argued that heterosexuality had assumed a near-total dominance in cultural discourse, and through this dominance had prevented more complex understandings of the production of oppression and exploitation under capitalism.¹⁶⁰ Borrowing a term from Louis Althusser (which in turn had been borrowed from Jacques Lacan), Ingraham used the idea of the “imaginary” to describe how individuals create an idealized relationship to their actual conditions of existence. Althusser had used this term in reference to ideology, describing how people maintain an idealized form of the political in the face of material evidence which might otherwise contradict their position.¹⁶¹ Thus, Althusser argued, the imaginary functioned as a representation of social reality that was able to mask opposition to its normative terms.¹⁶²

Ingraham used this model to draw attention to the *heterosexual* imaginary, defining it as “that way of thinking which conceals the operation of heterosexuality in structuring gender and closes off any critical analysis of heterosexuality as an organizing institution.”¹⁶³ As a result of this depiction of reality, even within critical gender studies (the object of Ingraham’s frustration), wherein gender is understood as socially constructed and contingent, the grounding frame of heterosexuality continues to circulate as natural, unquestioned and invisible. In protest, Ingraham

¹⁶⁰ Chrys Ingraham “The heterosexual imaginary: Feminist sociology and theories of gender” (1994) *Sociological Theory* 12 (2):203-219. Ingraham was of course not the first scholar to question heterosexuality as a conceptual force. See in particular other work mentioned in this chapter, most notably Adrienne Rich’s classic piece “On Compulsory Heterosexuality and Lesbian Existence” *supra* note 157 as well as Monique Wittig, *ibid*.

¹⁶¹ Louis Althusser, *Lenin and Philosophy and Other Essays* (London: Monthly Review Press, 1971) at 52, quoted in Ingraham, *ibid* at 203.

¹⁶² *Ibid*.

¹⁶³ *Ibid*.

argued for a variety of Marxist lesbian-feminism that could understand how the workings of capitalist patriarchal societies actually depended upon institutionalized heterosexuality rather than gender subordination, with gender itself inextricably bound up with the production of heterosexuality.¹⁶⁴ As an antidote, Ingraham recommended the following set of questions to feminist scholars interested in understanding the origins of inequality:

[We] need to ask not only how heterosexuality is imbricated in knowledges, but how these knowledges are related to capitalist and patriarchal social arrangements. How does heterosexuality carry out their project both ideologically and institutionally? How do so many institutions rely on the heterosexual imaginary? Considering the rising levels of violence and prejudice in U.S. society, how are we to understand the social and ideological controls regulating sexuality? What would a critical analysis of institutionalized heterosexuality reveal about its relationship to divisions of labor and wealth, national and state interests, and the production of social and economic hierarchies of difference?¹⁶⁵

Thus Ingraham sought to argue for the institution of heterosexuality as a central axis of ideological control in society, and a necessary location from which to conduct grounded materialist analysis on inequality and the production of hierarchy. By first challenging the ‘natural’ character of the heterosexual imaginary, Ingraham believed, one can begin to ask fundamental questions about the operation of gendered, hierarchical power relations in society. This understanding of the heterosexual imaginary will prove useful in later chapters, when attention is drawn to the workings of the fertility clinic and the deeply heteronormative frames of reproductive assistance in operation.

Production of Heteronormativity in Social Life and Family

Yet normative forms of heterosexuality, like all hegemonic structures, are elastic and mobile; they will shift across time and space and achieve hegemony only through political

¹⁶⁴ *Ibid* at 204.

¹⁶⁵ *Ibid* at 212.

intervention.¹⁶⁶ Heteronormativity is not only ideology, prejudice or homophobia, but “is produced in almost every aspect of the forms and arrangements of social life: nationality, the state, and the law; commerce; medicine; education; plus the conventions and affects of narrativity, romance, and other protected spaces of culture”.¹⁶⁷ Its imposition in societal institutions and public discourse affects the most intimate aspects of daily life, sense of family and security, expressions of identity and identifications with politics and the public sphere.

While this construction generally excludes sexual and gender minorities, neither does it include all heterosexuals. Through legal, social and political mechanisms Western culture stigmatizes a range of intimate heterosexualities, including polygyny, single parenthood, childless couples, extramarital affairs and even arranged marriage. Speaking in regard to the U.S., Cathy Cohen has demonstrated how heteronormative systems of oppression function to exclude not only lesbians, but also single mothers, welfare recipients and/or women of colour from the category of acceptable ‘normal’ femininity.¹⁶⁸ This provides political leverage to an understanding of how, for example, young mothers, sex workers, disabled men, people with AIDS, widowers - all of those who fall outside the normalizing ideals of heterosexual femininity and masculinity – may be situated in relation to prevailing systems of power and knowledge.

Heteronormativity aggressively locates the ‘family’ as the key private institution and as the idealized site for support, care, and education. The importance of other relationships and communities are thereby minimized as “family and heterosexuality merge, tightening any space

¹⁶⁶ See Bedford, *supra* note 141.

¹⁶⁷ Lauren Berlant and Michael Warner. “Sex in Public” in Michael Warner, ed., *Publics and Counterpublics* (New York: Zone Books, 2002) at 194.

¹⁶⁸ Cathy J. Cohen, “Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics?” (1997) *GLQ: A Journal of Lesbian and Gay Studies*, 3(4):438 at 464.

for kinship to broaden its meaning”¹⁶⁹ while the site of biological reproduction assumes pre-eminence in structuring the social realm. This conceptual framework seeks to account for how “[e]ach heterosexual couple ‘does’ heterosexuality as much through divisions of labour and distributions of household resources as through specifically sexual and reproductive practices”.¹⁷⁰

The fixation on the heterosexual alliance of the ‘household’ – and reluctance to bestow other relationships with equal primacy - has been linked by John D’Emilio to the emergence of capitalism and rise of wage labour. In his formulation, “the ideology of capitalist society has enshrined the family as the source of love, affection, and emotional security, the place where our need for stable, intimate human relationships is satisfied”.¹⁷¹ As D’Emilio astutely remarks, every society needs structures for reproduction and childbearing but the possibilities are certainly not limited to the privatized nuclear family.

The scope of queer theory thereby offers a helpful set of conceptual tools to approach the sex/gender duality, as well as the centrality of the “traditional family” in cultural frameworks of meaning, by foregrounding the role of (hetero)sexuality, kinship and discursive forms of power in creating what Michael Warner calls “regimes of the normal”.¹⁷² Through such work, the nature/culture distinction is challenged, providing an explanation of how the dualities of

¹⁶⁹ See Lind and Share, *supra* note 141 at 64.

¹⁷⁰ Stevi Jackson, “The Social Complexity of Heteronormativity” (2005) Paper presented at the ‘Heteronormativity - A fruitful concept?’ conference, Norwegian University of Science and Technology, Trondheim, Norway, 2-4 June 2005 at 14-15. As will be seen, this performative aspect of heterosexuality is particularly regnant for queer couples who seek to reproduce within the biologist framework of the fertility clinic. Even when the clinic is ostensibly welcoming of gay and lesbian couples, the heterosexual structure of idealized family is so profound as to squeeze out alternative formations such as multi-parent and single parent reproduction.

¹⁷¹ John D’Emilio, “Capitalism and Gay Identity”, in Roger Lancaster and Micaela di Leonardo, eds., *The Gender/Sexuality Reader: Culture, History, Political Economy* (New York: Routledge, 1997) at 174.

¹⁷² Warner, *supra* note 145.

sex/gender (among other binaries) operate as a normalizing technique of power.¹⁷³ This queerly relational approach to ontology has drawn from post-structuralist theory to illustrate the ways in which reproductive labour, human sexuality, anatomy, biology, the nature of things – even reality itself – is dependent upon social context for meaning.

Queer Scholarship on Biological Reproduction

Classic Gay and Lesbian Writings on Reproductive Bodies

As mentioned, queer scholarship has been greatly influenced by psychoanalysis and ideas about the construction of the self, psyche and other. A recurring trope has been the psychoanalytic concept of the “polymorphously perverse”, a term which Sigmund Freud coined to describe the latent human ability to locate erotic pleasure through any part of the body.¹⁷⁴ Freud argued that while a child may turn to any number of body parts for sexual gratification, through the civilising conventions of society the adult erotic field is gradually narrowed to focus on the genitals. Yet those adults with a polymorphously perverse disposition – either through a persistence of latent potential or through the process of active ‘seduction’ – are able to experience a greater range of bodily pleasures and may not obey the rules determining perverse behaviour.

Polymorphous perversity has been notably reinterpreted by a series of 20th century scholars. In *Eros and Civilization*, Herbert Marcuse critiqued Freud’s conservative reading of genital sexuality and proposed an active cultivation of non-reproductive forms of sexual behaviour, including oral and anal eroticisms, capable of resisting the restriction of *eros* to

¹⁷³ Butler is not alone in claiming that there are no tenable distinctions between nature/culture, biology/construction and sex/gender. See also: Grosz, *supra* note 120; Harding, *supra* note 113.)

¹⁷⁴ Sigmund Freud, “The Classic Theory: Three Essays on the Theory of Sexuality”, in *The Freud Reader*, ed. Peter Gay (New York, NY, US: W W Norton & Co., 1989) at 268.

procreative sexuality.¹⁷⁵ Marcuse envisioned an ideal of radical hedonism where sex for pleasure not reproduction was the norm; the homosexual was to be the archetypal form of this new hedonist. Dennis Altman then seized upon the utopian elements of this Marcusean strand to argue that (male) homosexual sex in particular represented an expression of pleasure and love free of any utilitarian ends.¹⁷⁶ Altman's work understood the homosexual libido to have been loosed from the imperatives of heterosexual reproduction, allowing a liberatory relation to consumer capitalism that was able to sidestep the demands of the modern industrial state.¹⁷⁷

More than thirty years later, Leo Bersani again picked up this utopian strand to trace Freud's understanding of polymorphous perversity to the writing of Michel Foucault. Bersani saw in Foucault's work a grounding in Freudian thought that was able to generate "Foucault's [call] for a degenitalizing of erotic intensities" and underscore Bersani's own argument for the self-shattering pleasures of sadomasochism.¹⁷⁸

While these authors differed on the nature of power, psychic life and sexual repression, they were in agreement regarding a deep skepticism of heterosexist models of desire, pleasure and the chores of reproduction. Yet their focus was largely (if not exclusively) upon male homosexuality and the radical potentials to be found in anonymous anal sex (Bersani) and non-reproductive sex pursued for the sake of pleasure (Marcuse and Altman). Marcuse summed this up nicely in arguing: "Against a society which employs sexuality as a means for a useful end, the perversions uphold sexuality as an end itself...and challenge its very foundations."¹⁷⁹

¹⁷⁵ Herbert Marcuse, *Eros and Civilization: A Philosophical Inquiry into Freud* (Boston: Beacon Press, 1955).

¹⁷⁶ Dennis Altman, *Homosexual Oppression and Liberation* (New York: New York University Press, 1971)

¹⁷⁷ *Ibid.* See also: G. R. Davidson, "Liberation, Commodity Culture and Community in 'the Golden Age of Promiscuity'" (2001) 23 Australian Humanities Review.

¹⁷⁸ Leo Bersani, *Homos* (Cambridge: Harvard University Press, 1995) at 98. See also: Jeffrey Escoffier, *Sexual Revolution* (New York: Thunder's Mouth Press, 2003).

¹⁷⁹ Marcuse, *supra* note 175, at 49-50.

Thus while the repudiation of social norms organized around genital heterosexuality and biological reproduction has long been advanced in queer scholarship as a broadly liberatory and even utopian political aim, it nevertheless finds itself based upon a specifically *phallic* homosexuality. This gleeful sodomy has positioned itself as merrily disinterested in accounting for the reproductivity of female-born bodies, and unconcerned with utilitarian drags such as the gendered domesticities of childcare.¹⁸⁰

However it was not only the gentlemen who were suspicious of reproduction as a social goal. The relationship between procreation and the heterosexual order also infuses Monique Wittig's work *The Straight Mind*, which understood heterosexuality and the categories of male and female as not only social constructions and tools of male domination, but as an actual *political regime*.¹⁸¹ She argued that the category "woman" as well as the category "man" are simply political and economic categories, rather than eternal or biological matters grounded on natural fact. Thus heterosexuality operated "as a social system which is based on the oppression of women by men and which produces the doctrine of the difference between the sexes to justify this oppression."¹⁸²

This doctrine of difference was insidiously channeled through biological form, via the rendering of the world into two neat sexes of male and female. In rejecting the production of

¹⁸⁰ While the suspicion of commodity culture and neoliberal ideals shall be addressed shortly, it is clear from the contemporary marketization of homosexual lifestyles that mere sexual perversion has been unable to deliver the utopic visions dreamed of by Marcuse and Altman. (To be fair, upon his return to America after the publication of his classic 1971 text, Altman already found a gay civilization in decline. In 1979, he chronicled how the "[c]omparative relaxation of the taboos against homosexuality has led to a blossoming of bars, saunas, restaurants, and theatres which hold out the promise of endless gang bangs available across the length and breadth of the country... what [this] represents however is the emergence of a luxury-oriented, commercial gay world where instant sex is provided in surroundings of some opulence... [This] has had the effect of giving many male homosexuals the illusion that oppression is a thing of the past.") See: Dennis Altman, *Coming out in the seventies (a collection of his writings)* (Sydney: Wild and Woolley, 1979).

¹⁸¹ Wittig, *supra* note 159.

¹⁸² *Ibid* at 20.

sexual difference, Wittig dismissed even recuperative readings of women's histories, wherein early matriarchal forms were civilized and peaceful (because of a biological predisposition) while male-dominated societies were brutish and warlike (because of a biological predisposition). Wittig refuted any foundation in biological explanations for the division of women and men, outside of social facts, as for her "this could never constitute a lesbian approach to women's oppression, since it assumes that the basis of society or the beginning of society lies in heterosexuality. *Matriarchy is no less heterosexual than patriarchy: it is only the sex of the oppressor that changes.*"¹⁸³

It is only the process of naturalizing history which allows one to presume that "men" and "women" have always existed and always will. This process in turn calls into being "the social phenomena which express our oppression," which for Wittig was most prominently rendered in the "forced production" of childbirth.¹⁸⁴ For her, the lesbian position offered a liberatory frame in which the rejection of childbirth as *the* creative female act became possible. She approvingly cites Andrea Dworkin's work to reject any "celebration of biological female potential" as merely another form of entrapment within the political categories erected by heterosexist society.¹⁸⁵ For Wittig, it was only by rejecting the binary formulation of sexual difference and refusing the yoke of compulsory childbearing that a lesbian could become politically liberated.

Indeed this direct equivalence of childbirth and reproduction with heteronormativity and the enslavements of gender oppression has a long (and continuing) history in queer theory. These queer intellectual histories have also been taken up by more recent work, which has been

¹⁸³ *Ibid* at 10. My emphasis.

¹⁸⁴ *Ibid.*

¹⁸⁵ *Ibid* at 13.

similarly wary of the biological potential of the reproductive body, as lodged within a larger critique of futurity.

Recent Queer Scholarship on Reproduction

In his much-chewed-over 2004 text, *No Future: Queer Theory and the Death Drive*, Lee Edelman makes a case for the rejection of liberal utopianism through a politics of negativity. As with other queer scholars who have addressed the subject, the primary fuel for Edelman's thesis crackles within a deep suspicion of the procreative imperative. In an early chapter of the book, Edelman infamously exhorts all queers to reject the reproductive imperative and “fuck the social order and the Child in whose name we’re collectively terrorized.”¹⁸⁶ The Child is thus positioned in antagonism to the Queer (who is read as an unparalleled figure of nonproductivity), as Edelman argues that the Child stands in as a marker for the universal value attributed to political futurity. Through this move he is able to concretise the Child as a site of heterosexist strivings upon which can be layered imperialism, middle-class logics, and a manifest destiny channeled through the property values of primogeniture.

For this is not a living child, a body that requires love and nurture and the gentle ministrations of sidewalk scrapes but, as Edelman describes, a stand-in for “the whole network of Symbolic relations and the future that serves as its prop.”¹⁸⁷ And so the Child is deposited center stage as an absurdly affective referent for the maudlin, the vulnerable, the terminally apple-cheeked, and the decidedly non-queer imperative to secure the well-being of a never-arrived future imaginary. Edelman’s ‘reproductive futurism’ thus sardonically locates the redemptive hopes of humanity within the small bodies of humans with no material form.

Perhaps more crucially this creature *cannot* exist: as the promise of an always-vanishing

¹⁸⁶ Lee Edelman, *No Future: Queer Theory and the Death Drive* (Duke University Press, 2004) at 29.

¹⁸⁷ *Ibid.*

future horizon it must blink its dewy eyes from the time of the never-here. As Edelman continues the passage in his book, he aims approbation toward purely fictional characters, at the literary signification of childhood at its most adorable: “fuck the social order and the Child in whose name we’re collectively terrorized; fuck Annie; fuck the waif from *Les Mis*; fuck the poor, innocent kid on the Net.”¹⁸⁸ Fuck the damnable Child who holds us all in check, demanding adherence to a standard of saintly innocence that ruins our distinctly adult enjoyments. This is a trope that finds its apex of abjection in Edelman's work, but it is by no means controversial to argue that the Child currently functions across much of queer theory as a cypher for the worst kind of normativity.

Indeed, despite rejecting certain elements of this ferociously antisocial thesis, scholars like Judith Halberstam are among many who have found themselves in agreement with Edelman's suspicion of reproductive futurity. Halberstam suggests in her book *In a Queer Time and Place* that an alternate vision of queer time must preclude the normative modalities of child-bearing and rearing; for Halberstam, “[q]ueer uses of time and space develop...in opposition to the institutions of family, heterosexuality, and reproduction.”¹⁸⁹ She offers instead the idea that “[q]ueer time...is...about the potentiality of a life unscripted by the conventions of family”.¹⁹⁰ This notion of a ludic freedom from the bourgeois trappings of reproductive temporality underscores much of the writing on queer kinship in recent years, leaving little purchase for the centering of intimate parent-child relationships.

For as the body of the queer-born infant/child slips into a jeremiad against heteronormativity, by extension the queer parent also vanishes into the bourgeois mist. If the

¹⁸⁸ *Ibid.*

¹⁸⁹ Judith Halberstam, *In a Queer Time and Place: Transgender Bodies, Subcultural Lives* (New York: New York University Press, 2005) at 1.

¹⁹⁰ *Ibid* at 2.

infant/child can only exist in a relation of heterosexual capital, then neither can a queer parent hold bodily integrity within these rigid economies. As Halberstam approvingly characterises the crux of Edelman's queer anti-thesis:

[W]hile the heteronormative political imagination propels itself forward in time and space through the indisputably positive image of the child, and while it projects itself back on the past through the dignified image of the parent, *the queer subject stands between heterosexual optimism and its realization.*¹⁹¹

Thus are queer bodies positioned as a bulwark against the “forward looking, reproductive and heteronormative politics of hope that animates all too many political projects.”¹⁹² This move *necessarily* excises queer subjects from the category of parent, and simultaneously casts those queers who do/have/are engaged in primary relations of child-focused care as failing to register within an anti-imperialist, queer counter-hegemonic imaginary.¹⁹³

Queer Theory and Reproductive Kinship

Yet not all queer scholars have joined this reification of queer subversion in the face of a heteronormative bummer. Judith Butler, for example, has recently analyzed queer sexualities and the procreative family, arguing for the importance of kinship as a politically and theoretically dense site for analysis *precisely as* family structures shift increasingly away from the heterosexual norm.¹⁹⁴ She traces recent scholarship in the new kinship studies to understand kinship as a cultural phenomenon interlinked with political, social, economic and forces. Through this analysis, she locates the site of the family as a location where anxieties about the destabilization of the ‘natural world’ take hold.

¹⁹¹ Judith Halberstam, “The *Anti-Social* Turn in Queer Studies” (2008) 5(2) Graduate Journal of Social Science at 141. (Emphasis mine.)

¹⁹² *Ibid.*

¹⁹³ *Ibid* at 142.

¹⁹⁴ Butler, *supra* note 46 [Kinship].

For example, Butler discusses recent moves against same-sex marriage in France by conservative political leaders and intellectuals. She locates the breakdown of the traditional married couple as the originary point for a host of repressive measures directed at the intimate practices of homosexuals. Queer couples thereby provide a site where the fears of a ‘loss of tradition’ can condense, as heterosexual couples invoke the ‘natural’ logics of reproduction and biological essentialism to maintain the fiction of a stabilized and hegemonic heterosexuality. For Butler:

...one must understand the invocation of the “symbolic order” that links marriage to filiation in a necessary and foundational way as a compensatory response to the historical breakup of marriage as a hegemonic institution...in this sense, the opposition to [same-sex marriage] is an effort to make the state sustain a certain fantasy of marriage and nation whose hegemony is already, and irreversibly, challenged at the level of social practice.¹⁹⁵

She notes how this echoes the work of Sarah Franklin and Susan McKinnon, who similarly understand kinship as a site where certain displacements are already at work, where anxieties about biotechnology and transnational migrations become focused and disavowed.¹⁹⁶ Butler’s analysis sheds light on how the breakdown of traditional family forms through such avenues as same-sex marriage, biotechnology, globalization and the transnational movement of bodies, has effected what might be called a ‘heterosexual backlash’ – a nostalgia for the hegemony of the traditional family that is enacted through a refusal to recognize and validate queer intimate ties. This is a process usually effected through law.

This process also rests closely upon the nature/culture divide and the reinscription of ‘natural’ sex/gender forms. As Catriona Sandilands has persuasively argued, “the naturalization

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

of heterosexuality has been historically accompanied by the heterosexualization of nature.”¹⁹⁷ Overlaid upon the gendered form of the nature/culture relation itself, and its mapping as feminine/masculine, are reinscribed the reproductive and nurturing norms of the natural world. Through this dialectical palimpsest, the nature/culture binary is reproduced via dominant understandings of sexed and gendered subjectivities, by which the baseline of nature easily becomes one of compulsory heterosexuality.¹⁹⁸ The heterosexual backlash thus performs a dizzying series of naturalizing moves to secure its normalization, in the process allowing queer sexualities to be dismissed as being “against nature” due to their failure to replicate the natural forms of heterosexuality and, by extension, their failure to perform an idealized model of “the ‘natural’ [which] is invariably associated with ‘procreative’.”¹⁹⁹

In France and Germany this led to massive public protests against same-sex marriage and a refusal to allow LGBTQ people access to reproductive technology.²⁰⁰ In the United States, in recent months, this has led to a spate of legislation at the state level seeking religious accommodation to avoid serving same-sex individuals and couples – particularly as involves same-sex marriage.²⁰¹ In Canada the effects have been less pronounced, but the judicial impulse to reconstitute a heterosexual family at the core of parentage disputes involving same-sex parents remains profound, as seen in the analysis of *C.(P.) v. L.(S.)* in Chapter Two. Analyzing this “compensatory response” to sustain the fantasy of kinship relations bounded by nature, even

¹⁹⁷ Catriona Sandilands, “From Unnatural Passions to Queer nature: Common Assumptions Linking Urban-Artificial-Queer in Opposition to Rural-Natural-Straight Deserve Closer Attention” (2001) *Alternatives Journal* 27.3 (2001): 30-35 at 34.

¹⁹⁸ Greta Gaard, “Toward a Queer Ecofeminism” (1997) *Hypatia* 12.1 at 131.

¹⁹⁹ *Ibid* at 120.

²⁰⁰ Butler, *supra* note 46 [Kinship].

²⁰¹ For a discussion of the *Hobby Lobby* ruling and the potential for discrimination at the state level, see: Ira C. Lupu, “Hobby Lobby and the Dubious Enterprise of Religious Exemptions” (2014). *Harvard Journal of Law & Gender*, 38(1).

as cultural and technological change has fundamentally shifted the role of biological and sexual relations in reproduction, will animate much of the work of this dissertation.²⁰²

For even as this breakdown of the ‘symbolic order’ has occurred, and the policing of the nature/culture divide has made the family a dense location for the coalescing of social anxieties, there have also been a series of salutary effects. Along with the rupture of traditional kinship forms, and in particular with the opening of kinship outside of the conjugal frame through donor insemination and gamete donation, potential has been created for kinship to expand to a broader set of community ties. Exploring these new kinship frames and their development by queer subjects through AHR will form another main thrust of this dissertation. As Butler concludes, the rupture of the nature/culture divide offers an opportunity for new kinship and sexual arrangements to compel a rethinking of culture itself, for “when the relations that bind are no longer traced to heterosexual procreation, the very homology between nature and culture...tends to become undermined.”²⁰³

Fascinatingly, within much of queer theory these same developments have led to a different sort of backlash. As was seen in the discussion of Edelman and Halberstam, kinship has indeed functioned as the site where anxieties about broad cultural developments take hold. Their vocal rejection of child-rearing operates as a condensed site for the expression of fears around shifting social realities – but this time in the opposite direction. Thus the anti-social turn can be seen as an expression of queer anxieties about homonormativity and the loss of queer

²⁰² As will be seen, this backlash is not only enacted by ‘repressive’ cultural forces. The discursive power of the biological tie continues to hold tremendous weight, and many LGBTQ parents using AHR also rely upon hegemonic discourses of home and family in order to invoke cultural authority. The complex discursive formulation takes place within an array of cultural forces, as people struggle to articulate their claims to legitimacy within a medico-judicial framework still squarely grounded upon heteronormativity. This response of queer subjects to structures of power will be explored at length in Chapters 9 and 10.

²⁰³ Butler, *supra* note 46 [Kinship] at 39.

hedonic pleasures (mandated first by the AIDS crisis and then by the ‘assimilation’ of gays). It also reflects longstanding debates within gay and lesbian movements about the collective goal of same-sex marriage,²⁰⁴ fueled by a fear that queer abrasions of the normal may have become dulled and flat in the yawning depths of the suburbs.

Homonormativity and Neoliberalism

Queer scholars have watched with some dismay as the failure to imagine new marital arrangements has collapsed back into the same-sex marriage model, guided by the privatized dictates of neoliberalism.²⁰⁵ Similarly, David Eng has asked that we remain attentive to how the conditions of late capitalism allow queer subjects to inhabit certain types of conventional family and kinship formations, or what he has termed “queer liberalism”.²⁰⁶ These are vital critiques of power, and rightly argue that one must not gamely jettison suspicion of how the bourgeois family operates via the reproduction of sexed and class privileges.

What should also be made suspicious, however, is the idea that a singular claim to biological reproduction can be held by the naturalized propriety of heterosexual love. I believe we must also question the ready equation of procreation with the most galling of normative projects, and with an inevitable capitulation to privatized modes of bourgeois subjecthood. The landscape of queer biological kinship remains contested by supporters and detractors from across the ideological spectrum, and it has been too easy for scholars to abandon these concerns

²⁰⁴ For the classic exchange on whether gay marriage should be a central platform of the LGBTQ rights movement, see: Thomas Stoddard, “Why Gay People Should Seek the Right to Marry” (1989) *OUT/LOOK* at 9, reprinted in William B. Rubenstein, Carlos A. Ball, and Jane S. Schacter, *Cases and Materials on Sexual Orientation and the Law* 678 (3d ed. 2008); Paula Ettelbrick, “Since When is Marriage a Path to Liberation?” (1989) *OUT/LOOK* at 14, reprinted in *Rubenstein et al*, supra, at 683. Both essays are also reprinted in Nan D. Hunter & William N. Eskridge, Jr., *Sexuality, Gender, and the Law* 1098 (2d ed. 2004). See also: Nancy Polikoff, “We Will Get What We Ask For: Why Legalizing Gay and Lesbian Marriage Will Not Dismantle the Legal Structure of Gender in Every Marriage” (1993) 79 *Virginia Law Review* 1535.

²⁰⁵ Brenda Cossman, *Sexual Citizens: The Legal and Cultural Regulation of Sex and Belonging*, (Stanford University Press: Stanford, 2007)

²⁰⁶ David L. Eng, *The Feeling of Kinship: Queer Liberalism and the Racialization of Intimacy* (Durham, NC and London: Duke University Press, 2010)

as merely homonormative and misaligned with the transgressive agenda of queer theory and politics. Rather than automatically conjuring the spectres of the neoliberal subject, queer family projects ask for fresh legal strategies and conceptual frames to understand how LGBTQ subjects are navigating the challenging and often hostile privatized landscape of for-profit reproductive assistance.

Thus, my project aims to center the inherently non-reproductive queer user of AHR, with the conviction that by reading the reproductive landscape slant-wise, from a perspective not already over-burdened with assumptions about the ‘natural’ family, we will be able to survey important conceptual vistas that would otherwise have remained obscured. For example, during my interviews I encountered the queer spawn of two married and non-monogamous transmen – a youngster conceived through the help of a sperm donor who lives in a different city. This child *literally has no mother* but instead can count three fathers, two of whom are biological. Such kinships demand a fundamental rethinking of the assumed linkage between compulsory heterosexuality, monogamy and the reproductive family, and have the capacity to destabilize the hierarchies of sex normativity. Why is it again that queers cannot be non-heterosexual, non-monogamous *and* reproductive? Through such stories I learned how family may be refigured by queer connections of blood and kin. I learned of people’s struggles with family law, and a frustration at reductive formations that assumed a same-sex couple would have similar needs and concerns to a straight couple. This mechanism of formal equality chafed for many (though not all) of my informants, and I came to see the need for a queer legal analytic that would be able to encompass both questions of substantive equality, as well as the wellbeing of queer people seeking to create families through AHR. Bringing the queer frame to the foreground plainly articulates how supposedly normative heterosexuality and family-making is neither the

empirical nor the legal reality. As a queer scholar, I suggest that rather than throwing out queer spawn with the heterosexual bathwater, we might instead look to question the opposition of ‘queer’ to ‘reproduction’ and explore the new intimacies being forged.²⁰⁷

Law and the Recognition of Family

The diverse literatures surveyed in this chapter have offered a comprehensive survey of the nature/culture divide, and the way that material forms of reproduction, kinship, gender, sex, power and labour can be read through the development of new forms of technology. In order to understand the workings of heteronormativity and its relation to the reproductive project, it has been necessary to gather a complex strand of inquiry through these independent, yet related, theoretical trajectories. However ‘the family’ is not merely a social relationship based on increasingly fragmented ties; it is also – and crucially – a *legal* formation, and one which requires the operation of juridical power to recognize and legitimate human (and non-human) relationality.

Constructive Relationality of Law

These concerns track closely to recent work by Marilyn Strathern on the *relational* quality of the new kinship studies.²⁰⁸ According to Strathern, the abstracted forms of family

²⁰⁷ While my queer orientation is perhaps not in question, I would like to make a declaration of not only my sexual but also *familial* orientation and own desire for children via technological intervention. I think this is important not only in terms of a feminist standpoint but also the generally narrative approach I am taking toward this legal ethnography. The voices I will seek to highlight in this account are necessarily filtered through my authorial screen, and I must to some extent keep intact the boundaries between author and subject, private and public, personal and professional. Nevertheless my subjective and self-conscious involvement in this project will intentionally aim for a more dialogic relation with research participants, and I intend to argue through form and substance against the codification of experience as represented in traditional research practices. Thus I hope that as the reader engages with the text and especially with the interview transcripts presented, my own conflicted role as scholar and commentator, as well as a queer with a family plan, will be visibly enucleated. For a discussion of the researcher dynamic as a dialogical process, see: Leigh Arden Ford and Robbin D. Crabtree “Telling, re-telling, and talking about telling: Disclosure and/as surviving incest” (2002) *Women's Studies in Communication* 25 (1): 35–53.

²⁰⁸ As described through this chapter, I am also interested in incorporating other branches of Marxist and feminist thought that interrogate relational forms of knowledge and embodiment.

which are imagined through the concept of ‘relations’ can receive important analytical purchase through an introduction to law’s taxonomies. As she explains:

Indeed, relationality – as an abstract value placed on relationships – is highlighted in a recognisable and conventional manner through attention to the law. [Threaded through such study] is a commentary on the way modernist legal thinking at once opens up and closes down predispositions to think in terms of relations. There is a particular purchase to bringing in legal thinking. It is a discipline and a practice that has to deal with different kinds of relationships.²⁰⁹

Thus she draws attention to the law as a domain of Euro-American institutional life, for the very reason that it both illuminates the relations between humans and the subjects and objects of our world, *and* is instrumental in creating the protocols and boundaries that direct those relations in the first place. Law is both a window through which to view the operations of human relations and a critical tool in structuring those relationships. As Strathern argues, for example, through the deployment of such concepts as intellectual property, the law gives categorical meaning to the products of people’s activities.²¹⁰

Interpersonal relations are also imagined and constructed through legal structures, as when the concept of family gives rise to categorical determinations over who and what may claim the rights of caretaking, dependency, symbolic recognition and access to state benefits and subsidies. The battle over same-sex marriage, for example, has not been about whether the social reality of gays and lesbians can include intimate affiliation and cohabitation. Clearly, the lived experience of these subjects already involves such intimacy. The struggle has been for legal recognition, to claim the conceptual category of family as well as the symbolic and tangible benefits that affix to membership in such a category.²¹¹

²⁰⁹ Marilyn Strathern, *Kinship, Law and the Unexpected: Relatives are Always a Surprise* (Cambridge: University of Cambridge Press, 2005) at viii.

²¹⁰ *Ibid* at 85-86.

²¹¹ As Judith Butler has argued in specific relation to same-sex marriage, it is not only about the construction of the categories, but about who should be eligible for inclusion through the desire of the state. As she writes: “Indeed, the

Understanding the law in this way – as an apparatus that reifies concepts such as family and then creates legal categories which may be policed – will prove helpful to a study of the ways in which concepts of ‘nature’ and ‘biology’ continue to circulate as constitutive and contradictory categories in Canadian law. For even as law faces new social phenomena and (of particular interest here) the complexities of kinship produced through assisted reproduction, it will look to existing conceptual and categorical norms to govern its progress. As Roxanne Mykitiuk has argued:

Law, and in particular legal reasoning, is all about categorizing, characterizing, sorting and fitting complex social phenomena and relations into pre-existing legal pigeon holes. Moreover, while science and medicine strive to find discoveries for the *future* while *simultaneously* unlocking the secrets of the *past*, law, with its duty to regulate society, looks *mainly to the past* to interpret the legal position and significance of novel developments, arrangements and techniques. Law, which is founded on precedent (at Common Law) and basic principles and doctrines, will take analogies from decided cases, past and present, wherever possible. Whereas scientific and medical advances create the possibility of disrupting our schemas of linguistic and social categorization (for some, our conceptions of reality) by fashioning novel material entities, law's impetus is to resist new orderings and to attempt to assimilate these new entities into current or past conceptual frameworks. Further, law will make authoritative pronouncements *to preserve* particular kinds of legally sanctioned relations even in the face of novel arrangements. There appears to be an inevitable incongruence between law's need to preserve stable conceptual categories on the one hand, and the scientific impulse toward the discovery and creation of novel entities and techniques on the other.²¹²

The drive to taxonomize complex social phenomena into narrow definitional and pre-existing bounds is one that characterizes the legal project. Thus law finds itself past-oriented, as Mykitiuk describes, and structured through the precedents of Common Law toward the assimilation of new formations into existing frames. And what is one of the most fundamental

argument against gay marriage is always, implicitly or explicitly, an argument about what the state should do, what it should provide, but it is also an argument about what kinds of intimate relations ought to be eligible for state legitimation. What is this desire to keep the state from offering recognition to nonheterosexual partners, and what is the desire to compel the state to offer such recognition? For both sides of the debate, at issue is not only the question of which relations of desire ought to be legitimated by the state, but of who may desire the state, *who may desire the state's desire.*” Butler, *supra* note 46 [Kinship] at 22.

²¹² Roxanne Mykitiuk, "Fragmenting the Body" (1994) 2 Australian Feminist Law Journal 63-98 at 69.

conceptual logics and organizing principles for society? As has been discussed at length above, Euro-American society has long rested upon the nature/culture divide and the essentialist rationales of heteronormativity.

Of course, like all forms of power/knowledge, neither is the law a unilinear or cohesive structure. There will necessarily be ruptures and incoherences in how any system of regulation operates. Indeed when the frame is tightened to the relationship between reproductive technology and nature in particular, scholars have demonstrated how the law operates through complex and often conflicting norms. This was seen in the previous chapter in relation to the balancing act between biology and sociality in determining parentage. As Emily Martin has similarly maintained in regard to British law, AHR's dissolution of strictly biological grounds for the maternity/paternity divide has often resulted in contradictory effects:

In the UK the legislation, rather confusingly, both reaffirms and disrupts conventional understandings about kinship. At times the status provisions appear to rest upon the assumption that parenthood is a non-negotiable and immutable "fact of life", despite the new technologies' capacity to subvert traditional reproductive norms. So, for example, rather than recognise that a child born following oocyte donation has two *biological* mothers, the law instead determines which one shall be considered the *only* biological mother. On the other hand, at other times the rules appear to recognise that the natural biological facts of procreation do not accurately reflect the realities of assisted reproduction. Hence, for example, although a child born to a single woman treated with donor sperm undoubtedly has a *biological* father, he or she will be *legally* fatherless.²¹³

These contradictory formations represent what Mykitiuk has called the "fragmentation" of legal categories, wherein novel material and social arrangements are engaged by the normalizing logics of legal doctrine. For even as law seeks to privilege those categories comfortably buttressed by precedent and practice, it must nevertheless also confront categorical gaps which cannot merely be shoehorned into existing models. These moments of fragmentation are also part of the relationship of the legal apparatus to new conceptual paradigms, and are

²¹³ Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Oxford: Hart Publishing, 2001) at 235-236.

fascinating locations of rupture to track the ways in which law's operation may privilege and abject certain ways of knowing and being.

Toward a Queer Legal Theory

As has been discussed, queer theory offers tools for a critical attention to the knowledges and social practices that repress difference in creating what Michael Warner calls “regimes of the normal”²¹⁴ regarding appropriate sexual practice. Queer scholarship has allowed for deep scrutiny of the process through which social exclusions are produced. For if difference derives specific forms and meanings through its “encounter with existing social relations and material social practices in particular places,” then the task is to expose the “tensions, contradictions and affiliations” embedded in such encounters.²¹⁵ This rests nicely with Mykitiuk's call for attention to the fragmentation of law. Extending queer logics to a study of heteronormativity and assisted reproduction in the Canadian legal order thus necessitates the reconceptualization of difference as constituted, fragmented and (re)configured in relation to place-specific struggles over rights, social practices, and relationships—particularly sexual and emotional intimacies.

What then might queer theory applied to law teach us about the limits of assisted human reproduction legislation and the LGBTQ people seeking to access these technologies? Can it offer a robust framework through which to theorise the structural conditions of queer intergenerational intimacy? What can queer theory tell us about or contribute to an analysis of the legal conditions being faced by queer parenting subjects?

Unfortunately, queer and legal theory offer a strained disciplinary divide at best. This chapter has mapped how queer theory is an unmappable discipline, intentionally inchoate, definitionally unstable and in rejection of a substantive project. This stands in contrast to legal

²¹⁴ Warner, *supra* note 145.

²¹⁵ Cindi Katz, “On the Grounds of Globalization: A Topography for Feminist Political Engagement” (2001) *Signs*, 26(4): 1213-1234.

scholarship, which even in its most critical formations, nevertheless finds itself oriented toward normative questions if not the pursuit of properly substantive remedies. There are exceptions within each tradition, of course, but the difficulty of reconciliation remains. As Janet Halley and Andrew Parker point out, “the failure of queer theory to engage the critical tradition in legal studies (and its resulting failure to grok the critique of rights)” has found itself met by an “hostility in centrist legal studies...to theoretical approaches more generally that do not quickly produce a ‘policy recommendation’.”²¹⁶ Such loggerheads, although complicated by polyvalences and tensions within both disciplines, have made conversation difficult.

By focusing attention on the sites of contestation, contradiction, reinstatement and reformulation made possible by assisted reproductive technology, this dissertation uses the figure of the queer parent to explore the conceptual power still wielded by the ‘traditional family’ in Canadian law. This use of queer legal theory to investigate assisted reproduction and the techno-mediated family is a relatively novel approach. As has been seen, queer scholarship has been generally quite hostile to the (apparently) homonormative elements of family formation and preferred to celebrate the inherently non-reproductive figure of the Queer. For its part, feminist scholarship that has explored assisted reproduction and the constructedness of ‘natural facts’ regarding reproduction – of which there has been a very great deal - has most often remained fixed on the heterosexual family as the primary site of contestation.

My project seeks to bring various theoretical strands into productive tension, through a broadly multidisciplinary analysis that refuses a primary focus on the heterosexual family. Rather than seeking to understand the legal challenges posed by deviations from the ‘naturally reproductive couple’, I disregard the primacy of this couple in the first instance. Through a materialist feminist focus on queer reproductive subjects and the medico-juridical terrain upon

²¹⁶ Halley & Parker, *supra* note 147.

which they stake their parenting claims, I seek to produce an embodied account of queer lives and the ambivalences that frame their experience.

I am inspired in this goal by Wittig's project and her rejection the terms of the 'class struggle' between men and women. Instead she took the organization of lesbian society – a society without men – as her analytical model. By foregrounding this mode of social organization as baseline, rather than as a deviant or abnormal cluster, Wittig was able to focus her lens on the operations of society created by the naturalization of heterosexual life. Wittig took the independent character of lesbian society as evidence that the “natural order” of women bound to men through social and reproductive functions was an artificial social fact.²¹⁷ For her, “lesbian society pragmatically reveals that the divisions from men of which women have been the object is a political one and shows that we have been ideologically rebuilt into a “natural group”...We have been compelled in our bodies and our minds to correspond, feature by feature, with the *idea* of nature that has been established for us.”²¹⁸

Conclusion

Material Realities of Queer Parents

While Wittig's work provides inspiration for this dissertation, her project was very much against childbearing and the process of reproduction. So where are we now, twenty years on from Wittig's thesis, and amidst the current complaints of Edelman and Halberstam and their equation of happy, shiny heteronormativity with the unbearable lameness of childbearing? It appears that there are few conceptual locations for the queer parent to exist within critical queer

²¹⁷ This is not unlike Foucault's analysis of the figure of the hermaphrodite, as a boundary marker that demonstrated the constructed nature of the male and female categories this figure defied. By looking to an abjected category not in *opposition* to the norm, which would create another binary, but as a tool to analyze the constitutive outside, the taxonomies which structure the operation of the possible are more readily seen *as* taxonomies, rather than simply as natural fact. Foucault, *supra* note 97.

²¹⁸ *Ibid* at 9.

theory; yet this figuration stands very much at odds with the empirical data gathered in this dissertation. Neither Wittig's political rejection of childbearing nor the repudiation of reproductive futurity by the anti-social turn can account for the queer parenting lives encountered by this research. My critique thus brings to the fore the theoretical terms at stake and the importance of centering queer lives in the conceptual models we create.²¹⁹

For as Eve Kosofsky Sedgwick has rightly pointed out, the anti-social thesis follows in the wake of queer theory's emergence in the late 1980s and early 1990s amidst the AIDS crisis and the paranoia wrought by widespread and uncertain death. As she describes: "It was not an uncommon experience then to be in a room of vibrant young people, conscious that within a year or two, all but a few of them would have sickened and died."²²⁰ Such a paranoid reading continues to infuse queer scholarship, but it does so increasingly outside of a context that reflects lived experience. For example, Edelman offers the following remark in a 1998 article that would later come to ground the invective for *No Future*:

Choosing to stand, as many of us do, outside the cycles of reproduction, choosing to stand, as we also do, by the side of those living and dying each day with the complications of AIDS, we know the deception of the societal lie that endlessly looks toward a future whose promise is always a day away.²²¹

Edelman's frame has been rightly impacted by the loss and grieving of the AIDS crisis, and seemingly endless waves of death which wrenched away the promise of a future for a generation of young gay men. Within this lived materiality, the hope of tomorrow *was* a deception, a lie to be furiously refused.

Given more than two decades of advances in medical technology, anti-retroviral drugs,

²¹⁹ Thanks to Lynne Huffer for helping me clarify my investment in critiquing the antisocial thesis.

²²⁰ Eve Kosofsky Sedgwick, "Melanie Klein and the Difference Affect Makes" (2007) *South Atlantic Quarterly* 106: 625-42 at 638.

²²¹ Lee Edelman, "The Future Is Kid Stuff: Queer Theory, Disidentification, and the Death Drive" (1998) *Narrative* 6(1) at 29.

and access to assisted reproduction alongside increasing LGBTQ civil rights, however, this is simply no longer the experience of many queers. Indeed, it is more likely that queer affiliations will produce the following scenario, a vision of multiplied community made possible through the lateral forms of kinship discussed in Attachment Two: “It was not an uncommon experience to be in a room of vibrant young people, conscious that they are all queer relations, all created through reproductive technologies, some even holding biological ties with the same donor.”²²² The material conditions of queer child-making offer abundant reproductivities and multiplied kinships as the opposite of wasting death. My feminist materialist analysis tracks the empirical realities of queer kinship in developing new conceptual models, and in opposition to much scholarship in the queer academy. For even as these lived reproductive projects have grown exponentially, the idea of queer parenting has remained eminently unfashionable as a theoretical project.²²³

In order to approach the empirical as well as discursive artifacts of the queer body in law, I believe it is helpful to move away from static categories of naturalised procreation. New frameworks are required; some of which may grow out of queer theoretical traditions; others which may take inspiration from feminist Marxism, science and technology studies and kinship

²²² For more on queer spawn and donor sibling relations, see Stu Marvel, *supra* note 8.

²²³ Sara Ahmed, “Happy Futures, Perhaps” in *Queer Times, Queer Belongings*, E. L. McCallum and Mikko Tuhkanen, eds. (Buffalo: SUNY Press, 2011) at 174. (Perhaps one should not underestimate the dictates of the academy and the many childless queer scholars who actually produce this scholarship. As a childless queer myself, I know it has been faintly embarrassing to attempt a recuperative approach to LGBTQ parenting. I understand this as stemming from the compulsory expectations of child-bearing which still hold tremendously normative sway over queer lives. For example while discussing the film *Children of Men* in the midst of a brilliant treatise on the affective role of happiness, Sara Ahmed slips into a rather aggrieved first person as she exhibits frustration at being told that lives without children are worthless. From a complex figuration of the dystopian pall of a future with no children, Ahmed puts forward an exhausted disclaimer about the supposed virtues of parenting: “This is not to say that the idea that lives are pointless without children should not be challenged: many of us who live our lives without having ‘children of our own’ are tired not only of being told we are pointless, but also of making the point that lives do not have to involve having children to have a point.” As a queer who routinely fields similar discussions with elderly aunts at Christmastime, I have great sympathy for Ahmed’s position. It is unsurprising that queers in the academy who have worked so hard to stake out territory apart from the dubious pleasures of home and family have sought to inure themselves against not just the compulsory labour of childbearing, but even the labour of writing about the damn thing.)

theory; but that together are able to capture the contemporary reality of childbearing and rearing in the shadow of law as experienced by the subjects of this research.

A Techno-Marxist-Feminist Analysis of the Queer Reproductive Family?

This chapter has surveyed a variety of literatures focused on the analysis of interlocking binary frames. It began by using Marxist ideas to explore the Western duality of ‘biological/social’ and the ‘nature/culture’ upon which this binary depends. It then picked up various feminist strands, as woven through Foucauldian and postmodernist thought, to explore the divisions of sex/gender and male/female in poststructuralist feminist analysis; queer theory’s insights on the natural/unnatural binaries of heteronormativity; and the biological/social problematizations of feminist science studies, corporeal feminism and the new kinship studies.

Taken as a guiding frame, this broad interrogation of nature/culture forms a helpful interdisciplinary rubric upon which to build an analysis of the queer reproductive family. For example, when queer theory comes to bear specifically upon the natural world, it offers a useful hermeneutic to understand how nature has been read not only as female, passive, inert and easily manipulated, but as uniquely *heterosexual*. This is a particularly urgent process, given how AHR technologies have revoked the singular claim to genetic reproduction formerly held by the heterosexual family. Yet queer theory has allowed itself to cordon off most questions of childbearing and rearing as hopelessly heteronormative, and has not developed a robust language for reproduction outside of heterosexual models of family. There have instead been studies made of the child-as-queer; the nascent queer body for which we warmly anticipate a maturity into adulthood.²²⁴ And while these works offer a strong foundation for thinking though

²²⁴ Kathryn Bond Stockton, *The Queer Child, or Growing Sideways in the Twentieth Century* (Durham: Duke University Press, 2009); Steven Bruhm & Natasha Hurley, *Curiouser: On the Queerness of Children* (Minneapolis: University of Minnesota Press, 2004); Kenneth B. Kidd, *Making American Boys: Boyology and the Feral Tale*

intergenerationality (by which I mean the vertical child-adult-elder structures of biological reproduction which have long typified heterosexual kinship) and queer relations of family, there has been far less attention paid to the queer parent and the new reproductive forms through which children are produced.

By the same token, much ink has been spilled on the social and legal ramification of new reproductive technologies, with feminist scholars ruminating at length upon the dramatic re-envisioning of 'nature' and 'family' that has resulted. These works have explored how existing models of kinship have been increasingly ruptured through novel relations of capital and care, yet few have used the robust language of heteronormativity and queer critique to bolster their analysis. I believe the *inherently* non-reproductive modalities of queer sexuality may allow a recentering of the frame of inquiry in conceptually important ways. When queer reproduction at the fertility clinic is foregrounded, it helps to lay bare a medico-juridical order that is broadly unable to account for *all manner* of families created beyond the realms of 'natural' reproduction.

For its part, family law has been woefully unable to account for many of the challenges posed by queer people and reproductive technology, in Canada and beyond. Relying instead upon existing models of the heterosexual family, the nature/culture binary and a stubbornly patriarchal worldview, law has been roundly criticized for its inability to expand frames of kinship and recognize the new forms of intimacy created through AHR. As may be seen in Attachments One and Two, family law in Canada is at the point of nearly comical failure, with donors who cannot be tracked, sperm banks with no order to disclose, receding pools of sperm with deeply racialized implications, and queer families all over encountering lateral kinships through online and social media. Clearly the solutions are not to be found in law alone.

(Minneapolis: University of Minnesota Press, 2004)

By bringing these disciplines into conversation, this dissertation seeks to account for the lived LGBTQ lives at the heart of this research. As my analysis proceeded, it became evident that neither strictly queer nor legal models could map these complex realities; nor could merely kinship theory or the singular analysis of biotechnology. In seeking to reconcile these divides in accounting for the empirics of this project, then, this dissertation aims to engage queer subjects of both law and conception. By utilizing what Janet Halley has phrased “the hedonics of critique”²²⁵ this analysis employs a wide-ranging theoretical dialectic in hopes of emerging finally with a vision of ‘thick life’²²⁶ that could not be imagined by one intellectual tradition alone. This careful approach to materiality will, it is hoped, show us something about the surprising discursive flexibilities of law(s) even as we seek to keep our embodied subjects at hand.

As has been seen, the subjectivating power of law opens certain possibilities for families while seeking to foreclose others. Of course the debate over the “future of the family”, as was discussed in Chapter Two, swirls not only around the legal battles produced through shifting cultural and sexual norms and the increased use of AHR. It also churns through ethical questions about test tube babies and the creation of human life in a laboratory. Issues such as stem cell research,²²⁷ the management of frozen embryos,²²⁸ pre-implantation genetic diagnosis,²²⁹ and the

²²⁵ Janet Halley, *Split Decisions: How and Why to Take a Break from Feminism* (Princeton: Princeton University Press, 2006) at 9.

²²⁶ Elizabeth Povinelli argues that by understanding the discursive powers that shape social life we can begin to approach what she describes as a politics of ‘thick life’ in which “the density of social representation is increased to meet the density of actual social worlds.” Elizabeth A. Povinelli, *The Empire of Love: Toward a Theory of Intimacy, Genealogy, and Carnality* (Durham: Duke University Press, 2006) at 21.

²²⁷ For an overview of the debate on stem cell research in the U.S. see: John A. Robertson, “Human embryonic stem cell research: ethical and legal issues” (2001) *Nature Reviews Genetics* 2, 74-78 and John A. Robertson, “Embryo Stem Cell Research: Ten Years of Controversy” (2010) *The Journal of Law, Medicine & Ethics*, 38: 191–203. For the debate on gendered concerns over stem cell research involving human eggs, see: Diane Beeson & Abby Lippman, “Egg harvesting for stem cell research: medical risks and ethical problems” (2006) *Reproductive BioMedicine Online* 13(4), 573-579. For a Canadian perspective on human embryonic stem cell research, see:

possibility of genetic conditions or chromosomal issues (especially regarding intracytoplasmic sperm injection)²³⁰ are bioethical concerns that continue to be hotly contested. These debates are indeed important, but they remain beyond the reach of this dissertation. Instead, the aim is to tunnel down to the normative bedrock upon which such interventions are predicated in the first place, to interrogate the heteronormativity of reproduction, the exclusions it produces, and the ways in which queer subjects complicate, challenge, reinforce and reveal such conceptual gaps in both law and society. It is these possibilities for being human, a body, a family that interests here, as produced through webs of biotechnology and social affiliation. This is, I believe, a queer project indeed.

Timothy Caulfield, Ubaka Ogbogu, Erin Nelson *et al*, “Stem cell research ethics: consensus statement on emerging issues” (2007) *Journal of Obstetrics and Gynaecology Canada* 29(10): 843-848.

²²⁸ The legal debate over frozen embryos has been centered around two main issues: 1) whether frozen embryos are to be regarded as a person, property, or something else; and 2) how disputes between gamete donors should be resolved as regards the disposition of surplus frozen embryos. For examples of the latter see: John A. Robertson, “Prior Agreements for Disposition of Frozen Embryos” (1990) 51 *Ohio St. L.J.* 407; 49 *B.C. L. Rev.* 529; Jessica L. Lambert, “Developing a Legal Framework for Resolving Disputes between Adoptive Parents of Frozen Embryos: A Comparison to Resolutions of Divorce Disputes between Progenitors” (2008) 49 *Boston College Law Review* 529. For examples of the former see: Michelle F. Sublett, “Frozen Embryos: What Are They and How Should the Law Treat Them” (1990) 38 *Clev. St. L. Rev.* 585; Lynne M. Thomas, “Abandoned Frozen Embryos and Texas Law of Abandoned Personal Property: Should There Be a Connection” (1997-1998) 29 *St. Mary's L.J.* 255.

²²⁹ See for example: Sarah Franklin & Celia Roberts, *Born and Made: An Ethnography of Preimplantation Genetic Diagnosis* (Princeton: Princeton University Press, 2006); Estair Van Wagner, Roxanne Mykitiuk & Jeff Nisker, “Constructing ‘Health’, Defining ‘Choice’: Legal and Policy Perspectives on the Post-PGD Embryo in Four Jurisdictions” (2008) *Medical Law International* 9: 45-92; Erik Perens & Adrienne Asch, “Disability Rights Critique of Prenatal Genetic Testing: Reflections and Recommendations” (2003) *Mental Retardation and Developmental Disabilities Research Reviews*, 9: 40-47; Jason C. Roberts, “Customizing Conception: A Survey of Preimplantation Genetic Diagnosis and the Resulting Social, Ethical, and Legal Dilemmas” (2002) 1 *Duke Law & Technology Review* 1-21.

²³⁰ Recent data indicates that one in ten children produced through intracytoplasmic sperm injection, or ICSI, may face significant health challenges, although the scientific results are not yet conclusive. See *infra* note 600 and the accompanying discussion.

SECTION II

Chapter Four: An Empirical Approach to AHR in Canada

The Creating Our Families Research Project

This project is greatly indebted to the empirical findings that emerged from a Canadian Institutes of Health Research-funded study entitled “Creating Our Families: A pilot study of the experiences of lesbian, gay, bisexual and trans people accessing assisted human reproduction services in Ontario” (FRN-103595). The study was developed in 2009 by Lori E. Ross (Re:searching for LGBTQ Health, Centre for Addiction & Mental Health), Leah S. Steele (St. Michael’s Hospital), and Rachel Epstein (LGBTQ Parenting Network, Sherbourne Health Centre), with the goal of interviewing LGBTQ people about their experiences with fertility clinics across the province.²³¹ The author was invited to join the project in 2010 as co-investigator and legal analyst. It is through the empirical research we conducted, as well as meetings with our advisory team, that this queer perspective on assisted reproduction has been developed.

Early versions of this dissertation were shredded almost entirely, as the practical knowledges encountered through the Creating Our Families project failed to mesh with the grand conceptual fabric that had been knit in the library. The initial intention of this dissertation was to track gay men across the globe as they sought out surrogates in the developing world. However it soon became clear that gay couples from Canada were not heading overseas to find surrogates;

²³¹ Lesley A. Tarasoff, MA, led participant recruitment and screening and completed the analysis of participant demographic data. Scott Anderson, MHSc, assisted in the development of the study, and datejie green, BA(Hons.), led data collection. Other staff and students from the Re:searching for LGBTQ Health team also contributed to this project.

on the contrary, the men interviewed in this project were clear about wanting to stay and find surrogates at home, despite frustration with a regulatory scheme that they perceived as functioning mainly to baffle their family plans. A great deal was learned in the homes of LGBTQ people across the province of Ontario, and it is this grounded knowledge that informs and inspires the coming pages.

The next section explains the background to the study, outlines some methodological concerns and challenges, and describes the process of data gathering, coding and analysis.

Research Methodology

The study was developed as a qualitative research project, grounded in the methodology of community-based research [CBR].²³² In line with CBR principles, the research team collaborated with an advisory committee of LGBTQ parenting educators, LGBTQ service users and AHR service providers throughout the project. In addition, the research team itself consisted of professional peer researchers (LGBTQ people), several of whom have used AHR services in the past.²³³ This project received ethics approval from the Research Ethics Board (REB) of the Centre for Addiction and Mental Health (protocol #048/2010) and the REB of York University (certificate #STU 2010-154).

Interview participants were recruited between July 2010 and March 2011 through online networks (*i.e.*, LGBTQ and health listservs), by mail (flyers) to over 200 service providers and organizations (*i.e.*, fertility clinics, HIV/AIDS service organizations, midwifery practices), through engagement with LGBTQ community agencies and advocates, and in person at Pride

²³² BA Israel, AJ Schulz, EA Parker, & Becker AB. (1998). Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health. *Annual Review of Public Health, 19*, 173-202.

²³³ Methodology data and text is condensed from a jointly-authored piece by Ross et al., "Creating Our Families: Lesbian, gay, bisexual, trans and queer people's experiences with assisted human reproduction services in Ontario, Canada" in preparation.

celebrations across Ontario. Interested individuals contacted the study office by telephone or email, and were subsequently screened by telephone to determine eligibility. Participants were eligible for an interview based on the following criteria: they identified as lesbian, gay, bisexual, trans and/or queer; were aged 18 years or older; had used or considered using AHR services since 2007; and had lived and/or used health services in Ontario. Purposeful sampling was used to select a group of interviewees whose experiences with AHR services were representative of those identified by the broader, screened group.²³⁴ This included anyone who had begun researching reproductive options, visited fertility clinics, sought the services of surrogate mothers, and/or accessed donor sperm either known or unknown. Interview participants were also selected based on their socio-demographic characteristics (i.e., sexual orientation, gender identity, racial/ethnic identity, and geographic location), in an effort to represent the diversity of the LGBTQ population in Ontario.²³⁵

Interviews took place between December 2010 and August 2011, with interviews lasting 60 to 90 minutes. The three trained interviewers, including the author, followed a semi-structured guide, with questions addressing each of the objectives.²³⁶ Prior to the interview, each participant completed a socio-demographic questionnaire.²³⁷ Written consent was obtained from all study participants prior to the interview.²³⁸

Written Consent Forms – Concerns and Considerations

In crafting the written consent forms, there was a concern that participants engaging in illegal trade (including payment to surrogates and payment for human gametes) would be put at

²³⁴ Pope C, Mays N. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ* 1995; 311: 42-45.; Marshall MN. Sampling for qualitative research. *Fam Pract* 1996; 13: 522-525.

²³⁵ See Appendix A for a detailed breakdown of participant demographics.

²³⁶ See Appendix B for a copy of the interview guide.

²³⁷ See Appendix C for a copy of the socio-demographic questionnaire.

²³⁸ See Appendix D for a copy of the written consent form.

risk by speaking openly about their activities.²³⁹ There was a long discussion among members of the research team about the potential scenario of our research being subpoenaed in evidence, thereby prompting us to release the names of our informants. Our ethical mandate was therefore strongly based upon a need to ensure the confidentiality of research participants.²⁴⁰ There was only one precursor to this type of subpoena in Canadian research history, wherein a graduate student at Simon Fraser University named Russell Ogden was subpoenaed to turn over his research materials on assisted suicide to a Vancouver coroner.²⁴¹

Briefly, in early 1994 Ogden had completed a path breaking and controversial study on assisted suicide that received international attention.²⁴² His research relied upon interviews with people actively participating with and assisting people to commit suicide, an unlawful act in Canada.²⁴³ Shortly following his successful Masters defense, Ogden was subpoenaed to appear before a coroner's inquest.²⁴⁴ When he appeared at the inquest, the coroner asked him to reveal some of his sources. Ogden refused, based on his pledge of confidentiality to the participants of

²³⁹ The criminalized provisions of the *AHRA* will be discussed at length in Chapter Five. For now, it is sufficient to say that criminal penalties do apply when making payment to any broker or direct provider of surrogate services, and when making payment for human sperm or ova.

²⁴⁰ See especially Fogel, C. 2007. Ethical issues in field-based criminological research in Canada. *International Journal of Criminal Justice Sciences* 2: 109–118. See also: Palys, T., & Lowman, J. (2002). Anticipating law: Research methods, ethics, and the law of privilege. *Sociological Methodology*, 32: 1-17.; Israel, M. (2004). Strictly confidential? Integrity and the disclosure of criminological and socio-legal research. *British Journal of Criminology*, 44, 715-740.

²⁴¹ Palys, T., & Lowman, J. (2000). Ethical and legal strategies for protecting confidential research information. *Canadian Journal of Law and Society*, 15(1): 39-80.; Lowman, J., & Palys, T. (2004). Ethics and institutional conflict of interest: The research confidentiality controversy at Simon Fraser University. *Sociological Practice*, 2(4): 245-264.

²⁴² Ogden, R. 1994. "Euthanasia and assisted suicide in persons with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). M.A. Thesis, School of Criminology, Simon Fraser University. See also: Mason, B. 1994. "SFU Research on Euthanasia and AIDS Attracts International Media Attention." *Simon Fraser Week*, February 17, pp. 1, 3.

²⁴³ While suicide has not been a crime in Canada since 1972, aiding or abetting a person to commit suicide is illegal. See: Martha Butler et al., *Euthanasia and Assisted Suicide in Canada* (2013) Parliamentary Information and Research Service, Library of Parliament, Ottawa.

²⁴⁴ *Inquest of Unknown Female* (1994). Oral Reasons for Judgement, the Honourable L.W. Campbell, Vancouver Coroner. Case file 91-240-0838.

the study - a pledge that he maintained was in accordance with University policy.²⁴⁵ After a lengthy legal debate, the coroner finally agreed that the costs of disrupting the researcher-participant privilege did not outweigh the benefits of knowing the privileged information. The issue was dismissed and Ogden was not compelled to release any identifying information on his research participants.²⁴⁶

Despite Ogden's successful defense of researcher-participant privilege, however, the Creating Our Families team was still deeply concerned with protecting the identities of all participants when conducting this potentially criminological research. As laid out by Ted Palys and John Lowman of the School of Criminology at Simon Fraser University, there are two main strategies that researchers may adopt to deal with the possibility of subpoena: a) methodological precautions, and b) legal strategy.²⁴⁷

Methodological Precautions

The sensitive nature of the Creating Our Families study placed an onus upon the researchers to conduct the research according to the highest ethical standards. LGBTQ parents and the communities that serve them have been operating within a 'gray zone' of legislation regarding the reimbursement of surrogacy and ova/sperm donors, and the research team deemed it critical to protect participant wellbeing through the safe handling of all data gathered. The strict confidentiality of this data was necessary to protect not only the standards upon which

²⁴⁵ Nicholas Blomley and Stephen Davis, "Russel Ogden Decision Review", October 1998, On line: SFU President's Homepage <<http://www.sfu.ca/pres/OgdenReview.htm>>

²⁴⁶ This was then followed by Ogden's suit against SFU for failing to support him adequately during the legal process. Ogden, who represented himself, argued the case as a point of contract: since he was undertaking research as he was required to do as a graduate student, according to taught professional standards, and had submitted his proposal to the Ethics Committee, was not the university obliged to stand beside him in court? On that point of contract, the judge said "No." The university makes its own decisions about how to safeguard "the highest ethical standards" it is charged with upholding, and has no particular obligation to pay the legal bills of a graduate student who ends up in court, however noble the cause. See: *Russel Ogden v. Simon Fraser University*. 1998. Burnaby Registry of the British Columbia Provincial Court: Case No. 26780. On line: T. Palys Homepage <<http://www.sfu.ca/~palys/steinbrg.htm>>

²⁴⁷ *Supra* note 241.

academic research at large depends, but also the practitioner and participant communities connected to this specific focus of research.

A common methodological precaution is to make one's research materials completely anonymous, so that even if they were to be subpoenaed they would be meaningless in terms of participant identification. As Palys and Lowman suggest, "in some types of research, one need never ask for or know participants' names in the first place; when we must obtain that information, any records (e.g. data files, interview transcripts, field notes) should be anonymised at the earliest opportunity."²⁴⁸

While this research project did require that names were initially needed to tabulate the screening form and exchange emails and phone calls, all identifying information was divorced from the data at the earliest possible opportunity. The data files, interview transcripts and field notes were all stored according to a numerical coding system, with a locked master key to keep track of the coding referents. The transcripts were then stripped of all identifiers, and stored both as encrypted files and under password in a secure computer system within a locked facility. Only team members had access to these records.

While the anonymization of data did occur at the earliest possible instance, there was some concern about the intimate bounds of the LGBTQ community in Ontario, where many of the participants may already be known to the research team. Palys and Lowman outline this second consideration:

In some cases, researchers cannot help but know the identity of participants. In this type of research, researchers need to anticipate the legal strategy to be used to assert evidentiary privilege, and design research in a way that maximises their chances of success.²⁴⁹

²⁴⁸ *Ibid* at 44.

²⁴⁹ *Supra* note 241 at 44.

Thus, while anonymous record-keeping was believed to provide some degree of protection, there was also discussion about the utility of developing a legal strategy as well.

Legal Strategy

The legal strategy suggested by Palys and Lowman was the same one that had been successfully applied by Russel Ogden before the Coroner's Court in British Columbia.²⁵⁰ As the only Canadian court case to involve a researcher subpoenaed to release research materials, this provided a conceptual model for the Creating Our Families team. Ogden had planned his consent form in a manner that appealed to the test outlined by Wigmore's *Evidence in Trials at Common Law*. This is a common law mechanism used to adjudicate claims of evidentiary privilege on a case-by-case basis. The test is based upon four key tenets, all of which must be present to ground a successful claim of privilege:

- 1) *The communications must originate in a confidence that they will not be disclosed.*
- 2) *This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.*
- 3) *The relation must be one which in the opinion of the community ought to be sedulously fostered.*
- 4) *The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.*²⁵¹

After reviewing the Ogden case and discussing concerns around pre-existing knowledge of the identity of many participants, and the advisement of the author, the Creating Our Families

²⁵⁰ Jackson, M., & MacCrimmon, M. (1999). Research confidentiality and academic privilege: A legal opinion. Legal opinion commissioned by Simon Fraser University (SFU) Research Ethics Policy Revision Task Force, online: <<http://www.sfu.ca/~palys/JackMacOpinion.pdf>>.

²⁵¹ In *R. v. Gruenke*, [1991] 3 S.C.R. 263, Lamer C.J. commented that: "the case-by-case analysis has generally involved an application of the 'Wigmore test,' which is a set of criteria for determining whether communications should be privileged (and therefore not admitted) in particular cases."

team decided to incorporate a legal strategy in addition to the methodological precautions described above. Under the Wigmore test, in order to claim confidential privilege, a researcher must demonstrate the *intent* to provide an *absolute guarantee* of privilege, and show that the *promise* of that confidence is *essential* to the research relationship. This intent was evidenced by the team through wording in the informed consent form, which contained a written promise of “the strictest confidentiality with an absolute guarantee of privacy.” The team’s intent was then formalized through the relationship of the researcher and participant with the signing of the informed consent form. The informed consent form thus explicitly integrated the conditions of the Wigmore test to assert a relationship of confidential privilege found to be valid in Canadian jurisprudence.²⁵²

The second part of the Wigmore test holds that the interest in protecting that relationship must also outweigh the competing interest in disclosure. Thus, any 'absolute' guarantee is necessarily limited by the possibility of unanticipated heinous discovery.²⁵³ Research confidentiality may also be overridden if a participant's innocence is at stake and one of the research team is called to testify in their defense.

Barring such unlikely scenarios, however, the revised informed consent form met the Wigmore criteria and offered an important safeguard of confidentiality to participants. Should the Creating Our Families research ever be subpoenaed, it was hoped, the team could argue that such an absolute guarantee rests upon a matter of case-by-case evidentiary privilege. It was agreed that using the Wigmore criteria as a guide to research design would allow the research

²⁵² The Supreme Court of Canada has made it clear that the assertion of a case-by-case claim for privilege must be made using the Wigmore test (see *R. v Gruenke* (1991). 3 S.C.R. 263.(religious advisor); *M(A) v Ryan* (1997) 143 DLR (4th) 1 (SCC) (therapist-patient); *Letorneau v Clearbrook Iron Works Ltd* [2004] FCJ 1796 (common law partners)).

²⁵³ Should one uncover, for example, an intent to commit murder that is clear, serious, and imminent as laid out in *Smith v Jones* (1999) 132 CCC (3d) 225 (SCC).

team to anticipate the evidentiary concerns of the courts in a way that maximized the protection of research participants by creating the best case for recognition of a researcher-participant privilege.²⁵⁴

Unfortunately, the ethics review board of the Center for Addiction and Mental Health [CAMH] was concerned with the possibility of a Court Order mandating the release of participant information, and proved unwilling to approve the wording. The staff lawyer instead suggested the following phrasing, which the Creating Our Families team ultimately deemed too weak to support the four necessary parts of the Wigmore test:

Given full and complete disclosure by research subjects is necessarily for the purposes of this investigation, the investigators intend that all information provided to them will remain absolutely and strictly confidential. However, *this intention may have legal limits*, for example, where required to be disclosed by Court Order, or where information is disclosed that suggests a person may be a risk to themselves or others etc.²⁵⁵

Rather than use this suggested wording, the team instead decided to adopt a two-part option for anonymity. The first option was of the standard variety, wherein all transcripts would be de-identified and names changed, but the participants would still be in a data bank for future contact, updates and questions. This would allow the team to send updates and research findings and keep track of contact information for future projects, although all publications would have the names changed and the data stripped of identifying characteristics. The second option was designed to protect participants who were engaging in criminalized activities, and offered them a more rigorous form of anonymity in which all identifying data – including contact information – would be immediately destroyed. This meant they could not be part of updates and publications stemming from the data, and would not be available for longitudinal study in the future. All

²⁵⁴ Palys, T. S., & Lowman, J. (2006). Protecting research confidentiality: Towards a research-participant shield law. *Canadian Journal of Law and Society*, 21(1), 163–185.

²⁵⁵ Personal correspondence, CAMH legal team, October 25, 2010. Emphasis added.

potentially identifying information would be wiped across the system and their transcript key would be left blank.

Data Gathering and Analysis

In total, 118 individuals or families responded to the study flyer to express interest in participating in the study. Of these, the team was able to contact 108 to complete eligibility screening, locating 100 participants of whom were eligible (93% of all respondents). The primary reason for ineligibility was use of AHR services prior to 2007.

Since participants often chose to be interviewed as couples, or in one case, together with a known sperm donor, a total of 66 individuals participated in the 40 interviews. The majority of the sample (72.7%) identified their gender as cisgender (non-trans) women, with a number of cisgender men and trans people also participating (13.6% and 13.6% respectively). With respect to sexual orientation, the majority of study participants self-identified as either lesbian (32%) or queer (33%), with six other sexual identities represented. Approximately half of the sample lived in the Toronto region, with the remainder distributed across the province of Ontario.

The majority of participants were aged 31-40 years, married or in a common-law relationship, White, university educated, and with an annual household income of greater than \$66,000 CAD. Participants typically accessed, or attempted to access AHR for one of two primary purposes: family creation (including services such as cycle monitoring, intrauterine insemination, *in vitro* fertilization, and surrogacy), and for some trans participants, fertility preservation prior to or during transition (including services such as embryo and sperm storage, egg extraction and storage, and ovarian tissue preservation).

Interviews were digitally recorded, transcribed verbatim and checked for accuracy. Thematic content analysis was undertaken to identify common themes in the data generated from this question.²⁵⁶ Three members of the team, including the author, independently analyzed the transcripts, and results were compared for consistency. Further data analysis was carried out by the targeting of key words with software program QDA Miner 4.

To the best of our team's knowledge, this represents the largest study yet conducted to focus exclusively on how LGBTQ communities are accessing reproductive technologies. The team was mainly comprised of people from the field of public health, and as such the interviews focused on issues such as counseling, gatekeeping, and access to sperm, eggs, and known gamete donors. The interests of the author was represented in these matters, as well as questions about the legal issues faced by LGBTQ people in planning their families, in the reproductive clinic and in securing donor gametes and surrogates.

Based on the empirical knowledge collected through this project, my dissertation aims to translate the actual experience of queer Canadians with AHR into a new theoretical framework capable of addressing the complexity of family law in the 21st century. These interviews are rich in stores of resilience and hope, and articulate a thrilling new vision for reproductive law and technology. Study participants raised, for example, pressing concerns around access to gametes, surrogates, and the rights of the donor-conceived child. It is contended that such issues must lay the ground for urgently-required policy development in Canada, even as attention is maintained upon the operations of power that undergird both law and medicine. This dissertation is thereby

²⁵⁶ Elo S, Kyngas H. The qualitative content analysis process. *J Adv Nurs* 2008; 62:107-15.; Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; 3: 77-101.

driven by certainty that the voices within stand as powerful affirmations of how a queer analysis can guide Canada toward a more just AHR policy for all.

Making Sense of the Data

Over the long process of analyzing these interviews conducted with queer Canadians using AHR, a palpable sense of their frustration with law and policy emerged. The inertia of the *Assisted Human Reproduction Act* will be discussed in Chapter Five, but in short, this sweeping piece of legislation has been of little use in providing guidance to Canadians using reproductive technology – and even more so when LGBTQ people were the ones seeking fertility care. Yet when looking to the ways in which the courts had begun wrestling with similar issues, it became clear that the jurisprudential tools being used to understand queer family-making were also hopelessly saturated in a heterosexual modality. It grew evident that queer families and their needs pose a substantive challenge to courts and legislators alike. These challenges form the substance of Attachments One and Two.

Another key element of analysis involved the demographics of the study. The Creating our Families project made substantial efforts to reach out to racialized, poor and minority LGBTQ communities during our screening process, and intentionally chose not to interview many of the white women who responded to our study in hopes of gaining a more balanced demographic profile. The author personally travelled to remote reaches of Northern Ontario to interview people in non-urban settings, visiting townships hundreds of miles from Thunder Bay and Sault Ste. Marie. Despite this methodological selection and commitment to a diversity of experience, our study was still overwhelmingly white, female, educated and middle-class.

Indeed, a full 40.9% of participants reported a combined household income of more than \$100,000.²⁵⁷

Despite best efforts, this sampling might to some degree reflect the nature of the urban-focused networks through which the project solicited participants. It might also reflect the class, race, educational background and experience of the Creating Our Families team itself, as participants were occasionally familiar to members of the team due to our own membership within local queer communities. It is also possible that poor or racialized participants were not able to volunteer (at minimum) one hour of their time for the study. Members from immigrant, colonized or undocumented communities may have been wary of the purposes and intentions of the project, as well as the subjection of their experience to scientific knowledge practices. People from transgender communities in particular have reason to be suspicious of medicalized frames of research, and CAMH was a leading member of the research team. Finally, this might reflect the composition of the Ontario LGBTQ community itself, and in particular those individuals and groups prepared to enter into parenting arrangements.

Even accounting for these methodological and positional biases, however, the lopsided response to our call for participants is notable. I believe that the remarkable concentration of privilege among research participants serves primarily to demonstrate the exclusive nature of these technologies. Even the white, wealthy families that were interviewed bemoaned the costs of AHR, with a substantial financial outlay consistently flagged as a major barrier for these households. It is not possible to draw firm quantitative conclusions from a relatively small purposeful sample (40 interviewees selected from 108 eligible participants). Nevertheless, this analysis squares with the experiences of select lesbian interviewees of colour and from lower

²⁵⁷ For more detail, please see Appendix A for a detailed breakdown of participant demographics.

socioeconomic groups who *had* thought about accessing AHR and decided ultimately to go the ‘low-tech’ route of home insemination with a known donor or sexual intercourse with a male friend. These experiences and the racial and class implications for AHR will be explored in more depth in Chapters 7 and 8.

Conclusion

The increasing ubiquity of AHR demands new approaches to evaluate historic categories of parental affiliation and caregiving. As Nicholas Bala has argued, “Canadian jurisdictions need statutory reform to better address the issues being raised by the growing use of AHRs.”²⁵⁸ This was clearly supported by the Creating Our Families study, which canvassed LGBTQ people about the many issues they encountered when seeking to access AHRs. Yet judges continue to strain at the bounds of existing family law to account for what appear to be novel and confusing kinships.²⁵⁹

The next chapter will explore this legal matrix, canvassing the history of Canada’s primary federal regulation around assisted reproduction, and then looking at how this and other laws have specifically impacted queer people and their families. It traces the attempt to create an overarching legislative structure to regulate AHR research and clinical application in Canada, and how this has been informed (or otherwise) by LGBTQ perspectives.

²⁵⁸ Bala, *supra* note 28 at 528.

²⁵⁹ For classic examples of this struggle with new family forms, see: Wadlington, Walter, *Artificial Conception: The Challenge for Family Law*, 69 Va. L. Rev. 465 (1983); Silva-Ruiz, Pedro F, *Artificial Reproduction Techniques, Fertility Regulation: The Challenge of Contemporary Family Law*, 34 Am. J. Comp. L. Supp. 125 (1986); Garrison, Marsha, *Law Making for Baby Making: An Interpretive Approach to the Determination of Legal Parentage*, 113 Harv. L. Rev. 835 (1999-2000).

Chapter Five: Laws of Conception

Introduction

The story of Canadian regulation in the field of assisted human reproduction is a remarkable one. It is a history of progress and regress, uniquely inflected by feminist voices and involving decades of struggle to develop a clear regulatory framework for the governance of a range of biotechnologies. As it stands today, twenty-five years after the first government commission was struck to examine the issue of new reproductive technologies, Canada still lacks many guidelines for their application. As Francoise Baylis has recently protested in frustration at this long series of regulatory failures and disappointments:

So it is that more than 30 years of hard work by dedicated Canadians committed to promoting and protecting the interests of those who use, and are born of, assisted reproduction has come to naught. Since the mid-1980s Canadians have advocated for the regulation of reproductive and genetic technologies. In 1993 the final report of the Royal Commission on New Reproductive Technologies recommended federal legislation. In 2004, after many failed attempts, legislation was passed. And, in 2010 much of that legislation was found to be unconstitutional.²⁶⁰

This chapter will canvass these decades of effort to develop and approve a comprehensive regulatory scheme to manage all clinical and research activities relating to assisted human reproduction and genetic research. This is well-traveled terrain, with many other academic and popular commentators having traced this tale across the arcs of a convoluted history.²⁶¹ Chapter Five will instead seek to apply a queer lens to this history, looking to locate the ways in which heteronormative frames and binary formulations of nature/culture (and their

²⁶⁰ Françoise Baylis, *The Demise of Assisted Human Reproduction Canada*, *J Obstet Gynaecol Can* 2012;34(6):511–513 at 513.

²⁶¹ Such texts will form many of the touchstones of this chapter, most notably the *Misconceptions* books published in the wake of the controversies around the Royal Commission of New Reproductive Technology, *infra* note 296. For a new look at these debates, see a recently published anthology on reproduction and women's rights in Canada: Paterson, S., Scala, F., and Sokolon, M. (eds.) *Fertile Ground: Exploring Reproduction in Canada* (Montreal: McGill-Queen's University Press, 2014).

absences) have underscored its rationale and rhetoric. It will attend to the moments in which queer bodies do emerge from the debates, and analyze these spaces of anxiety and inclusion as produced within the larger frameworks of both feminist and ‘mainstream’ ideological positions.²⁶² Importantly it will also look to the absences of queer perspectives, and analyze how this lack of stakeholder recognition may have contributed to the current reproductive landscape faced by prospective LGBTQ parents.

Anxieties Over New Technology

This genealogy begins with the main challenges faced by early regulators. The first problem stemmed from the difficulty of even *defining* what these new innovations were. When biotechnologies began to receive national press, particularly research in assisted reproduction and *in vitro* fertilization (IVF), they were often framed as elements of a strange and frightening scientific order. Surrogacy, test tube babies, cloning and other reproductive technologies “became a pervasive theme in horror films and science fiction fantasies” as these new innovations “appeared to promise both amazing new control over nature and terrifying dehumanization.”²⁶³

²⁶² This discursive binary between ‘feminist’ and ‘mainstream’ thinkers is one that settled in the work of the Royal Commission on New Reproductive Technologies, as discussed below. For example, the Commission included thirteen proposed studies of embryo/fetal tissue research, five of which were divided into a request for “one mainstream study, one feminist study.” This epistemological framing creates an obvious tension between feminist perspectives and so-called ‘popular’ thinking without indicating how or why such perspectives might differ. Such tension was evident not only in these forms of knowledge production, but across the makeup of the Commissioners themselves, who were later rent through internal divisions into ‘feminists’ and ‘everybody else’. Judy G. Morrison, *Delivery Delayed*, Unpublished MA Thesis, 1997. At page 130.

²⁶³ Dorothy Nelkin and M. Susan Lindee (1998). Cloning in the Popular Imagination. *Cambridge Quarterly of Healthcare Ethics*, 7, pp 145-149 at 145. See also Busby, Karen & Delaney Vun, “Revisiting the Handmaid’s Tale: Feminist Theory Meets Empirical Research on Surrogate Mothers,” 26 *Can. J. Fam. L.* 13 (2010) for a discussion of how Margaret Atwood’s popular novel fueled second-wave feminist concerns around women’s exploitation.

Functioning as a site of anxiety for the disruption of the nature/culture binary, these fears took vigorous and remarkably international form, and were perhaps most sharply clarified by radical feminist movements and their suspicion of the potential for technological domination over women's bodies. There was particular concern about the medicalization of women's bodies and the subjection of female reproductive functions to patriarchal control.

The concept of *medicalization* describes a process "in which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders."²⁶⁴ The process of diagnosing a pathology requires its marking as deviance from the norm, thereby affirming a certain set of bodies and conditions as 'healthy' and designating others as 'unhealthy' and in need of treatment. As Bryan Turner explains, the medicalization of society has involved "the growth of medical dominance under the auspices of the state, associated with the development of a professional body of knowledge" alongside "a regulation and management of populations and bodies in the interests of a discourse which identifies and controls that which is normal."²⁶⁵ The baseline of 'normal' which emerges from this professionalization is most often a white, heterosexual, middle-class, able bodied male – the standard bearer of the heterosexual imaginary.

The sexist and heterosexist gaze of medicalization has thus resulted in particularized control over women and queers, and perhaps nowhere have these bodies been more medically managed than in terms of their relationship to reproduction.²⁶⁶ As Marcia Inhorn explains in relation to studies of infertility, such projects make clear that "women's bodies are considered

²⁶⁴ Conrad, P. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18: 209-232 at 209.

²⁶⁵ Turner, B. 1995. *Medical Power and Social Knowledge*. Second Edition. Thousand Oaks, CA: Sage. At 208-210

²⁶⁶ Michelle Walks, "Breaking the Silence, Infertility, Motherhood, and Queer Culture," *Journal of the Association for Research on Mothering*, Vol 9(2), 2007.

the locus of ‘disease’, and hence the site of anxious surveillance and intervention.”²⁶⁷ This concern over the gendered nature of medicalization and its specific effects on female bodies has long been a central feminist concern, and one which animated much of the response to an expanded access to reproductive assistance in the early 1980s.

International Radical Feminist Movement

Radical feminists led the early charge against the growing prevalence of AHR. While radical feminists were a diverse set of authors without consensus on many issues, their stance may roughly be characterized by the presumption of *a foundational link between new reproductive technology and patriarchal culture*.²⁶⁸ Thus, new reproductive technologies were viewed as an instantiation of patriarchal culture and an intensification of male scientific rationale directed toward dominion over female reproduction.²⁶⁹ From the position of many commentators, these were dangerous and untested procedures that were being forced upon women’s bodies as guinea pigs of experimental science.²⁷⁰ These technologies were thus a force to be resisted and critiqued, and many radical feminists even expressed suspicion of other women who willingly undertook procedures such as IVF; as collaborators with the patriarchal

²⁶⁷ Inhorn, *supra* note 2.

²⁶⁸ Sarah Franklin, 2011 ‘Transbiology: a feminist account of being after IVF’ in The Scholar & Feminist Online, Special Issue ‘Critical Conceptions: Technology, Justice, and the Global Reproduction Market’, ed. Rebecca Jordan-Young at 1. See for example the founding anthology of feminist debates over new reproductive technology: Rita Arditti, Renate Duelli Klein, and Shelley Minden, eds., *Test-Tube Women: What Future for Motherhood?* (London: Pandora, 1984). For a review of early feminist work on new reproductive technologies, see: Sarah Franklin and Maureen McNeil, "Reproductive Futures: Recent Literature and Current Debates on Reproductive Technologies," *Feminist Studies* 14.3 (1988): 545-61.

²⁶⁹ *Ibid.* Franklin, Transbiology. See also Mary O'Brien. *The Politics of Reproduction* (London: Routledge, 1981).

²⁷⁰ Albury, R. “Who Owns the Embryo?” In Rita Arditti, Renate Klein, and Shelly Minden, eds. *Test-Tube Women: What Future for Motherhood?* (London: Pandora, 1984.).

reproductive order, such women were brainwashed collaborators who doubted their own power.²⁷¹

But sometimes women also collude because we have been brainwashed. The information and education we get is one-sided and male-centered and the hidden conviction creeps into our own minds that men and their technology must be better than our own body and our own experiences with it.²⁷²

This widespread unease with new technologies coalesced into a remarkably global feminist movement in the mid-1980s, with the development of a network representing women from more than thirty countries.²⁷³ FINRRAGE, or the Feminist International Network of Resistance to Reproductive and Genetic Engineering, consisted of prominent social critics Gena Corea, Janice Raymond, Renate Klein, Patricia Spallone and Deborah Steinberg, among others. FINRRAGE was perhaps the most vocal wing of a movement concerned with guarding the ‘natural’ reproductive functions of women from male control, and produced literature, analysis and organized conferences to bring these concerns to the fore. As the FINRRAGE manifesto states:

We, women, declare that the female body, with its unique capacity for creating human life, is being exploited and dissected as raw material for the technological production of human beings. For us women, for nature, and for the exploited peoples of the world, this development is a declaration of war. Genetic and reproductive engineering is another attempt to end self determination over our own bodies.²⁷⁴

²⁷¹ Yet as Sarah Franklin helpfully points out, this was by no means the only position among radical feminists (and certainly not among the feminist community at large). This easy equivocation of reproductive technology with patriarchy was also resisted by many. Franklin., *supra* note 268.

²⁷² Renate Duelli Klein, “What’s ‘new’ about the ‘new’ reproductive technologies?”. In *Man-Made Women: How New Reproductive Technologies Affect Women*, Gena Corea et al. (eds.) (Bloomington: Indiana University Press, 1987) at 65.

²⁷³ Gena Corea et al. “FINRRAGE: The Struggle Over New Reproductive Technology,” reprinted at http://www.finrrage.org/pdf_files/History%20of%20Finrrage/FINRRAGE.pdf. See also the prologue of *Made to Order: The Myth of Genetic and Reproductive Progress*, eds. Patricia Spallone and Deborah Lynn Steinberg (Oxford: Pergamon Press, 1987), 1-12.

²⁷⁴ Renate Duelli Klein, “Genetic and Reproductive Engineering – The Global View.” In Jocelyn A. Scutt, ed. *The Baby Machine: The Commercialisation of Motherhood*. (Carlton: McCulloch Publishing Ltd., 1988) at 258.

Radical feminists such as Corea understood the expansion of reproductive technology within a patriarchal order as necessarily leading to women being commodified and exploited for their biological capacities. Drawing a parallel with prostitution and the commodification of female body parts through sexual labour, Corea envisioned a dystopic future in which the reproductive elements of a woman's body would be stripped away and sold piecemeal:

Just as the patriarchal state now finds it acceptable to market parts of a woman's body (breast, vagina, buttocks) for sexual purposes in prostitution...so it will soon find it reasonable to market other parts of a woman (womb, ovaries, egg) for reproductive purposes.²⁷⁵

Many members of FINRRAGE were also deeply concerned with the issue of surrogate motherhood, and predicted that expanded reproductive technology would lead to the commodification of women as factories of reproductive labour. This outcome would impact women from lower socio-economic brackets, who would be reduced merely to 'breeders' in this new economy. As impacted by race and nationality, women of colour and those of precarious legal status would be unable to resist the patriarchal imperative to reproduce for (someone else's) profit. Yet white women were also seen as cogs in this patriarchal machine, forced to produce eggs of 'superior' value to be incubated by bodies of colour. Corea again was a powerful oracle on the matter, imagining a site of commerce she called the "reproductive brothel" where women both white and black would be used as breeding machines for the patriarchy:

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, "valuable"

²⁷⁵ Gena Corea, "The Reproductive Brothel." In Gena Corea and Renate D. Klein, eds. *Man Made Women: How New Reproductive Technologies Affect Women*. (Bloomington: Indiana University Press, 1987) at 42.

females as young as 2 years and some as old as 50 or 60 could be induced to produce eggs.²⁷⁶

There were of course many other feminist positions taken on the subject of new reproductive technologies,²⁷⁷ some of which explicitly sought to counterbalance the perceived extremism of writers like Corea and Klein. For example Naomi Pfeffer and Anne Woollett published an early 1983 account of female infertility that was sympathetic to the issues faced by women in response to the oppositional tactics of more radical commentators.²⁷⁸ From the mid-1980s onward other FINRRAGE members also produced works on how and why women were accessing IVF and other reproductive technologies, seeking to moderate the ‘hard line’ of feminist opposition to technology “which increasingly, to some, resembled a caricature of radical feminist goals.”²⁷⁹

Feminist Movements in Canada

In Canada during this period, the women’s movement had been recently galvanized by the 1982 patriation of the Canadian Constitution, including the development of a *Charter of Rights and Freedoms* that had seen sustained lobbying for constitutional reforms from organized movements in regard to Aboriginal rights and Québécois distinct society. Emerging from the same era was a campaign for women’s rights that drew speakers and leaders from across the

²⁷⁶ Gena Corea, *The Mother Machine, : Reproductive Technologies from Artificial Insemination to Artificial Wombs* (New York: Harper & Row, 1985) at 278-279.

²⁷⁷ For example Donna Haraway was also writing during this period, using a Marxist feminist analysis to understand the relationship between technology and reproduction. In a slightly different forum, corporeal feminists such as Luce Irigaray, Moira Gatens, Gayatri Spivak, Hélène Cixous, and Elizabeth Grosz had been developing an understanding of the body itself as the site of inquiry, and a site produced through social systems of meanings and discourse. Irigaray, Luce. *Speculum of the Other Woman*. Gillian C Gill, trans. 1985. (New York: Cornell University Press, 1974.).

²⁷⁸ Naomi Pfeffer and Anne Woollett, *The Experience of Infertility* (London: Virago, 1983).

²⁷⁹ Franklin, *Transbiology*, supra note 268 at 2.

country, as “a collective and highly focused campaign, a campaign in which many women who were lawyers played some of the key roles as advisors and strategists.”²⁸⁰

This campaign successfully lobbied for the inclusion of a guarantee of equality in the wording of section 15 of the new Charter, entrenching rights to protection of the law free from discrimination based on “race, national or ethnic origin, colour, religion, sex, age or mental or physical disability”.²⁸¹ Sexual orientation was not included in this list of grounds, despite an amendment that called for its enumeration proposed by then-MP Svend Robinson.²⁸² Mr. Robinson would later come out as Canada’s first openly gay MP in 1988.²⁸³

The wording of section 15 marked an important milestone for the nascent Canadian women’s movement.²⁸⁴ Successful organization and activism around the lobbying effort had resulted in the establishment of the Women’s Legal Education and Action Fund (LEAF) - a body which has continued to exert a considerable influence on women’s rights in Canada.²⁸⁵ Another

²⁸⁰ Mossman, M.J. (1998) “The paradox of feminist engagement with the law” in N. Mandell (ed.), *Feminist issues: race, class and sexuality* (2nd Ed.), pp. 180-207, (Scarborough, Ontario: Prentice Hall. At 42, 1998) at 182. See also the film: *Constitute This!* for archival footage of the era and the complex debates which pushed the Canadian women’s movement forward.

²⁸¹ Charter, s. 15²⁸¹ *Canadian Charter of Rights and Freedoms*, s 15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

²⁸² A parliamentary committee rejected the amendment by twenty-two votes against and two for, with then Minister of Justice, Jean Chrétien, saying: “We have explained that there are other grounds of discrimination that will be defined by the courts. We wanted to have an enumeration of grounds and we do not think it should be a list that can go on forever.” In Wintemute, Robert, 'Sexual Orientation and the Charter: The Achievement of Formal Legal Equality (1985-2005) and Its Limits' (2004) *McGill Law Journal*, 49(4), at 1146. See also: *Minutes of Proceedings and Evidence of the Special Joint Committee of the Senate and of the House of Commons on the Constitution of Canada*, 1st Sess., 32d Parl., Issue No. 48 at 48:20-21, 48:31-34.

²⁸³ Wintemute, *ibid.*

²⁸⁴ This remains the case, no matter how limited the actual gains from the *Charter* may have been. See Bruce Ryder’s work on Charter equality provisions, including: Ryder, Bruce and Lawrence, Emily and Faria, Cidalia, “What’s Law Good For? An Empirical Overview of Charter Equality Rights Decisions” *Supreme Court Law Review* (2d), Vol. 24, p. 103, 2004; Ryder, Bruce and Hashmani, Taufiq, “Managing Charter Equality Rights: The Supreme Court of Canada’s Disposition of Leave to Appeal Applications in Section 15 Cases, 1989-2010” *Supreme Court Law Review* (2d), Vol. 51, 2010. See also Margot Young’s critical work in this area, including: Young, Margot E., “Blissed Out: Section 15 at Twenty” *Supreme Court Law Review*, 2d, Vol. 33, pp. 45-69, 2006; Young, Margot E., “Unequal to the Task: ‘Kapp’ing the Substantive Potential of Section 15” *Supreme Court Law Review*, Vol. 50, 2010.

²⁸⁵ LEAF is a national, charitable, non-profit organization, founded in 1985. LEAF works to advance the substantive equality rights of women and girls in Canada through litigation, law reform and public education using the *Canadian Charter of Rights and Freedoms*. LEAF works to ensure Canadian courts provide the equality rights

central body representing women's issues at the time was the National Action Committee on the Status of Women (NAC), which emerged from the Charter debates as a strong force in dialogue with government.

Issues of women and reproductive technology were already on the Canadian map by the time of the *Charter* discussions. The 1978 birth of Louise Brown in Britain as the world's first successful IVF baby had global impact, indicating the potential for heretofore unseen ethical issues in human reproduction. Four years later, there was a much-publicized case of a Scarborough, Ontario couple arranging a traditional surrogate contract with a woman from Florida, which used the genetic material of the husband to impregnate the American surrogate.²⁸⁶ The Canadian couple paid \$20,000 to the woman, who traveled to Canada to give birth to the child and left the country shortly afterward.²⁸⁷ Although the child was initially seized by the Metro Toronto Catholic Children's Aid Society, the baby was eventually returned to the couple, with the Ontario Supreme Court ruling that the Scarborough man was the legal and biological father.²⁸⁸

The absence of government regulation over these emerging reproductive technologies became a cause of concern for many Canadian women, with local perspectives often impacted by the international forum of feminist discussion of how biotechnologies were to be understood. Some women echoed FINRRAGE in expressing a range of concerns based primarily on concern for 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.

guaranteed to women and girls by Section 15 of the Canadian Charter, and is a frequent intervener in Supreme Court cases involving gender issues.

²⁸⁶ 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) at 415.

²⁸⁷ *Ibid.* See also Ellie Teshler, "I need laws' on surrogate motherhood, judge says," *Toronto Star*, June 26, 1982.

²⁸⁸ *Ibid.* See also "Judge rules 'surrogate' has right to keep baby," *Toronto Globe and Mail*, June 6, 1981.

Nationally-distributed newspaper *The Globe and Mail* organized a roundtable on the issue of what was called ‘new reproductive technology’ (NRT) in 1983, inviting to the debate Suzanne Scorsone, Director of the Archdiocesan Office of Catholic Family Life. Scorsone spoke forcefully against the surrogate transaction with the woman from Florida, drawing upon radical feminist thought and imagery to cast the case within a patriarchal biblical tradition:

Essentially what we are looking at here is the recreation of concubinage. The idea of a childless man, a man whose wife cannot bear children, taking a second-class wife on a contract basis of one form or another and using her reproductive services is something as old as Abraham and Hagar, and older, and it's not just within the Judeo-Christian tradition, it's right across the world. Now one of the evolutions within the Judeo-Christian tradition and, I think, one of the really good things about our society generally, at this point, is that women have not, any longer, been placed in that secondary class position with their reproductive services being used, and the woman herself being treated as an object. If we start having surrogate mothers who can be contracted for this, what we are doing is re-creating a sanitized form, without the sexual intercourse, of this second-class concubine status.²⁸⁹

Scorsone's rejection of masculine control over women's reproductivity put her in line with Dworkin and other feminists who made a direct link between reproductive technologies and prostitution (or in this case, “concubinage”), as sexual or sexualized activities that were understood to increase patriarchal power and harm women. Scorsone's religious tenor also led her to oppose assisted insemination and IVF for single women and, presumably, lesbians, although the latter were never mentioned during this debate.²⁹⁰ She also evinced a particularly vigorous opposition to surrogate contracts on the grounds that “it gives public sanction to the notion that child creation is legitimate in a concept or in a situation other than the committed and permanently committed love of a husband and a wife.”²⁹¹

²⁸⁹ *Ibid* at 416. See also: ‘The borrowed-womb debate’ *Toronto Globe and Mail*, August 2, 1982.

²⁹⁰ Scorsone would later serve as a Commissioner on the Royal Commission for New Reproductive Technologies, at which point she would make her perspective on lesbians and same-sex relationships very clear indeed.

²⁹¹ Brodribb, *supra* note 286 at 417.

Despite their ideological differences, Somer Brodribb, in a 1986 paper in the *Canadian Journal of Women and the Law*, echoed many of Scorsone's concerns. Brodribb also expressed deep concern about "the ways in which patriarchal jurisprudence is moving to absorb and direct medical developments in reproductive technology,"²⁹² rejecting the use of AHR as a patriarchal strategy of dominance aimed at removing reproductive autonomy from the hands of women. Furthermore, she argued that "the masculinist, racist, and classist nature of scientific rationality, and its consequent devastation of women and nature, demonstrates that these technologies are not neutral."²⁹³ Brodribb was particularly concerned that any governmental push to regulate AHR would be motivated by the perceived threat to fatherhood, and therefore to patriarchy, and would result in a slew of court cases that were likely undermine the future potential of legal recognition for gay and lesbian parents.²⁹⁴

Discourses of commercialization and fears of stratified reproduction were also strongly prevalent. The high cost of interventions such as IVF were viewed as a mechanism to keep them out of the grasp of anyone but white middle-class women, thereby ensuring the sterility of the disabled, non-white and lower classes. There was seen to be real potential for a new eugenics movement, with a belief that "NRTs are actually just new ways to reproduce OLD inequalities."²⁹⁵ These voices took up the radical feminist stance of viewing AHR as a patriarchal tool, while often understanding this inequality as having international consequences.

Anthropologist Sari Tudiver, for example, wrote of the negative effects on women and children already being wrecked by a global economy.²⁹⁶ She predicted that new reproductive

²⁹² *Ibid* at 407.

²⁹³ *Ibid* at 408.

²⁹⁴ *Ibid*.

²⁹⁵ Tannis Doe. "The New Reproductive Technologies: Discriminating Misconceptions of Choice." *Herizons*, 8, no. 1 (Spring, 1994): 45.

²⁹⁶ Sari Tudiver, "Canada and the Global Context of the New Reproductive Technologies: A Cautionary

technologies would only exacerbate and expand existing inequalities, with embryos being harvested for organs and tissues and women being sold into reproductive slavery.²⁹⁷ Women who chose not to have children, or who could not conceive, would be labeled as deviant or selfish as the social value of women was narrowed down to their biological capacity to reproduce. Tudiver feared that AHR was thereby poised to reinforce a white, middle-class ableist concept of motherhood as well as entrenching women's social role as mother, while threatening to legitimize discrimination based on race, gender, class and ability.²⁹⁸

There were of course other feminist voices which emerged during the 1980s and early 1990s, which took a positive stance on AHR and saw them as useful tools for women and their families. These perspectives emerged powerfully from the infertility community, for example, with some women arguing for the coverage of IVF cycles within Canada's framework of socialized medicine.²⁹⁹ However the dominant discourse was strongly inflected by a radical feminist critique which remained wary of the harmful effects of commercialization on women's bodies. A concern for inequality as exacerbated by medical expertise, the biotechnology industry and scientific research came to the fore, creating an explicitly feminist national discourse that "successfully forged an inextricable link...between the profit potential of human reproductive technologies and the systemic oppression of women."³⁰⁰

For example, by the early 1990s there were some Canadians seeking to draw the patriarchal critique into conversation with an intersectional analysis, arguing that these technologies would serve to exploit the reproductive services of all women, with particular

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.

²⁹⁷ *Ibid.*, at 69-70

²⁹⁸ *Ibid.*

²⁹⁹ Mavis Jones & Brian Salter, "Proceeding Carefully: Assisted Human Reproduction Policy in Canada" (2010) at

6.

³⁰⁰ *Ibid.*

impact upon racialized, poor and otherwise marginalized women. Scholar Sunera Thobani expressed the concern that:

Reproductive technologies are directed at all women. They serve to increase the control by the racist, patriarchal, scientific and medical communities over women's reproductive abilities. The control of women's reproductive ability and sexuality, the control of women's bodies, is a cornerstone of patriarchal power. We are seeing the extension of this patriarchal control over women's bodies through the development of this technology.³⁰¹

Steps Toward Regulation in Canada

Concerns over commodification, oppression and exacerbated inequality thus provided the main drivers in the feminist community. By the mid-1980s groups such as NAC had taken up Corea's framework of the reproductive brothel, arguing that new reproductive technologies would turn women into "breeders" of the human race. Drawing upon Canadian author Margaret Atwood's dystopian novel, about a future where a fertile underclass of women are compelled to act as reproductive servants, or "handmaids," to a non-fertile elite, this nightmarish scenario was brandished as a prophecy of what would come to be if AHR was not adequately regulated.³⁰²

Policy Development around AHR

The case of the couple from Scarborough who had commissioned an Ontario surrogate, and the flurry of media surrounding it, was generally viewed as a driver behind a 1982 request to the Ontario Law Reform Commission to develop a report on the legal implications of the new reproductive technologies. The next year, the Ontario Law Reform Commission produced their *Report on Human Artificial Reproduction and Related Matters* to much consternation among some members of the Canadian feminist community. According to a 1986 critique by Mary Anne Coffey, the *Report* was not an examination of the technologies, so much as it represented a

³⁰¹ Sunera Thobani, "More than Sexist...", *Healthsharing*, 12, no. 1 (spring, 1991): 13.

³⁰² Indeed, NAC even took the title of Atwood's book as the title of their submission to the forthcoming Royal Commission on New Reproductive Technologies. NAC, *A Technological Handmaid's Tale: Executive Summary*, CWMA NAC fond X10-24, box 651 file 5, ii.

social prescription for their control.³⁰³ She also soundly criticized the document for taking a strictly patriarchal and heterosexist worldview, which limited access to AHR to heterosexual and heterosexual relationships “while female reproductive and social independence from men is penalized or rendered problematic.”³⁰⁴ The *Report* also left control entirely in the hands of medical and legal professionals, without apparent concern for women’s issues of matters of class, race, ability or sexuality.³⁰⁵ As Coffey wrote with urgency, these were vital matters that needed to be squarely addressed by feminist thinkers and political actors:

For feminists concerned with the social effects of reproductive technology, this is therefore a crucial time: technical knowledge and applications are advancing much more rapidly than corresponding social definition and ordering, which means that public policy is in a state of flux and is likely to remain so for some time to come. New systems of socio-ethical interpretation and legal regulation are currently under construction in many jurisdictions or have only recently been formulated in law. Newly enacted statutes may be difficult to amend, but the current proposals for Canadian federal and provincial legislation are still subject to public debate and as such can be influenced by feminist criticism and lobbying efforts.³⁰⁶

Coffey was especially concerned for the inclusion of lesbian perspectives in these critical and lobbying efforts, for as she saw it: “If proposed legislation does not meet the material needs of all women, including lesbian women, it must be countered with informed dissent and active resistance by feminists.”³⁰⁷ However tensions between the material needs of women, including lesbians, and radical feminist perspectives which sought a moratorium on access to all NRTs, would prove a difficult rift to bridge.

And so, despite a suspicion of the patriarchal state, the goal swiftly became one of *additional* regulation and engagement as a way to reign in the medicalization of women’s bodies.

³⁰³ Coffey, Mary Anne, *Of Father Born: A Lesbian Feminist Critique of the Ontario Law Reform Commission Recommendations on Artificial Insemination*, 1 *Can. J. Women & L.* 424 (1985-1986) at 431.

³⁰⁴ *Ibid.*

³⁰⁵ *Ibid* at 433.

³⁰⁶ *Ibid.*

³⁰⁷ *Ibid.*

“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.”³⁰⁸ It was demanded that government, not just the medical and research communities, take control of regulation to ensure the safety of women.³⁰⁹

FINRRAGE had studied a series of governmental reports that had been commissioned to provide advice on the management of new reproductive technologies.³¹⁰ These included the aforementioned Ontario Law Reform Commission report, as well as the Warnock Report (1984, UK) and the Waller report (1984, Australia). All had been deemed to lack a clear feminist research agenda.³¹¹ Patricia Spallone, a prominent FINRRAGE member, described these reports as capitulations by government to the interests of scientific capital which failed to protect women’s needs and integrity.³¹²

Canadian feminists swiftly concluded that without the participation of their voices and perspectives, it was likely that any emergent legislation would simply reinforce patriarchal value systems.³¹³ Concerned that a federal study would follow in the footsteps of UK and Australia, not to mention the Ontario Law Reform Commission, it was seen as vital that a feminist approach be part of any analysis of the emergence of new reproductive technologies.³¹⁴ Yet the

³⁰⁸ Tanya Daley, “The Politics of ‘Choice’: Canadian Feminism and the Royal Commission on New Reproductive Technologies,” Unpublished MA thesis, 2011 at 2. See also: 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.

³⁰⁹ Jones and Salter, *supra* note 299.

³¹⁰ 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,) at 167.

³¹¹ *Ibid.*

³¹² *Ibid.*

³¹³ Eichler, M. (1993) Frankenstein meets Kafka: The Royal Commission on New Reproductive Technologies. In G. Basen, M. Eichler, & A. Lippman (Eds.), *Misconceptions: The social construction of choice and the new reproductive and genetic technologies*, vol. 1, 196-222. Hull: Voyageur.

³¹⁴ Jones and Salter, *supra* note 299.

ability to carry out a multidisciplinary study of new reproductive technologies in Canada was beyond the means of the women's movement alone. Thus, a collection of feminist activists, academics and health advocates came together in the spring of 1987 to form The Canadian Coalition for a Royal Commission on New Reproductive Technologies under the guidance of Canadian sociologist Margrit Eichler, with the goal of heightening public awareness and sparking a federal investigation of the impact of NRTs.³¹⁵ This remained a highly contested goal, with some feminist academics and activists speaking against the Commission format as a process which would remain inaccessible to feminist influence.³¹⁶

A Royal Commission was nevertheless the targeted vehicle for a feminist-led inquiry into new reproductive technology, due to its substantial budget, research staff, ability to foster public debate and the perceived success of a Royal Commission on the Status of Women which had run from 1967-1971.³¹⁷ The Royal Commission was to be the access point for feminists to the state, and they sought to define its mandate from the start.³¹⁸ As Mavis Jones and Brian Salter describe: "By framing the policy problem as one of protecting the vulnerable from exploitation, they brought the social and ethical implications of genetic technologies into sharp relief."³¹⁹

After two years of sustained lobbying the Coalition's efforts were successful. In the autumn of 1989, the Mulroney government announced the appointment of a Royal Commission on New Reproductive Technologies (RCNRT) which would not consider biotechnology as solely a matter of interest to economic policy. Instead the RCNRT would operate on a mandate:

³¹⁵ Eichler, *supra* note 313.

³¹⁶ Annette Burfoot, 'In-appropriation - a critique of Proceed With Care - Final Report of the Royal Commission on New Reproductive Technologies' (1995) *Women's Studies International Forum*, 18(4) at 500. See also: Brodribb, Somer, & Vandelac, Louise. (1987). Comments at the March 1987 CRIAW roundtable on feminist ethics. *Feminist Ethics*, 2(2), 60-68.

³¹⁷ *Ibid*, Burfoot.

³¹⁸ Lorna Weir and Jasmin Habib, "A Critical Feminist Analysis of the Final Report of the Royal Commission on New Reproductive Technologies" (1992) *Studies in Political Economy* 52 at 147.

³¹⁹ Jones & Salter, *supra* note 299 at 12.

[T]o examine current and potential scientific and medical developments related to reproductive technologies, but also to go beyond them to consider:

- the impact of the technologies on society as a whole;
- their impact on identified groups in society, specifically women, children, and families; and –
- the ethical, legal, social, economic, and health implications of these technologies.³²⁰

A pediatrician and medical geneticist named Patricia Baird was tapped to lead the RCNRT and given a budget of \$24.7 million to fulfill this sweeping mandate. Commissioners included two self-identified feminists as well as a lesbian named Dr. Grace Marion Jantzen,³²¹ a professor of religion who was Canadian-born but living and lecturing in London, England.³²² There was, however, no representation from the heterosexual infertile community, or other patient-advocacy groups who might be expected to hold concern for questions of access and state-funding for reproductive technology.³²³ Nor was there representation by people of colour, Aboriginal people, or members of the disability community. Nevertheless, hopes for the RCNRT were high.

Public Consultations by RCNRT

³²⁰ Royal Commission on New Reproductive Technologies. *Proceed with care: final report of the Royal Commission on New Reproductive Technologies* (Ottawa: Ministry of Government Services Canada, 1993) at 3.

³²¹ Interestingly, most of the feminist writings about the Royal Commission, and especially the rift that was to occur between Baird and certain Commissioners, do not mention Jantzen's lesbianism nor her feminist scholarship. Yet Jantzen, a Quaker and a leading voice in the feminist philosophy of religion, would later bring the work of Irigaray, Lacan, Foucault and Derrida to feminist theology and the philosophy of religion, and challenge the preoccupations of male-dominated Western philosophy which Jantzen saw as driven by a concern with death. Her work with the RCNRT in particular had demonstrated to Jantzen the "glaring interconnection between power and gender" in the study of new reproductive technologies, and she reflected on her time with the Royal Commission as a period in which she "began to take serious notice of who are the beneficiaries and who are the victims of systems of power/knowledge. In the case of new reproductive technologies, the beneficiaries are those with powerful vested interests: pharmaceutical companies, big science, big business. The victims, too often, are women, children, aboriginal people, disabled people, ethnic minorities." From *Power, Gender and Christian Mysticism* at xv. See also a eulogy written upon her death in 2006: Jeremy Carrette, The Guardian, 'Grace Jantzen: A feminist voice expanding the philosophy of religion', Thursday 11 May 2006.

³²² Royal Commission on New Reproductive Technologies, *Proceed with Care, vol I*, (Ottawa: Minister of Government Services Canada, 1993,) at 3.

³²³ As Tanya Daley notes in her MA thesis on infertility communities, 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. At 69. Daley, *supra* note 308 at 69.

The Commission's progress was never smooth, and continued delays in appointing key staff, organizing research plans and coordinating public consultations resulted in great frustration both inside and outside the RCNRT. There were allegations of irregular research ethics and a lack of transparency, and the Commission kept data, protocols and selection of personnel under wraps with the research not being subject to peer review.³²⁴ Nevertheless, nation-wide public hearings eventually commenced, and women's groups took the lead in responding.

Representation by National Action Committee on the Status of Women at RCNRT

Over fifty women's groups made submissions to the Royal Commission from 1990 to 1992.³²⁵ Overwhelmingly, these groups called for the regulation of NRTs from a feminist perspective, asking government to understand the political, social and economic factors that shaped women's realities. The social construction of motherhood was especially critiqued, with groups calling attention to the way that these technologies served to institutionalize women's "natural" role as wife and mother. A group from Laval University, *le Groupe de recherche multidisciplinaire féministe*, argued that women were no longer under pressure from the clergy and law to have children, yet 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.³²⁶

NAC came down even more strongly against these technologies, calling for a halt on the construction of new IVF clinics, a ban on all commercial trade in sperm and ova, and a ban on

³²⁴ Valverde and Weir *supra* note 75 at 277.

³²⁵ Proceed With Care, *supra* note 320.

³²⁶ Daley, *supra* note 308.

commercial surrogacy.³²⁷ In a brief which took its title and inspiration from Atwood’s dystopian novel, NAC argued that “these technologies represent the wrong direction in society’s attempt to solve the problems of infertility. We believe that, on balance, the new reproductive technologies are oppressive to women. They are not effective in preventing or curing infertility or disability but will contribute to economic and social trends that erode women’s overall rights, well-being, and social standing.”³²⁸ Instead, they suggested a focus on the prevention of infertility and maternal support programs to address the causes of infant disability, as well as research into the emotional and physical impact of IVF on mothers and children.³²⁹

The brief makes only one reference to the reproductive needs of lesbians (in regard to the barriers faced in accessing IVF) and none to gay men. Other Canadian literature stemming from radical feminist movements had noted that very few same-sex female couples sought out IVF, with the majority opting for assisted insemination either with a known or anonymous donor.³³⁰ However the future closing of sperm clinics and fertility centers through increased regulation over NRTs was not seen to be an access concern for lesbians, nor was the current barring of lesbians from those same clinics. Indeed there was a period of history in which same-sex couples faced substantial hurdles in accessing reproductive technology. As testified before the RCNRT, a study from that era had found that 19 of 33 surveyed clinics which performed AHR would deny

³²⁷ National Action Committee on the Status of Women, *The New Reproductive Technologies: A Technological Handmaids Tale: A Brief Presented to the Royal Commission on New Reproductive Technologies* (Ottawa: National Action Committee on the Status of Women, 1991).

³²⁸ *Ibid.*

³²⁹ *Ibid* at 297.

³³⁰ Coffey, *supra* note 303.

services to women who identified as lesbian.³³¹ A case from British Columbia, which began in 1993, indicates that such refusals were not an uncommon part of clinical practice.³³²

The dispute arose after Dr. Korn, a Vancouver fertility specialist, had been obliged to provide expert witness testimony to a custody and support case involving two lesbians - a former patient and her partner.³³³ While the names of the women were protected, Korn's was not, and he received unwanted publicity for his role in the case including telephone calls criticizing him for providing artificial insemination to lesbians.³³⁴ He subsequently announced his refusal to provide reproductive assistance to all lesbian women, although he would still provide other medical services. Pursuant to this policy he refused to provide assisted insemination to a same-sex couple who had sought out his medical practice in April 1993, instead referring them to other physicians. The women lodged an unsuccessful complaint with the College of Physicians and Surgeons of British Columbia asking that Korn be disciplined for unethical actions.³³⁵ They then lodged another complaint with the British Columbia Council of Human Rights, which found that Korn did not have justification to deny them services under the *B.C. Human Rights Act*.³³⁶ A judicial review of the decision by the British Columbia Supreme Court found that the human rights complaint had been decided correctly, with Korn indeed in violation of the *Act*.³³⁷ As the first case to be decided after "sexual orientation" was added as a protected ground in the B.C. *Human Rights Code* in 1992, this was an important victory for lesbians seeking access to donor sperm in British Columbia.

³³¹ Proceed With Care, *supra* note 320 at 454.

³³² *Korn v. Potter* (1996), 134 D.L.R. (4th) 437, 22 B.C.L.R. (3d) 163 (S.C.)

³³³ The case was *Anderson v. Luoma* (1986), 50 R.F.L. (2d) 127.

³³⁴ Korn, *supra* note 332 at para 7.

³³⁵ *Ibid* at para 4.

³³⁶ The grounds of this complaint were that Korn denied the women "a service or facility customarily available to the public" due to "sexual orientation and/or family status, contrary to s.3 of the *Human Rights Act* of British Columbia." *Ibid* at para 16.

³³⁷ *Ibid*.

Representation by Infertility Groups at RCNRT

While the concerns of heterosexual infertility communities did not align precisely with lesbian women and gay men, infertility associations were one of the organized national voices arguing against the prohibition of NRTs. Such groups were largely represented by the Infertility Awareness Association of Canada, who had placed a call to all members in developing a submission to the RCNRT.³³⁸ The potential for federal restrictions on NRTs was a cause for concern, and the IAAC responded with panic.³³⁹ The IAAC's brief was also focused on the social construction of motherhood and the pressures of a pro-natalist society, but from the perspective of infertile citizens who demanded entrance into this culture.³⁴⁰ The brief discussed the social pressure felt by the infertile and their sadness, loss, anger, guilt and feelings of exclusion from the fundamental identity of parenthood.³⁴¹

The submission included a statement from Marie Morrissey of the IAAC, who declared that the infertile heterosexuals of society perceived themselves as isolated, marginalized, and even excluded from the health care system because they are viewed as having “unimportant problems.”³⁴² Access to NRTs would allow the infertile to overcome their disability³⁴³ and participate in society. Thus their focus was not on the potential for looming danger of an autocratic patriarchy, but for unrestricted access to fertility services and, crucially, the funding of such services under provincial healthcare.³⁴⁴ Representatives from the IAAC publicly opposed

³³⁸ Daley, *supra* note 308 at 82.

³³⁹ *Ibid.*

³⁴⁰ 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.

³⁴¹ *Ibid.*

³⁴² *Ibid.*

³⁴³ Infertile people identified themselves as reproductively disabled, with 53.5% of the IAAC's surveyed membership affirming that “infertility is a disability.” IAAC's Royal Commission Survey, *Infertility Awareness*, 7, no. 4 (May, 1991), 11.

³⁴⁴ *Ibid.*

the position staked out by NAC, out of fear that NAC's campaign could substantially limit their future access to reproductive assistance.³⁴⁵

This pivotal disagreement over issues of access to NRTs, and the claims of infertile women to "reproductive autonomy" and the "choice" of IVF, led to a bitter rift within the feminist community.³⁴⁶ Some women left NAC because of its position on the strict regulation of all NRTs, including the ban on surrogate motherhood. Indeed as Tanya Daley reports, the pages of the IAAC newsletter and the IAAC submission to the Royal Commission 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 they now perceived as excluding them. As described by Karen Woolridge, a regular contributor to *Infertility Awareness*: "I mourned the loss of friends in the women's movement and the loss of the support of the community itself."³⁴⁷

IAAC was silent on the issue of gays and lesbians and their access to reproductive technology, as its focus remained only on heterosexual couples suffering from infertility. The tacit acceptance of the medical model of infertility also meant that the potential medicalization of assisted insemination, something that had been noted with concern by lesbian feminist authors such as Coffey, was not flagged as an issue. Nor were matters of access to fertility clinics by lesbians, although there was some discussion about the needs of single women under the rubric of choice.³⁴⁸

³⁴⁵ Nancy Jackson, "The Royal Commission – It's Time to Speak Out!" *Infertility Awareness*, 6, no. 1 (Sept/Oct, 1989) at 6.

³⁴⁶ *Ibid.*

³⁴⁷ Karen Woolridge, "Feminism at the Conference," *Infertility Awareness*, 7, no. 5 (July/August, 1991) at 12.

³⁴⁸ IAAC submission., *supra* note 340.

Representation of Gays and Lesbians at RCNRT

Gay and lesbian groups were represented directly at the Royal Commission, although at this point in the gay and lesbian movement the focus was primarily on fighting for the legal recognition of same-sex relationships. In the submission to the RCNRT by Equality for Gays and Lesbians Everywhere (EGALE), a national advocacy organization based in Ottawa, the group stated that the gay and lesbian community had chosen to stay out of this debate until the fundamental issue of the legal recognition of same-sex relationships was addressed.³⁴⁹ However, they did respond to the potential restriction of insemination to heterosexual couples, declaring such a decision to be “morally wrong.”³⁵⁰ They explained that 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 the struggle for equal rights.³⁵¹

Commissioners for the RCNRT also heard from single women and lesbians who described the forms of discrimination they had experienced in the traditional medical setting.³⁵² Some witnesses told the Commission that the “overmedicalization of assisted insemination using donor sperm has created a situation in which medical practitioners have become gatekeepers,” enforcing what they perceive to be community standards about family formation by establishing access criteria that exclude single or lesbian women.³⁵³ For example, a representative from the Halifax Lesbian Committee on New Reproductive Technologies expressed concern about the categorization of donor insemination as a medical technology:

³⁴⁹ 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.

³⁵⁰ *Ibid.*

³⁵¹ *Ibid.*

³⁵² Proceed with Care, *supra* note 320 at 385.

³⁵³ *Ibid.*

[A] problematic...recommendation is a designation of alternative insemination as the practice of medicine...This would make self-insemination subject to legal prosecution.³⁵⁴

Similarly, other women expressed concern that the utilization of new reproductive technologies not be limited to married heterosexual couples. Drawing upon a feminist framework that stressed inclusion over restriction, historian Katherine Arnup testified to the RCNRT as a private citizen, urging that broad access to NRTs be granted to all Canadians:

Increasingly the use of all of the new reproductive technology is being limited to married or at least cohabiting heterosexual couples. Single women, whether they are heterosexual or lesbian, find themselves denied access to fertility treatment and to artificial insemination [AI]. And I am here today to suggest that it is critical that these technologies not be limited to a select population. I believe that access to AI should not be influenced by race, class, physical disability, marital status or sexual orientation.³⁵⁵

The Commission also learned about what was termed self-insemination [SI], through studies based on the experiences of lesbian women who had used SI and others who had been involved in its provision.³⁵⁶ Women who chose SI reported a desire to have control over the process, to avoid intercourse, to avoid unnecessary medications, or to avoid having to justify their wish to be a parent to clinical staff.³⁵⁷ The majority of women who chose SI used anonymous donors for fear of legal complications and from a desire to raise the child without the involvement of the donor. Although some said they were able to get safe frozen sperm from "friendly MDs," this was the exception, not the rule.³⁵⁸

³⁵⁴ M. Patrell, Halifax Lesbian Committee on New Reproductive Technologies, Public Hearings Transcripts, Halifax, Nova Scotia, October 17, 1990., in Proceed with Care, *supra* note 320.

³⁵⁵ K. Arnup, private citizen, Public Hearings Transcripts, Toronto, Ontario, November 20, 1990., in Proceed with Care, *supra* note 320.

³⁵⁶ Proceed with Care, *supra* note 320 at 459.

³⁵⁷ *Ibid.*

³⁵⁸ *Ibid.*

Women-organized assisted insemination networks were also discussed, as was their aim of providing knowledge, resources and access to donor sperm.³⁵⁹ Reports indicated that these networks were mainly using fresh sperm, with little information available about the donors; at the time of the proceedings, only one group of women in Ontario had their own equipment to cryopreserve sperm.³⁶⁰ The issue of fresh sperm was emerging as a serious issue due largely to the ballooning AIDS crisis and the frequent reliance of lesbians upon gay men to act as donors.³⁶¹ The Commission heard how HIV testing and screening for STDs was fairly rare, as “in interviews with 19 women involved in SI networks, only 9 reported that donors were tested for HIV, and only 7 used frozen sperm.”³⁶² These concerns about health screening and data-keeping protocols were to be reflected directly in the RCNRT final report, taking precedence over the questions of access and grassroots support.

Representation of Anti-Gay Positions at RCRNT

Finally, there were a number of briefs and public policy positions *against* homosexual families heard by the RCRNT. Delivered largely by religious organizations in response to the new family forms made possible through AHR, these opinions located heterosexual marriage as the reassuring bulwark upon which moral ground should be staked. A brief from the Canadian Conference of Catholic Bishops is instructive in this regard, with its insistence that “the vitality and stability of society require that children come into the world within a family and that the family be firmly based on marriage.”³⁶³ Similarly, the Pentecostal Assemblies of Canada held

³⁵⁹ Brodribb similarly describes how a group of unmarried and lesbian women in Windsor, Ontario, established the first Canadian women's artificial insemination service in June 1982. Brodribb, *supra* note 286 at 415.

³⁶⁰ Proceed with Care, *supra* note 320.

³⁶¹ *Ibid.*

³⁶² *Ibid.*

³⁶³ *Brief to the Commission from the Canadian Conference of Catholic Bishops, January 28, 1991.* in Proceed with Care, *supra* note 320.

that “using the sperm of an outside donor is considered by a majority of our members to be immoral and would conflict with their view of the sanctity of marriage and procreation.”³⁶⁴

This position was also shared by non-Christian religious organizations who spoke before the RCNRT. For example the Muslim Women’s Auxiliary allowed that assisted insemination could be “acceptable between husband and wife,” while any form of “insemination where the sperm is brought from outside is not acceptable.”³⁶⁵ This was also the stance of private citizens as well, with a brief by an E. Kelly targeting self-insemination as an affective danger to the next generation. As Kelly pleaded with the Commission: “I urge you not to consider [AI] for lesbians and unmarried women...Our Canadian society does not need more confused, emotionally deprived children.”³⁶⁶

Public Polls Undertaken by RCNRT

The Commission also undertook a series of public polls. The methodology of these polls faced heavy criticism from within the RCNRT’s ranks, and in particular by Commissioner Louise Vandelac – the only social scientist with extensive experience with surveys and opinion polls.³⁶⁷ It was felt by multiple commentators that the use of polls as a route to determine public

³⁶⁴ H. Hilsden, Pentecostal Assemblies of Canada, Public Hearings Transcripts, Toronto, Ontario, November 20, 1990., in Proceed with Care, *supra* note 320.

³⁶⁵ Brief to the Commission from the Muslim Women's Auxiliary, July 29, 1990., in Proceed with Care, *supra* note 320.

³⁶⁶ Brief to the Commission from E. Kelly, December 17, 1990., in Proceed with Care, *supra* note 320.

³⁶⁷ Louise Vandelac, "From Bird to Baird: The Royal Commission ne suivent mais ne se ressembler pas" Presented at the Association Nationale de la Femme et du Droite. Vancouver, BC, February 19 - 21, 1993. As Vandelac made clear, polls were seen to be questionable instruments for a variety of reasons: they may be carried out by companies who may lack expertise in the particular subject matter; they may be executed with flawed or inadequate background information; they may be financed by potentially biased organizations; they lack direct contact with the individual, which may be particularly inappropriate for sensitive topics such as NRTs; they may contain leading or misleading questions; complex responses are difficult if not impossible to capture; poll results are sometimes difficult to interpret; and polling overall leads to the impression of wide public engagement when such consultation is far from meaningful.

policy was a dangerous and flawed course.³⁶⁸ Despite these concerns the RCRNT carried out four public polls, including a survey of 7,664 Canadians on the topic of ‘Social Values and Attitudes of Canadians Toward New Reproductive Technologies’ which included a section on gay and lesbian families. Conducted by phone and in writing between December 1991 and July 1992, this survey purported to gain a greater understanding of Canadians' general outlook with regard to a sense of tolerance and equality.³⁶⁹ To this end, it included “several items asking about the principle of equality; attitudes toward immigration and the extent to which Canadians welcome others to our society, tolerance levels for homosexual relationships, and general attitudes toward women and women's role in society.”³⁷⁰

The survey found that 90% of participants agreed with the equality provisions in s.15 of the *Charter*, with over two-thirds in strong agreement. Similarly, a majority felt that equality between men and women had not been achieved (69%), and that women gaining more power in society would have a positive impact overall (76%). However when it came to the matter of “homosexual relationships” the answers were scattered widely, with 35% expressing acceptance, 21% having no opinion, 16% saying they were unacceptable, and 27% finding such relationships

³⁶⁸ These concerns were raised at a conference held in Nova Scotia in summer 1990, in the context of the public polls being carried out on behalf of the RCNRT. See: Christine Overall. "Report on the Search Conference Held by the Royal Commission on New Reproductive Technologies, Wolfville, N.S., June 18-20, 1990" (Kingston) July 1990. at p 6. Indeed, the first Angus Reid poll proved to be a major site of contention among the Commissioners. The results of the poll were released to the media before internal discussion and consultation, provoking four Commissioners to publically call the results into question. As they protested:

We were shocked to see the article in *Le Droit* on September 20, 1990 on the Angus Reid poll commissioned last June 1990, despite vigorous opposition of several commissionerswe know of no research that says this [that supports the published findings in the *Le Droit* article] ... One Commission staff member told us that these figures come from the Angus Reid poll. If this is true, it represents a flagrant manipulation of public opinion.

Quoted in Federal Court Statement of Claim. Schedule 12 (Letter from Vandelac, Herbert, McTeer. Hatfield to Baird Oct. 12. 1990). See also: *Le Droit*. September 20. 1990. pp. 36-7; "Most Canadians know little of reproductive issues: poll" *Montreal Gazette*, Sept. 19, 1990.

³⁶⁹ Proceed with Care, *supra* note 320 at 28.

³⁷⁰ *Ibid* at 28.

totally unacceptable.³⁷¹ In another part of the survey it was asked whether a homosexual couple with children constituted a family. Thirty-seven percent of respondents answered in the affirmative, while just 13% considered a childless homosexual couple to be a family.³⁷²

When it came to reproductive technology and gays and lesbians, the responses were even more polarized. According to survey results, 74% of respondents supported reproductive technology to help an infertile heterosexual couple conceive.³⁷³ The specific scenario of a single woman using anonymous donor sperm was supported by 30% of respondents, while a lesbian couple using donor sperm was supported by just 11%.³⁷⁴ The scenario of a gay male couple using a gestational surrogate was not raised.

Feminist Position on Gay and Lesbian Reproduction

Even with potentially shaky methodology and the overgeneralization of complex social issues, the results were clear: a full 89% of Canadians did not support a lesbian couple using donor sperm. The response from the Canadian feminist community on this statistic was far from cohesive. The largest women's group in the country, NAC, had not addressed any issues specific to gay or lesbian families in their brief to the Commission, despite the substantial presence of lesbians within its diverse membership. Miriam Smith explains the ongoing tensions between lesbians and straight women in the feminist movement, with straight women often apprehensive about advocating for lesbian rights and jeopardizing their political success on other matters.³⁷⁵ As she writes, "The fear that participants in the women's movement would be branded as dykes

³⁷¹ *Ibid* at 29.

³⁷² *Ibid* at 43.

³⁷³ *Ibid*.

³⁷⁴ *Ibid*.

³⁷⁵ Miriam Smith, *Lesbian and Gay Rights in Canada.: Social Movements and Equality-Seeking, 1971-1995*. (Toronto: University of Toronto Press, 1999).

played a major role in the early years of the women's movement in Canada."³⁷⁶ This is affirmed by Jeri Dawn Wine, a founder of the Canadian National Lesbian Forum, who maintains that "NAC avoided the split over lesbian participation that the National Organization for Women suffered in the United States only at the cost of a decade of silence on the part of Canadian lesbians."³⁷⁷

Instead, the diverse membership of NAC was dominated by a radical feminist position that called for prohibition over regulation in line with international groups such as FINRRAGE. As Lorna Weir and Jasmin Habib explain, few feminist organizations in Canada had much expertise in the area of new reproductive technologies before the RCNRT, and therefore drew extensively upon the radical feminist position developed elsewhere:

The general understanding that preceded the Baird Commission was consonant with the international and largely radical feminist literature then extant that viewed reproductive medicine as a research agenda dominated by masculine gender interests.³⁷⁸

The dystopian visions of Corea's *Mother Machine* were thus refracted through a uniquely Canadian lens, forming a Technological Handmaid's Tale in which NRTs were an unqualified danger to women. However as time passed, and women's groups conducted research, wrote briefs and interacted with the RCNRT, feminist movements developed their analyses and (in some cases) broke off into other groups. Canadian feminist author Heather Menzies said in 1992 that she wished a thorough discussion on NRTs had occurred within the women's movement

³⁷⁶ In the United States, the National Organization for Women was publically split over the issues of lesbian rights; in Canada NAC was able to avoid this open division, although it did not place lesbian issues on the national agenda until 1985. *Ibid* at 29.

³⁷⁷ Jill Vickers, Pauline Rankin and Christine Appelle, *Politics as if Women Mattered* (Toronto: University of Toronto Press, 1993) at 75.

³⁷⁸ Weir and Habib, *supra* note 318. Note that the RCNRT is often called the "Baird Commission" after the Chair of the Commission, Patricia Baird.

before the creation of the Royal Commission.³⁷⁹ Such discussion might have allowed tensions to be worked out in private, allowing a unified feminist front to be presented to the Commission.

As it happened, however, NAC's stance was viewed by many involuntarily childless heterosexuals as a dismissal of their lived experience, and a presumption that they were too foolish to make their own informed decisions. According to NAC, greater research on the causes of infertility was called for, rather than (for example) a call for funding of fertility services under provincial healthcare plans, as was supported by IAAC. In this midst of these tensions, the reproductive concerns of gays and lesbians were sidelined as the larger federal battle for LGBT rights remained focused on the issue of same-sex relationship recognition.

These were the complex and often competing messages conveyed to the RCNRT, with the 'feminist' position roughly typified as one of prohibition, especially in regard to commercial surrogacy, trade in gametes and expanded access to IVF. This lack of attention to gay and lesbian reproductive concerns, and a distracted submission from EGALÉ,³⁸⁰ left the field open to ideological positions on the right and left, including many from conservative religious quarters which drew specific attention to the threat posed by gay and lesbian potential parents.

Feminist Criticisms of Baird and the RCNRT

Yet even as these messages filtered slowly through the wheels of the RCNRT, frustration with its operations and lack of transparency had reached a boiling point. Despite the Commission's origin as being "born of lobbying by feminist groups, it had been rapidly disowned by women's organizations".³⁸¹ Indeed by late 1991 then-head of NAC, Judy Rebick,

³⁷⁹ Heather Menzies, "Some Thoughts on Writing about Infertility," *Infertility Awareness*, 8, no. 3 (Jan/Feb, 1992) at 1.

³⁸⁰ In addition, EGALÉ has been "repeatedly criticized for its alleged lack of contact with gays and lesbians outside of Ottawa." Miriam Smith, *Lesbian and Gay Rights in Canada*, *supra* note 375 at 154.

³⁸¹ Gray, Charlotte. , "The report on new reproductive technologies: Will it lead to change, or gather dust?" *CMAJ*. 1994 Jan 15;150(2):266-268 at 266.

publically declared a lack of confidence in the Commission and in the apparent hostility of Chairperson Baird to the inclusion of feminist perspectives.³⁸² Of particular suspicion was the autocratic role being played by Baird herself,³⁸³ and the lack of confidence in her leadership of the RCNRT. Four fellow commissioners, including two of the most prominent feminist voices, attempted to take Baird to court to force her to share details of the gathered research.³⁸⁴ After a public falling-out, the dissenting commissioners were fired.

Many of the women who had originally pushed for the Commission were livid at these opaque and antagonistic dealings. Margrit Eichler, who had headed the original Canadian Coalition for a Royal Commission on New Reproductive Technologies, was 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 1993.³⁸⁵ Eichler joined forces with other frustrated feminist leaders, including some who had been working inside the Commission, to publish an appraisal of the RCNRT even before the report's release.³⁸⁶ They found that the

³⁸² David Leyton-Brown, *Canadian Annual Review of Politics and Public Affairs*, (Toronto, ON: University of Toronto Press, 1991) at 46.

³⁸³ Baird had already been under fire from some members of the disability rights movement in respect to an article she had co-authored in 1982, in which she discussed the benefit of extending the prenatal diagnosis program in British Columbia to detect Down Syndrome and neural tube defects in the unborn. Baird and her co-author maintained that the cost of providing prenatal diagnosis and abortion for defective fetuses was far lower than providing extra medical and social services for disabled individuals over their lifetimes. In a radio interview she explained: "I can tell you in our prenatal diagnosis program in the last few years we've detected 62 abnormal fetuses [she is referring to unborn babies with spinal bifida]. The parents have elected in every single case to terminate. So that is 62 individuals who would have been seriously handicapped and a burden on the health-care system even if you figured they only lived on the average five years." (Quoted in Donald DeMarco, "Canada's Commission on Reproduction," *The Interim: Canada's Life and Family Newspaper*, <http://www.theinterim.com/issues/canada%E2%80%99s-commission-on-reproduction/>). For more on the subject please see the scholarly article in question [A. D. Sadovnick and P. A. Baird (1982), "A cost-benefit analysis of prenatal diagnosis for neural tube defects selectively offered to relatives of index cases", *American Journal of Medical Genetics*, 12(1), 63-73.] as well as a scathing critique of the economic reckoning involved in Baird's analysis [John P. Moore, 1995, "The tragic Mistreatment of Down Syndrome Babies," *The Interim: Canada's Life and Family Newspaper* <http://www.theinterim.com/issues/abortion/the-tragic-mistreatment-of-down-syndrome-babies/>].

³⁸⁴ Leyton-Brown, *supra* note 382.

³⁸⁵ Eichler, *supra* note 313 at 217.

³⁸⁶ *Ibid.* Some accounts of the internal workings of the Commission were published in the anthology *Misconceptions* under anonymous pseudonyms due to a "gag-order" that had been imposed by Chairperson Baird. See: Anonymous,

conduct of the Commission and its staff, as well as its research and its evaluation of the issues, were largely deficient.

Publication of Proceed with Care

When *Proceed With Care*, the final report of the Baird Commission, was finally released in late 1993 it spanned 1275 pages housed in two volumes, was supported by fifteen volumes of research findings, and put forth 293 recommendations. It was also nearly two years late and three million dollars over its \$25 million budget. While some initially responded with relief at its apparent gender sensitivity,³⁸⁷ other critics charged that many of their worst fears had been realized.

Feminist Positions and Concerns Addressed by the Report

The Commission concurred with many of the points flagged by feminists as politically sensitive. There were multiple chapters devoted to the issue of infertility, including suggestions to focus money and research on preventing infertility and supporting maternal health.³⁸⁸ There were also recommendations to license only those clinics that conducted sex selection testing for medical reasons, and to preclude court-ordered obstetrical interventions.³⁸⁹ All of these issues had been primary concerns of the feminist platform.

Under the terms of the report, proscriptions were to be enforced by a newly created federal watchdog. The Commission encouraged the federal government to “establish a regulatory and licensing body - a National Reproductive Technologies Commission (NRTC) - with

Misconceptions.

³⁸⁷ Weir and Habib. They note: “The Royal Commission responded to the sites that feminists had constituted as politically sensitive, but failed to extend the critique into areas that had not been problematized or only weakly addressed by feminists. Thus bioscience other than clinical medicine, genetics, the biotechnology industry and other forms of capital were left untouched by feminist perspectives.” *Supra* note 318 at 149

³⁸⁸ *Proceed With Care*, *supra* note 320.

³⁸⁹ *Ibid.*

licensing required for the provision of new reproductive technologies to people.”³⁹⁰ The NRTC would be composed of at least 50% female members and charged with regulating the lawful use of assisted reproductive technologies. While the system of regulation was unclear, the aim was to ensure a uniform country-wide system.

Key among the recommendations made by *Proceed with Care* was a call for revisions to the *Criminal Code* in order to prohibit several aspects of new reproductive technologies. Of special concern was the sale of human reproductive material, including eggs and sperm, as well as acting as an intermediary to bring about a preconception arrangement, receiving payment or any financial or commercial benefit for acting as an intermediary, and/or making payment for a preconception arrangement.³⁹¹

The report suggested that commissioning parents and any brokers be subject to criminal sanction, although the surrogate herself should not be criminalized for participating in the arrangement. As well, all surrogacy contracts were recommended to be unenforceable, with the woman who gives birth to a child to be considered the legal mother of the child, regardless of the source of the egg.³⁹² There was no mention of the specific impact these prohibitions might have upon gay men, nor upon lesbian couples who might opt to have one partner carry the other woman’s egg. There was specific attention paid to the reproductive needs of lesbians in regard to donor insemination (DI), however, opened by a section that intoned:

Perhaps the most controversial aspect of the practice evident in testimony before the Commission was the use of DI by single women and lesbians. This mirrors attitudes found in the Commission's national surveys. Many respondents were of the view that

³⁹⁰ *Proceed With Care*, *supra* note 320 at xxxii.

³⁹¹ *Ibid* at 1022.

³⁹² *Ibid*.

because DI gives women without a male partner the chance to have children, it devalues the role of males in relation to their children and deprives children of a father.³⁹³

Despite adverse public sentiment toward the reproduction of lesbians and single women, as evidenced both in polls and testimony, the Commission concluded that donor insemination should not be restricted only to heterosexuals but be provided in a fair and equitable manner to all. There was seen to be no clear reason to deny single women and lesbians access to safe donor sperm, as their needs were not all that different from heterosexual couples, with the Commission explaining that they “essentially have the same diagnosis as married women – lack of a male partner who is fertile and a strong wish to have a child.”³⁹⁴ Equality principles, the Commission continued, therefore dictated that lesbians should not be barred from forming a family. And since the practice was already continuing, it was important to regulate donor semen by bringing it into the medical system. This medicalization of donor sperm would make it “safe” and ensure that women did not have to risk their health or lives.³⁹⁵

Increased Regulation of Lesbians and Donor Insemination

While these may appear as progressive moves, particularly given the situation at the time in other countries,³⁹⁶ it was through increased regulation and surveillance by the medical establishment that such reproductive methods were to be made safe. Rather than, for example, recommending a strengthened support of the grassroots women’s networks that had already sprung up around teaching and access to donor sperm, the Commission suggested the

³⁹³ *Ibid.* at 430.

³⁹⁴ *Ibid.*

³⁹⁵ *Ibid.* at 460.

³⁹⁶ For example, Ingrid Lüttichau has outlined the fierce battles that racked the Danish national legislature in 1997, within the context of a relatively progressive Scandinavian state, over the lesbian use of donor insemination. Ingrid Luttichau. 2004. “We Are Family’: The Regulation of ‘Female-Only’ Reproduction.” *Social and Legal Studies* 13(1): 81-101.

establishment of an Assisted Insemination Sub-Committee with responsibility for licensing the collection, storage, distribution and use of sperm in connection with assisted insemination.³⁹⁷

The compulsory licensing requirements would apply to any individual or facility engaged in “the assisted insemination of a woman other than the social partner of the sperm donor.”³⁹⁸ According to this framework, known donors would be subject to the same regulatory regime as anonymous sperm. Under the mandate of keeping women ‘safe’, the RCNRT recommended that all licensed facilities ensure the screening of donors and testing of donor sperm for infectious diseases, “including a six-month quarantine on donated sperm to allow for human immunodeficiency virus [HIV] testing of donors.”³⁹⁹ Gay men had been referred to as frequent sperm donors to lesbian women in public hearings before the Commission, and the report’s specific reference to screening for the AIDS virus, and no other, may be read as a reaction to the fears of viral contamination understood as circulating in the gay community.

This medicalization was further ensured by a suggested ban upon fresh sperm (“only frozen sperm from licensed storage and distribution facilities should be used”), a ban on sperm imports, and the suggestion that “a license is required to perform insemination at any site other than the vagina even if the recipient is the social partner.”⁴⁰⁰ The move to bring donor insemination within the ambit of medical licensing and treatment would not only mean that a lesbian could no longer inseminate her partner, it also drew lesbians into closer proximity to a medical culture of pharmaceuticals and hormones. These proscriptions, when taken together, mean that local women’s organizations which had been developing expertise in sperm donation, access, insemination and storage would no longer be able to provide lesbians access to fresh

³⁹⁷Proceed With Care, *supra* note 320 at 1025.

³⁹⁸ *Ibid.*

³⁹⁹ *Ibid.*

⁴⁰⁰ *Ibid* at 1026.

sperm. Nor would they be able to assist in procedures such as intra-uterine insemination and the deposit of sperm directly into the cervix.

Nature/Culture Binary and Heterosexist Logic

Thus under the guise of lesbian access and apparent inclusion of diverse perspectives, the RCNRT actually built the foundation for a system that assumed the HIV-positive status of gay donors and effectively shut down grassroots women's organizations aimed at supporting lesbians and single women. At the same time a criminal stance was taken against paid surrogacy arrangements and the sale of eggs and sperm, which would oblige gay men to seek out altruistic gestational surrogates and ova donors, or altruistic traditional surrogates who would agree to use their own eggs. Any payment that was to be exchanged would be driven underground, with the commissioning parents subject to criminal penalties.

These initial recommendations proposed by the RCNRT, and the competing strains of radical feminism and increased medicalization which infused it, were to have a long-lasting effect upon the regulations which would eventually be promulgated.

Feminist Critiques of the Report

The report also received a range of biting feminist critiques upon its release, not least for its "muted conciliatory tone" and failure to genuinely reflect the language of inclusion in the recommendations.⁴⁰¹ The appearance of broad-based consultation was seen as complicity with a conservative stance on a host of issues ranging from family formation to the medical and scientific professions, as well the pharmaceutical and bioengineering industries.⁴⁰²

⁴⁰¹ Diana Majury, "Is Care Enough - Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies" 17 Dalhousie L.J. 279 (1994) at 285.

⁴⁰² Critiques in this vein came from diverse sources, including: Shannon E. (1994). Ash, "The Royal Commission on NRTs: Less ...in 1,200 pages.," *Kinesis*, 4;(February, 1994); Anonymous 1-6, and Louise Vandelac's "The Baird Commission: From 'Access' to 'Reproductive Technologies' to the 'Excesses' of Practitioners or the Art of Diversion

It was also critiqued for its failure to attend to economic issues, particularly in regard to the enormously lucrative market in pharmaceuticals and technology that was blossoming around infertility treatment.⁴⁰³ As Laura Sky explained, “while explicitly stating its concern about commodification, nothing in this chapter addressed the mechanisms by which the process of commodification could be halted. This report may, in some instances, echo the concerns of women’s groups, but through its contradictions and omissions, it offers no substantive solutions and does all concerned Canadians a disservice.”⁴⁰⁴

In general, the use of feminist language throughout the report was found to exist without a grounding in the social reality of women’s lives, and was seen as a willful appropriation of rhetoric that lacked underlying substance. Diana Majury accused the report of taking a “Polyanna approach to equality” wherein racism, sexism, oppression and “lesbian hatred” are framed as matters of individual opinion rather than as systemic and institutionalized discrimination.⁴⁰⁵ Anne Burfoot argued that while a passing attempt at a range of opinions had been attempted, “important considerations of differences among women’s voices - especially those who resist new reproductive technologies for various reasons - are lost in the Commission’s Report.”⁴⁰⁶ According to Burfoot, radical feminist voices had been decontextualized and removed from their

and Relentless Pursuit," in Basen, Gwynne, Lippman, Abby, & Eichler, Margrit (Eds.). (1993). *Misconceptions: The social construction of choice and the new reproductive and genetic technologies*. Hull, Canada: Voyageur Press; Massey, Christine, & Morrison, Judy. (1994, February) Women and NRTs: Beyond the report. *Kinesis*, 8-9.; National Action Committee on the Status of Women [NAC]. (1994b). *The regulation of reproductive technology* (working paper). Ottawa, Canada: Author.; National Action Committee on the Status of Women WAC], 1994; Eichler, M., “The construction of technologically-mediated families”, *Journal of Comparative Family Studies*, 27 (Summer 1996): 281-308.

⁴⁰³ Laura Sky, “Commercial Interests and New Reproductive Technologies,” *Canadian Women’s Studies/Les cahiers de la femme*, vol 14, no. 3 (Summer, 1994).

⁴⁰⁴ *Ibid.*, at 108.

⁴⁰⁵ Majury, *supra* note 401.

⁴⁰⁶ Burfoot, *supra* note 316 at 500.

political grounding, simultaneously appropriating the language of resistance and denying it an actual platform.⁴⁰⁷

For their part, Allison Harvison Young and Angela Wasunna understood the surprising strategy of rooting prohibitions within the powers of criminal law as allowing for the assertion of a federal legislative jurisdiction.⁴⁰⁸ They also pointed out that such a “command model” is attractive for politicians because, irrespective of effectiveness, such laws are easily touted as concrete evidence of action.⁴⁰⁹ However they were deeply skeptical of the top-down approach, criticizing it as resting upon too ill-fashioned a regulatory instrument, and crudely wedged within the constitutional division of powers without regard for social realities or cultural diversities.⁴¹⁰

But perhaps most damningly, and as feminists had anticipated, the Royal Commission’s report did not soon lead to effective regulatory measures.

⁴⁰⁷ *Ibid.*

⁴⁰⁸ Alison Harvison Young and Angela Wasunna , “Wrestling with the Limits of the Law: Regulating Reproductive Technologies,” *Health Law Journal* 6 (1998).

⁴⁰⁹ *Ibid* at 242.

⁴¹⁰ *Ibid* at 240.

Chapter Six: After the RCNRT

Next Phase of Development

Shortly after the report of the Royal Commission on New Reproductive Technologies was released, a federal election was called. The Liberal government of Jean Chretien, newly elected to office, shelved the report. He then directed Federal Minister of Health Diane Marleau to call for a voluntary moratorium on nine reproductive and genetic technologies and practices, including commercial surrogacy arrangements, the buying and selling of eggs, sperm and embryos, and egg donation in exchange for *in vitro* fertilization (IVF) services.⁴¹¹ This moratorium was touted as the first phase of a comprehensive federal response to the Commission report and proposed as an interim strategy until a permanent management regime could be implemented.⁴¹² It was widely unsuccessful and openly flouted.⁴¹³ This was followed by an Advisory Committee on Reproductive and Genetic Technologies, convened in January 1996 in order to advise on compliance and track new developments.⁴¹⁴

Strict provisions against sperm donation were tabled by Parliament in early 1996, reflecting many of the concerns of HIV and 'safety' the RCNRT had identified.⁴¹⁵ Bill C-47 emerged in June of that year, following in the deep traces of the Baird Commission, suggesting a federal criminal law power and imposing extremely steep penalties for violation.⁴¹⁶ When the Bill was first introduced, some private fertility clinics balked at the proposed prohibitions and

⁴¹¹ Health Canada, News Release 1995-57, "Health Minister Calls for Moratorium on Applying Nine Reproductive Technologies and Practices in Humans" (July 27, 1995).

⁴¹² Nancy Miller Chenier & Marilyn Pilon, "Legislative Summary of Bill C-47: Human Reproduction and Genetic Technologies Act" (Ottawa, 1997) at i.

⁴¹³ Penni Mitchell, New reproductive technology bill awaits delivery. *Network Magazine of the Canadian Women's Health Network*; Spring 1998, Vol. 1 Issue 2, p10-11 at 10.

⁴¹⁴ Chenier and Pilon, *supra* note 412 at ii.

⁴¹⁵ *Processing and Distribution of Semen for Assisted Conception Regulations* SOR/96-254, enacted under the *Food and Drugs Act*, R.S.C. c. F-27.

⁴¹⁶ *An Act respecting human reproductive technologies and commercial transactions relating to human reproduction*, 2nd Sess., 35th Parl., 1996 ("Bill C-47").

vowed to ignore them.⁴¹⁷ Meanwhile women's advocacy groups, who had been waiting nearly a decade for legislation, were disappointed at the lack of an overall education and management structure that would establish the conditions under which new tests and procedures could be introduced.⁴¹⁸ In April 1997 the Canadian Parliament came to a close and a federal election was called. Bill C-47 died on the order paper and despite Jean Chretien's Liberal party winning another majority, a replacement bill would not be tabled until 2002.

Next Steps Toward Legislation

Under the name *An Act respecting assisted human reproduction and related research* a series of three nearly identical bills followed. All three listed a range of activities and technologies that were to be prohibited, outlined regulations for those that were to be permitted, and defined the criminal sanctions against violators of the *Act*.⁴¹⁹ New Reproductive Technologies were now known as Assisted Human Reproduction (AHR).

Finally, eleven years after the RCNRT had submitted its report, the *Assisted Human Reproduction Act [AHRA]* received Royal Assent and officially became law. Shortly afterward, however, the Attorney General of Quebec submitted a constitutional question to the Quebec Court of Appeal challenging the validity of certain provisions of the *AHRA*.⁴²⁰ Quebec was

⁴¹⁷ Mitchell, *supra* note 413 at 10.

⁴¹⁸ *Ibid.*

⁴¹⁹ Bill C-56, *Assisted Human Reproduction Act*, 1st sess., 37th Parl., 2002.; Bill C-13, *An Act respecting assisted human reproduction and related research*, 2nd sess., 37th Parl., 2003.; Bill C-6, *An Act respecting assisted human reproduction and related research*, 2nd sess., 37th Parl., 2003.

⁴²⁰ In the matter of a Reference by the Government of Quebec pursuant to the *Court of Appeal Reference Act*, R.S.Q., c. R-23, concerning the constitutional validity of sections 8 to 19, 40 to 53, 60, 61 and 68 of the *Assisted Human Reproduction Act*, S.C. 2004, c. 2, 2008 QCCA 1167.

Section 1 of the Quebec Court of Appeal Reference Act, R.S.Q., c.R-23, provides that "The Government may refer to the Court of Appeal, for hearing and consideration, any question which it deems expedient, and thereupon the court shall hear and consider the same." Section 5 of that Act further provides, "The court shall send to the Government for its information its opinion duly certified upon the questions so referred, giving its reasons in support thereof, in like manner as in the case of judgments rendered upon appeals brought before the said court." Although a court's response to questions posed on a reference is considered to be an advisory opinion, many legal scholars have suggested that reference opinions are in fact treated as if they were binding judgments. See, for example, Gerald

concerned that sections of the bills encroached on the exclusive legislative authority of the provinces, as the strategic move to couch federal legislation within the criminal power had not been well received.⁴²¹ Quebec's appellate court found that certain provisions were not in fact legitimately enacted under federal authority, nor did the federal government have the power of conferring a criminal law purpose on the management of "controlled" assisted reproductive activities.⁴²² This ruling was appealed by the Government of Canada to the Supreme Court of Canada (SCC), with arguments heard in April 2009. More than thirty years of feminist organizing around reproductive technologies in Canada was stalled yet again.

Analysis of Radical Feminist Position

There was a broad and robust field of feminist debate in Canada during the 1980s and throughout the Royal Commission on New Reproductive Technologies. A tremendous diversity of voices existed both in Canada and abroad, and by no means were all women of a 'sex negative' or radical feminist stripe, firmly against the commercialization of women's bodies in any form.⁴²³ In the mid-1980s, however, when a federal response to NRTs was looming on the horizon, a remarkably consistent vision emerged from the National Action Committee on the Status of Women.

Rubin, "The Nature, Use and Effect of Reference Cases in Canadian Constitutional Law," McGill Law Journal, Vol. 6, No.3, 1959–1960, pp.168–190.

⁴²¹ Initially, only sections 8 to 12 (dealing with issues of consent, embryo creation and the management of human gametes, human-animal hybrids and the reimbursement of expenditures incurred by donors and surrogate mothers) were disputed as being *ultra vires* Parliament; this was later expanded to include sections 13 to 19, 40 to 53, 60, 61 and 68.

⁴²² In the matter of a Reference by the Government of Quebec pursuant to the *Court of Appeal Reference Act*, R.S.Q., c. R-23, concerning the constitutional validity of sections 8 to 19, 40 to 53, 60, 61 and 68 of the *Assisted Human Reproduction Act*, S.C. 2004, c. 2, 2008 QCCA 1167.

⁴²³ Early forms of this counter-critique were of course raging, in Canada and abroad, through the 'sex wars' which wracked second-wave feminism and called into question issues of women's oppression, the patriarchy, and the role of sex and sexual pleasure. Emerging from an (in)famous conference on the subject, Carole Vance's edited collection remains a touchstone of these fiery debates. Carole Vance, ed., *Pleasure and Danger*, (Routledge & Kegan, Paul, 1984). Within new veins of postmodernist scholarship specifically about the law, a Foucauldian analysis as applied to legal feminism was soon to emerge from the writing of Carol Smart and her important 1989 text. See: Carol Smart, *Feminism and the Power of Law* (Routledge: London, 1989).

NAC and other women's groups were deeply concerned about the potential for patriarchal domination and harm to women inherent in NRTs, and as such opposed the use of such technology on principle. Questions of direct concern to lesbians, such as low-tech options using donor sperm which had long been popular within the lesbian community, were not addressed by the group, although some concerns existed over the medicalization of grassroots networks by fertility professionals.⁴²⁴ Gay male reproduction and the potential for more equitable surrogacy contracts never emerged as a point for discussion, nor did the reproductive concerns of transgender people, although it may be argued that such matters were not in common circulation even among gay and lesbian circles at the time.⁴²⁵ However it is no exaggeration to say that the main focus of the national women's movement remained on IVF, surrogacy and the commercialization of eggs, sperm and embryos.

The vision of female bodies and female 'nature' being produced in these debates was one standing in opposition to technology, commerce and masculine authority. The radical feminist and anti-technology stance that emerged through FINRRAGE and in certain Canadian quarters was deeply dependent upon a nature/culture binary to generate meaning, envisioning a 'natural' experience of sexuality and reproduction that existed apart from 'cultural' forms of patriarchal domination.

In its barest form, this position takes up an essentialist framing of the female body which understands that body as the 'natural' repository for the business of child-making and bearing. Although unremarked upon in the debates, it is precisely the heterosexual feature of 'normal'

⁴²⁴ Coffey, *supra* note 303.

⁴²⁵ Perhaps unsurprisingly, EGALE's submission to RCNRT was silent on the reproductive rights and concerns of transgender people.

reproduction that bestows its natural complexion, and which may then be contrasted against the ‘unnatural’ and ‘exploitative’ mechanisms of IVF. Yet as Dion Farquhar argues:

...the experience of conception through heterosexual penile-vaginal intercourse in a state-triangulated legal marriage without reproductive technologies is no more ‘natural’ than an institutional medically mediated conception in a laboratory petri dish with anonymous donor sperm.⁴²⁶

The radical feminist position thus leaves unexplored the dissonance between heterosexual intercourse as the pathway to ‘natural’ reproduction and female empowerment; and heterosexual intercourse as the ultimate expression of sexual domination of men over women.⁴²⁷ It also, implicitly, leaves intact the ‘natural family’ in the condition of a ‘state-triangulated legal marriage’ as the ideal location for human reproduction. The rhetoric of “choice” commonly leveraged by this analysis - as in a woman’s right to choose to be pregnant, to choose not to be pregnant, to choose not to remain pregnant – still remains within a heterosexual dialectic, wherein men are the protagonists with whom to have sex, to avoid sex with, or to demand abortions from. Thus the legal construct of the family as two-parent, heterosexual and reproductive is (ironically) reinforced through radical feminist anti-patriarchal hymns to the biological essentialism of the female body.

So long as the conceptual framework remains fixed on the heterosexual order – whether in resistance or domination – a deeply conservative reading remains possible wherein this arrangement stands in for “nature itself”. For example in a lengthy dissent appended to the Report, Commissioner Scorsone acknowledges the double standard inherent in the policy

⁴²⁶ Farquhar, Dion. “Feminist Politics of Hagiography/Demonology? Reproductive Technologies as Pornography/Sexworks.” In Bat-Ami Bar On and Ann Ferguson, eds. *Daring to be Good: Essays in Feminist Ethico-Politics*. (New York: Routledge, 1998) at 195.

⁴²⁷ Dominance feminism, as this analysis has come to be called, has been developed most influentially within the work of Marxist feminist Catherine MacKinnon. See for example: MacKinnon, Catharine A. *Toward a Feminist Theory of the State*. (Cambridge: Harvard University Press, 1989).

suggested by the RCNRT, wherein the reproductive desires of a single woman would be met through access to donor sperm (however restricted), whereas a single man with the same desires would be criminalized. As she explains, however, this difference is not discriminatory but “derived from the physical realities of sexual dimorphism.”⁴²⁸ The simple biological realities of gender must determine how each will be treated, but this rests not upon social distinctions but the workings of nature. As Scorsone continues, “Be it granted, only a woman can become pregnant, as only a man can produce sperm. Neither fact is discriminatory; they are simply an empirically observable given, a function of the highly adaptive, population variability-maintaining sexual dimorphism that human beings share with most organisms above the evolutionary level of the worm.”⁴²⁹

While positioned from a different ideological stance than most other feminist commentators, Scorsone similarly relies upon radical feminist arguments to mark the “evident” physical realities of the body and foreground an essentialized “woman” as the focus of attention. Like much of the Report, she proceeds from a binary distinction between men and women, and one that assumes a stable and fixed meaning to each body. As Weir and Habib point out, “[t]he notion that expertise could in any way be constitutive of the body was a thought that seemingly never occurred to the Commissioners.”⁴³⁰

Propelled by the concern with female exploitation and danger, as well as the challenge poised to the heterosexual order by NRTs, radical feminists like Scorsone sought to distinguish two sexes upon the basis of anatomy. She continued to hold a position that “is deeply vested with a binary of nature and culture, with the sexed body guaranteed in the order of nature” and

⁴²⁸ Proceed With Care, *supra* note 320 at 1101.

⁴²⁹ *Ibid* at 1131.

⁴³⁰ Weir and Habib, *supra* note 318 at 151.

technologies such as commercial surrogacy viewed as a transgression of this order.⁴³¹ The effect was a total prohibition upon bodily relations seen as standing against nature *and* culture – including both surrogacy and (for Scorsone at least) the unnatural projects of lesbian donor insemination.⁴³²

Queer Analysis of RCNRT

A queer position on reproductive technology, however, would not need to privilege ‘natural’ reproduction as the site of bodily empowerment. These heterosexist logics do not necessarily dictate the ways in which same-sex relationships locate their definitions of empowerment, liberation or oppression.⁴³³ By stepping outside the binary model of nature/culture, man/woman offered by a queer vantage, one may avoid the monolithic power formulation of ‘male technology vs. female nature’ that the radical feminist critique puts forth. When the nature/culture binary is not the governing frame, it becomes possible to view the use of reproductive technologies as a contested site of power, rather than the power of one group (the patriarchy) over the other (oppressed women). This may allow for more complex readings of commodification, exploitation, embodiment and resistance to emerge.

Of course this queer history has not been the dominant story of AHR in Canada. Instead, the system of legal regulation that currently exists has been marked by a remarkable encounter with institutionalized radical feminism.⁴³⁴ The mandate of the RCNRT was not to craft

⁴³¹ *Ibid.*

⁴³² Proceed With Care, *supra* note 320 at 1091.

⁴³³ Of course many same-sex couples may seek state validation as “just like” a “normal family” and therefore as equally deserving of legal recognition. The operation of power is multidimensional and not reducible to a singular narrative. As Brenda Cossman has argued, through processes of inclusion and exclusion, queer lives under the law are simultaneously “both normative and transgressive”. These complex reckonings will be tracked in relation to empirical data around queer family formation in Chapter 9. See Brenda Cossman, “Lesbians, Gay Men, and the Canadian Charter of Rights and Freedoms,” 40 Osgoode Hall L. J. 223 (2002) at 225.

⁴³⁴ For an analysis of this, see Janet Halley’s recent work on governance feminism and the ways in which radical

legislation, but to lay out the policy concerns and implications for the development of new reproductive technologies in Canada. However the original framework laid out in *Proceed With Care* proved to be enormously influential on the multiple legislative drafts that worked their way through Parliament. When the *AHRA* finally passed into law it reflected the Commission's original desire for a federal governing body to regulate and oversee issues related to reproductive technology. It also selected some allowable activities for control and licensing (such as donor insemination, screening and access to gametes, and the manipulation of *in vitro* embryos) and imposed strict criminal prohibitions on others (including the commercialization of reproduction including payment for eggs, sperm, and any role in the arrangement of commercial surrogacy). While the RCNRT had rejected all forms of surrogacy as a potential harm to women, the *AHRA* did make allowance for altruistic surrogates who would be permitted to receive the reimbursement of expenses. However the central distinction drawn by the Report, between two categories of activities for which different approaches were recommended, precisely guided the *AHRA*'s distinction between prohibited activities and controlled activities.⁴³⁵

The remainder of this chapter will pick up with the 2010 Supreme Court *Reference Case* and look at the legal impact this history and its binary modalities has had, and continues to have, on LGBTQ people in Canada.

Supreme Court Reference Case

The Supreme Court of Canada decision in *Reference Re Assisted Human Reproduction*

feminist modes of thought in particular have been formalized into techniques of governance. In: Halley, Janet E. and Kotiswaran, Prabha and Thomas, Chantal and Shamir, Hila, "From the International to the Local in Feminist Legal Responses to Rape, Prostitution/Sex Work and Sex Trafficking: Four Studies in Contemporary Governance Feminism" (2006) Harvard Journal of Law & Gender, Vol. 29, No. 2.

⁴³⁵ This point was also made by by LeBel and Deschamps JJ at para 206 of the *AHRA Reference Case*, which will be discussed in detail in the next section.

Act was a lengthy 167-page decision split among three separate opinions.⁴³⁶ Yet over the course of the ruling, the Supreme Court justices made only a single mention of LGBTQ users of AHR services. The reasons written by Chief Justice McLachlin failed to discuss gay and lesbians at all, as did the brief opinion of Cromwell J., while the judgment written by LeBel and Deschamps JJ. paused but once to note that AHR “represents the only option for homosexuals who wish to reproduce.”⁴³⁷

An “unusually fractured court” found itself split three ways (4-4-1) across this decision with three separate opinions filed.⁴³⁸ Four judges led by McLachlin C.J.C rendered the opinion that all impugned provisions of the *AHRA* were a valid exercise of the criminal law power.⁴³⁹ Four judges speaking through LeBel and Deschamps JJ. held that while the absolute prohibitions against certain assisted human reproduction practices described in the statute as “Prohibited Activities” were constitutional, the impugned regulatory sections which formed the bulk of the statute were not.⁴⁴⁰ The tiebreaking opinion was delivered by Justice Cromwell, the newest member of the court, who split the difference between the other two opinions, concluding that some of the impugned provisions were valid while others were *ultra vires*. He agreed with LeBel and Deschamps JJ.’s pith and substance analysis, but parted company in respect of certain of the regulatory provisions at issue.

⁴³⁶ Reference re *Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 S.C.R. 457.

⁴³⁷ Decision of LeBel, Deschamps, Abella and Rothstein JJ, written by LeBel and Deschamps: “Rather, both those who testified before the Baird Commission and those who participated in the parliamentary debates acknowledged that the development of assisted human reproduction amounts to a step forward for the constantly growing number of people dealing with infertility. Moreover, it represents the only option for homosexuals who wish to reproduce. The risks for the health and safety of people who resort to these technologies do not distinguish the field of assisted human reproduction from other fields of medical practice that have evolved after a period of experimentation, such as that of organ transplants or grafts.” Italics added. Reference re *Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 S.C.R. 457 at para. 254.

⁴³⁸ Graeme G Mitchell, “Not a General Regulatory Power—A Comment on *Reference re Assisted Human Reproduction Act*” (2011) 54(2) Sup Ct L Rev 633 at 634.

⁴³⁹ *Supra* note 436, with Binnie, Fish and Charron JJ. concurring.

⁴⁴⁰ *Supra* note 436, with Abella and Rothstein JJ. concurring. See also: Barbara von Tigerstrom, “Federal Health Legislation and the *Assisted Human Reproduction Act* Reference” (2011) 74:1 Sask L Rev 33.

Justice Cromwell framed the issue as “whether the federal criminal law power permits Parliament to regulate virtually all aspects of research and clinical practice in relation to assisted human reproduction.”⁴⁴¹ Answering that question in the negative, he went on to agree with the Chief Justice that the prohibitions contained in sections 8, 9 and 12 “in purpose and effect prohibit negative practices associated with assisted reproduction and that they fall within the traditional ambit of the federal criminal law power.”⁴⁴² Thus it remains unconstitutional to create or use an embryo without the donor’s consent (s.8), or to remove ova or sperm from a person under 18 years of age (s.9)

Section 12 in particular he read with ss. 6 and 7, which reiterate the principle of non-commercialization of the human body by prohibiting any form of payment to surrogate mothers, as well as the purchase or sale of ova, sperm, in vitro embryos, and human cells or genes. These sections were conceded by the Attorney General of Quebec to be valid federal criminal law. Cromwell understood the regulations of s. 12, which control the reimbursement of expenditures incurred by gamete donors and surrogate mothers, as “a form of exemption from the strictness of the regime” set by the prohibitions, and concluded that it was necessary to define their scope.⁴⁴³

However, he also agreed with Justices LeBel and Deschamps that sections 10 (use of human reproductive material and in vitro embryos except in accordance with the regulations and a licence), 11 (combining parts of human genomes with other genomes except in accordance with the regulations and a licence), 13 (undertaking a controlled activity on licensed premises only), 14 to 18 (privacy and access to information provisions), sections 40(2) to 40(5) (provisions relating to the Assisted Human Reproduction Agency of Canada), and sections 44 (2)

⁴⁴¹ *Ibid* at para. 283.

⁴⁴² *Ibid* at para 291.

⁴⁴³ *Ibid* at para 290.

and (3) (relating to inspectors assuming the management of premises and the costs incurred) were *ultra vires* Parliament.⁴⁴⁴

LGBTQ Issues in the Reference Case

As discussed below, the primary issue for many gays and lesbians involves access to reproductive material as well as regulations around surrogacy. Sections 6 and 7 were not contested in the case, and it remains a criminal act to pay a surrogate mother or purchase sperm or ova in Canada. Although s.12 remains under federal criminal law, it is as “a form of exemption from the strictness of the regime,” to allow for the reimbursement of expenses incurred by altruistic surrogates.⁴⁴⁵ Unfortunately, s.12 has never been proclaimed into force, nor have any regulations been promulgated under this section.

The statement of principles laid out in the *AHRA* explicitly aimed to prevent discrimination against persons who seek to undergo AHR procedures, “including on the basis of sexual orientation and marital status.”⁴⁴⁶ This was one of the feminist imprints left by the RCNRT, which, as discussed in Chapter Five, had made mention of the prevailing discrimination against lesbians and single women in Canadian society. Notwithstanding the spirited dissent by Scorsone, the Commission had expressed its view that:

it is wrong to forbid some people access to medical services on the basis of social factors while others are permitted to use them; using criteria such as a woman's marital status or *sexual orientation* to determine access to donor insemination, based on historical prejudices and stereotypes, amounts to discrimination as defined under human rights law and contravenes the Commission's guiding principle of equality.⁴⁴⁷

As has been seen, if the history of the *AHRA* allowed a footnote for issues faced by

⁴⁴⁴ *Ibid.*

⁴⁴⁵ *Ibid.*

⁴⁴⁶ *Assisted Human Reproduction Act*, SC 2004, c 2 [*AHRA*], s. 2(e).

⁴⁴⁷ *Proceed With Care*, *supra* note 320 at 278. Emphasis mine.

lesbian and bisexual women, it was silent on the reproductive concerns of gay men and trans people. The issue of sexual orientation has never been at the fore regarding AHR in Canada, and it is no hyperbole to say that the present legal regime has been crafted with scarce consideration of the reproductive needs of ‘homosexuals.’ Despite this omission, of course, LGBTQ people in Canada who wish to become parents remain heavily dependent upon adoption services and the often-expensive modes of AHR.⁴⁴⁸ These are bureaucratically onerous and pricey options, leaving LGBTQ communities vulnerable to legislative gaps and judicial decisions which do not account for their unique realities.⁴⁴⁹ The *AHRA Reference* case once again emphasized this gap, leaving continued legal uncertainty alongside the virtual erasure of LGBTQ people in Canada from the discussion of how and why AHR technologies are to be used in the future.

Written as it was at the close of 2010, the *Reference Case* performed a rather impressive feat by hardly mentioning the needs of queer families within its pages. Instead the familiar trope of nature/culture was in play, as Supreme Court Chief Justice Beverly McLachlin contrasted the

⁴⁴⁸ For a background to the experience of LGBTQ people with adoption in Ontario, see: Ross, L.E., Epstein, R., Anderson, S., Eady, A. (2009). Policy, practice and personal narratives: Experiences of LGBTQ people with adoption in Ontario, Canada. *Adoption Quarterly*, 12(3/4), 272-293; Ross, L.E., Epstein, R., Goldfinger, C., Yager, C. (2009). Policy and Practice regarding lesbian, gay, bisexual, transgender, transsexual and Two-Spirit adoption in Ontario. *Canadian Public Policy*, 35(4), 451-467; Ross, L.E., Epstein, R., Goldfinger, C., Steele, L.S., Anderson, S., Strike, C. (2008). Lesbian and queer mothers navigating the adoption system: the impacts on mental health. *Health Sociology Review*, 17(3): 254-266; Ross, L.E., Steele, L., Epstein, R. (2006).

For a discussion of how lesbian and bisexual women in particular are navigating the provision of AHR services, see: Lesbian and bisexual women’s recommendations for improving the provision of assisted reproductive technology services. *Fertility and Sterility*, 86(3), 735-8; Ross, L.E., Steele, L., & Epstein, R. (2006). Service use and gaps in services for lesbian and bisexual women during donor insemination, pregnancy and the postpartum period. *Journal of Obstetrics and Gynaecology Canada*, 28(5), 505-511.

⁴⁴⁹ As an example, trans people have only recently gained recognition of their gender identity as an enumerated ground for protection against discrimination in provincial and territorial human rights legislation. The Northwest Territories was the first jurisdiction to add “gender identity” to its human rights legislation in 2002 (*Human Rights Act*, SNWT 2002, c 18, s 5(1)). Manitoba added “gender identity” to its Human Rights Code in June 2012 as did Ontario, which also added “gender expression.” *Human Rights Code, CCSM c H175*, s 9(2)(g), as amended by *Human Rights Code Amendment Act*, SM 2012, c 38, s 5(2); *Human Rights Code, RSO 1990*, c H. 19, s 1, as amended by *Toby’s Act (Right to be Free from Discrimination and Harassment Because of Gender Identity or Gender Expression)*, 2012, SO 2012, c 7, s 1. Prior to these amendments, the grounds of “gender” under the Ontario Code in particular had been held to include “gender identity”, but recent developments now make the legislation explicit. The term “gender identity” refers to a person’s own identification of being masculine, feminine, male, female, or trans. Gender identity is unrelated to sexual orientation; not all trans people identify as lesbian, gay, bisexual, or queer. Gender expression is the public expression of gender identity, including actions, dress, hairstyles, etc., performed to demonstrate one’s gender identity.

biological ‘facts of life’ against the moral confusions presented by technologically mediated reproduction. As she explained in the opening lines of her judgment: “Since time immemorial, human beings have been conceived naturally.”⁴⁵⁰ New reproductive technologies have thereby posed a challenge to moral, religious and juridical leaders alike, as these “new questions do not fit neatly within the traditional legal frameworks that have developed in a world of natural conception.”⁴⁵¹

McLachlin C.J. develops her judicial reasoning around this foundational conceptual binary, with the stability and certainty of natural biological reproduction pitted against the potential social ills of reproductive technology. By appealing to the eternal stability of the heterosexual couple, she reinstates the ‘natural facts’ of reproduction as the touchstone against which all else is to be read. With the heterosexual imaginary as her lens the ruling lands on solidly conservative footing, reading the potential for abuse in these technologies as one that may “legitimately be considered a public health evil to be addressed by the criminal law.”⁴⁵²

Within this binary, LGBTQ reproduction must take up the opposite pole to ‘natural reproduction’ as figured since time immemorial. The assisted reproduction of queer people is necessarily grouped with the cluster of new technologies, which together pose a legitimate public health evil and may require criminal penalty. What this means for LGBTQ people then is not only an erasure, but a placement among the monstrous, the abject, the criminal. It may be noted that the joint reasons for judgment penned by LeBel and Deschamps JJ did *not* rely upon this constitutive nature/culture binary. Although queer people were mentioned only briefly by the justices, their text quite centrally framed the needs of infertile heterosexuals. This ruling diverged markedly from the Chief Justice in finding that *none* of the impugned provisions fell under the

⁴⁵⁰ Reference re *Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 S.C.R. 457 at para. 2.

⁴⁵¹ *Ibid.*

⁴⁵² *Ibid* at para 62.

criminal law power, instead viewing “the regulation of assisted human reproduction as a health service,”⁴⁵³ although ultimately it was Cromwell J’s terse ruling which settled the matter.

Next Steps for the Regulation of AHR in Canada

In June 2012, Parliament repealed the invalidated sections and amended the *AHRA*, while also abolishing the Assisted Human Reproduction Agency of Canada.⁴⁵⁴ As such, the federal role relating to assisted human reproduction has been reduced considerably, as has the need for administrative and regulatory enforcement. Also notable has been the removal from section 12 of the requirement for a license to reimburse expenditures.⁴⁵⁵ As a result of Bill C-38, all responsibilities under the amended Act were transferred to the Minister of Health. All activities that were deemed to pertain to provincial jurisdiction over healthcare must now be regulated by each province, although there is no legal requirement to do so. In the words of Angela Cameron and Vanessa Gruben, the decision has “left a legal vacuum to be filled only when and how each province and territory see fit.”⁴⁵⁶ This presents the real possibility of a heterogeneous landscape of regulation in which domestic reproductive tourism may become the norm.⁴⁵⁷

Legal uncertainty unduly impacts those with already precarious claims on the state, not least because the construction of dominant legal categories as neutral and universal actually obscures their historical particularism. When litigants challenge this abstracted form of legal rights and advance contextual narratives based on culture, race, or sexuality, Canadian courts

⁴⁵³ *Ibid* at para 227.

⁴⁵⁴ *Jobs, Growth and Long-term Prosperity Act*, SC 2012, c. 19. Ss. 713-745. Division 56 of Part 4 amends the *Assisted Human Reproduction Act* to respond to the Supreme Court of Canada decision in *Reference re Assisted Human Reproduction Act* that was rendered in 2010, including by repealing the provisions that were found to be unconstitutional and abolishing the Assisted Human Reproduction Agency of Canada.

⁴⁵⁵ *Ibid* at s.719.

⁴⁵⁶ Angela Cameron and Vanessa Gruben, “Quebec’s Constitutional Challenge to the *Assisted Human Reproduction Act*: Overlooking Women’s Reproductive Autonomy?” Forthcoming in: Stephanie Patterson, Francesca Scala and Marlene Sokolon eds., *Fertile Ground: Exploring Reproduction in Canada* (Montreal: McGill-Queen’s University Press, 2014).

⁴⁵⁷ Raywat Deonandan and Tarun Rahman, “Implications and reflections on the 2010 Supreme Court ruling on Canada’s AHR Act,” *Int J Womens Health*. 2011; 3: 405–408 at 406.

have historically found such claims difficult to manage.⁴⁵⁸ As Hester Lessard has explained, the supposed formal equality of access to rights “has no content other than the highly abstract content of entitlement to respect by the state for one's status as a rights holder, and it contemplates an individual who is simply and fundamentally a rights-holding self, with no defining attributes, history, economic status, or social location.”⁴⁵⁹

In contrast to Lessard I would argue that, at least in the case of AHR, this abstracted content of entitlement *does* have a set of defining attributes, which are deeply embedded within the normative presumptions of heterosexual coupling.⁴⁶⁰ As was clear in the *AHRA Reference*, the infertile heterosexual couple is contemplated as the exemplary user of AHR services. Other dependent populations are either ignored (as in the McLachlin C.J. and Cromwell J. decisions), or marked only in passing (as in the LeBel and Deschamps JJ. ruling). This judgment is based upon the assumption that heterosexual families constitute the norm, with all other demands for reproductive technology to be understood within this guiding framework. The SCC ruling thus assumes that LGBTQ needs are *similar in kind* to those of heterosexual families, if perhaps more

⁴⁵⁸ In regard to LGBTQ rights, *Mossop v. Canada (A.G.)*, [1993] 1 S.C.R. 554 demonstrated the limited success of litigants' arguments which intentionally sought to avoid the normalizing weight of Canadian family law. As Brenda Cossman writes, “the [*Mossop*] case represented an interesting attempt by the litigants to frame the issue in the discourse of equality, while consciously trying to mitigate the sameness argument. In a conscious attempt to disrupt the heteronormativity of law, Mossop and the intervenors supporting his claim tried to limit their reliance on sameness arguments and the heterosexual equivalency of same-sex relationships. Even in arguing for a functional equivalency approach, Mossop himself refused to make arguments on the basis of sexual monogamy...*Functional approaches to the family are invariably measured against a set of norms about what families do or ought to do.*” In Cossman, *supra* note 433 at 226-227. This ‘set of norms’ is thereby rooted upon the heteronormativity of law - the assumption, in individuals or in institutions, that everyone is heterosexual, and that heterosexuality is superior to homosexuality and bisexuality. “Heteronormativity refers to the privileging of heterosexual relationships and identities through the establishment of said relationships and identities as the norm by which all others are evaluated.” Hylton, M.E. (2005). Heteronormativity and the experiences of lesbian and bisexual women as social work students. *Journal of Social Work Education*, 41(1), 67-82 at 69.

⁴⁵⁹ Hester Lessard, “Mothers, Fathers, and Naming: Reflections on the Law Equality Framework and *Trociuk v. British Columbia (Attorney General)*” (2004) 16(1) Can. J. Women & the Law 165-211 at 176. See also Shelley Gavigan, “Legal Forms, Family Forms, Gendered Norms: What Is a Spouse?” (1999) 14 Canadian Journal of Law and Society 127.

⁴⁶⁰ For a more substantive discussion of this point, see Ross et al., “Creating Our Families: Lesbian, gay, bisexual, trans and queer people's experiences with assisted human reproduction services in Ontario, Canada,” in preparation (email l.ross@utoronto.ca for a copy).

starkly rendered. Reproductive assistance may thereby constitute a necessary rather than occasional requirement for “homosexuals who wish to reproduce,” but the mechanics and legal considerations are basically the same. Thus, LGBTQ concerns warrant no more than a passing acknowledgement, as the universality of the heterosexually reproductive family can accommodate all forms of socio-biological kinship – scientifically-aided or otherwise.⁴⁶¹ Thus, Canada’s long journey to develop law and policy around new reproductive technologies has rarely accounted for the cultural specificity and community values of LGBTQ Canadians.

⁴⁶¹ For a philosophical meditation on the psychic lives of those who live outside of normative kinship, with specific reference to children born through donor insemination, see: Judith Butler (2002) ‘Is Kinship Always Already Heterosexual?’ *Differences: A Journal of Feminist Cultural Studies* 13(1): 14-44.

SECTION III

Chapter Seven: Interrogating Medical Infertility

Introduction

The piecemeal legal geography around AHR in Canada, as it applies to LGBT people in particular, is explored in two attachments to this dissertation, both of which have been published in other fora. However queer families seeking reproductive assistance do not only face issues of legal access – they must manage the clinical geography and language of medicine as well. This chapter explores the ways in which ‘medical infertility’ operates as a powerful diagnostic tool and structuring logic for queer people seeking AHR.

Indeed, amidst the thousands of pages of data gathered by the Creating Our Families research project, one central issue overwhelmingly emerged: A concern with how ‘infertility’ operates as a governing clinical discourse. Overwhelmingly, participants expressed their frustration with the limitations of the concept when applied to LGBTQ people. As discussed in a joint publication by the Creating Our Families team, the problem with ‘infertility’ is woven through a series of related clinical assumptions that rely heavily upon a heterosexual imaginary:

Specifically, the overarching framework of AHR services presumes that service users are heterosexual, cisgender (non-trans), partnered, and experiencing infertility. These assumptions manifest in fertility clinic practices and procedures that do not meet the specific needs of LGBTQ service users, for whom one or more of the assumptions associated with an infertility model are incorrect.⁴⁶²

Instead, the exemplary user of AHR services is a male-female heterosexual couple who are experiencing a hiccup in the ‘natural’ biological processes of fertility. In this framing, the clinic is simply there to “give a helping hand” to Nature and allow the couple to fulfill their

⁴⁶² Ross et al., “Creating Our Families: Lesbian, gay, bisexual, trans and queer people’s experiences with assisted human reproduction services in Ontario, Canada,” in preparation.

biological destiny.⁴⁶³ For obvious reasons, this conceptual framework does not work for many LGBTQ people.

As recounted by a bisexual woman named Carol in a same-sex relationship in Toronto, when the interviewer mentioned the word “infertility” she had the following to say: “I hate that word...I’m not infertile. I need some assistance accessing sperm, that’s it.” Carol went on to recount an exchange with a gynecologist who had read in her file that she was attending a fertility clinic in order to get pregnant:

Carol: He was like “Oh I see you’re at [a Toronto fertility clinic] for some infertility issues.” I said “No, not infertility. I’m just gay and I need some sperm.” (*laughs*)

Carol: And he said “Well, you know, infertility...like same difference.” And I was like “No, it’s not.”...It’s a very contentious word...’Cause it labels me as – I mean not to minimize people who have infertility issues and that’s nothing to be ashamed of – but it’s not what my issue is. It’s a totally different piece and because I have to access the same spaces as people who are infertile it’s assumed that I have a physical, emotional, whatever kind of problems getting pregnant. And it’s not a problem getting pregnant it’s just that I can’t do it by having sex with my partner so I need to do it in other ways.

As this chapter will explore, a diagnosis of infertility built upon the failure of sexual intercourse to produce a viable pregnancy holds little traction for many queer folks. As will be argued, this represents more than merely a flawed medical diagnosis with unwanted consequences of mandatory testing and drug treatment. ‘Infertility’ also reflects the foundational logics of the nature/culture binary and is a discourse based on heterosexist assumptions of the ideal functioning of bodies and biologies. Infertility functions to narrow the field of reproductive possibility for law and medicine alike, and operates as a form of structural exclusion upon queer as well as straight families.

⁴⁶³ Sarah Franklin has remarked upon the tendency of clinics to produce promotional material that represents IVF as a simple, natural procedure through the use of phrases such as “giving Nature a helping hand”. Franklin, Sarah (1997) *Embodied Progress: A Cultural Account of Assisted Conception* (London: Routledge) at 103.

This section thus proposes a fundamental challenge to how naturalized conceptions of fertility and its inverse, infertility, have been constructed. In its place, I will argue for a more nuanced set of understandings of reproduction as a *relational* mode of embodiment.

The Natural Order of Family

In marking the shift to an intent-based structure of family creation through AHR, most commentators begin by stating the natural inevitability of fertility – biological procreation as how things have been done since “time immemorial”⁴⁶⁴ – before turning their critical attention onto the ambiguous vistas now opened by reproductive technology. In what is a typical framing of this teleological march, Marjorie Maguire Shultz has noted that “through most of history, biological procreation was more a matter of fate than intention.”⁴⁶⁵ This simple historical yesteryear is contrasted against the modern age of reproductive technology and our confusing, complex kinships threaded by knots of intention. Such analyses, even when sympathetic, must ultimately locate non-biological forms of family as a deviance from proper, ‘natural’ kinship. They uncritically rely upon the heterosexual facts of reproduction as standing at the core of an unproblematized natural order.

With the chapters of Section Three, I intend to sidestep these well-trodden channels of debate and look instead at how even alternative visions of the “future of the family” have depended upon an uncontested norm of coital procreation. This in turn has blunted the ability to imagine categories outside the ‘natural’. I begin by looking at the notion of medical infertility and how it is produced in opposition to properly reproductive bodies, demonstrating how a singular category of infertility not only creates a false binary but also serves to mask the sharp

⁴⁶⁴ *AHRA Reference Case*, *supra* note 436 at para 2.

⁴⁶⁵ Shultz, intent-based parenthood, 1990, *infra* note 923 at 304.

differences that exist among so-called infertile people.

History of Infertility

The last three decades have brought tremendous developments in reproductive technologies, alongside ever more complex ethical and legal questions on the nature of such interventions. As infertility slowly emerged as a public health issue, debate initially raged around the role and social meaning of technology itself in ameliorating childlessness.⁴⁶⁶ More recent years have seen an explosive growth in the epidemiological understanding of infertility as treatment for reproductive malfunctions, with a burgeoning private industry poised to offer biomedical interventions for their amelioration. At present, both popular and scholarly debate remain concerned with bioethical matters regarding the appropriateness of these technologies *qua* technology – especially in regard to embryo management and surrogacy – while also grappling with practical matters of how to regard the new family forms being produced. There has also developed a strong question about the state's responsibility for providing access to such treatments, particularly in countries that offer some measure of insurance coverage for reproductive assistance.⁴⁶⁷

This snapshot genealogy marks a drastic shift from how reproductive matters were viewed in the late nineteenth century, when attention was focused on the issue of fertility as a

⁴⁶⁶ See for example, Ginsburg FD, Rapp R, eds. *Conceiving the New World Order: The Global Politics of Reproduction*. (Berkeley: Univ. Calif. Press, 1995); Franklin S, Ragona H, eds. *Reproducing Reproduction: Kinship, Power, and Technological Innovation*. (Philadelphia: Univ. Penn. Press, 1998); David-Floyd R, Dumit J, eds. *Cyborg Babies: From Techno-Sex to Techno-Tots*. (New York: Routledge, 1998); Delaney C. 1986. "The meaning of paternity and the virgin birth debate.." *Man* 21(3):494–513; Rothman BK. 1988. "Reproductive technology and the commodification of life.." *Women Health* 13(1/2):95–100.

⁴⁶⁷ On the anti-funding side are popular media sources and public commentators such as: Andre Picard, *When the state funds IVF, the cost is too high for everyone*. *Globe and Mail*, May. 11, 2011; On the pro-funding side are infertility patient advocates, among others. See: Mathias Gysler, *Why Ontario must fund IVF now* (Summer 2010), Infertility Awareness Association of Canada.

threat to the health of women, their children and society at large.⁴⁶⁸ Such a response sought to restrict the fertility of women – and disabled, nonwhite and poor women in particular – to prevent the reproduction of minority populations the state deemed as inferior.⁴⁶⁹ Governance over the reproductive potential of certain bodies actively relied upon the logics of eugenics to exclude and sterilize those who did not conform to norms of the ideal citizen.⁴⁷⁰ These norms clustered around vectors of race, gender, sexuality and ability, working to create a blunt tool of reproductive coercion. In the U.S. this was affirmed through the legitimization of state-directed eugenics programs in *Buck v. Bell*, an infamous 1927 ruling written by Justice Oliver Wendell Holmes, Jr. that confirmed the constitutionality of forced sterilization regarding the poor and mentally ill.⁴⁷¹

Sterilization was also a favored tool of the colonial project in both the U.S. and Canada. In an anthology entitled *The State of Native America: Genocide, Colonization, and Resistance*, M. Annette Jaimes and Theresa Halsey quote a study indicating that “as many as 42 percent of all Indian women of childbearing age had [by 1974] been sterilized without their consent.”⁴⁷² This trend expanded after the mid-1960s and President Johnson’s ‘War on Poverty’, as Jane

⁴⁶⁸ Heitman, Elizabeth, 'Infertility As A Public Health Problem: Why Assisted Reproductive Technologies Are Not The Answer', 6 Stan. L. & Pol'y Rev. 89 1994-1995.

⁴⁶⁹ For a ground-breaking analysis of how the reproductive rights of African-Americans have been restricted by the state, see: Dorothy Roberts, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* (New York, NY: Pantheon Books, 1997); For an analysis of racialized governmental practices carried out against the bodies and reproductive systems of indigenous women see: Andrea Smith *Conquest: Sexual Violence and American Indian Genocide* (New York: South End Press, 2005).

⁴⁷⁰ See also Mark A. Largent. *Breeding Contempt: The History of Coerced Sterilization in the United States*. (New Brunswick, N.J.: Rutgers University Press, 2008) and Paul A. Lombardo, *Three Generations, No Imbeciles: Eugenics, The Supreme Court, and Buck v. Bell*. (Baltimore: Johns Hopkins University Press, 2008). Criminal sterilization laws were commonly applied in the U.S. until the Supreme Court ruling in *Skinner v. Oklahoma*, 316 U.S. 535 (1942), after which punitive sterilizations were no longer permitted to be performed on convicted criminals. Forced sterilizations were, however, still performed regularly on women with a perceived mental disability.

⁴⁷¹ 274 U.S. 200 (1927).

⁴⁷² M. Annette Jaimes & Theresa Halsey, “American Indian Women: At the Centre of Indigenous Resistance in Contemporary North America” in M. Annette Jaimes, ed. *The State of Native America: Genocide, Colonization, and Resistance* (Boston: South End Press, 1992) at 311–44.

Lawrence documents how large numbers of sterilizations also targeted African-American and Hispanic women as part of ‘humanitarian’ measures to keep population numbers down within poor communities.⁴⁷³ Homosexuality has also operated as a target of reproductive restrictions. In Oregon, for example, as one of thirty-three U.S. states that passed forced sterilization laws, reproductive purges were initially aimed at punishing men for having homosexual sex. For years, the state “favored castration over vasectomies” and the Oregon Legislature failed to abolish the ominously-titled ‘Board of Eugenics’ until October 1983.⁴⁷⁴

The role of government in assuring particular fertility outcomes for its citizens has a long and continuing history, and it is only recently that attention has shifted to a concern with promoting and enhancing childbirth.⁴⁷⁵ Many exclusionary elements of reproductive governance are still in force, however, from the legal barriers discussed in Section II to the discursive clinical frame that is the subject of Section III. This exclusion is wrapped within the clinical and legal certainty of the term *infertility*, as a restrictive conceptual model that impacts not only gender and sexual minority communities, but also single men and women seeking to produce genetic offspring.

Defining Infertility

The word *fertile* dates from 1375–1425 and derives from late Middle English via Latin.

The Miriam-Webster Medical Dictionary defines ‘fertile’ as follows:

⁴⁷³ Jane Lawrence, "The Indian Health Service and the Sterilization of Native American Women." (2000) *American Indian Quarterly* 24, 3:400-419. See also: Carpio, Myla Vicenti. "The lost generation: American Indian women and sterilization abuse." *Social Justice*, 31.4 (Winter 2004): 40(14).

⁴⁷⁴ Julie Sullivan, "State will admit sterilization past", *Portland Oregonian* (November 15, 2002).

⁴⁷⁵ It may well be argued that government inaction on the issue of funding for reproductive technologies represents more than a political distaste for the complex bioethical matters at play. By allowing the regulation and application of reproductive technologies to remain in the hands of a few private clinics, it is ensured that only wealthier citizens will be able to access these prohibitively expensive technologies. While regulatory laxity is certainly not as aggressive a maneuver as the forced sterilization of (for example) Aboriginal women as described in *supra* note 469, nevertheless it may result in a similar outcome of childlessness.

1 : capable of growing or developing <fertile egg>; **2** : developing spores or spore-bearing organs; **3 a** : capable of breeding or reproducing **b** of an estrous cycle : marked by the production of one or more viable eggs.⁴⁷⁶

Here the relevant aspects of human fertility may be summarized as: “**1**.the state or quality of being fertile; **2**.*Biology*. the ability to produce offspring; power of reproduction: the amazing fertility of rabbits.”⁴⁷⁷ Fertility is defined as the ability to produce offspring through one’s own reproductive material; a biological organism that is capable of breeding or reproducing.

These definitions have distinctly agricultural overtones, and indeed the varieties of assisted insemination in use today can trace a lineage from the practical matters of animal husbandry. Russian scientist Ilya Ivanovich Ivanov studied assisted insemination in domestic farm animals, dogs, rabbits and poultry, and in 1899 pioneered the methods which are now refined in the intra-uterine insemination of humans.⁴⁷⁸ The first reports on human applications originated in the early 1940s and into the 1950s, with assisted insemination eventually applied in cases where fertility had been impeded by immunological problems, marking the start of a new approach to assisted human reproduction: Infertility treatment.⁴⁷⁹

As Amy Agigian rightly inquires, however, “At the risk of belaboring the obvious: Since when has childlessness been an illness?”⁴⁸⁰ The shift from childlessness from a social to a medical phenomenon occurred at some point in the late 1960s as advances in medical technology

⁴⁷⁶ Miriam Webster Medical Dictionary, Accessed online November 9, 2011, <<http://www.intelihealth.com/cgi-bin/dictionary.cgi/fertility> >

⁴⁷⁷ Dictionary.com Unabridged., Random House, Inc. <http://dictionary.reference.com/browse/fertility> (accessed:., Accessed online November 09, 2011)., <<http://dictionary.reference.com/browse/fertility> >

⁴⁷⁸ Willem Ombelet and Johan Van Robays, History of human artificial insemination, F, V & V IN OBGYN, 2010, MONOGRAPH: 1-5

⁴⁷⁹ Guttmacher AF. The Role of Artificial Insemination in the Treatment of Human Sterility. Bull NY. Acad Med. 1943;19(8):573-91; Kohlberg K. The practice of artificial insemination in humans. Dtsch Med Wochenschr. 1953;78:835-9, quoted in Ombelet and Van Robays, *ibid*.

⁴⁸⁰ Agigian, A., *Baby Steps: How Lesbian Insemination is Changing the World*. (Middletown, CT: Wesleyan University Press. At, 2004) at 49.

made the governance of female reproductive cycles possible.⁴⁸¹ As Linda Whiteford and Lois Gonzalez (1995) explain:

The development of infertility as a medical condition [was] dependent on medical advances in the understanding of human endocrinology and medical technology. Until the 1950s infertility was often thought of as emotional, rather than medical in origin. Not until the 1960s and 1970s, when the development of synthetic drugs allowed physicians to control ovulatory cycles and the technology of laparoscopy allowed them to see women's internal reproductive biology, did infertility become medicalized.⁴⁸²

The origins of infertility have also been dated to 1978 and the IVF conception and birth of Baby Louise in the UK.⁴⁸³ According to some scholars, it was not until the medical technology existed to remake a 'barren' womb into a fertile womb that the diagnosis could conceptually exist. Infertility thus was developed as a new category between reproductively sterile and reproductively healthy – an in-between state upon which medical science is empowered to act. As Margarete Sandelowski and Sheryl de Lacey note:

Infertility was 'invented' with the in vitro conception and birth in 1978 of Baby Louise. That is, in the spirit and language of the Foucaudian-inspired 'genealogical method', infertility was discovered—or, more precisely, discursively created—when *in*-fertility became possible. Whereas barrenness used to connote a divine curse of biblical proportions and *sterility* an absolutely irreversible physical condition, infertility connects a medically and socially liminal state in which affected persons hover between reproductive inability and capacity: that is, 'not yet pregnant' but ever hopeful of achieving pregnancy and having a baby to take home.⁴⁸⁴

⁴⁸¹ Michelle Walks, Lesbian infertility *supra* note 266.

⁴⁸² Whiteford, L. M. and L. Gonzalez. 1995. "Stigma: The Hidden Burden of Infertility." *Social Science and Medicine* 40 (1): 27-36 at 29.

⁴⁸³ Note the discussion in Chapter Five, discussing how the birth of the world's first IVF baby served as a trigger in Canada for provincial reports on assisted reproduction, as well as a determined feminist movement against the development of such technologies.

⁴⁸⁴ Sandelowski, M. and S. de Lacey, "The Uses of a 'Disease': Infertility as Rhetorical Vehicle." *Infertility Around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies*. Eds. M. Inhorn and F. van Balen. (Berkeley, CA: University of California Press, 2002) 33-51. At 34-35

What precisely was invented, however, has been far from clear-cut. The indeterminacy of this liminal state and the complex temporalities and relational character of infertility have made it a deeply slippery notion. This ‘in-between-ness’ has also hampered attempts to clarify its meanings and thereby track its incidence on an international scale. Indeed as a recent study concludes:

A global picture of infertility is not available partly due to the difficulty in defining the condition. In the literature, infertility is used synonymously with sterility, infecundity, childlessness, and subfertility. These terms are used both interchangeably and inconsistently; an explicit detailing of each component of the definition is needed to clarify what is being measured.⁴⁸⁵

Another report, this one funded by the World Health Organization, also points to discrepancies in use: “The terms infertility, sterility, and infecundity are often used loosely, without regard to precise definition. Moreover, definitions of these terms may differ substantially between demographic and medical usage and between languages.”⁴⁸⁶

In trying to think through the failures of infertility as an etiological category, one might start with a basic quibble. Given the understanding of fertility as “capable of breeding or reproducing,” one might reasonably expect to find its antithesis in *infertility*, describing the condition of *not* being fertile, *not* capable of growing or developing offspring, *not* capable of breeding or reproducing. At a very basic level, then, it may be asked: What exactly is the difference between infertility and sterility?

While a strict dictionary definition makes no genuine distinction – both describe the condition of being unable to produce offspring – the medical community has adopted a

⁴⁸⁵ Mascarenhas MN, Cheung H, Mathers CD, Stevens GA. “Measuring infertility in populations: constructing a standard definition for use with demographic and reproductive health surveys.” *Popul Health Metr.* 2012 Aug 31;10(1):17 at 1.

⁴⁸⁶ Rutstein SO, Shah IH. “Infecundity, Infertility, and Childlessness in Developing Countries.” DHS Comparative Report No. 9: Calverton, Maryland, USA: ORC Macro and the World Health Organization, 2004.

functional use of infertility that describes it as “a temporary condition, usually due to age, but often due to unknown causes.”⁴⁸⁷ Sterility, on the other hand, is understood as a “permanent condition, frequently due to known causes such as menopause or removal of the ovaries.”⁴⁸⁸ This temporal differentiation may appear to clarify the boundaries, but even within the understanding of infertility as an impermanent condition lies confusion.

Siladitya Bhattacharya, Professor of Reproductive Medicine at the University of Aberdeen, has pointed in a recent co-authored work to deep tensions within the definition of infertility.⁴⁸⁹ In a meta-analysis of prevalence studies measuring infertility, Bhattacharya located a major rift between two frameworks: those applied by clinicians and those applied by demographers. For example, the following definitions are the common understandings in play within most Western *clinical* settings:

Infertility is a disease, defined by the failure to achieve a successful pregnancy after *12 months* or more of regular unprotected intercourse. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after *six months* for women over age 35 years.⁴⁹⁰

Infertility should be defined as the failure to conceive after regular unprotected sexual intercourse after *two years* in the absence of a known reproductive pathology.⁴⁹¹

Thus even within the clinical framework are widely differing time frames – six months, one year and two years – which apply unevenly depending on which definition is chosen. It may

⁴⁸⁷ Lawrence J. Kaplan & Carolyn M. Kaplan, “Natural Reproduction and Reproduction-Aiding Techniques,” in *The Ethics of Reproductive Technology*, Kenneth D. Alpern, ed., (New York: Oxford University Press, 1992) at 30. See also: Meeker, Heather J. "Issues of Property, Ethics and Consent in the Transplantation of Fetal Reproductive Tissue." *High Technology Law Review* 9.2 (1994): 175.

⁴⁸⁸ Kaplan and Kaplan, *ibid*.

⁴⁸⁹ Gurunath S, Pandian Z, Anderson RA and Bhattacharya S , “Defining infertility-a systematic review of prevalence studies.” *Human Reprod Update* 2011 Sep-Oct;17(5):575-88. At 575.

⁴⁹⁰ American Society for Reproductive Medicine Practice Committee. , “Definitions of infertility and recurrent pregnancy loss.” *Fertil Steril*. 2008;89:1603. Emphasis mine.

⁴⁹¹ National Collaborating Centre for Women’s and Children’s Health. *National Institute for Health and Clinical Excellence Guidelines, Fertility Assessment and treatment for people with fertility problems*. (London: RCOG Press; 2004.). Emphasis mine.

also include the diagnosis of infertility after three or more consecutive miscarriages or stillbirths.⁴⁹² The first definition, from the American Society for Reproductive Medicine, aims to set an age threshold wherein older women may be diagnosed as infertile after just six months. Otherwise a one-year period of unprotected (heterosexual) sex without intercourse is expected to lead to conception. The second definition comes from the U.S. National Institute for Health and Clinical Excellence. This definition does not involve an age-related threshold, and places the outside limit of healthy conception at two years. Both similarly locate the failure to successfully conceive as the primary indicator of infertility.

When turning to the demographic setting, however, a radically different definition of infertility applies:

Primary infertility is defined as the absence of a live birth for couples that have been in a union for at least *five years*, during which neither partner used contraception, and where the female partner expresses a desire for a child.⁴⁹³

Primary infertility is measured among women who have engaged in regular sexual intercourse for *five or more years*, have not used contraception for that period of time, and have not had a live birth.⁴⁹⁴

Demographers focus on the absence of live birth, rather than merely conception, and apply a much greater time horizon. These definitions look to a duration of five years or more before diagnosing a sexually active woman (or her partner) as being infertile.

There is a clear disciplinary divide at work here, wherein clinicians are interested in diagnosing reproductive issues within a much shorter time span and remain focused on the object of their labours: successful implantation and gestation. Demographers are more interested in tracking larger social trends, and apply a longer time period as well as a concern with population

⁴⁹² Emily Jackson, *Regulating Reproduction*, *supra* note 213 at 164.

⁴⁹³ Mascarenhas, *supra* note 485.

⁴⁹⁴ Rutstein, *supra* note 486.

shifts (i.e. live births) rather than the ability to conceive. In practice, however, these contrasting conceptual frames render infertility a difficult phenomenon to track. As it stands, “existing definitions of infertility lack uniformity, rendering comparisons in prevalence between countries or over time problematic. The absence of an agreed definition also compromises clinical management and undermines the impact of research findings.”⁴⁹⁵

This matters not least because of the power that a diagnosis of infertility has in channeling the reproductive hopes of a roughly estimated 72 million heterosexual parents struggling to conceive.⁴⁹⁶ Infertility is big business, with a report estimating U.S. infertility services at a value of \$4 billion dollars in 2009, producing more than 50,000 babies per year.⁴⁹⁷ The same report catalogued 483 U.S. fertility clinics, 100+ sperm banks and 1,700 reproductive endocrinologists in the domestic market, supported by a global market for fertility drugs that tops \$1 billion.⁴⁹⁸

Since Bhattacharya and co-authors conducted their meta-analysis in 2011, a Canadian study has also chimed in to critique the poorly defined concept of infertility, and question its validity as the diagnostic rubric through which to track national as well as global health outcomes.⁴⁹⁹ After reviewing the evidence, Bhattacharya *et al* ultimately sided with the clinical approach in seeking an optimal definition of infertility for medical practitioners. For research geared toward reproductive endocrinology, they concluded, a shorter time span and focus on conception makes sense. However by refining the term rather than interrogating it, they missed

⁴⁹⁵ Bhattacharya et al, *supra* note 489 at 575.

⁴⁹⁶ Boivin J, Bunting L, Collins JA, Nygren KG, “International estimates of infertility prevalence and treatment-seeking: potential need and demand for infertility medical care.”. *Hum Reprod* 2007;22:1506-15.

⁴⁹⁷ Market Data Enterprises, *U.S. Fertility Clinics & Infertility Services - An Industry Analysis*, Report # FS32, August 2009.

⁴⁹⁸ *Ibid.*

⁴⁹⁹ Bushnik T, Cook JL, Yuzpe AA, Tough S, Collins J. “Estimating the prevalence of infertility in Canada.” *Hum Reprod.* 2012 Mar;27(3):738-46

an opportunity to question its underlying definitional tension. Unfortunately, this palliative approach also preserves the normative definitional bounds of infertility, as well as its attendant pathology, stigma and heterosexism.

Unpacking Infertility

In order to unpack the failures of infertility, and its binary anchor fertility, we will return first to the typical clinical formulation. This definition engages a twelve-month time period, and is focused on conception (although also gesturing to the ability to “have” children) and the lack of contraception.

“Fertility: The ability to conceive and have children, the ability to become pregnant through *normal* sexual activity. Infertility: The *failure* to conceive after a year of regular intercourse without contraception.”⁵⁰⁰

Notwithstanding the clinical/demographic divide, this is the understanding of infertility most commonly applied across clinical information brochures, message boards, popular media and insurance companies. It operates as a temporal marker of conception, creating categories of “normal” and “failed” sexual activity. It also renders certain bodies illegible altogether. As this chapter contends, such a definition is steeped in complex discourses that must be pulled carefully apart to better render the field of access to reproductive technology. Not only is it resolutely heterosexual, but it also invokes a series of other problematic assumptions.

The first assumption being made is that *all normal sex is reproductive*. This is an understanding of sexuality rooted in religious prohibitions against non-reproductive intercourse. Medieval theologians in the eleventh century first applied the term “sodomy” to a range of non-procreative sexual practices, including bestiality, masturbation, oral sex, tribadism, *coitus*

⁵⁰⁰ *Fertility*. Medterms.com. MedTerms online medical dictionary A-Z List , Accessed online November 9, 2011, <<http://www.medterms.com/script/main/art.asp?articlekey=3412>>. Italics mine.

interruptus, and procreative sexual acts performed in the wrong position, as well as the more familiar contemporary usage of anal sex.⁵⁰¹ These were all understood to be “unnatural acts” which women were most likely incapable of committing (although there was some debate on this point), with the common thread across perversions being their non-procreative nature.⁵⁰² This vision of ‘normal’ sex has been understood by a generation of feminists as steeped in religious dogma and filtered through to contemporary cultural practices which differentiate between ‘good’ sex and ‘bad’ sex.⁵⁰³ Thus the idea that sex is abnormal due *precisely because of its* innate non-reproductivity is fundamental to an Old Testament understanding of proper biological function. This is the understanding that we find exactly reproduced in the modern clinical definition of infertility.

The perversions of non-reproductive sex have not been without punishment, of course, and there were periods in human history when the death penalty was leveraged against the vice of “unnatural acts” broadly figured. Yet at the same time as (mostly) men were falling prey to the dictates of Canon law a gendered burden was also being placed upon women to conceive offspring, and preferably male heirs. This brings up the second point, as *the body charged with responsibility for fertility in this definition is an unmistakably female body*.

The powerful dictates of social reproduction have demanded that women marry and have children, with this codification of the family ethic resting at the heart of the gendered division of

⁵⁰¹ Rubenstein, William, Carlos Ball & Jane Schachter. *Cases and Materials on Sexual Orientation Law* (West 3rd ed. 2008).

⁵⁰² *Ibid* at 99.

⁵⁰³ Gayle Rubin has perhaps most famously made this point with her ‘sex hierarchy’ of practices considered socially worthy (procreative, married, heterosexual and “vanilla”) and those which trigger social approbation (non-procreative, unmarried, homosexual and “with manufactured objects”). Rubin, Gayle. “Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality”, in Carole Vance, ed., *Pleasure and Danger*, (Routledge & Kegan, Paul, 1984).

labour.⁵⁰⁴ These commands ripple through the notion that twelve months of unprotected sex without conception must constitute a failure of the specifically (non)pregnant body. The American Society for Reproductive Medicine [ASRM] has attributed male-factor infertility to approximately one-third of cases, with factors affecting women comprising another one-third. As the ASRM explains, “for the remaining one-third of infertile couples, infertility is caused by a combination of problems in both partners or, in about 20 percent of cases, is unexplained.”⁵⁰⁵ So while approximately two-thirds of cases of infertility are not solely attributable to the female (heterosexual) partner, the responsibility for fertility *by definition* falls squarely upon female organs.

There are certainly other ways to describe and diagnose subfertility in adult heterosexuals, not least because ‘male factor infertility’ occurs roughly in equivalence to the experience of women. Keeping the focus trained on the female body increases the burden experienced by women and may also increase shame and stigma for men. As Marcia Inhorn describes, “male infertility is a social and health problem that remains deeply hidden...studies have shown male infertility to be among the most stigmatizing of all male health conditions.”⁵⁰⁶ A recent cross-sectional analysis of 357 men in infertile heterosexual couples came to a similar conclusion, determining that male partners who feel solely responsible for infertility are at a

⁵⁰⁴ This well-established feminist insight is central to a materialist analysis of the public/private divide and political economy. An early example of this literature that is still relevant for its attention to the gendered pressures of childbirth and rearing is Mimi Abramovitz’s classic 1988 text *Regulating the Lives of Women: Social Welfare Policy from Colonial Times to the Present*. (Boston: South End Press.)

⁵⁰⁵ American Society of Reproductive Medicine, “Resources: What Causes Infertility?”, Accessed online November 8, 2011. <<http://www.asrm.org/awards/index.aspx?id=3012>>

⁵⁰⁶ Marcia Inhorn, “Middle Eastern masculinities in the age of new reproductive technologies: male infertility and stigma in Egypt and Lebanon.”. *Med Anthropol Q* 18(2):162-82 (2004) at 162-163. See also: Jane RW Fisher, Karin Hammarberg, “Psychological and social aspects of infertility in men: an overview of the evidence and implications for psychologically informed clinical care and future research.”, *Asian Journal of Andrology*, 2012, 14, 1, 121.

higher risk for sexual, emotional, and psychological strain relative to men without this belief.⁵⁰⁷ Such men also experience a lower sexual and personal quality of life.⁵⁰⁸ Once again, the particular imprimatur of pathology and shame that infuse the clinical understanding of infertility betrays its origins in ancient dictates around the proper comport and function of gendered sexual relations.

The third assumption being made by this definition of infertility is that *the female body is open for business*. This availability for intercourse glosses over the ways in which actual bodies determine how their sexual agency will be enacted. It also assumes that this sex is being pursued with an exclusive partner. Such monogamous arrangements may well be the case for some couples, but a degree of bodily access and mutuality are here implied that cannot so easily be taken for granted. As Marjorie M. Schultz argues in relation to normative aspirations of marriage and family (which I argue undergird this definition): “The important issue becomes not who is, but who *should* be having sex with the mother: her husband. Thus, the social construct, in fact normative and mutable, draws substantial but disguised legitimacy from the representation that it simply expresses “givens” of nature.”⁵⁰⁹

This mechanical definition of intercourse also elides the complexity of sexual negotiations to create polarized categories of sexual functioning. Exactly how frequent and of what duration must sex be to count as “normal” sex? What precisely does the regularity of intercourse entail? Who makes these critical determinations? These are very real questions for

⁵⁰⁷ Smith, J. F., Walsh, T. J., Shindel, A. W., Turek, P. J., Wing, H., Pasch, L., Katz, P. P. and The Infertility Outcomes Program Project Group (2009), “Sexual, Marital, and Social Impact of a Man's Perceived Infertility Diagnosis.” *Journal of Sexual Medicine*, 6: 2505–2515.

⁵⁰⁸ *Ibid.*

⁵⁰⁹ Marjorie M. Schultz, “Reproductive Technology and Intent-Based Parenthood: An Opportunity for Gender Neutrality,” (1990) *Wisconsin Law Review* 297 at 317.

people facing a diagnosis of so-called infertility. So real, that the failure to perform to an idealized model of sexual performance and virility/fertility is what some psychotherapists have referred to as ‘reproductive trauma’.⁵¹⁰ Even the presence of fertility counselors cannot erode the foundational pathology assumed by this vision of a willing female body, ready to engage in virile sex at the drop of an ovum. Thus not only does a diagnosis of infertility operate to channel the despair of couples struggling to conceive, but it is actually *creating* the stigmatized categories which help produce the traumas of the clinic. The diagnosis of infertility produces the category of ‘the infertile woman’ or ‘the infertile man’ for which the medicalized response of reproductive technology must then be applied. The longitudinal shifts of human fertility are erased in favour of a singular atemporal diagnosis – *you are infertile* - against which a modern medical apparatus stands ready to act.

Despite this growing medical industry, another issue is that *a diagnosis of infertility is not necessarily an indication of a permanent state* that requires intervention. Approximately half of all heterosexual couples who qualify as infertile on the 12 month definition will conceive without assistance during the following year.⁵¹¹ Emily Jackson has estimated that one in six heterosexual couples in developed countries will experience infertility while of reproductive age, with some moving through this temporary and/or unexplained condition to conceive, as others remain in a state where procreation without medical intervention remains impossible.⁵¹² Since patients in assisted conception clinics are the primary source of epidemiological data – those heterosexuals who have already determined that some form of reproductive issue exists and have actively sought out assistance – the treatment of infertility is skewed towards immediate intervention.

⁵¹⁰ Janet Jaffe, and Martha Diamond. *Reproductive Trauma: Psychotherapy with Infertility and Pregnancy Loss*, (American Psychological Association (APA) Press, 2010.)

⁵¹¹ Emily Jackson, *Regulating Reproduction*, *supra* note 213 at 162.

⁵¹² *Ibid.*

Thus the actual incidence of heterosexual fertility problems is probably unknowable, as couples shift through phases of fertility and non-fertility at different times, and may or may not seek out clinical assistance depending on their age, inclination or socioeconomic bracket.⁵¹³ Amidst all these complex reckonings, disciplinary divides and temporal shifts, queer couples and single people remain rarely accounted for. There have been no large-scale studies of, for example, lesbian infertility or the infertility of gay men, and the infertility faced by transgender people has only recently been addressed.⁵¹⁴

Which leads to the final and most critical point: the current definition of infertility *excludes LGBTQ communities and single people from the discussion entirely*. By the terms of entry, same-sex intercourse is a failure. For while a lesbian couple might happily engage in “a year of regular sexual intercourse without contraception,” to use the language of the definition above, it will surprise no one if this fails to result in successful conception. A single gay man may have not engaged in sex at all for a calendar year but still wish to investigate reproductive options. Where is his experience within this narrow figuring of infertility? Clearly the issues here are not (necessarily) one of subfertile reproductive capacity. Infertility is also therefore a *relational* condition, as a diagnosis of clinical infertility can only be made once an individual has approached a medical practitioner with an unfulfilled desire for a child within a (heterosexual) relationship.⁵¹⁵

⁵¹³ The financial barriers posed by the high cost of AHR will be discussed in detail below.

⁵¹⁴ Walks, *supra* note 266 is one of the few scholars to mention issues of transgender infertility, although the small body of extant literature has been expanding quickly. For a sampling, see: De Sutter, Petra (2007) “Reproduction and Fertility Issues for Transpeople.” In *Principles of Transgender Medicine and Surgery*, 209–222.; Nixon, Laura (2014) “Right to (Trans) Parent: A Reproductive Justice Approach to Reproductive Rights, Fertility, and Family-Building Issues Facing Transgender People” 20 *Wm. & Mary J. Women & L.* 73; Murphy, T. F. (2014) “Assisted Gestation and Transgender Women” *Bioethics*.

⁵¹⁵ It is important to notice that such diagnosis does not always lead to a ‘cure’ for the condition. As Jackson also rightly points out - reproductive technologies do not always work. Indeed even when they are affordable, Jackson reports that most infertility treatment actually fails. This is obscured both by media coverage, that tends to focus

Yet when queers and single people enter the clinic, they also find their experience mediated by the pathology created through definitions of fertility and infertility. They enter an environment geared toward addressing the presumed dysfunction of reproductive organs, and minimizing the traumas expected to result. The twin dynamos of hypermedicalization and normative heterosexuality interact to create an environment which many queer people describe as deeply foreign to their needs and intentions. The frustration and anger which results from this encounter will be discussed at length in Chapter Eight.

Reproductive Trauma and the Infertility Trap

I use the idea of ‘the infertility trap’ to describe the conceptual narrowing effected by a specific set of normative presumptions about reproduction. The infertility trap is laid by antiquated categories which embrace medieval concepts of sexuality, place an undue burden on female bodies, foster stigma by promoting blunt polarities of normalcy and failure, presume a high degree of sexual availability, flatten shifting and relational timelines, and ignore the lived realities of single people and queers. It is also created by the definitional inconsistencies of the term infertility itself, which has drastically limited the ways in which both clinical and demographic researchers conceive of adult procreation. The infertility trap is based upon a misleading characterization of reproductive potential, intense temporal anxiety, and heavy reliance upon invasive and often expensive forms of reproductive technology.

upon the “miracle” babies born through assisted conception, as well as academic interest in reproductive technologies, which is skewed toward discussion of issues that are not raised by unsuccessful treatment, (such as the determination of legal parenthood.). As she writes, “an examination of the academic literature could give the impression that donor anonymity is the most compelling issue raised by donor insemination (DI), whereas the chief concern for people undergoing DI might actually be the 90.1 percent chance that their treatment will fail.” Jackson, *Regulating Reproduction*, *supra* note 213 at 163.

The infertility trap impacts not only LGBTQ people but heterosexual couples as well. The reproductive trauma that heterosexuals may experience is located within their own expectations of ‘normal’ reproduction, and amplified by the clinical model of medicalization and pathology. This process is saturated with stigma not only for the gendered effects discussed above, but for lingering associations from the nineteenth century that equated sterility with “slack moral habits” like masturbation or excessive sexual activity.⁵¹⁶ While there is perhaps no longer a direct equation made between sinful behaviour and sterility, the idea that people may be in some way responsible for their ability to procreate persists.⁵¹⁷ Focus on the reproductivity of female bodies means that women are generally viewed as bearing the brunt of this responsibility. As Emily Jackson explains:

Today it is widely assumed that women are infertile as a result of their own choices, for example, by choosing to delay childbearing, by having had an abortion, through contracting sexually transmitted infections, or by over-use of particular contraceptives. So a woman’s inability to conceive is commonly thought to be the consequence of her deviation from conventional gender roles, through an over-zealous pursuit of her career or through sexual promiscuity. She is then responsible for her infertility, which is “nature’s” punishment for her unnatural behaviour.⁵¹⁸

Thus the cultural deviation of women from the cycles of ‘nature’ is seen as the root of the problem, with references to a fictitious “infertility epidemic”⁵¹⁹ in the Western world making it appear as if infertility is a modern issue stemming from female promiscuity and/or deferral of childbearing.⁵²⁰ The ‘choice’ of women to delay childbearing until later in life, in particular, is

⁵¹⁶ *Ibid* at 203. As Jackson reports (quoting Pfeffer 1993), Victorian doctors were reluctant to investigate the possibility of male infertility, not wishing to ask men to produce a semen sample “in case its production corrupted them” (Pfeffer, 1993, p. 39).

⁵¹⁷ *Ibid.*

⁵¹⁸ *Ibid.*

⁵¹⁹ Notwithstanding the difficulty of tracking infertility, for all the reasons discussed above, there is some evidence that *female* fertility, at least, may actually be increasing. Despite some evidence of declining sperm counts a recent study has concluded that there has been “a clear rise in couple fertility in recent decades” Joffe, 2000, p. 1963).

Quoted in Jackson, *ibid* at 202, footnote 236.

⁵²⁰ Jackson, *ibid* at 203.

often viewed as an individual decision rather than as a function of neoliberal economic systems which lack public infrastructure for childcare and penalize women for going on the ‘mommy track’.⁵²¹ A post-menopausal woman’s reproductive incapacity is therefore sometimes considered to be the “just dessert” for opting for a career over a family, and her responsibility for choices made earlier in life.⁵²²

Defining Reproductive Trauma

Under a chapter subheading entitled “What is Reproductive Trauma?” doctors Janet Jaffe, Martha Diamond and David Diamond – all specialists in the field of Reproductive Psychology - define ‘reproductive trauma’ as based upon the following assumptions:

Being unable to have a baby as and when you had hoped is one of the most painful crises that couples confront. Clearly this is not how you thought it would be...What makes the experience of infertility a trauma? The diagnosis of infertility, and the medical interventions often needed to treat it, represent a threat to our physical integrity, our sense of being healthy and whole. One of the most fundamental aspects of our physical selves is our reproductive capability. When that does not function properly, we doubt everything else. Infertility is a trauma because it attacks both the physical and emotional sense of self, it presents us with multiple, complicated losses, it affects our most important relationships, and it shifts our sense of belonging in the world.⁵²³

Once again, this formulation depends upon a naturalized heterosexuality that takes as given the above presumptions of infertility. When the ‘medical interventions often needed’ to ‘have a baby as and when you had hoped’ are framed as an aberration to ‘our sense of being healthy and whole,’ a specific form of reproductive heterosexual coupling is privileged as the

⁵²¹ In a seminal 1989 article in the *Harvard Business Review*, a female scholar named Felice Schwartz ignited a firestorm with an analysis of what came to be called the ‘mommy track’. Schwartz warned that companies were losing many talented women due to their inflexible working conditions, and suggested streaming women into two tracks – a fast-track that would be focused on professional career advancement, and a slow-track that would be more flexible for women concerned primarily with childrearing and family. Felice N. Schwartz, “Management Women and the New Facts of Life,” *Harvard Business Review* 89 (1989), pp. 65–76.

⁵²² Jackson, *Regulating Reproduction*, *supra* note 213 at 203.

⁵²³ J. Jaffe, M. Diamond and D. Diamond, *Unsung Lullabies, Understanding and Coping with Infertility*, (St Martin's Press, 2005) at 5.

ideal. It imagines an unsullied ‘natural’ form of procreation that evokes the time immemorial, as contrasted with the threat to human integrity posed by reproductive assistance. When the clinic is involved, and whenever medical interventions are required, it is because something has malfunctioned. The encounter with the clinic, with the diagnosis of infertility, is the cause of multiple and complicated losses. In this formulation, where ‘healthy and whole’ does not belong inside a fertility clinic, it is expected that all people seeking reproductive assistance must be suffering from ‘one of the most painful crises that couples confront.’

A series of presumptions underlie this concern for the reproductive health of heterosexual couples, and set the foundation for how counseling and support are offered at the clinic:

- 1) The logics of the nature/culture binary assume that natural reproduction only occurs within the private embrace of heterosexual intercourse.
- 2) When reproduction does require assistance, it is because something has gone wrong and threatened the integrity of the natural function.
- 3) This failure is necessarily experienced as sorrow and loss and may be labeled “reproductive trauma.”
- 4) Reproductive trauma can be ameliorated by a positive outcome and successful conception in the clinic.

Thus the modern fertility industry perpetrates a neat double move: on one hand reinscribing the normative diagnostic bounds of infertility and the pathology it contains, and on the other, simultaneously attempting to palliate its effects. This double move is predicated upon the nature/culture binary and made possible by a singular attention to *wounded heterosexuality*.⁵²⁴ By this I refer specifically to a heterosexuality which cannot fulfill the normative expectations of biological procreation via sexual intercourse.⁵²⁵

⁵²⁴ Discussions of heterosexuality and heteronormativity have taken up significant portions of previous chapters. See for example Ingraham, *supra* note 160 and the discussion of heterosexuality at *supra* note 458.

⁵²⁵ I am figuring normative heterosexuality as: opposite-sex, coupled, biologically reproductive, emotionally loving, financially independent and appropriately gendered (i.e. men are masculine; women are feminine). While for this project I will be focused on biological reproduction, other examples of wounded heterosexuality might be a man

To be clear: The inability to conceive is a very real phenomenon and one which wreaks profound misery in the lives of heterosexual couples seeking to have biological children. However, my argument is that some (much?) of this trauma is generated by the clinical structures themselves and the misconceptions bundled into the diagnosis of infertility. This trauma also affects LGBTQ parents and single people as they encounter this governing master discourse when seeking reproductive assistance.

The assumption that fertility clinic patients bring with them a wounded heterosexuality marked by reproductive trauma is profound. Indeed at present, fertility clinics are almost exclusively geared toward mitigating the wounded heterosexuality of the infertile couple. To illustrate how deeply the discourses of trauma currently saturate the clinical encounter, one need look no further than Canada's largest fertility clinics.

Reproductive Trauma in Canadian Fertility Clinics

Genesis Fertility Centre in Vancouver is the biggest IVF clinic in British Columbia. The range of counseling services advertised by the clinic is strictly limited to the script of wounded heterosexuality. From their website: "Many women describe the experience of coping with infertility and IVF treatment as an 'emotional rollercoaster.' Studies show that women experiencing fertility issues have distress levels equal to women with cancer, AIDS, or other life threatening issues. [Our counselors] can help you learn strategies for dealing with stress, managing your IVF cycle, and nurturing your relationship with your partner."⁵²⁶

The same narrative is on display at Manitoba's only fertility and gynecology clinic: "Infertility can be a painful, emotional and exhausting experience. We encourage you to partake

with an inadequate masculinity, a homosexual longing, or an inability to financially care for his family.
⁵²⁶ Genesis Fertility Centre website. Accessed January 14, 2012. <<http://www.genesis-fertility.com/>>

in counseling as you prepare for treatment and afterwards. Our counselor is available to help you through the trying and sometimes devastating roller coaster of infertility and to assist you with any ethical questions and concerns you may have.”⁵²⁷ Continuing this theme, the McGill Reproductive Center in Montreal explains how “counseling can facilitate coping with such overwhelming feelings of sadness, anger or blame”⁵²⁸ while the Ottawa Fertility Centre offers the same rollercoaster image to its clients:

The experience of infertility is profoundly emotional. Clients usually have experienced long periods of disappointment and sadness over difficulties conceiving children before they are ever referred to the Ottawa Fertility Centre. Infertility can result in depression, feelings of isolation, relationship stress, problems with friends and family, and interference with work and social relationships. It has been described as an emotional roller coaster.”⁵²⁹

ReproMed clinic in Toronto offers access to similar counseling services to help alleviate reproductive trauma and provide support to individuals in “dealing with emotions and issues related to infertility such as: grief, anger, jealousy, guilt, self-image, and isolation.”⁵³⁰ The clinic also provides couples with support on issues “specifically affected by infertility such as: intimacy, sexuality, self-esteem, blame, communication, expectations, finances, and decision-making.”⁵³¹

This is a litany of the traumas of failed reproduction, even as these clinics seek compassionately to ameliorate its painful effects. And these effects *are* painful. Heterosexual

⁵²⁷ Heartland Center for Reproductive Medicine, Accessed January 14, 2012. <<http://www.heartlandfertility.mb.ca/>>

⁵²⁸ McGill Reproductive Centre, Accessed January 14, 2012. <<http://www.mcgillivf.com/e/McgillIVF.asp>>

⁵²⁹ Ottawa Fertility Centre, Accessed January 14, 2012. <<http://www.conceive.ca/>>

⁵³⁰ ReproMed – The Toronto Institute for Reproductive Medicine, Accessed January 14, 2012.

<<http://www.repromedltd.com>>

⁵³¹ It should be noted that the counseling services provided by ReproMed also make explicit reference to addressing issues and finding resources specific to single men or women, as well as matters specific to LGBTQ individuals/couples, such as family of origin, issues of biology, legal issues, and homophobia. The counselor contracted by ReproMed is uniquely committed to providing service that is anti-discriminatory, inclusive and non-judgmental and has worked actively with LGBTQ advocacy and support groups in Toronto, including the author. While one might hope this as the norm at all Canadian fertility clinics, such a holistic approach remains remarkable.

couples face genuine difficulty in reorienting their family-creation plans, and a number of compassionate ethnographies have traced these emotional struggles.⁵³² Our society is powerfully centered around the ideal of reproductive heterosexual intercourse, and deviations from this norm are difficult for heterosexuals as well as for LGBTQ couples and individuals. My argument, however, is that the normative underpinnings of the infertility trap are actively contributing to the sadness and distress faced by heterosexual as well as queer families in the clinic. This normalizing regime needs to be addressed, and Chapters Nine and Ten will outline an alternative conception that seeks to avoid the limitations of a diagnosis of infertility for heterosexual and queer families alike.

For while the current conceptual model may be doing a disservice to heterosexual couples, there is no doubt that it is drastically under-serving LGBTQ populations. Queer families are not (necessarily) dealing with “disappointment and sadness over difficulties conceiving children” but are seeking reproductive assistance because of an inherently non-reproductive sexuality. What they find upon entering the clinic, however, is a space of wounded heterosexuality almost exclusively aimed at the needs of two-parent male-female couples. The heterosexist presumptions of reproductive trauma are thereby extended onto the queer bodies caught in the infertility trap.

When queer people who enter the clinic *are also experiencing what they perceive as infertility*, the devastating effects are compounded. Not only are they subjected to the

⁵³² One of the first American ethnographies to examine the industry of reproductive technology from the perspective of the consumer was a book by Gay Becker called *The Elusive Embryo: How Women and Men Approach New Reproductive Technologies* (Berkeley: University of California Press, 2000). This followed on Becker’s earlier book *Healing the Infertile Family: Strengthening Your Relationship in the Search for Parenthood* (Berkeley, Calif: University of California Press, 1997). Another key first-person ethnographic study of reproductive medicine was written by Charis Thompson, with her work *Making Parents: The Ontological Choreography of Reproductive Technologies* (Cambridge, Mass.: MIT Press, 2005).

heterosexist models of family which prevail, but they are then counseled with the same tools developed to care for heterosexual couples. As the empirical data below will show, this is often not appropriate for queer people, single people or trans-identified people. They find themselves doubly stigmatized by being unable to conceive ‘naturally,’ and may be subjected to highly inappropriate suggestions that conflict with their gender identity, stated intention or family-planning modality.⁵³³

Queer Health and Subfertility

Although data is scarce, existing information indicates that queer people may be even more at risk than heterosexuals for some conditions that lead to subfertility. A social determinants of health model links the wellbeing of various populations to health conditions, with sexual orientation and gender identity tied to subfertility in regard to endometriosis, Polycystic Ovaries (PCO) and Polycystic Ovarian Syndrome (PCOS).⁵³⁴ As Michelle Weeks explains, queer folks often experience misinformation when being screened for these conditions, even as negative attitudes and homophobic experiences in turn influence the patterns of health-seeking behaviour.⁵³⁵

Endometriosis is a condition in which menstrual tissue grows outside of the uterus on the pelvis, causing rubbery bands of scar tissue to form between surfaces inside the body. This scar tissue can prevent the fallopian tubes from capturing the egg, thereby preventing conception. Endometriosis is a fairly common condition, affecting between 4 and 10 million women in the

⁵³³ Empirical discussion in Chapter 9 explores how the diagnosis of infertility in one woman within a lesbian partnership may automatically turn the focus to the other woman, even when her desire not to bear children has been clearly stated in advance. The gendered labour of female bodies as reproductive bodies so deeply permeates the clinic, it is expected that a diagnosis of infertility in the intended birth mother will naturally provoke the woman’s partner to offer up her own womb in its stead. The Creating Our Families research shows this is not the case.

⁵³⁴ Walks, *supra* note 266.

⁵³⁵ *Ibid.*

United States, and is often managed through the use of hormones such as oral contraceptives.⁵³⁶ Lesbian women thereby experience a “higher rate of untreated endometriosis [which] may contribute to infertility problems” due to the fact that, “many straight women receive ‘accidental’ treatment for mild endometriosis by spending years on oral contraceptives.”⁵³⁷

There are also higher experiences of PCO and PCOS among lesbian women. According to a 2004 report that tracked the health outcomes of women visiting a fertility clinic in Britain, the “self identified lesbian women had a significantly higher prevalence of PCO and PCOS compared with heterosexual women.”⁵³⁸ In detail, polycystic ovaries were observed in 80 percent of lesbian women and in 32 percent of heterosexual women, with further analysis revealing that 38 percent of lesbian women and 14 percent of heterosexual women had PCOS.⁵³⁹ High rates of PCO and PCOS may translate into difficulty conceiving or carrying babies to term, as “women with PCOS may miscarry at a rate of approximately 40 percent, compared with a 15 percent rate in the general population.”⁵⁴⁰ The study offered no explanation as to why lesbian women experienced higher rather of polycystic ovaries than heterosexual women.

There are clearly specific concerns that need to be addressed among lesbian women in regard to conception and childbirth, and urgent research that needs to be done among gay and transgender communities. Yet as has been seen from the definitions above, the diagnosis of infertility currently in circulation depends upon a rigidly heterosexual viewpoint. As sociologist

⁵³⁶ *Ibid.*

⁵³⁷ Jussim, J. 2000. “Lesbians Facing the Gay Baby Boom with Empty Arms.” *Gay Health*. Available online. Accessed November 10, 2011: <<http://www.gayhealth.com/templates/common/feature.html?record=86>>. There has also been found to be a negative correlation between ovarian cancer and the consumption of oral contraceptives.

⁵³⁸ Agrawal, R., S. Sharma, J. Bekir, G. Conway, J. Bailey, A. H. Balen, and G. Prelevic. 2004. “Prevalence of Polycystic Ovaries and Polycystic Ovarian Syndrome in Lesbian Women Compared with Heterosexual Women.” *Fertility and Sterility* 82 (5) (November): 1352-1357 at 1355.

⁵³⁹ *Ibid* at 1354.

⁵⁴⁰ *Ibid* at 1356.

Laura Mamo argues in regard to lesbian women in her important work on *Queering Reproduction*, this epidemiological rigidity does not have to be the case. In regard to the timeline at work in the definition of infertility she suggests the following:

The definition could be extended to lesbians by referring to twelve cycles of intravaginal insemination rather than twelve months of unprotected heterosex, but this shift has not taken place. Instead, either lesbians are immediately routed toward infertility medicine due to the obvious absence of sperm, or their pregnancy attempts take place outside of biomedicine. In many ways, the starting place of lesbians' trajectories depend on what they think and feel about biomedicine, advanced technology, and natural reproduction, as well as what they know about women's health movements and their connections with alternative insemination.⁵⁴¹

There are multiple ways in which infertility could be adapted and transformed to meet the needs of not only queer folks and single people, but heterosexual couples as well. Michelle Weeks, for example, calls for more education of physicians and queer folks regarding risk factors and screenings for endometriosis and PCO/PCOS. She also argues that "physicians and the general public need to understand that queer individuals and couples bring unique situations and perspectives to the table, in regards to diagnoses and experiences with infertility."⁵⁴²

The next chapter will draw heavily upon interview data gathered through the Creating Our Families research project to illustrate the unique perspective of LGBTQ people on medicine, law and reproductive technology, and how this shapes their reproductive outcomes. By doing so, it highlights the ways in which fertility clinics have been poorly calibrated to the needs of their LGBTQ clients. It will showcase the voices of study participants as they entered the clinic, and explore the assumptions of pathology, mandatory testing, misreading of queer bodies and reliance upon a heavily medicalized and unswervingly heterosexual mode of treatment.

⁵⁴¹ Mamo, *supra* note 76 at 162.

⁵⁴² Walks, *supra* note 534 at 137-138.

Chapter Eight: The Infertility Trap and LGBTQ Experience

Introduction

Previous chapters have laid an historical and theoretical framework for the ways in which queer people find themselves positioned in regard to reproductive technologies. Chapter Seven in particular detailed how reproductive trauma operates under the presumption of wounded heterosexuality and a reification of ‘natural’ reproduction as a singular form of heterosexual intercourse.

The stories in this chapter include people who conceived both within and outside of the clinical model of reproduction. As Laura Mamo suggests, “the biomedical in/fertility framework is well institutionalized as the key access point and structure for reproductive assistance. Thus, it may be that for lesbians who want to conceive, infertility medicine is becoming ‘an obligatory point of passage.’”⁵⁴³ This is borne out by the data, which indicates that lesbian women using anonymous donor sperm focused on the clinic as the site of insemination, often using language that indicated an apparent lack of choice in the matter. Women who used known donors had more latitude, however, and this chapter will detail a couple who began their path to conception at the clinic but soon rejected the medical model of reproductive assistance. Gay men and their reliance upon surrogates will also be discussed in Chapter Nine, as will transgender women and concerns around the heterosexist norm of the two-parent family.

Barriers Faced by LGBTQ People in the Clinic

It is important to note at the start of this chapter that the barriers formed by the clinical structure are not explicitly discriminatory. While the words “sexual orientation” do not appear in

⁵⁴³ Mamo, *supra* note 76 at 132.

section 15(1) of the *Charter* as enumerated grounds for protection against discrimination,⁵⁴⁴ when the question of same-sex equality finally reached the Supreme Court in *Egan v. Canada*, a unanimous ruling held that sexual orientation should be recognized as an analogous ground for *Charter* protection.⁵⁴⁵ Also at the federal level, the preamble to the *AHRA* reflects a concern for discrimination against same-sex couples and individuals that dates from the support of lesbian access to donor sperm by the RCNRT, and includes a statutory declaration that “persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status.”⁵⁴⁶

On the basis of lower court decisions, provincial legislation, the *AHRA* and judicial interpretation of legislation in light of section 15 of the *Charter*, it is difficult to imagine that lesbian, gay, bisexual or transgender people in Canada would today be denied access to assisted reproduction, as has occurred in the past.⁵⁴⁷ Nevertheless, profound structural barriers remain.

⁵⁴⁴ The enumerated grounds are, of course, “race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.” See also discussion in Chapter Five regarding the push by Svend Robinson to include “sexual orientation” in the original draft of the *Charter*.

⁵⁴⁵ [1995] 2 S.C.R. 513, 124 D.L.R. (4th) 609 [*Egan*]. While the judgment was unanimous the Court produced two different sets of reasons. Justice La Forest, writing for a group of four judges, observed that: “whether or not sexual orientation is based on biological or physiological factors, which may be a matter of some controversy, it is a deeply personal characteristic that is either unchangeable or changeable only at unacceptable personal costs ... ” (at para 5). The perceived immutability of sexual orientation was an important factor in their decision. Justices Cory and Iacobucci, writing for the remaining five judges, found that “homosexuals, whether as individuals or couples, form an identifiable minority who have suffered and continue to suffer serious social, political and economic disadvantage.” (at para 175). Their concern was not with causality, but the current group status of homosexuals as an oppressed minority. See also: Wintemute, *supra* note 282.

⁵⁴⁶ *Assisted Human Reproduction Act*, s. 2(e).

⁵⁴⁷ Each fertility clinic has its own internal intake policy regarding counseling and psychological evaluation. While a client’s status as ‘lesbian’ or ‘transgender’ would certainly not be sufficient to deny them service, it is possible to envision a counselor drawing upon related ‘lifestyle’ factors to question a petition for LGBTQ parenthood. The opacity of the clinical intake process makes it difficult to estimate the likelihood of such a scenario. See also *infra* note *Korn v. Potter*. A 2009 human rights complaint filed against a Winnipeg family doctor who allegedly refused a lesbian couple as patients offers some indication of the barriers that still exist. In an interview at the time of the incident, Dr. Kamelika Elias said that she didn’t know how to treat lesbians, that it was against her religion, and that gay people “get a lot of diseases and infections” about which she has no experience treating. Jen Skerritt, “Lesbians a Mystery to Winnipeg MD”, *Winnipeg Free Press*, January 27, 2009. More recently, a fertility clinic in Calgary refused to help a woman become impregnated with sperm from a donor who did not share her skin colour. One of the doctors at the privately-owned Regional Fertility Program told a single white woman seeking *in vitro*

In 2009, a report by Ontario’s Expert Panel on Infertility and Adoption highlighted some of the challenges faced by same-sex families seeking reproductive assistance. The report noted that members of LGBTQ communities rarely encountered gender-neutral language in clinical assessments or application documents, that brochures and posters depicted only heterosexual couples, and that LGBTQ communities may face even greater barriers outside major urban centres.⁵⁴⁸ These outcomes are the result of the normative frames of heterosexuality and infertility discussed in Chapter Seven. Charis Thompson refers to the processes of naturalization in operation at reproductive centers as the “bedrock” – the discursive and structural practices that are dictated less by scientific or formal reasoning than by norms of socialization. As she explains, this bedrock:

[A]lso encompasses the ways in which scientific, biological, or “natural” idioms normalize and control the physically or socially deviant, pathological, and dangerous. Examining naturalization invites an analysis of the role that is played by specific configurations of bedrock in establishing the moral, epistemic, and technical taken-for-granted that are essential to the practice of infertility medicine.⁵⁴⁹

The bedrock of the clinic is formed by positive attention to the reproductive needs of heterosexuals, and attenuating the pathology and trauma of deviance from ‘nature’ that infertility medicine seeks to perform. As discussed, the clinic operates to soothe wounded heterosexuality and recast its technological interventions as giving nature a ‘helping hand’. However the stability of the heterosexual imaginary is also reliant upon the abjection of the Other, of the

fertilization that she could only receive sperm from only white donors. While the public outcry around this incident led to an official retraction on the part of the clinic, it points to the opacity of the clinical intake process and discretionary power held by individual medical practitioners. Such factors makes it difficult to estimate the likelihood of such a scenario in which LGBTQ users are barred or restricted – particularly in regard to transgender persons, for whom considerable social stigma still exists. See also *supra* note 332 and the lesbian discrimination case of *Korn v. Potter*.

⁵⁴⁸ Raising Expectations, *infra* note 786 at 133. See also: Butler, Martha Anne and Kirkby, Cynthia, “Same-sex marriage, divorce and families : selected recent developments” Parliamentary Information and Research Service, (Ottawa, Ontario: Library of Parliament, 2013).

⁵⁴⁹ Thompson, *supra* note 532 at 81.

genuinely pathological, the agentive unnatural. The co-production of histories of infertility and homosexuality has created an epistemic twinning between queer barrenness and the unwanted barrenness of heterosexuality. This episteme sits uncomfortably at the bedrock of clinical practice, pressed both by a legal mandate to assist queer families, as well as the heterosexual imperative to procreate naturally. The result is a clinical discourse that privileges the ‘natural’ order and seeks to recreate queer families in the image of the heterosexual couple.

This chapter will draw upon the voices of research participants to illustrate precisely how the inclusions and exclusions of law and medicine impact those bodies who fall outside the heterosexual imaginary, and the ways in which participants have responded. As will be seen, the queer agents in this chapter both trouble and affirm the constitutive discourses of the clinic, and in particular the link between compulsory heterosexuality and compulsory motherhood.

The Medicalization of Queer Bodies

As discussed in the previous chapter, the diagnosis of infertility depends on a gendered and heterosexist discourse of failure and loss. The medicalization of AHR has pulled all aspects of reproductive assistance into a clinical space of monitoring, surveillance, pharmaceuticals and vigorous intervention.⁵⁵⁰ There is a presumption of illness that attaches to the reproductive journey, with childlessness understood as a disease that requires swift and often aggressive treatment. This pathologization of reproduction can have painful consequences for the queer person, even before they enter the fertility clinic.

⁵⁵⁰ For example as traced in Chapters Five, Six and Seven, the federal regulation and medicalization of donor semen brought it into a clinical site of testing and vigorous surveillance. It also resulted in the dissolution of grassroots women’s networks that had been created to support assisted insemination on behalf of lesbians and single women.

Laura Mamo has argued that the medicalization of reproduction and sexuality are intimately linked as ongoing cultural practices. She traces Foucault's genealogy of the 'invention' of homosexuality (and heterosexuality) by late 19th century sexologists and psychologists, and the role of the medical profession in creating the category of the homosexual invert.⁵⁵¹ This had both psychic and physical dimensions as, for example, the sexual organs of a lesbian woman would be compared to that of a 'normal' heterosexual woman to locate the source of her pathology; Mamo describes how "lesbians stood in contrast to the ideal fertile woman who possessed the normal-sized uterus, large breasts, and wide hips necessary for childbearing and breastfeeding."⁵⁵² Scientific and social discourses constructed lesbian sexuality as a betrayal of the 'natural order' of the sexes as well as of the 'naturally' procreative order of society.⁵⁵³ The twinning of pathology in both the frame of *infertility* (as discussed in Chapter Seven) and the figure of the *homosexual* demonstrates how both have shared a long and interrelated history as constructions of 'unnatural' deviance and illness. These are overlapping systems of meaning that continue to shape the landscape of family formation.⁵⁵⁴

Queer people, then, and especially trans-identified people, have long been familiar with the medical gaze. Trans people continue to be reliant upon medical authority for basic survival, including legal access to their chosen gender identity. To change the sex designation on one's birth certificate in Ontario, for example, a letter of support from a practicing physician or psychologist (or psychological associate) authorized to practice in Canada must be provided.⁵⁵⁵

⁵⁵¹ Mamo, *supra* note 76 at 34-37.

⁵⁵² *Ibid* at 37.

⁵⁵³ *Ibid* at 38.

⁵⁵⁴ *Ibid* at 13.

⁵⁵⁵ In 2012 "gender identity" and "gender expression" were added as grounds of discrimination in the Ontario *Human Rights Code*. The Ontario Human Rights Commission is currently updating its policy to reflect these codes. *Human Rights Code*, RSO 1990, c H.19 RSS. See also *supra* note 449 for a deeper discussion of recent legislative developments around gender identity and expression.

In the past, government interpretation of the *Vital Statistics Act* has required sex reassignment surgery in addition to the medical letter before allowing a change to the birth certificate.⁵⁵⁶ At the same time, the listing of ‘Gender Identity Disorder’ as a psychiatric diagnosis of pathology has historically located trans people within a highly medicalized system based not upon client-centered care but concerns over liability litigation.⁵⁵⁷

In order to protect themselves from lawsuits, the medical profession requires that a transsexual have a psychiatric diagnosis requiring the surgery. Though you may be able to have breast reduction or enhancement surgery, or facelift, etc. essentially on demand, you cannot have SRS [sex reassignment surgery] without a psychiatrist’s letter saying you need it.⁵⁵⁸

Trans-identified people seeking AHR are thus obliged to wrestle not only with reproductive trauma and the heterosexual presumptions of the clinic, but a fraught history with medical expertise. Even as social movements increasingly redefine homosexuality as well as transgender identity in nonmedical terms, these bedrocks persist. To be sure, at times and under certain conditions, medicalization may be welcomed as a way to make sense of people’s lives; in other moments it may be viewed as a hostile intrusion by an objectifying medical apparatus.⁵⁵⁹ These are uneven and multi-directional processes of power, and as Mamo rightly insists: “There are no one-way arrows.”⁵⁶⁰

⁵⁵⁶ Vital Statistics Act, R.S.O. 1990, Chapter V.4.

⁵⁵⁷ The latest version of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) has revised ‘Gender Identity Disorder’ to what it considered the less-stigmatizing ‘Gender Dysphoria’. However this new definition retains the distress implicit in the original category, and places the responsibility for alleviating such distress upon the individual (and her medical practitioners), not upon a culture structured according to a strict, presumably fixed, gender binary. As such, even the updated version has received strenuous critique from trans activists and allies. See for example: W.P.A.T.H.: *Response of the World Professional Association for Transgender Health to Proposed D.S.M. V Criteria for Gender Incongruence*. 25th May 2010.

⁵⁵⁸ Findlay, B., *Finding our Place: Transgendered Law Reform Project*, (Vancouver: High Risk Project Society (March, 1996) at 8.

⁵⁵⁹ For example, gender reassignment surgery may involve a trying process of medical and surgical expertise enacted upon trans bodies, even as it provides a welcome conduit for many to physical self-recognition and a cohesion of embodied identity.

⁵⁶⁰ She is speaking in exclusive reference to lesbian bodies, but the disciplinary logics apply equally to

The overwhelming presumptions of infertility discussed in the last chapter serve to haunt the clinic in a special way for queer people. They create a space in which the negative presumptions of infertility interlock with fears of subjectivation by the medical apparatus, lending itself to both a distrust of medical knowledge, as well as a suppliant hope for its benefits. Queer bodies are both in step and out of sync with the heteronormative goal of ameliorating infertility, simultaneously the focus of technologies aimed at the (normative) heterosexual infertility user, and the creator of a possibility for the restructuring of that normativity. For some queer people, this combination can lead to great emotional turmoil. One of the most affecting interviews I conducted was with a transman in his late 30s. As Daniel described his experience of seeking reproductive assistance, he was literally shaking with emotion.

Interviewer: So you've now decided you're going to take up the fertility clinic route...what was that experience like for you? Let's go through it step by step.

Daniel: Okay. First, it was very, very scary...Worrying that it means infertile even though at that time it'd been literally a handful of times that we'd tried at home...I had no concerns about my fertility. So, mostly, I just thought the clinic is gonna pin-point to ovulation and help me get pregnant. But then I guess there was still a part of me thinking "Well that's where you go when you can't have a baby. Clinics are for people who are having trouble, who are having difficulty. Do I belong there...do I not belong there?" So for all that it was scary.

The clinic is here figured as a site of helpful intervention – a place to track ovulation and allow for successful conception. At the same time it is also viewed as a site of reproductive illness – a place for people who are unable to conceive. Daniel struggles to navigate this contradiction, afraid that his association with the clinic will mean that *he* is actually infertile despite having no evidence to that effect. The baseline of reproductive pathology reinforces Daniel's fears that the clinic is not a space in which he belongs, as a site of wounded

transgendered persons. Mamo, *supra* note 76 at 53.

heterosexuality and a place in which one may encounter (and be ensnared in) the trap of infertility.

Discourses of Failure and Pathology

The impact of reproductive trauma was experienced by lesbian couples as well. It was not uncommon to hear how the pathologies of the clinic can shift knowledge of one's own body and heighten one's anxiety. As the normalization of infertility creates the ideal user of technology as heterosexual, it also constructs the range of "normal" treatment options upon an expectation of aggressive medical attention. These gendered and heterosexist processes assume that the female body in the clinic will be a diseased body, incapable of achieving conception without directed medical assistance. Yet as other ethnographies of lesbian families have described, and this project confirms, many women initially expect that getting pregnant will be an easy, low-tech process carried out without the need for much medical assistance.⁵⁶¹ The medicalization of reproduction, however, creates not only doubt in this do-it-yourself approach, but routinizes the application of high-tech methods as the best (if not *only*) approach.⁵⁶²

This complex of doubt and the expectation of advanced technological assistance was expressed by Antoinette and Donna, a queer female couple living in a medium-sized city in central Ontario. Donna had given birth to their first child, and they had decided that Antoinette would carry the second child with assistance from a known sperm donor. Antoinette had been doing concerted research online, and calling around to fertility clinics to ensure that – if clinical assistance was required – their family's reproductive needs could be met. She was anxious as to whether the clinics would allow them to use a known donor, whether they could use fresh sperm,

⁵⁶¹ Mamo, *supra* note 76; Agigian, *supra* note 480.

⁵⁶² Becker, *The Elusive Embryo*, *supra* note 532.

if the donor would be subjected to psychological evaluations, and if the whole process could be carried out before their planned move to another city. They were intending to start with the low-tech home option, which had been successful for Donna, but had not yet tried home insemination with Antoinette. Here, the women describe the ways in which discourses of failure and pathology had saturated their experience, to the point that they began to doubt Antoinette's reproductive capability:

I: So at this point you were planning to do home insemination first. And if things didn't work out then the clinic was going to be your fallback plan.

Antoinette: Yeah. Pretty much. And that's kind of what I felt we had to have in place.

Donna: Yeah. That's also because for [our first child], when I was cycle-monitoring for him, uh, my cycle's pretty regular. I think that part of it was because Antoinette's cycle is not very regular. And that might have been why you were doing this intense research because of fears that it wasn't going to work.

Antoinette: Yeah.

Donna: And, uh, we never really trusted her body for some reason.

Antoinette: Well, that's what the clinics do to you. They make you not trust your body. Like, that's what they're there to do. That's how they make money, is to make you not trust your body.

The processes of bodily normalization which take place under the rubric of infertility exert a profound impact on queer people, as bodies which already exist outside the normative bounds of heterosexuality. As Mamo suggests, "Those who do not fit within normalized categories are ready targets for the intervention of expert knowledge, as was true for the so-called barren women who became objects of early-twentieth-century scientific and medical discourse as a result of their 'deviations' from normal reproductive women."⁵⁶³ As a queerly reproductive body within the pull of clinical expertise and the medical apparatus of reproductive technology, Antoinette found herself being subjectivated as a target for expert knowledge. Her

⁵⁶³ Mamo, *supra* note 76 at 158.

irregular cycle was grounds for fear of failure and a turn to the expertise of the clinic, even before they had begun to try home insemination. Yet as she recognized the power of the medical discourse – that which makes the women not trust Antoinette’s body – she sought to negotiate her ‘patient’ role through determined self-advocacy as an informed consumer and researcher of medical options. Antoinette thus produced herself as a competent consumer-citizen able to navigate the complex economy of reproductive options and fulfill her procreative intentions.⁵⁶⁴

Treatments of the Clinic

The infertility trap manifests not only in regard to the ideal user (heterosexual, suffering pathology) and the range of ideal treatment (aggressive, successful), but in terms of the pace at which such treatment is extended. This protocol of care similarly follows the model of expectation set by heterosexual couples, with screening and surveillance mechanisms designed to a) diagnose infertility and b) swiftly ameliorate the reproductive crisis which follows this diagnosis. Depending on medical provider, clinical location and the negotiations made by queer clients, this may take the form of a step-by-step incremental approach to reproductive care, or a fast-track directly into ‘high-tech’ biotechnologies.

Demonstrating one of these negotiations is a couple named Aisha and Winona - two lesbian women who had planned to conceive with an anonymous sperm donor, with Aisha to carry the baby. They had purchased frozen sperm through a Toronto-area sperm bank, and were seeking help only with the process of insemination. As they made clear during their first appointment, they were not interested in accessing any reproductive treatment beyond assistance to inseminate with the donor they had chosen. Under the *AHRA* they were unable to inseminate

⁵⁶⁴ The economies of the clinic and the families produced through consumerist (albeit stratified) practices will be discussed at length in Chapter Eleven.

at home with an anonymous donor, even if Winona had known how to carry out intra-uterine insemination and lead a catheter into Aisha's uterus.⁵⁶⁵

In the absence of indications to the contrary, there would be no reason to assume reproductive impairment on Aisha's part. The women had not been inseminating at home before making an appointment at the clinic, so even an analogy to the heterosexist diagnosis of infertility – twelve months of penetrative sex without conception – would clearly not capture their situation. Yet by virtue of walking through the clinic's front doors, Aisha was obliged to undergo a battery of mandatory diagnostic testing that assumed the presence of a reproductive impairment.⁵⁶⁶ The rationale for this testing is generally shrouded in rhetorics of efficiency - cost, time and clarity – although Aisha and Winona also suspected the intentional exploitation of public health funds. Despite their middle-class economic status and college education, the women found little room to argue with their doctor about the required testing. Instead, Aisha and Winona were swept firmly into the infertility trap and subjected to a regime of medicalization designed expressly for the heterosexual couple. In this extended passage, they discuss their frustration at a medical system that barreled on without regard for their situation or needs.

Interviewer: Did the clinic ask you anything about your fertility? Did you have to go through fertility testing in the beginning?

Aisha: Yes. Yeah. Yeah.

Winona: Yep.

⁵⁶⁵ The women could also have thawed the sperm and inseminated Aisha with an intra-cervical tool such as a syringe or oral medicine dropper.

⁵⁶⁶ There are no standard regulations in place at North American clinics to determine mandatory diagnostic procedures. Clinics instead follow different internal protocols, dependent on a mix between client preference and their own best practices. In my personal experience in Atlanta, Georgia, as well as the experience of Ontario participants in the Creating Our Families research study (see *supra* note 231), a battery of blood work and diagnostic tests is mandatory before fertility treatment can begin.

Aisha: A whole slew of it. Which, I actually didn't really want to do...And fairly invasive really. I think. Like...

I: Did you ask at any point, "Why do I have to have these tests?" Or did they explain it very much?

Aisha: Um...I didn't ask, I don't think. I don't remember asking.

Winona: Well, and as for their explanations, it was just really to sort of see where you were at. And to see that, you know, everything was in the best place to conceive, I think is how they put it basically, but...

Aisha: That's right. In fact, remember Doctor Jones explained...He was like "Okay, we're going to do all of these tests. And if they come back, you know..." He was very sweet, but, "If they come back, you know, in a certain way, then we might have to give you some drugs." And I was like, "Am I in grade six or something?" (*laughs*) That sounded so bizarre. And (*jokingly*) "You might have to give me some drugs." You know? So I think that, because they're a fertility center, they're not in the business of being just a sperm bank. They're a fertility center and so what they want to make sure that you're set up and aligned to be, you know, as...

Winona: ...as fertile as possible...

Aisha: ...as possible...before they go in. Because, right, I'm sure it affects their success rates, and everything else. And the diagnostic testing, again— I don't know if it's a conspiracy theory or what— but all of this is covered through OHIP. So every time you go in and all of the tests they do, they are billing back to the Ontario government. We didn't have to pay anything out-of-pocket for it. And it's not really given as a choice, like "Do you just want to come in and try?" Or "Should we go through this?" It's just presented as a..."Here's what we're going to do. Here's all the steps leading up to when you can then come in."

Aisha and Winona expressed a series of frustrations with the screening protocols, the invasive character of unwanted tests and the paternalistic language of medical diagnosis. They also experienced their suspicion with the clinic's mandatory screening in the language of a "conspiracy theory," making sense of these protocols as a cash-grab from the provincial health care fund.

Rather than view the coverage of these services as a welcome provision by the Ontario Health Insurance Plan [OHIP], as might a heterosexual couple experiencing difficulty with conception, Aisha could make no sense of the program except as an example of clinical self-interest. As a reproductive body outside the normative structure of heterosexuality and infertility, yet struggling to negotiate a place for herself within the clinic, Aisha read the failure to attend to her needs as a lesbian as a non-patient-centric and therefore selfishly motivated action. In order to access the sperm they had purchased, she was obliged to allow herself to be categorized by the diagnostic logics of the clinic and be made a candidate for pharmaceutical treatment. Thus “the social category of being a lesbian or a single woman is transformed into a biomedical infertility classification, triggering referral to infertility and fertility services.”⁵⁶⁷ Aisha’s social status as a lesbian was transformed by Doctor Wilson into a legible medical category – an infertility status – thereby assigning her a medical classification and allowing her to access the reproductive services she desired.

As discussed, this process of transformation is necessary because the reproductive clinic is built around a structure of wounded heterosexuality which assumes that couples will *require* substantial diagnostics to locate their infertility. The system has been designed to process this imagined need, and even, to some degree, to help mitigate the costs. Notwithstanding the issue Aisha raised of excessive billing to provincial insurance,⁵⁶⁸ this is structured as a pro-natalist medical structure for heterosexual couples in need. It is a biopolitical initiative aimed at allowing heterosexual couples with the time, inclination and OHIP coverage to determine why their regular intercourse is not leading to pregnancy. Should the diagnosis then compel such couples

⁵⁶⁷ Mamo, *supra* note 76 at 131

⁵⁶⁸ Ontario has progressively de-listed many AHR treatments that formerly lay under provincial insurance coverage, thereby reducing the burden on state responsibility for reproductive assistance. While the issue of excessive OHIP billing may be genuine, it is not one that can be authoritatively addressed based on the limited data of this research.

to move on to expensive IVF procedures and other costly reproductive options, access will narrow to only those who can afford such out-of-pocket initiatives.⁵⁶⁹ As Charis Thompson has rightly framed it: “Contemporary infertility and its treatment are conceptualized and structured around a strongly coupled, heterosexual, consumer-oriented, normative nuclear-family scenography.”⁵⁷⁰

For the queer person with a reproductive plan, however, these compassionate supports may be perceived as overly medicalized and even invasive responses. At the very least, such protocols are not well-calibrated for a same-sex couple who simply need access to sperm.⁵⁷¹ However the medical system cannot understand the social practices of lesbianism that brought Aisha and Winona to the door without first transforming them into an epidemiological classification. The framework of the clinic funnels these women into a system designed to assess the capacities of their reproductive equipment, regardless of social context. For Lou-Ann and Rosie, another lesbian couple from the study, this experience led to no small degree of resentment.

Lou-Ann: I think there was a period of anger about having to use these types of services when we’re not infertile, and I don’t remember how long that anger lasted. I think it probably intensified during the cycle monitoring weeks because then you’re up really early in the morning. And sitting in a waiting room for two hours...

Rosie: ...Before you go to work and then you’re just like, “Really? Come on.”

Lou-Ann: And in terms of the services, this is a whole world that we had to learn about that I really wish I never had to learn about...And some people have to do it for physical problems and some people have to do it because they’re gay.

⁵⁶⁹ To date, only Quebec covers multiple rounds of insemination and IVF under provincial medical coverage. For more on this interesting jurisdictional anomaly see Chapter Eleven.

⁵⁷⁰ Charis Thompson, *Making Parents*, *supra* note 532 at 55.

⁵⁷¹ This is not to say that all LGBTQ people are unproblematically fertile, as discussed elsewhere in this Chapter and in Chapter Eight.

Rosie: Yeah I think, well I think it was a struggle definitely and there was really a point when I kind of thought about, “Yeah, I think maybe we have to give it up.” Because it was so hard and definitely not easy. It’s not just, you know, because we have to do it but also accessing all the services, and all the little things that you have to do, and waking up really early in the morning.

Lou-Ann: Yeah we were grumpy in the mornings too so we’d argue.

I: So you both would go to the cycle monitoring?

Lou-Ann: Yeah we always went together. I never went on my own. Which (*laughs*), which was great and supportive but also meant we argued more. ‘Cause we’re both up early and grumpy. So...

Rosie: Yeah. But, you know, we got her. (*Gestures toward baby.*)

Lou-Ann: Yeah.

Rosie: I wouldn’t have changed a thing because now we have her.

These couples were all successful in negotiating the infertility trap of the clinic and accessing the insemination services they required to conceive. However they also expressed varying degrees of frustration, doubt, resignation and despair at the process. As Rosie says, there was a period during which she and Lou-Ann nearly gave up due to anger at having to undergo early-morning cycle monitoring when there were no clinical indications it was necessary.

Many of the queer couples I interviewed had expected to start right away with the business of getting pregnant; instead they found a medicalized structure in place that required extensive gatekeeping and screening. The presumption of illness was always at the fore, even when not appropriate to the situation or the actors seeking reproductive assistance.

Queer Response to Clinical Bedrock

LGBTQ people were not passive recipients of reproductive services, however, and a number of study participants described their attempts to actively resist a range of unwanted

testing. Resistance to medical protocols was especially pronounced with trans-identified people and their partners, who were intimately familiar with the normalizing structures of the clinic and had developed a responsive vocabulary against these biomedical regimes. Kristin, a cisgender woman who conceived a child with her partner Isabel, a transwoman, recounts her attempt to set limits on the tests she would undergo. In this passage, Kristin is talking about her response to the medical procedures the clinic wants her to take.

Kristin: They were also quite insistent on treating me as if I was infertile and testing me endlessly to prove I was fertile before they wasted their resources on trying to get me pregnant. And I mean, I eventually said no to anything that involved radiation.

Isabel: Or Clomid.

Kristin: Or Clomid – which they wanted to give me before they even tried to impregnate me once!

In this reading the insistence on mandatory testing is again ascribed to non-compassionate motives on the part of the clinic. However this time it is not the ‘conspiracy theory’ of tapping provincial healthcare reserves, as Aisha advanced, but Kristin’s suspicion that she would be viewed as a “waste of resources” if she were found to be infertile. (Although interestingly, in another passage of the interview, Isabel also suggested that fleecing OHIP might be a motivation.)

In Kristin’s analysis her queer reproductive body experiences the baseline assumption of infertility as a suspicion, a threshold that must be disproven to qualify for the benefits of reproductive assistance. While the perception of the gatekeeping function may be viewed differently, the heterosexism of infertility again displaces the queer frame of reference. These medical procedures are again experienced as non-patient-centric and an example of clinical self-interest, drastically out of step with queer timelines for conception.

Standard Clinical Regime

It may be helpful at this point to overview just what this range of fertility testing might involve. It is also important to note that testing protocols will vary widely from clinic to clinic. There are no standard regulations in North America to lay out mandatory diagnostic procedures, with each facility determining their own best practices. The stories of the Creating Our Families participants, however, indicate that the following series of tests is fairly standard practice in at least Ontario fertility clinics.

When a couple like Kristin and Isabel first walk into the clinic, they will have an appointment with an on-site fertility counselor, nurse or doctor. The medical practitioner will offer an appraisal of the reproductive options open to the couple, listing the procedures and risks involved. The person intending to carry the baby, in this case Kristin, will then have initial blood work drawn to provide information about how her ovaries function on a daily basis.⁵⁷² These tests include a breakdown of levels of Follicle-Stimulating Hormone, Luteinizing Hormone, and estradiol (biologically available estrogen). Kristin will also be screened for uncommon causes of decreased ovulation, such as elevated prolactin and an under-active thyroid. Bloodwork will commonly include screening for HIV, Hepatitis B, Hepatitis C, and Syphilis, and may involve confirmation of the immune system status to other conditions that may affect the pregnant body, such as Measles, Mumps, Rubella, Chicken Pox, Parvovirus and Toxoplasmosis. If the woman is considering donor sperm, basic testing will then include a blood test for cytomegalovirus (CMV) exposure.

⁵⁷² Interestingly, the clinic may also ask the non-carrying partner in a same-sex female couple to undergo bloodwork and testing as well. This is discussed through reference to interview data below.

In Kristin and Isabel's case they were planning to use Isabel's sperm to conceive, and so her semen will also be collected to undergo testing for low motility or abnormal morphology. As the women are sexual partners, under the dictates of the *Semen Regulations* it will be possible to inseminate Kristin with Isabel's fresh, washed sperm. First, however, Kristin will be encouraged to undergo a procedure to check for issues with her uterus, ovaries, endometrium and fallopian tubes. Many women also undergo a hysterosalpingogram to x-ray the uterus and check for blockages of the fallopian tubes, a painful procedure which involves exposing the pelvis and ovaries to a small amount of radiation. Using a technique called fluoroscopy, dye is injected through the cervix and into the uterus, from where it flows through the fallopian tubes. (Kristin was articulate in her refusal to be exposed to radiation and rejection of this procedure, but this was certainly not the case for all study participants.)

Other participants underwent sonohysterography, an ultrasound procedure used to evaluate the endometrium. The technique involves the placement of a catheter into the endometrial canal with subsequent instillation of sterile saline solution. Depending on the clinic she may also be asked to have an Antral Follicle Count performed in order to obtain an ultrasound assessment of the ovaries, as well an Anti-Mullerian Hormone Level blood test to measure ovarian responsiveness and the number of potential eggs remaining in her ovaries.⁵⁷³

This barrage of jargon is intentional. As my research made clear, when queer people seek out reproductive assistance in Ontario fertility clinics – and even when making explicit the absence of a medical issue - they are being urged if not required to undergo comprehensive diagnostic blood testing before assistance can begin. It also appears as if women and transmen

⁵⁷³ This breakdown is from a representative fertility clinic in Ontario, and the profile of mandatory testing matches with my own experience and that of study participants. Fertility Ontario – Diagnostic Services. Accessed November 17, 2011. <http://www.fertilityontario.com/Diagnostic_Services.html>

are being advised to perform the deeply uncomfortable hysterosalpingogram. This is a highly medicalized system of treatment and one which requires costly and often unnecessary procedures under a dizzying array of names.

Should the woman be planning to inseminate with frozen donor sperm, it is likely that she will also be prescribed oral fertility drugs such as Clomid or progesterone to stimulate her ovaries and improve the chances of insemination.⁵⁷⁴ Kristin was planning to use her partner's fresh sperm, and even she reported feeling pressure from the clinic to take Clomid, which, as she says, "they wanted to give me before they even tried to impregnate me once!" If she does not successfully conceive after a few rounds of insemination with oral pharmaceuticals, she may then be encouraged to try injectable drugs such as Bravelle, Menopur or Repronex.

Once the woman has begun the drug cycle, her ovaries will be monitored by sonography and the final process of ovulation triggered by an injection of Human Chorionic Gonadotropin before the prepared semen sample is injected directly into the uterus with a fine catheter. As U.S. and Canadian clinics are currently self-regulating the range of mandatory testing will vary; however the Creating Our Families research makes it clear that people are being encouraged to undergo screening and drug regimes which may be inappropriate for their situation. When Kristin and Isabel were pressed to describe exactly what was mandated for their intake, and what they resisted, they offered the following description of the clinic's medical protocols:

Kristin: They wanted to do a test that involved radioactive dye... I said, "I don't want you putting radioactive dye into my reproductive system as I try to get pregnant. So no." (*laughs*) And, uh, then they offered me Clomid.

⁵⁷⁴ American Society for Reproductive Medicine: Medications for Inducing Ovulation . Accessed November 17, 2011.
<http://www.asrm.org/uploadedFiles/ASRM_Content/Resources/Patient_Resources/Fact_Sheets_and_Info_Booklets/ovulation_drugs.pdf>

Isabel: Yeah!

Kristin: They were like, “Well why don’t we just give you some Clomid? Like, see what happens.” And I was like, “Well, I totally don’t want twins. And I’m not infertile.” So I was like, “No!” (*laughs*) So...yeah...those were the two things that I said no to.

Isabel: And again, like, they would have billed OHIP for prescribing that and dispensing, possibly.

Kristin: Yeah...yeah.

I: And did you get a sense of why they were so keen to prescribe infertility drugs to someone who had no fertility problems?

Kristin: Well, Isabel’s analysis is convincing...about billing OHIP.

Isabel: (*laughs*)

Kristin: I also thought it was, like, uh...to someone with a hammer everything looks like a nail situation. Like, you’re a fertility clinic and you’re not built for helping fertile people get pregnant. You’re built for infertility and that just becomes your mindset after a while.

This theme - that people take unwanted drugs to stimulate their fertility despite not presenting with a medical issue - was commonly expressed by many participants. A suspicion of the clinic was also present, with a number of women independently suggesting that access to OHIP funds might be the real motivator behind clinical protocols. Others clearly identified the framework of ‘infertility’ as the problem. As Kristin says succinctly: “You’re built for infertility and that just becomes your mindset after a while.” This mindset, unfortunately, imposed real-world consequences upon the queer people seeking to navigate the space of the clinic. Pressure to undergo extensive testing and – potentially dangerous - pharmaceutical treatment was widely reported. As a lesbian-identified woman named Simone relates in the passage below, the pressure to begin drug therapy started even *before* she had begun her fertility diagnostics (where it would be found that she had so-called “gorgeous ovaries”):

Simone: I can remember they really pushed the drugs on you, the fertility drugs. They try and convince you to, you know, make you ovulate more or whatever. So I didn't want to do it, at least... Yeah I didn't want to be pregnant that badly.

Interviewer: So first they commented that you have gorgeous ovaries and then they were also saying –

Simone: Well this is even before they looked at the ovaries I think. This was like “You know this is an option you can think about.” Cause they just, you know, it's like a factory. Trying to just push people in, get them knocked up (*laughs*) and push them out (*laughs*) or whatever. I don't know. So yeah like they really offer up the drugs right away almost or they said “You know we can try it a couple times and then you can decide” or you know.

Interviewer: And this is before they even tested you?

Simone: Yeah. Yeah.

Lesbian women may feel obliged to seek out biomedical forms of assistance when using anonymous donor sperm, with a known sperm donor, or when seeking to inseminate with the sperm of a partner with whom one does not have penetrative sex. The institutionalization of the medical structure of reproductive assistance has made it the ‘first step’ for many on the journey to conception, even if for basic screening and bloodwork. The more recent technologization of donor sperm has made it especially likely that the clinic will be a necessary point of passage.

Despite active negotiation of this medical frame, queer people are being subjectivated by a system based on dysfunction, and clinical temporalities which remain in sync with exclusively heterosexual rhythms. For example, even based on the (flawed) heterosexual definition of infertility, which the clinics profess to follow, a medical issue is flagged after twelve months of sexual intercourse without conception. By this model, then, lesbian couples should undergo one calendar year of drug-free insemination before ramping up to more invasive methods, and particularly injectable drugs. Too high of a dose of any of these drugs can lead to a serious

condition called ovarian hyperstimulation syndrome, wherein the ovaries swell and fill with fluid, leading to bleeding, infection and even life-threatening complications.⁵⁷⁵ Based on numerous retellings of the reproductive ‘factory’ story, and the immediate clinical push toward bloodwork, scans and drugs, this one-year window is not being observed.

Potential Benefits of Testing

Of course this testing may sometimes have a positive side. Certainly not all LGBTQ people are robustly fertile, and some face reproductive issues which might be usefully caught by diagnostic testing. As discussed in Chapter Seven, some research indicates that lesbian women may actually be more prone to endometriosis, Polycystic Ovaries and Polycystic Ovarian Syndrome than heterosexual women.⁵⁷⁶ Clinical screening methods may well be viewed as appropriate in hindsight, when potential issues were caught early and addressed successfully.

For example I conducted an interview with a lesbian couple who had undergone reciprocal IVF – a procedure in which the egg of one woman is fertilized with donor sperm and transferred into the uterus of the other. Here, Nicole and Paula discuss their positive experience with sonohysterography, an ultrasound test involving the infusion of a saline solution into the uterus. Mandatory testing had revealed polyps in Paula’s uterus, which they then removed before beginning IVF.

Paula: So, I had the two polyps that had to be removed because they can cause miscarriages and, you know, I never would have known about that if we hadn’t gone through this procedure. If we had been doing home inseminations or if I was with a man and having sex, I could have had multiple miscarriages or trouble getting pregnant and I

⁵⁷⁵ Vloeberghs V, Peeraer K, Pexsters A, D’Hooghe T., Ovarian hyperstimulation syndrome and complications of AHR. *International Journal of Gynecology & Obstetrics*, Volume 107, Pages S22, October 2009.

⁵⁷⁶ See the discussion in Chapter Eight under the subheading ‘Queer Health and Subfertility’.

never would have known why until I would have had to go to a doctor anyways. So it's good to be all checked out (*laughs*).

Nicole: Which we had said in relation (*laughs*) to the fact that it is quite medical and maybe antiseptic at the clinic, but that those battery of tests can actually be a reasonable thing. They have to catch the...

Paula: ...I mean we had some friends that are straight and are trying to get pregnant and having a hard time. Yeah, sometimes it is hard.

Nicole's positive review of the tests as "a reasonable thing" is a pragmatic evaluation, welcoming the finding of Paula's potential conception issues despite the medicalized and "maybe antiseptic" setting of the clinic. It is interesting to note that the women had already chosen to undergo the process of reciprocal IVF, which is a far more engaged and complex intervention than (for example) donor sperm insemination.

The partner who is providing the eggs for reciprocal IVF, in this case Nicole, must undergo a grueling procedure involving pituitary suppression and ovarian stimulation through daily drug injection, in which hormonal medications are used to stimulate the ovaries to induce maturation of multiple eggs. Her cycle will then be manipulated with oral contraceptive pills and/or Lupron, after which controlled ovarian stimulation with Follicle Stimulating Hormone may begin. When the follicles are mature, Nicole's eggs will be retrieved via ultrasound-guided needle through the top of the vagina into the ovaries. The extracted eggs are then fertilized with donor sperm, after which the embryo transfer of fertilized eggs occurs via catheter into the uterus. The only technical difference between standard IVF and reciprocal IVF is the involvement of two women, with the transfer happening into Paula's uterus rather than

Nicole's.⁵⁷⁷ Paula must therefore undergo her own battery of tests, including the sonohysterography which located the polyps in her uterus.

Thus Paula and Nicole had negotiated a decision-making position within the clinic based upon their willingness to undergo advanced medical procedures and drug intervention. They had already accepted a location within 'high-tech' clinical practice, and were grateful for the testing which "caught" Paula's polyps before the difficult and costly procedure of reciprocal IVF began. Their starting point is therefore quite different than that of the women in the first part of this chapter.

Monica and Rochelle, on the other hand, were a lesbian couple who had expected to get easily pregnant and were simply seeking out the clinic for assistance with 'low-tech' donor insemination.

Monica: ...And then it turned out that Rochelle had endometriosis.

I: And she didn't know beforehand?

Monica: No, I mean, she'd always had painful periods, so I think it kind of explained a number of things. And so, she originally thought, you know, "We don't really need a fertility specialist." Like I remember her saying, "It's not like we're infertile, we just need somebody to get us pregnant." Like, "I don't need to go through all the stuff, right? I don't need to take medication, I don't..." She didn't really feel like she needed to do all these different things.

Despite her reluctance to take the tests, Rochelle was required to undergo the standard series of blood and diagnostic evaluations. It was during these tests that the doctors found indications of endometriosis. Rochelle and Monica navigated their participation in the full biomedical regime of the clinic by deciding to try a first round of donor insemination just to "see

⁵⁷⁷Source: Reproductive Science Center LGBT Services at IVF New England – Reciprocal IVF Treatment. Accessed November 23, 2011. <<http://gayivf.rscnewengland.com/reciprocal-ivf-treatment.htm>>

what happens” before considering more intensive procedures. This initial round was unsuccessful, and the women went back to their doctor for advice about how best to proceed.

Monica: And then after that, our doctor said, cause we were older, you know, I think Rochelle was thirty eight at the time. He kind of said, “You know what...” And we had limited, we only bought five samples [of donor sperm], so, you don’t want to use them all up and it’s expensive. Each time, we figured, between the sperm and the procedures about a thousand bucks, so and I kind of thought, “We can’t go through our sperm this quickly.” And he said, “You know because of the endometriosis, you would improve your chances if you had surgery.” So we tried in the summer, I think that was maybe June or July with nothing and then in September she had the surgery and then she got pregnant right after that in October.

I: And it was laser surgery?

Monica: Yes. Laparoscopic and, so that was actually quite effective. So she got pregnant that fall...So that was great, we only had to use two of our samples, which was super.

Their pragmatic approach to the scarcity of donor sperm and the cost of privatized reproductive assistance led the women to quickly acquiesce to the option of surgery. The objective of achieving pregnancy with limited resources necessitated an aggressive surgical approach, which Monica recalled with satisfaction. The choreography of their interaction with the fertility clinic involved an exercise of agency through their willing subjectification to the objectifying medical modes and diagnoses (“endometriosis”) of the clinic.

As Charis Cussins has argued in the context of heterosexual IVF, objectification and agency are co-constitutive, not distinct social processes.⁵⁷⁸ Thus women can adopt the role of patient and manage medical treatments to achieve their goals of, in the case of Monica and Rochelle, getting pregnant while conserving scarce donor sperm resources and limited funds. They intended for Monica to conceive their second child from the same donor sperm, and following Rochelle’s socialization within the medical system, Monica also willingly submitted to

⁵⁷⁸ Charis Cussins, "Ontological Choreography: Agency through Objectification in Infertility Clinics," (1996) *Social Studies of Science* 26:575-610. (Cussins is the surname formerly used by Charis Thompson.)

the full range of testing. After the birth of their first child, for example, Monica describes her willingness to undergo a hysterosalpingogram despite a certainty that she would not be facing any issues of reproductive impairment.

Monica: I had presumed everything would be fine for me because you know, I've got seven nieces and nephews, I just felt like our family obviously is fertile and this isn't going to be an issue. And I remember Rochelle was in the hospital and I went for the dye test where they check your tubes.

I: Yes.

Monica: And it didn't work. It was extremely painful and he tried twice and it was like agonizingly painful and he said, "You know, you've got blocked tubes, the dye is just not going to go through." And I remember, Rochelle just had the C section, she was in the hospital, Frida [their first child] was just a few days old and I just, just thought, you know, it had been fairly smooth for her after all that initial stuff. And it just wasn't in my realm of conception that I would have any issues at all. So I remember being devastated. Like I just can't believe this, you know, cause he said, you know, "You have to go straight to *in vitro*, there's no other options for you." So that just, you know, lots more money, lots more, just lots more uncertainty right.

Monica then experienced a series of three unsuccessful IVF cycles. Rather than follow the surgical pathway, as Rochelle had done, Monica took the advice of her doctor to go "straight to *in vitro*" without exploring other options. Over the course of one year Monica had her eggs extracted and fertilized, and underwent one fresh and two frozen cycles of IVF without success. Finally, approximately a year after her diagnosis with blocked tubes, Monica had a fresh cycle of IVF that implanted successfully. Unfortunately she shortly experienced hyper-ovarian stimulation as a result of the injectable hormones she had prescribed as part of the IVF treatment.

Monica: ...I developed right away, what do you call it, uh I'm drawing a blank, what do you call it, where you bloat up. Where you've got too much of the, oh it will come to me. Anyway I had to be hospitalized shortly afterwards because I ballooned up, like I was three months pregnant and uh, cause you develop all this extra fluid going through...

I: OK. What was the cause of this?

Monica: It was the *in vitro*, so it's a side effect of the medication. Hyper stimulation, so in a very small percentage. Like, I think a lot of women hyper stimulate but a very small percentage, you actually get the severe fluid retention. So I was hospitalized for a few days and eventually it passed...but I actually maintained a lot of fluid throughout my pregnancy, it was very odd actually. Um, and then the pregnancy was generally pretty straight forward, other than the fluid retention and then I developed gestational diabetes, but you know, that's more genetic than anything...

The story of Monica and Rochelle is instructive as a complex negotiation of their social expectations as lesbians in search of donor insemination, skepticism of infertility as a diagnostic, and the biomedical trajectory of surgery, medication and reproductive intervention designed to meet that diagnostic. Clearly, although these tests are designed to account for heterosexual infertility they do not always pose an unwanted hurdle for LGBTQ people. Monica spoke of her experience without anger, and was able to persevere through physical and financial hardship to meet her family's reproductive goals.

Yet after her negative experience at a Toronto-area clinic, Antoinette looked ruefully back at the treatment she had received. Although Antoinette had also gotten successfully pregnant, and their children were lively presences in the room during the interview, there were still regrets about the way treatment had proceeded.

I: Had they not been mandatory at the clinic, do you think you would have wanted to have those tests done?

Antoinette: I probably would have *not* wanted to. Because all we wanted was the sperm. And my philosophy always was, if there's no problem, don't go investigating it. Like, unless I'd tried twelve times with live sperm, you know, and had a problem, then I probably wouldn't have sought those — 'cause they're really uncomfortable tests.

The mandatory application of diagnostic tests, without regard for the social positioning of the client of reproductive technology, posed a problem for some women. Others, at least in retrospect, welcomed these tests and the results they offered in achieving their goals of pregnancy and reproduction. Queer folks were adept at constructing the narrative and agency of

their own medical histories, as they managed to maneuver the biomedical trajectory in ways that mimic, borrow and supplant normalization tendencies.⁵⁷⁹ Yet most had little option as to whether this trajectory was the proper course. The disciplinary forces of the clinic operated to flatten the social experience of LGBTQ people, pressing them into a medical model which may, in retrospect, appear effective for some, but which for others is recalled as oppressive and heterosexist. A blanket proscription aimed at the infertile heterosexual couple is frankly unwise in terms of time, cost and emotional wellbeing. Foregrounding patient agency and latitude to navigate the medicalized discourses of the clinic will also require recognition that not every person passing through the clinic doors is a heterosexual ‘patient’ who will present with a medical problem for treatment.

Other Models for Treatment

There are some clinics that do not mandate this barrage of testing for same-sex couples. Interestingly, the data indicates that Ontario clinics operate from this baseline of heterosexual infertility, requiring all people seeking reproductive assistance to undergo standard diagnostics. However a lesbian couple who lived near the Ontario border had sought out reproductive assistance in Manitoba, as the closest clinic to their home. They reported a more flexible regime that was adapted for the social experience of same-sex couples. As they recounted, the doctor had not suggested or directed diagnostic testing, instead contextualizing their needs as a same-sex partnership and counseling a ‘low-tech’ approach to start. After conducting her own cycle monitoring at home, Trish immediately began insemination with anonymous donor sperm and conceived upon the first round.

⁵⁷⁹ Mamo, *supra* note 76 at 163.

Interviewer: When you were at the fertility clinic in Winnipeg did they put you through fertility tests? Was that part of your intake?

Trish: No.

Interviewer: Did they ask if you wanted to have them?

Trish: No. They said that they don't - they wouldn't do that unless I wasn't getting pregnant. They don't put people through fertility tests unless there's a reason - unless they're not getting pregnant when they should be...So [the doctor] said, "If we try three times and you don't get pregnant then we're gonna look into it. But we'll give it three tries first."

Trish and Anya were grateful for the ease of their experience and rated both the doctor and the clinic very highly. They did not recall any LGBTQ-specific issues with their treatment, and even looked back on their time at the clinic with some fondness. This was partly because of the speed of their successful insemination – their child was conceived on the first try – but also due to their evasion of the infertility trap. In recognizing their social positioning as a lesbian couple, the doctor was able to accurately respond with patient-centric care that was appropriate to their age, sexuality, reproductive history and health. This is a working model of reproductive assistance that remains quite uncommon. Few reproductive providers are able to recognize the particular needs of LGBTQ people without depending upon the rubric of wounded heterosexuality and the hypermedicalization of queer experience.

Perhaps unsurprisingly, the most sustained critique of fertility clinics and the flattening of queer experience came from a couple who had rejected the clinical mode entirely. Jacqueline and Tonya had recruited Jacqueline's brother to serve as their donor, and the two women visited a clinic in Toronto to learn more about their reproductive options. When they encountered the onerous demands of the *Semen Regulations* on known third-party donors, however, they decided

to carry out the process at home.⁵⁸⁰ This experience with the barriers posed to known donors continued to irritate Jacqueline long after their visit to the clinic.

Jacqueline: I'm serious, like I'm still angry to this day about, about that clinic experience. Cause I think that a lot of people that are going in with known donors or friends, they virtually put a barrier up and it makes so that if you want an anonymous donor it's already out of the price range. But if you have a known donor or you want to co-parent or anything like this, it just makes the cost even more. And for the average family it's already expensive, so can you imagine what it does if they're going to store this stuff for six months and do these extra procedures... financially [it] can be impossible for some families.

Their rejection of the medical protocols for known third-party donors led to a decision to avoid the clinic altogether, which meant an avoidance of the testing regime as well as the early-morning cycle monitoring described by other study participants with distaste. Jacqueline and Tonya describe the intentionally 'low-tech' modes of reproduction they pursued, structured in no small part by distrust of the medical practices of the clinic:

Jacqueline: [For the insemination] we used a medicine syringe, just a little medicine syringe, we did nothing special other than charting Tonya's cycle. Which I did for a good year before we actually did the insemination itself, because I don't trust those clinics. Even though we were [planning on] going to the clinic, I had already started charting her cycle ahead of time from what I'd been reading, because I'm just that kind of nerd. But, you know, we charted a number of different ways because the temperature thing doesn't always work out. So finally we used a whole combination of, I'd say our own home grown method of figuring it out, and we were able to nail it down to two days.

They describe the series of tests the clinic had scheduled after their first intake session, and the scheduling of a hysterosalpingogram for Tonya as part of standard protocol. As Jacqueline said with incredulity: "Isn't this something that you do with someone with a potential blockage? And when there may be some *reason* why you might want to do this procedure?" the women ended up cancelling the appointment, not least because they had already begun inseminating at home and were concerned about the potential for the dye to interfere with

⁵⁸⁰ Tonya and Jacqueline's experience is described at length in Attachment One in the section on known semen donors.

Tonya's pregnancy. As Tonya explains, they had already started to "feel hopeful" that they could do home insemination, which both of the women much preferred to the hypermedicalization of the clinic. Ultimately Tonya successfully conceived two children at home through simple intra-cervical insemination. Her dominant emotion was relief at being able to avoid the surveillance, heterosexism and barriers of the clinic.

Tonya: Well I have to say, well I was a little surprised by the whole thing, I thought it would be simple but I was actually kind of relieved because once I went there, I didn't feel comfortable, I just thought, I don't want to go through it.

Jacqueline: I don't understand how anyone gets pregnant there.

Heterosexual Reiterations of the Clinic

The queer families described above experienced a variety of different clinical encounters. The norms of reproductive medicine and their heterosexist foundations are cemented by both law and protocol, yet these norms still require reiteration for their sustainability. Clinical practices must be enacted by doctors, nurses, students as well as by the people seeking reproductive assistance. It is within these enactments and the meanings attributed to the disciplinary modes of the clinic that queer people found rhetoric and strategies to allow them to achieve their goals of conception. In some cases this meant leaving the clinical framework altogether. In others it meant contesting or refusing certain diagnostics or pharmaceuticals. Queer people occasionally found purchase and recognition within the clinic, as with the lesbian couple who traveled to Winnipeg for reproductive assistance. They may also be grateful for diagnostic testing and the heterosexist logics of the clinic, not least when it apparently functions to carry them closer to their aims.

Queer agents are uniquely able to trouble the relations of coherence among heterosexuality and the ‘helping hand’ to nature that the fertility industry aims to provide. Queer reproductive projects thereby have the capacity to open the “matrix of intelligibility” and trouble anticipated structures of continuity between sex, gender, sexual practice and reproduction.⁵⁸¹ Yet as has been seen, the resolute heterosexuality of the infertility trap may also render queer reproductive needs as marginal. The internal logics of the clinic are based around etiologies of disease and trauma, and leave scarce room for alternative versions of family.

Heterosexual Bureaucracies

When seen through the rigid modality of infertility, family arrangements that exist outside of the heterosexual dyad become hard to read. This extends not only to the trajectories of care, as discussed above with the presumptions of heterosexual disease. It is also overlaid upon structural relations as well. This means that bureaucratic protocols designed for the two-parent heterosexual couple are applied without hesitation onto the queer couple. For example, Monica discussed the headache she Rochelle experienced at a critical moment in their IVF cycle. Due to the clinic’s rigid paperwork requirements, they would not proceed with Monica’s IVF treatment unless Rochelle’s blood work was current.

Monica: One thing that we encountered was, blood work had to be a year old. You had to be up to date. But I remember when I went to have my second *in vitro*, I got a call saying “Rochelle’s blood work is not up to date.” Which isn’t so relevant for us, right, like we’re not using...like if it’s a male and we’re using their sperm. I can see there might be issues with *that* blood work needing to be up to date but...

I: Right.

⁵⁸¹ Butler, *Gender Trouble*, *supra* note 100 at 17.

Monica: And that's where she said, "And I realize for you that that's not an issue but our policy is that the partner has to have their blood work up to date." And I think I remember, that they won't do the procedure unless they have that on file.

I: Right.

Monica: So it was like a big rush, like we had to rush to get it done, otherwise...

I: Was this within a day or two, or the same day as your IVF?

Monica: No it was a few days before because we needed to get our results back pretty quickly...

I: So that can be stressful?

Monica: Yeah. Because obviously, you know, timing is everything with IVF.

Monica: That sort of surprised us and I think they were apologetic about it but basically said...

I: It's the policy.

Monica: It's the policy, the partner needs to have it, whether or not it makes sense for you, but it needs to be up to date.

This last-minute scramble to complete the necessary documents was a harried episode for the women during an already stressful period. And while the clinic's staff recognized, and even apologized for, the arbitrary nature of the policy, it was nevertheless enforced as a matter of protocol. The structural elements of heteronormativity pervade the bureaucratic operations of the clinic, obscuring other social arrangements and intimate frames. This bedrock defies scientific or procedural logic, and yet is reproduced by the clinical staff as a necessary operation in the production of structural coherence. Adherence to the heterosexual matrix of intelligibility also extended to expectations around the two-parent model of reproductive partnership.

For example, Wendy and her partner Kanako described how they *both* underwent standard screening and bloodwork at an Ottawa fertility clinic, despite the fact that Wendy had clearly presented as the only one intending to carry the child. The clinic's intake protocols

included mandatory testing for both partners, even though for many queer couples, only *one* party is there as a reproductive agent.

Kanako: We were both tested for...all kinds of sexually transmitted diseases.

Wendy: Not sure why you were tested.

Kanako: The standard thing before they start apparently, that they check everybody for diseases you would pass on I guess in pregnancy.

I: (*to Kanako*) But if you were not...did you declare specifically from the start that you had no intention of becoming pregnant?

Kanako: No. No...I'd never said "No. I wouldn't get pregnant."

Wendy: Although when they did talk about the testing you did say, "But I'm not..."

Kanako: Yeah.

Wendy: I remember that.

Kanako: "I'm not the one that's getting pregnant."

Wendy: "And that's what, well that's the standard and this is what we do."

Another same-sex female couple, Mahta and Veronica, had a similar experience, with the non-reproductive partner subjected to a range of intake testing. In the following passage, they describe being asked to take the test for cytomegalovirus (CMV) – a necessary requirement when a woman is inseminating with donor sperm. Approximately half of North American adults have been affected by CMV, but it is usually without symptoms and the infection results in the presence of antibodies in the blood.⁵⁸² If a woman does not have immunity to CMV, however, using a sperm sample from a donor who is CMV-antibody-positive creates a small risk of infection in the newborn.⁵⁸³ It had been clearly established that Veronica was the only partner

⁵⁸² Reproductive Medicine and Surgery Center of Virginia, Therapeutic Donor Insemination, Accessed November 17, 2011. <<http://www.rmscva.com/iui-donor-insemination.html>>

⁵⁸³ *Ibid.*

inseminating with donor sperm, yet both she and Mahta were told they both needed to get bloodwork taken, including the test for CMV. They had some difficulty remembering the exact name of the virus – they had already cycled through the acronyms CHC, CIB and CHA as this passage begins.

Mahta: You can catch it from others just like some sort of sexually transmitted disease that you can get. It would not affect you at any time. It's either CIB or CBI - either of those.

Veronica: Something like that. And then if the donor had it...it would have been a bad thing.

I: But they tested you for this?

Mahta: Yeah.

Veronica: Both of us.

I (*to Mahta*): And did they explain why you were being tested for anything?

Mahta: Well I told them, I said: "I have nothing to do with the whole process. So why?" and then they're like, "Oh you have to be tested." I'm like, "Okay." I mean, well, it's not like I really have a choice there. Whatever they say, you have to do.

Mahta notes her lack of ability to negotiate the heterosexual model of intake, wherein both partners are tested for their reproductive capacity and for the presence of infertility. The practices of the clinic expect that the male-female partnership is aiming at biological reproduction, and as such both partners are viewed as (at least potentially) reproductive bodies. When the goal is donor insemination, however, the focus is only on the individual who will be trying to conceive. In the cases above, only Veronica is planning to carry the child; only Wendy intends to get pregnant. As Mahta said clearly: "I have nothing to do with the whole process." However the clinic still pushes *both* members of the reproductive partnership to undergo testing,

and specifically a screening protocol which is required only when planning to become pregnant from donor sperm. The reasons for this are three-fold.

First, as discussed, is the foundational mode of the heterosexual imaginary. As both partners are expected to have a biological stake in the child, it is expected to be necessary to evaluate both parties to the reproductive union. This mode persists in the clinic's ready application to queer families, despite its evidently inappropriate character for same-sex couples. Bureaucracy, screening and internal protocols designed for heterosexual families are overlaid upon queer experience to unfortunate effects.

Second, is the assumption analyzed in Chapter Seven in the unpacking of infertility: that *the female body is open for business*. In a later section of this chapter, it will be shown how easily the focus can shift from one female body to the next, when the first lesbian partner is deemed an unsuitable candidate for pregnancy.⁵⁸⁴ Every body in the clinic is thought to be a potentially reproductive body, even when this contradicts what has been indicated by the individual herself. Thus even when Mahta protests that she has nothing to do with the process, and Kanako explains that she will not be bearing the child, the clinic still treats her like a possible candidate for reproduction. In this way "infertility medicine appropriates compulsory heterosexuality and transforms it into 'compulsory reproduction.' The new grounding assumption becomes 'If you *can* achieve pregnancy, you *must* procreate.'"⁵⁸⁵

Finally, there is the question of negotiation and agency within a limited range of options. A language of hapless resignation was pronounced in all three of these interviews. As Mahta said, "[I]t's not like I really have a choice there. Whatever they say, you have to do." Monica

⁵⁸⁴ This is discussed in the section "Queer Pregnancy at the Clinic" below.

⁵⁸⁵ Mamo, *supra* note 76 at 228.

relayed the language of the clinic's staff regarding mandatory testing, and their blunt explanation that "it's the policy" whether it makes sense or not. Similarly, Wendy recounted what the intake staff had told her, as they made it clear: "[T]hat's the standard and this is what we do." As the machinery of the clinic grinds along, these women found themselves unable to exercise much control over their own treatment.

This loss of control is referenced very clearly by Wendy and Kanako at a later point in the interview. As discussion progressed, the question arose of how these procedures had made them feel, given that Kanako was not the one getting pregnant and the tests would be unnecessary. Their sense of vulnerability within a dispassionate clinical structure was painfully apparent.

I: Okay, so they just ran a bunch of tests. They ran a bunch of tests on you...was any of this making you feel any which way?

Kanako: I did think it was odd.

I: Yeah.

Kanako: I did think it was odd that I was tested...Um but never really questioned it.

I: You just figured it was part of the package.

Kanako: Yeah, yeah.

Wendy: It's part of what you do, right? You want to get pregnant, it's part of what you do. You're in a vulnerable place when you're trying to get pregnant, when you're trying to conceive. I think.

Kanako: Emotionally and physically, right?

Wendy: And emotionally and physically and if they say X Y and Zee, sometimes you'll go "Okay, X, Y, and Zee." Right? Because you want that outcome.

To summarize thus far, the bedrock of the clinic is founded upon a prevailing model of medical infertility, which assumes that couples and individuals seeking assisted reproduction

have a reproductive malfunction that requires treatment. Even a healthy body will thereby be subject to a suite of diagnostic procedures, some of which may be uncomfortable and invasive. As well, every body in the clinic is understood to be a reproductive body, even when this stands in conflict with stated reproductive intentions. At the fore remains a traumatic model of wounded heterosexuality, constantly anticipating the worst. Interestingly, these discourses do not shift once conception is achieved, but continue to presume the presence of failure, risk and medical pathology.

“Congratulations, you’re pregnant. Oh my God, let’s be careful.”

This final section of the chapter explores how even a successful conception is treated as a high-risk situation within the infertility trap. Like Trish and Anya at the clinic in Manitoba, a few queer families reported achieving conception on their very first try. Kristin and Isabel were such a couple. After recounting their struggle with mandatory testing and their resistance against the obligatory prescription of drugs like Clomid, the women talked about the procedures that snapped into place after Kristin became pregnant after the first round of insemination.

I: Okay. So first time was the charm and...

Kristin: First time’s the charm. And we were outta there. I mean, that was it. They...well no, they wanted...they were doing a bunch of follow-ups, and very reluctant to acknowledge that I had gotten pregnant, that I was statistically likely to remain pregnant and that they could let me go. So I mean they aren’t...

I: What do you mean?

Kristin: Well, they wanted to do constant ultrasounds on the fetus as it developed. And they...um...I eventually just stopped coming.

Isabel: Yeah, that’s right. We did finally brush them off.

Kristin: Yeah, we just stopped showing up! We’re like “No, I’m pregnant. I don’t need to go anymore.” And...yeah, there was..if I said anything about being pregnant, the doctor was like “Well, you know, don’t get too excited...”

Isabel: I mean, anybody can miscarry but, you know...

Kristin: Anyone can miscarry but there's also nothing wrong if you haven't miscarried...with assuming that you're not going to. I think there was...you know...I think 'cause they're a fertility clinic and they've dealt with a lot of disappointment, they...I think the instinct was to protect me from disappointment. But it wasn't really what I needed.

Isabel: It was just another case of them being overly involved.

This story of unwanted medical intervention and the reproductive traumas of the clinic was seconded by other participants. The techniques of surveillance, emotional insulation and risk-management which pervade the medical approach to infertility were experienced as culturally inappropriate for queer families who had not experienced reproductive trauma. At the start of Attachment One we met Carol, a bisexual woman who conceived using donor sperm despite a frustrating diagnosis of "infertility" which Carol had strongly felt did not apply to her case. In this passage, Carol describes her experience with the clinic and the manner in which the clinic aggressively tracked the progress of her pregnancy.

Carol: The experience after we got pregnant was really interesting 'cause every pregnancy there is treated as high risk because of the fact that you're using their services...so even though I was a low risk pregnancy, they offer a blood test to show you're pregnant, then another one two weeks later, and then I think we had like three blood tests over the course of the first few weeks. Like every few weeks just to see that you're actually progressing in the pregnancy.

I: Yeah.

Carol: And then they do ultrasounds--I don't remember I think at like six weeks, at two months, at three months, whatever. Other friends who got pregnant who weren't accessing services like this, they don't have an ultrasound till twenty weeks. I had two or three already by that point, which I thought was cool 'cause I got the pictures and I liked it.

Interviewer: *(laughs)*

Carol: We got a midwife right away who advised, "You don't have to do those if you don't want to. You can tell them that." But it's just automatic. You automatically get several blood tests, several ultrasounds, and then they recommended progesterone

suppositories for the first trimester and I can't remember exactly what they do but it was just a precautionary thing. And I asked, you know, "Do I really need to do it?" "Well, you're not necessarily at risk but it doesn't hurt just to make sure." And because the fact that we got through so much trouble to get pregnant, "Whatever they say might help, I'm not risking losing this pregnancy." So we did it but we had to pay for them and they're really just not comfortable.

Carol: But it was just awkward and I debated, you know, "Do I really want to take this [progesterone] and do I really want to worry about it?" But, again, we just spent how much money and how much time trying to get pregnant and I don't want to have to do this again if I don't have to. So I need to keep [the baby] and I'll take them. So that was really annoying. So just the, again the ultrasound part I liked but everything else is - the treatment idea is "Congratulations, you're pregnant. Oh my God, let's be careful."

For Carol, the degree of medical intervention supplied by the clinic is experienced with some ambivalence. Her sense is that the pregnancy is low risk and not in need of surveillance, yet she also understands the "automatic" mechanisms of the clinic as being there to support her and ensure the baby is brought successfully to term. Her negotiation with the hypermedicalization of her pregnancy is one of grudging acquiescence, recognizing the medical apparatus as a useful mode despite the discomfort that may be involved. This is guided by the long-term investment she has already made in the epistemic practices of the clinic: the time, emotional effort and finances expended, and the desire to ensure a healthy birth of her child. Similar to Paula and Nicole and their acceptance of a location within 'high-tech' clinical practice due to their pursuit of reciprocal IVF, Carol has already subjectivated herself as an infertility patient and therefore finds it easier to engage the risk management techniques of the clinic.

This stands in contrast to women like Kristin and Isabel, who perceived the clinic's post-conception recommendations for regular ultrasounds to be "overly involved" and eventually stopped attending appointments altogether. Kristin had conceived after just one round of insemination with Isabel's sperm, allowing them to invest relatively minimal resources into the medical process. As will be discussed in Chapter Nine, Isabel also experienced profound mis-

gendering by the clinic, alongside their expectation that she was prepared to behave like a heterosexual man. The lack of trans-sensitive care coupled with their low-tech and rapid process through the medical system almost certainly contributed to an easy dismissal of subjectivation as infertility patients.

As the interviews made clear, the infertility trap operates as a normative bedrock, obliging queer people to navigate an often hypermedicalized system that assumes pathology and limits room for negotiation. While queer people navigated these heteronormative landscapes in different ways depending on their situation, embodiment and investment in the process, the language of grim resignation to mechanisms beyond their control was widespread. This included choices about their own medical treatment, testing and drug regimes, the treatment of their partners, and even the ways in which they were treated after pregnancy.

Conclusion

In her work on the performance of female gender, Judith Butler has outlined the ways in which heterosexuality is naturalized through the idealization of maternal desire as a cultural given.⁵⁸⁶ It is through the depiction of female desire to have children as ‘natural’ that the reproductive union of men and women is able to assume a seamless harmony. This in turn offers a script for the culturally inscribed expectations of heterosexual childbirth and nurturing, as reproduction comes to be understood as simple biological fact, a process that has occurred naturally “since time immemorial.”

⁵⁸⁶ Butler, *Gender Trouble*, *supra* note 100.

Butler argues that heterosexuality necessarily involves the “cultural construction of the female body *as* a maternal body.”⁵⁸⁷ She reads the production of maternal desire as natural to womanhood as an effect or consequence of a system of compulsory heterosexuality, in which the female body is expected to assume a desire for maternity as the essence of self. Thus, in Butler’s terms, it becomes possible to understand “the maternal libidinal economy as a product of an historically specific organization of [hetero]sexuality.”⁵⁸⁸

The clinic marks a location wherein the maternal libidinal economy is both in crisis (due to reproductive trauma) and under active reinforcement and stabilization (through the palliative care of reproductive medicine). This chapter has explored the ways in which queer bodies encounter this system of compulsory heterosexuality, crisis and medicalization. It has argued that the clinic’s labour is directed at stabilizing the heterosexual model of ‘natural’ reproduction, and has tracked the manner in which clinical procedures and standards seek to reassemble this fractured norm. The use of technology to recreate ‘natural’ reproductive outcomes, I contend, is rendered all the more starkly when queer agents are placed at the center of analysis. This argument has used interview data to explore queer desires for maternity and paternity outside of the heterosexual organization of desire, and tracked the ways in which their use of AHR variously challenges, rejects, reframes and affirms prevailing heteronorms.

The next chapter will further explore the crisis of the maternal libidinal economy wrought by infertility, and map out the categories of reproduction in play at the clinic. It will refine these operational categories from a queer perspective, challenging the ‘natural facts’ of heterosexual reproductivity and seeking to create a queer paradigm for reproductive kinship.

⁵⁸⁷ *Ibid* at 90.

⁵⁸⁸ *Ibid* at 92.

Chapter Nine: Rejecting Infertility and Developing New Models

Introduction

This chapter argues for a new paradigm that is able to embrace the fragmentations in normative heterosexuality wrought through the widespread use of reproductive technology. Despite advances in biotechnology and the legal recognition of new family forms beyond a strictly heterosexual reproductivity, the governing clinical paradigm of 'infertility' continues to find bedrock in a limited imaginary. It is based in an assumption of trauma, pathology, deviance and loss that cannot account for queer parenting arrangements, nor the desire to avoid excessive medicalization of reproductive assistance.

As a corrective, this chapter will turn aside from the narrowed vista that infertility offers. I hope to expand this conceptual imaginary through a new set of neologisms: *orthofertility*, *parafertility* and *synfertility*. I will show why these terms represent an important new way of thinking through a critical impasse, and demonstrate their utility in scenarios from the clinic to the courtroom. In creating new vocabularies to render the particular legal, clinical and social needs of queer people accessing assisted reproductive technologies, the aim is to radically shift away from the normative model of wounded heterosexuality that currently holds sway.

By disaggregating 'the infertile' into more complex categories, the variegated needs of a whole spectrum of users of reproductive technology will become clear. The hope is that by decentering the singular heterosexual reproductive couple from the heart of the medico-judicial imaginary – by which I mean both clinical spaces and family law - a more partial, contingent and reflexive framework can emerge. Such a relational mode can more readily engage the concerns of *all* communities seeking to access assisted reproductive technologies, as well as the children

born through such procedures.

Beyond the Infertility Trap

The chart below describes the current state of infertility thinking. It offers only two options: normal reproductive (heterosexual) intercourse or a failed (heterosexual) fertility that requires reproductive assistance. As we have seen already this constitutes an infertility trap: a reductive model that relies upon medieval and gendered concepts of sexuality, fosters stigma, flattens shifting and relational timelines, and ignores the lived realities of single people and queers. It is hampered by definitional inconsistencies, intense temporal anxiety, and heavy reliance upon invasive and often expensive forms of technology.

In this section I will clarify the effacement happening under the rubric of infertility, and show why new conceptual models are required to fracture this oppositional thinking.

Current Understanding of Infertility

Normal Healthy Fertility	Pathology of Infertility
<i>*Natural*</i>	<i>*Artificial*</i>
Ability to conceive and have children; the ability to become pregnant through <i>normal</i> sexual activity.	The <i>failure</i> to conceive after a year of regular intercourse without contraception.

The binary framing of *natural fertility* versus *artificially-assisted* reproduction was explored in Chapters Seven and Eight. This dichotomy depends upon the opposition of nature to technology, and assumes that the physical, social and legal organization of penile-vaginal penetration around the nuclear heterosexual family represents an unproblematic and pre-

culturally natural form of reproduction. It has also been discussed at length how this binary marginalizes and pathologizes queer and single people.

This medical formulation is aimed at the reproductive intervention (*artificial*) in contrast to biological reproduction which occurs without intervention (*natural*). It makes no distinctions between the different types of bodies and family arrangements seeking assisted reproductive technologies; focus remains on the *technology* as the key actor of intervention. This is in keeping with the histories of development of AHR, in which early feminist critics rejected the imposition upon female bodies of reproductive technology *qua* technology. However it may be useful to view technology not as an adjunct to human aspirations for family, but as constitutive of those very kinship forms. As Haraway reminds us, “We’re inside of what we make, and it’s inside of us.”⁵⁸⁹ A perspective that seeks to trace this world of connections – attending to “which ones get made and unmade” in Haraway’s terms – clarifies the contestations and negotiations occurring through the production of human subjectivity through technology.⁵⁹⁰

Such a nuanced materialism seeks to trace the pathways of kin and family construction pursued through reproductive technology, understanding how it is that clinical interventions may in turn reflect new possibilities for being human into the legal order. Rather than allowing the spectre of technology to divide the *natural* from *artificial*, this approach focuses on the *bodies at work* both inside and outside the clinic, seeking a richer ontology of the networks of meaning being produced. In challenging the naturalized bedrock of infertility, it is hoped that a more queerly relational understanding of the kinships being forged through, by and with AHR will emerge.

⁵⁸⁹ Donna Haraway quoted in an interview with Kunzru, Hari. “You Are Cyborg.” *Wired* 5.02, February 1997. <http://www.wired.com/wired/archive/5.02/ffharaway_pr.html>.

⁵⁹⁰ *Ibid.*

Heterosexual Gold Standard of the Clinic

As has been argued, the primary goal of fertility clinics is to replicate the mechanics of heterosexual coupling. The gold standard thus becomes the re-creation of a ‘normal healthy fertility,’ maintaining the correlation between biological and social parenting for the benefit of heterosexual clients. The clinic’s labour revolves around the centrality of two-parent genetic kinship, as part of a larger cultural incapacity to privilege other structures of family not based on biological alignment.⁵⁹¹ As has been seen, the trauma of the clinical encounter is produced by the body’s deviance from expected ‘natural’ forms of reproduction, as idealized through the private embrace of heterosexual intercourse. The work of the clinic, then, is to ameliorate this trauma and reproduce what would have occurred ‘naturally’ – in Sarah Franklin’s terms by “giving Nature a helping hand.”⁵⁹²

As discussed in Chapter Seven, the fertility industry thus enacts a tidy double move: on one hand reinscribing the normative diagnostic bounds of infertility and the pathology it contains, and on the other, simultaneously attempting to palliate its effects. To rupture this closed

⁵⁹¹ This argument locates itself within a rich trajectory of feminist legal analysis, which has long sought to question the private family as a properly heterosexual unit. Scholars have interrogated the primacy of marriage as the organizing model of society (Cossman, Brenda; Ryder, Bruce, What is Marriage-Like Like--The Irrelevance of Conjugalinity, *Canadian Journal of Family Law*, Vol. 18, Issue 2 (2001)), taxation regimes (Boyd, Susan B and Young, Claire F.L., Feminism, Law, and Public Policy: Family Feuds and Taxing Times, *Osgoode Hall Law Journal*, Vol. 42, Issue 4 (Winter 2004), pp. 545-582; Philipps, Lisa and Young, Margot, Sex, Tax and the Charter: A Review of *Thibaudeau v. Canada*, *Review of Constitutional Studies*, Vol. 2, Issue 2 (1995), pp. 221-304), custody claims (Kim, Natasha, Much to Do about Something: Destabilizing Law's Support of Dominant Ideologies in the Context of Lesbian Mother Custody Claims in Canada, *Dalhousie Journal of Legal Studies*, Vol. 9, pp. 73-119, 9 *Dalhousie J. Legal Stud.* 73 (2000)) and welfare law (Gavigan, Shelley A. M and Chunn, Dorothy E., From Mothers' Allowance to Mothers Need Not Apply: Canadian Welfare Law as Liberal and Neo-Liberal Reforms, *Osgoode Hall Law Journal*, Vol. 45, Issue 4 (2007), pp. 733-772; Wiegers, Wanda A., National Child Benefit: Social Inequality under the New Social Union, The, *Ottawa Law Review*, Vol. 33, Issue 1 (2001-2002), pp. 25-94). This work continues to be vitally important in rethinking the bounds of family law, even as much of the legal landscape has shifted in the past twenty years. See for example: Gavigan, Shelley A. M., Something Old, Something New - Re-Theorizing Patriarchal Relations and Privatization from the Outskirts of Family Law, *Theoretical Inquiries in Law*, Vol. 13, Issue 1 (January 2012), pp. 271-302.

⁵⁹² Sarah Franklin, *Embodied Progress: A Cultural Account of Assisted Conception* (London: Routledge, 1997) at 103.

circuit, I will begin by clarifying the terms for these two affectively weighted categories – people who require assisted reproduction (*poor sods*) and people who (*blessedly*) do not.

Distinguishing Between Two Categories of Parents

I believe these categories mask substantial internal divergence. In the chart below, the white column indicates those couples who conceive through heterosexual intercourse, while the shaded columns describe a variety of assisted reproduction projects. The key distinction I wish to make is not between the experience of natural or artificial reproduction, as with the fertility/infertility dichotomy and its focus on technological intervention. Instead I wish to look at the *kinships produced* through such engagements. This conceptual distinction will lead to what I think are rather helpful consequences beyond the infertility trap. To begin, I think it useful to make a central distinction between two categories of parents: *intra-reproductive* and *extra-reproductive*.

Normal Healthy Fertility <i>*Natural*</i> INTRA-REPRODUCTIVE	Pathology of Infertility <i>*Artificial*</i> INTRA-REPRODUCTIVE	Pathology of Infertility <i>*Artificial*</i> EXTRA-REPRODUCTIVE	Pathology of Infertility <i>*Artificial*</i> EXTRA-REPRODUCTIVE
Two adults with reproductive alignment combine gametes through sexual intercourse to produce offspring.	Two adults with reproductive alignment combine gametes through assisted reproduction to produce offspring.	Two adults with reproductive alignment are unable to combine gametes by sexual intercourse <i>or</i> assisted reproduction to produce offspring. Gametes required from outside parenting dyad.	Any number of adults with or without reproductive alignment do not combine gametes via sexual intercourse. Assisted reproduction elected to produce offspring. Gametes required from outside parenting dyad, monad, triad, etc.

Intra-reproductive Parents

Intra-reproductive relations are indicated in the first and second columns of the chart. I define intra-reproductive parents as two adults with a *reproductive alignment* who use their own reproductive material to create a child. The term reproductive alignment describes any scenario in which two adults produce complementary gametes which may be paired to produce offspring. This most commonly describes heterosexual couples where the male contributes sperm and the woman an ovum. The child of such a heterosexual union is genetically related to both of her parents as the product of an intra-reproductive relationship. The genders of the sexual partners are not important, although to be sure this column is heavily represented by heterosexual couples.

Heterosexuals do not hold a monopoly, however, upon paired gamete reproduction from within the adult sexual partnership; one may also find bisexual, two-spirited and trans-identified people in reproductively aligned scenarios. An example might be a gay couple in which one man is transgendered, and is impregnated following vaginal intercourse with his cisgendered male partner (this exact scenario will be discussed in Chapter Ten). Although these men may be in a same-sex partnership, they are still able to genetically reproduce from within the parenting dyad. Their child would also be genetically related to both her fathers, with whom she shares both a social and biological tie. Indeed, what all parents in column one share is the successful conception of a child through sexual intercourse.

Reference to reproductive alignment allows us to avoid the same-sex vs opposite-sex dichotomy by invoking the *relational* quality of biological reproduction. This framing is more readily able to account for mobile gender identifications, such as among two-spirited and trans-

identified people, and resists the eclipse of reproductively aligned bisexual people into a heterosexual matrix. It draws attention strictly to the reproductive character of the gametes rather than adult sexuality or gender identifications.⁵⁹³ It also functions to highlight the privileged role that is accorded to the alignment of biological *and* social kinship in creating family. Intra-reproductive parents represent an idealized mode of procreation, wherein both adult caregivers are also genetically related to the child. This is what is commonly understood to be the normal, healthy fertility of natural conception.

Parents in the second column are also intra-reproductive, although they have required some form of technological assistance to conceive. An example might be a cisgendered heterosexual couple in which the man is experiencing male-factor infertility. The couple pursues multiple rounds of IVF, their ova and sperm are blended in the laboratory of the fertility clinic, and ultimately the woman is successfully implanted with an embryo and brings a child to term. As with the couples in column one, children produced intra-reproductively will be genetically related to both parents. The only difference in column two is the need for technological intervention – the correlative outcome between social and genetic parenting will be the same. Intra-reproductive relations, assisted and otherwise, represent the idealized form of human reproduction in Western society and fall directly in line with standard kinship norms of child-making and rearing.

Extra-reproductive Parents

Columns three and four refer to the second category of relations: extra-reproductive parents. These adults cannot create a child with genetic material from within the sexual family,

⁵⁹³ While the use of a term like alignment carries with it the spectre of ‘misalignment’ and the potential of creating a normative regime of its own, the intention is not to erect new categories of sexual propriety but to demonstrate the range of actors, intentions, bodies and technologies which may align in surprising and familiar ways.

and instead will rely upon donated eggs, sperm and/or a surrogate in order to procreate. There may be one parent, two parents, or multiple parents involved in the reproductive process. If two parents, the child will not share a biological connection with both of them, and perhaps not with either. All extra-reproductive parents require assistance to conceive, although there are further distinctions to be made.

Column three encompasses parents *with* a reproductive alignment inside their sexual dyad, who find themselves unable to combine gametes to produce offspring. These couples have been unable to conceive either through intercourse *or* assisted reproduction, despite the presence of complementary gametes. This most often describes heterosexual couples in which one or both partners learn through medical diagnosis of their impaired reproductive material or facilities. These parents experienced an *unplanned* extra-reproductivity in their reliance upon outside gametes or surrogate labour to conceive. In many ways the parents of column three experience the brunt of reproductive trauma, as their expectations for the intra-reproductivity of ‘normal’ reproduction are dashed.⁵⁹⁴

Finally in column four are located any number of adults with or without reproductive alignment who do not combine their gametes via sexual intercourse. Instead, there is an *elective* use of assisted reproduction to produce offspring, and reliance upon gametes and/or reproductive labour sourced from outside the parenting dyad or monad. Here is where we will find most LGBTQ people as well as all single parents, multiple-parent arrangements and (interestingly)

⁵⁹⁴ This chapter will shortly explore the complex interaction of privilege and deprivation experienced by unplanned extra-reproductivity.

older heterosexual parents.⁵⁹⁵ This is a category of *purposive* kinship which expects to locate procreation outside the marital bed.⁵⁹⁶

This category of parent may involve only one set of donated gametes - as in the case of two bisexual women who use anonymous donor sperm to inseminate one of the partners. Their child would be genetically related to one mother, but not the other. It may also involve a wide host of actors, such as the case of a gay couple using a gestational surrogate. In this instance we would find the intended male parents as well as the surrogate and a third-party egg donor. If we imagine that each woman also has a partner of her own, this would bring the number of potentially involved parties to six adults.

I argue that these four columns mark out very different modes of reproductive access with diverging needs and outcomes. Lumping columns two through four under the broad rubric of ‘infertility’ sweeps aside their specificities while creating a traumatic rupture from the non-clinical idealized mode of reproduction in column one. Marking out these differences directs focus onto the relations of kinship as mediated by technology, rather than on technology laid bare, and begins to open the closed figuration of medical infertility.⁵⁹⁷

⁵⁹⁵ The connections that join these reproductive outsiders in purposive queer kinship will be explored shortly. As will be seen, the inclusion of older heterosexual couples within a queer matrix offers a useful platform to engage both the criticisms commonly leveraged at their reproductive projects, as well as their planned strategies (most commonly, securing an egg donor) for procreation outside the sexual union. These connections also push us closer to an argument that threads through this dissertation: that queer perspectives and analytical strategies offer a useful vantage to think through the use of reproductive technologies.

⁵⁹⁶ There is an interesting point to be made here about (i.e.) a single woman who chooses to have sex with a man in order to become pregnant. While her purposive intent may be to parent the child alone, the matrix of heterosexual presumption makes this a difficult proposition. She is collapsed back into the first column of intra-reproductive parentage and the hegemonic weight of the heterosexual legal order. It is precisely the normative weight of heterosexuality which leads many lesbian and single women who intend a parenting project without a father to choose anonymous donor sperm rather than a known donor or sexual partner, as discussed in Chapter Six.

⁵⁹⁷ It is also important to note that my focus here is explicitly on human reproductive relations. This schema does not make account for those people – straight and queer alike – who choose not to have children at all, or who instead raise plants or animals. While childless family formations as well as inter-species relations also challenge the

The disaggregation of these categories shows how the infertility discourse operates upon a foundational inability to envision more complex kinships *even before the moment of conception occurs*. This in turn prevents thinking on a host of related matters around parentage, law and the privatized social order. To explore this further, the next section will take a detailed look at the differences between intra-reproductive and extra-reproductive parenting projects.

Intra-reproductive Family Formation

As discussed, the second column introduces us to a reproductively aligned pair of adults who use their own gametes to reproduce. The majority of this column is comprised of heterosexual couples seeking fertility assistance, although trans-identified people and couples with a bisexual partner will also account for some of this population.⁵⁹⁸ A ready example might be cervical narrowing or blockage, a condition that occurs when the cervix cannot produce sufficient mucus to allow for sperm mobility. If sperm cannot pass through into the uterus after sexual intercourse, the ovum will not be fertilized. Should a heterosexual couple be experiencing cervical blockage, all that is required from the clinic is assistance to traverse the woman's mucosal barrier for insemination with her partner's washed sperm. They will be using their own reproductive material to create a child, usually through the relatively non-intrusive procedure of intra-uterine insemination (IUI). They are not challenging any issues of biological parentage, nor are they in need of any gametes from outside the adult pair-bond.

This intra-reproductive situation does not trouble any presumptions of parentage, rely upon sperm or ova donors, or require a surrogate, and effectively maintains the heterosexual

dominant mode, and surely deserve their own taxonomies, my intention for this project is more narrowly focused.

⁵⁹⁸ To my knowledge, no quantitative data has been published as to the gender identity and sexual orientation demographics of AHR users. However the Creating Our Family study made it clear that transpeople and bisexually-identified people are seeking out clinical assistance to use their own gametes and reproduce within the sexual dyad.

model for reproductive coupling. A simple medical intervention is all that is required to restore the viability of the intra-reproductive genetic material. While this procedure will probably occur in a fertility clinic, which is where the couple would likely be channeled after difficulty conceiving, it could conceivably be carried out in a doctor's office as well.

However life is not always so simple, and in some cases a more drastic intervention may be indicated. Should the man's sperm present low motility or abnormal morphology, for example, the washed sperm cannot simply be injected into the uterus. Instead, the couple may require a more specialized form of IVF like Intracytoplasmic Sperm Injection (ICSI). For this, the woman must first undergo the phases of standard IVF, involving ovarian stimulation through daily drug injection, egg retrieval via ultrasound-guided needle, fertilization of the extracted eggs, embryo transfer, and luteal phase and pregnancy test a few days after the transfer. ICSI involves an extra step in the process of fertilization, wherein the retrieved eggs are examined under a microscope and injected with a single sperm. Many clinics also offer advanced microsurgical techniques such as Assisted Hatching (AH) to increase the chance of an embryo implanting and biopsy procedures for preimplantation genetic diagnosis (PGD).⁵⁹⁹

Unfortunately, these procedures are not without risk. ICSI now accounts for approximately half of all IVF procedures performed, despite recent data which indicates that one

⁵⁹⁹ I hope to take up the bioethical problematics of procedures such as PGD in future work; for the time being it should be understood that the battery of available assisted reproductive technologies includes techniques not only to create human life, but to create a *certain type* of human life. For excellent analyses of the social construction of PGD see: Roxanne Mykitiuk and Jeff Nisker, "The Social Determinants of 'Health' of Embryos: Practices, Purposes, and Implications," in Jeff Nisker, Francoise Baylis, Isabel Karpin, Carolyn McLeod & Roxanne Mykitiuk (eds.), *The "Healthy" Embryo: Social, Biomedical, Legal and Philosophical Perspectives*, Cambridge University Press (2010); Estair Van Wagner, Roxanne Mykitiuk and Jeff Nisker, "Constructing 'Health', Defining 'Choice': Legal and Policy Perspectives on the Post-PGD Embryo in Four Jurisdictions," *Medical Law International March 2008 vol. 9 no. 1* 45-92; Sarah Franklin and Celia Roberts, *Born and Made: An Ethnography of Preimplantation Genetic Diagnosis* (Princeton, NJ: Princeton University Press, 2006).

in ten children produced through ICSI may face significant impairment.⁶⁰⁰ In most cases where ICSI is recommended, the woman will be in possession of a reproductive system in functioning order. Yet she will choose to take potentially dangerous drugs; undergo an expensive, painful egg extraction; have on average three to four rounds of embryo implantation; and risk a greater chance of conceiving multiples, who in turn will face an elevated chance of health risks. Consent to such extraordinary treatment stems from a singular, if deeply compelling reason: ICSI allows sperm of low quality or motility to replicate the blending of reproductive material that occurs through heterosexual intercourse. It creates a child or children reflecting the gamete contribution of both parents, with the purpose of emulating the idealized model of reproductive heterosexuality. So powerful is the cultural interdiction to have social and biological kinship align, that parents are willing to spend thousands of dollars on intra-reproductive procedures while accepting the possibility of health risks to both mother and child(ren).⁶⁰¹

Of course parents with intra-reproductive aspirations are not merely ‘dupes’ of the system. These are profound social institutions, with normative heterosexuality deeply rooted within the biological imperative and influencing the forms of technological development which have occurred. Indeed Sarah Franklin has argued that the introduction of IVF was in fact *directly aimed* at enabling greater conformity to traditional family values.⁶⁰² One of the ironies of the proliferation of IVF has thus been its ability, in quite a short period of time, to create a multiplicity of reproductive modes which challenge those traditional family values.

⁶⁰⁰ Michael J. Davies, Vivienne M. Moore, Kristyn J. Willson, Phillipa Van Essen, Kevin Priest, Heather Scott, Eric A. Haan, and Annabelle Chan, “Reproductive Technologies and the Risk of Birth Defects,” *N Engl J Med* 2012; 366:1803-1813

⁶⁰¹ According to the American Society of Reproductive Medicine, the average cost for a single IVF cycle is \$12,400. The average live delivery rate for IVF in 2005 was 31.6% per retrieval, meaning that a rough estimate of cycle costs alone, independent from drugs, diagnostic fees and other costs, would run at least \$37,200 (for a 94.8% chance of pregnancy). American Society of Reproductive Medicine, FAQ, <http://www.asrm.org/awards/index.aspx?id=3012>

⁶⁰² Sarah Franklin, *supra* note 112 at 174.

IVF has “undermined the very basis of normative ‘biological’ parenting by introducing a seemingly endless, and inevitably somewhat parodic, *sequelae* of quasi-, semi- or pseudo-biological forms of parenting.”⁶⁰³ And so we see, for example, reciprocal IVF being used by two lesbian parents to reflect and refract the desire for a blood connection, and as a strategy to triangulate their parentage to their daughter. As will be discussed, these ‘semi- biological’ and extra-reproductive forms of parenting are reshaping existing kinship norms through the mediation of technology designed to precisely hold such norms in place, both influenced by and in parodic response to the hegemonic authority of intra-reproductive parentage.

Intra-reproductive Families in Law

The ‘naturalness’ of the intra-reproductive family is also affirmed through its reification in law. When a child is born to an intra-reproductive partnership, the unremarkable nature of this arrangement means that no special legal considerations are required.⁶⁰⁴ The parents may simply file a statement of live birth to their provincial registry and apply for the infant’s birth certificate, social insurance number and child benefits. There is no declaration of parentage, no adoption needed, and no contracts or lawyers to manage. Be they formed through sexual intercourse or assisted reproduction, intra-reproductive families are viewed identically through the lens of parental and custodial rights. This may be understood as a privileged form of reproduction that extends from column one across to column two, enfolding both in the legally unproblematic alignment between biological and social kinship.

⁶⁰³ *Ibid.*

⁶⁰⁴ An exception would be a child born to a pregnant transman and his cisgendered male partner. While their arrangement may be strictly intra-reproductive, all statements of live birth in Canadian provinces presume that the party who gives birth will be the ‘mother’. There would of course be no mother if a child was born to two fathers, one of whom was the gestating parent. It is difficult to imagine grounds for contesting the parentage of a child born to two fathers, however, when both intended social parents are also the biological progenitors.

Scientific ideas and practices embed consequential social and political decisions, and in modern states the application of the life sciences in particular is intricately connected with the exercise of political control. Reproductive technologies lie at the heart of this fostering of populations, and the easy embrace of intra-reproductive families within the legal order is one avenue by which the Canadian state promotes a certain, naturalized vision of (heterosexual) reproductive life through technological means. This ordering of life itself represents a crucial mode of centralized, institutionalized control.

Of course it is not only intra-reproductive families which find purchase in law; a great deal of the wrangling over the 'new kinships' described in Chapter Two stems from the law's attempt to order and consolidate extra-reproductive arrangements. Yet a queer legal analysis allows us to critically examine the stakes of intra-reproductive AHR and its attachment to the privileged model of heterosexual reproduction.⁶⁰⁵ It understands the alignment of biology and sociality as reinforced by a legal culture that rewards parents for pursuing intra-reproductive arrangements, and struggles to place other forms of family into this heterosexual matrix. It also illustrates the institutional culture of fertility clinics and their central mandate as alleviators of wounded heterosexuality, despite an ever-increasing role as sites for the quasi-, semi- and pseudo-biological negotiations being carried out by queer families.

⁶⁰⁵ Importantly it is the *ideal* of heterosexual reproduction which determines the legal order, not necessarily the actual progenitor of a child. The presumption of paternity, for example, was designed not to protect the biological tie but to uphold the social structure of heterosexuality through the apparent coherence of the nuclear family. Intra-reproductive procreation in the fertility clinic affords a degree of biological certainty that, ironically, more closely approximates this heterosexual ideal than 'old-fashioned' reproduction performed through sexual coitus. (For exceptions to this coherence, see the public outcry which followed revelations that Ottawa fertility doctor Norman Barwin had accidentally swapped sperm samples in his clinic. A series of women who had been inseminated by Barwin in 2004, 2006/07 and 1985/86 discovered, following DNA testing, that the biological father of their children was not their husband.) See: Tom Blackwell, 'Worst nightmare': Respected fertility doctor impregnated three women with the wrong sperm, National Post, January 13, 2013. Accessed September 30, 2013. <<http://news.nationalpost.com/2013/01/31/respected-fertility-doctor-and-order-of-canada-member-admits-using-wrong-sperm-in-three-artificial-inseminations/>>

Extra-reproductive Family Formation

A move away from the closed circle of family genetics arrives at the parents in columns three and four. These are parents who, for a variety of reasons, are not capable of producing and gestating offspring from their own gametes. As may be recalled, this category could include reproductively aligned heterosexual and bisexual couples with non-viable gametes, as well as post-menopausal heterosexual women and their partners. It also includes lesbian couples, gay couples, bisexual people partnered in a same-sex relationship, some partnerships with a transgender or transsexual person, and single people of all ages, orientations and gender identifications. Finally it may include multiple-parent arrangements wherein three or more adults intend to play a role in the child's life. These prospective parents will all have an extra-reproductive need that compels recourse to assisted reproduction and/or surrogacy.⁶⁰⁶

As discussed, an extra-reproductive arrangement occurs when the genetic material required to create an embryo is sourced from *outside* the parenting monad, dyad, triad, etc. There will not be a strict alignment between biological affiliation and social parenting, meaning that the child may be raised by one or more parents to whom she is not biologically related. The child may also have a biological tie to someone who is not a social parent, for example an anonymous sperm donor living in another country. This category can also include reproductively aligned parents who have created an embryo but require the assistance of a surrogate for gestation: while the genetic material may be from within the parenting dyad, there exists a quasi-biological relationship of blood, nurture and physical connection between the child and surrogate. What defines an extra-reproductive family is the presence of gamete donors or surrogates outside the

⁶⁰⁶ This also includes interventions that are not carried out in a clinical setting, such as home insemination by a lesbian couple and their known donor. As mentioned, my concern is not with the degree of technological expertise, but the relational forms of kinship produced through mediations of science and sociality.

heterosexual dyad; it refers to techno-assisted kinship relations that do not match up with the normative ideal of the traditional family.

I distinguish extra-reproductive parenting through AHR from such parenting models as adoption, step-parentage or absent parentage, in which there may also be a dis-alignment between biological and social parenting. The difference is marked by AHR's complex entanglements of semi- and quasi-biological relationality, as well as the presence of purposive intent before conception occurs.⁶⁰⁷ An example of extra-reproductive family formation through purposive intent might be a gay couple seeking to have children. One or both men may contribute sperm to the parenting project, and they may also be reliant upon a gestational surrogate as well as an egg donor. In fact the presence of an egg donor is very likely, as most clinics in Canada refuse to assist in traditional surrogacy arrangements wherein the surrogate uses her own ova to inseminate.⁶⁰⁸

⁶⁰⁷ Adoption may be distinguished from AHR in a variety of grounds, as was recently reviewed in *Pratten v British Columbia (AG)*, [2012] BCJ no 2460. The case sought to draw an analogy between adopted children and children produced through anonymous sperm donation, with Pratten making arguments based on ss. 15 and 7 of the *Charter* to assert that she was discriminated against based on her status as a child of AHR. In British Columbia, adopted children can open their adoption files and have access to any genetic information held therein when they turn nineteen, whereas Pratten could not access information about her sperm donor. At the appeals court level, Frankel J. found that the analogy between adoption and AHR failed. The purpose of the law was "to remedy the disadvantages created by the state-sanctioned dissociation of adoptees from their biological parents." (at para 37) Distinguishing between children on the basis of the manner of conception was therefore valid, ameliorative in purpose and protected under s. 15(2) of the *Charter*. See also Lori Chambers and Heather Hillsburg, "Desperately Seeking Daddy: A Critique of *Pratten v. British Columbia (Attorney General)*", 28 *Canadian Journal of Law and Society* 229 2013 for an extended discussion of why this analogy fails.

⁶⁰⁸ For example, Genesis Fertility Centre in Vancouver explains:

"At Genesis, we do not perform traditional surrogacy for legal and emotional reasons. To date, the only surrogacy cases that have been challenged in court (e.g. where the surrogate is not willing to give the child to the intended parents) have been traditional surrogacy cases. For this reason we do not engage in traditional surrogacy. Protection of the intended parents, fetus/child and the surrogate is at the heart of the program." <<http://genesis-fertility.com/fertility-services/surrogacy>>

The closer a fertility project creeps to intra-reproductivity and the alignment of biology and sociality, the more valid are the legal claims to parentage. This direct line between genetics and parentage rights is what extra-reproductive family arrangements challenge in both clinical practice and law.

First, the men will need to hire independent legal counsel for both themselves and the surrogate, draw up a surrogacy agreement, and sign and notarize informed consent forms including legal contracts, affidavits and the appointment of a local guardian. Through the mediation of legal professionals this family can begin to take form, shaped by the techno-bureaucratic apparatus of the clinic. All parties will then undergo counseling, where the surrogate will be individually counseled and profiled to ensure her willing compliance and understanding of the risks involved. If she is married, the consent of her spouse may also be required.⁶⁰⁹ At the same time, an independent egg donor will be identified and her services retained.⁶¹⁰

Once the clinical procedures begin, the egg donor will most likely undergo hyper-ovarian stimulation through a course of injectable drugs.⁶¹¹ The surrogate will begin a parallel course of drugs in order to align her cycle with the egg donor. Both women will be required to take the diagnostic tests outlined in Chapter Eight although neither will have complained of issues related to poor fertility; on the contrary, they are present because of a proven fecundity!⁶¹² One or both members of the male couple will be designated as the gamete-providing parent, and as IVF or ICSI will be the preferred mode of treatment, the semen will receive the full complement of tests: a routine analysis reports the number of sperm, the motility and volume, as well as an

⁶⁰⁹ This depends on the individual clinic, and not all make their procedures of consent a public matter.

⁶¹⁰ For more on gamete donors and the AHRA see Chapters Five and Six. For more on the market in human eggs in Canada, see: Motluk A. (2010) 'The human egg trade. How Canada's fertility laws are failing donors, doctors, and parents.' *The Walrus* April: 30-37.

⁶¹¹ It is also possible that the couple will secure frozen eggs which can be thawed for fertilization and implantation. This will depend on access, availability, cost and their inclination for a specific type of gamete donor.

⁶¹² According to standard practice, surrogates are only selected as gestational carriers after they have given birth to at least one child. Egg donors will have undergone independent testing to ensure the viability of their ova, although it appears that the most important factor in successful egg donation may be age. See for example: Patrizio P, Silber SJ, Ord T, Mareello E, Balmaceda JP, Asch RH. "Variables that influence the selection of an egg donor." *Hum Reprod* 7:59-62, 1992. 180.

assessment of sperm morphology, an antisperm antibody screen, and a trial wash.⁶¹³ If everything proceeds as planned, the donor egg will be fertilized and implanted in the surrogate. Her expenses over the next nine months may be covered (to an uncertain degree) by the two men, although they are prohibited from providing payment for her services.⁶¹⁴

Legal mechanisms such as surrogate, donor and parenting contracts mark out the contours of this intentionality.⁶¹⁵ Informed consent, general consent and release documents, gamete provider ‘consent to use’ agreements, and consent to use sperm for embryo creation are required documentation on the path to conception at the clinic. This clarity of intention structures the circumstances of a child’s creation, which is enabled not through sexual intercourse but technological and bureaucratic means. Indeed, the legal affiliations developed through purposive intent are the key mechanism by which extra-reproductive families are bound together (as opposed to the genetic ties which bind intra-reproductive families).

Extra-Reproductive Families in Law

Legal parentage involves the determination of who, in law, are the parents or parent of a child. This is a different question than who may have responsibility for a child or rights in relation to that child.⁶¹⁶ A legal parent is also not necessarily coterminous with the individuals listed as a “parent” on a child’s birth certificate, although this does provide evidence (if not

⁶¹³ Fertility Ontario, Diagnostic Services. Accessed November 17, 2013. <http://www.fertilityontario.com/Diagnostic_Services.html>

⁶¹⁴ The uncertainty of section 12 of the *AHRA* and the particular impact on gay men is discussed in Attachment One.

⁶¹⁵ The validity and enforceability of such contracts varies across provincial jurisdiction. Controversy is far more likely to occur with contracts drawn up between a known sperm donor and the intended parents, as such agreements are generally unenforceable and function only as statements of intent. Surrogate reproduction with an egg donor in Ontario, as in the current example, will involve IVF and the mandatory techno-bureaucratic contracts of the fertility clinic and therefore hold more weight. Nevertheless, surrogacy contracts are likely unenforceable and are specifically not enforceable in Alberta, and under the Quebec *Civil Code*. See the following discussion on surrogacy contracts and Chapter Eleven for more detail.

⁶¹⁶ Barbara Findlay, “Baby Steps: Assisted Reproductive Technology and the B.C. Family Law Act” (Vancouver, 2013) at 6.1.5.

proof) of parentage.⁶¹⁷ Legal parentage falls within provincial jurisdiction, and there is substantial variation across Canada in terms of approaches to extra-reproductive families.⁶¹⁸

In 2001, British Columbia became the first jurisdiction in the world to permit a lesbian couple to file a joint birth registration. Following a successful human rights challenge, the province's Vital Statistics Agency was obliged to allow for the registration of same-sex parents with non-genetic ties, in this case for a child conceived via donor sperm.⁶¹⁹ The issue was shortly litigated in other provinces as well. Four years later in Alberta, the lesbian co-mother of a child conceived through anonymous sperm donation applied to have the presumption of paternity in the Alberta *Family Law Act* declared unconstitutional.⁶²⁰ The *FLA* expressly provided for extra-reproductive *heterosexual* families, presuming the male spouse of a woman to be the legal parent of a donor-conceived child if he had consented prior to conception. However the *same-sex* partner of a donor-conceived child enjoyed no such presumption.⁶²¹ The court in *Fraess* held that

⁶¹⁷ *Ibid.*

⁶¹⁸ There are presumptions of paternity in all provincial family law statutes. *Family Relations Act*, RSBC 1996, c 128, s 95; *Children's Law Reform Act*, RSO, 1990, c 12, s 8; *Child, Youth and Family Enhancement Act*, RSA, 2000, c C-12, s 1(1)(a); *Family Law Act*, SA, 2003, c F-45, s 1(f), s 8(1); *Family Maintenance Act*, CCSM, c F20, s 23; *Family Services Act*, SNB, 1980, c F2.2, s 103; *Children's Law Act*, RSNL, 1990, c C-13, ss 7 & 10; *Children's Law Act*, SNWT, 1997, c14, s 8; *Maintenance and Custody Act*, RSNS 1989, c 160, s 2(j); *Child and Family Services Act*, RSNS, 1990 c 5, s 3(1)(r)(vii); *Custody Jurisdiction and Enforcement Act*, RSPEI 1988, c C-33, s 3(1); *Child Status Act*, RSPEI 1988, c C-6, s 9(1); *Civil Code of Quebec*, SQ 1991, c 64, art 525; *Children's Law Act*, SS 2002, c C-8. 1, s 45; *Children's Act*, RSYT, 2002, c 31, s 12.

⁶¹⁹ *Gill v. Maher*, [2001] B.C.H.R.T.D. No. 34. OR *Gill & Maher, Murray & Popoff v Ministry of Health*, 2001 BCHRT 34, (sub nom *Gill v British Columbia (Ministry of Health)* (No 1)) 40 CHRR D/321. Two lesbian couples filed a human rights complaint alleging discrimination on the basis of sexual orientation. If the Vital Statistics Agency received an application to register a birth with a "female name" and a "male name," they registered the female as the mother and the male as the father. There was no question as to whether the named man was genetically related to the child. However if they received a request with two "female names" they rejected the application. In *Gill v. Maher*, the BC Human Rights Tribunal held there was no distinction between an unrelated male parent and an unrelated female parent seeking registration.

⁶²⁰ *Fraess v. HRMQ* (AB), [2005] A.J. No 1665. 2005 ABQB 889, 278 D.L.R. (4th) 187, 56 Alta L.R. (4th) 01.

⁶²¹ "Men married or partnered to women can receive parental status immediately upon the birth of the child conceived through artificial insemination provided that they consented to being a parent in advance of the conception. Women married or partnered to women cannot." *Ibid* at para 6.

the *FLA* contravened s.15 of the *Charter* and directed language to be read in that would extend a presumption of parentage to the same-sex spouse of a biological mother.⁶²²

Extra-reproductive heterosexual families using donor sperm have enjoyed the presumption of paternity long afforded to the traditional marital family, while same-sex couples have been obliged to file human rights and *Charter* litigation to claim the same parental rights.⁶²³ The issue here is not the ‘strange new world’ of reproductive technology, but the centrality of the heterosexual order and its long-standing ability to normalize the social parenting of intended fathers. The analogy in *Fraess* was therefore a simple move for the court, extending the uncontested status of second parent to a lesbian co-mother due to the women’s use of anonymous donor sperm.⁶²⁴ When the genetic father is a *known* donor, however, different provisions may apply.⁶²⁵

⁶²² *Ibid.*

⁶²³ For successful *Charter* litigation on the same issue from Ontario, see *M.D.R. v Ontario (Deputy Registrar General) (Rutherford)* (2006) 81 OR (3d) 81, 270 DLR (4th) 90, 141 CRR (2d) 292, 30 RFL (6th) 25. While Ontario allowed same-sex social parents the option of applying for a declaration of legal parentage under Ontario legislation, the applicants sought “access to the benefit of being able to register both intended parents as of *right*, with the resulting presumption of parentage, or access to the social and symbolic institution of having their names on the birth record at first instance.” At para 150.

⁶²⁴ When the role of second parent *is* contested, due to a potentially competing claim by a parent with a genetic link to the child, the determination of the court is not as fluid. This then becomes a matter not of discrimination against protected *Charter* groups but of the best interests of the child. For example in *C(MA) v K(M)*, 2009 ONCJ 18, a lesbian couple was unsuccessful in limiting the access of the sperm donor father and then unsuccessful in dispensing with his consent to an adoption by the co-mother. The court held that the mothers had failed to show the value of an order dispensing with the donor's consent, ultimately determining it was “in the child's best interests to include preserving her connection with [the] father.” (at para 74).

While argued on different grounds, a controversial decision by the Supreme Court in 2003 held that the biological father of a child may be registered as a parent over the objection of the child’s mother. This case involved a single heterosexual mother who had conceived through sexual intercourse, but its reification of the heterosexual genetic dyad created a potentially chilling precedent for lesbian and single women considering conception with a known donor. *Trociuk v. British Columbia (A.G.)*, 2003 SCC 34 (CanLII), 226 D.L.R. (4th) 1, [2003] 7 W.W.R. 391, 107 CRR (2d) 277, 36 R.F.L. (5th) 429, 14 B.C.L.R. (4th) 12. For an analysis of this case, see Lori Chambers “In the Name of the Father: Children, Naming Practices and the Law in Canada” (2010) 43 U.B.C. L. Rev 1.

⁶²⁵ A case currently pending in Ontario frames a clear conflict for parental rights between two lesbian mothers and a known donor. The outcome of *W.W. v X.X. and Y.Y.*, 2013 ONSC 879 will be the first Canadian ruling that involves a signed donor contract relinquishing rights to the child, a biological progenitor contesting that contract and petitioning to affirm his parental rights, and a lesbian couple seeking to uphold the terms of the original contract. For more on the background and import of this case, see Fiona Kelly “Equal Parents, Equal Children: Reforming Canada's Parentage Laws to Recognize the Completeness of Women-led Families” 64 U.N.B.L.J. 253 2013.

For example in Ontario, following amendments in January 2007, the *Vital Statistics Act* allows a non-biological parent to certify a birth statement for a child born through assisted human reproduction. For an “other parent” to register they must be acknowledged by the child’s mother and – importantly - the biological father *must be unknown*. Thus, two lesbian mothers may register their child's birth, but *only* if they have used an anonymous donor.⁶²⁶ With this amendment, as Joanna Radbord argues, “the government has attempted to do the minimum required, and has failed to consider the equality rights of co-mothers in crafting its remedy.”⁶²⁷ Should equivocation exist, the biological tie remains a trump over preconception intention, reflecting the “facts of life” and the legislative valorization of two-parent genetic intra-reproductive family.⁶²⁸ Nor is this trend unique to Canada; scholars from other common law jurisdictions have found similar outcomes in privileging biology over social and engaged parenting.⁶²⁹ Angela Campbell has drawn attention to the strangeness of this prioritization in the context of reproductive technologies:

In circumstances involving assisted reproduction, identifying biology as a basis for [parentage] seems perplexing, given that the point of using reproductive materials or services from third parties is to acquire parental status even where one cannot rely (or chooses not to rely) on biological/'natural' methods of procreation. Thus, locating parenthood should command more than tracing a child's genetic heritage.⁶³⁰

⁶²⁶ Joanna Radbord, “Same-sex Parents and the Law” (2013) 33 Windsor Review of Legal and Social Issues 1.

⁶²⁷ *Ibid* at 11.

⁶²⁸ Note this varies by degree across the provinces. Alberta, British Columbia, Manitoba, Prince Edward Island and Quebec have legal parentage laws that contemplate same-sex couples and assisted conception, with Quebec being the only province that explicitly addresses parentage where the sperm donor is known. Quebec also makes provision for a single woman as a child's sole legal parent. *Family Law Act*, SA 2003, c F-4.5, s 5. 1(1)(a); *Family Law Act*, SBC 2011, c 25, s 30 (B.C.'s *Family Law Act* comes into force on 18 March, 2013); *Vital Statistics Act*, CCSM c V60, s. 3(6); *Child Status Act*, RSPEI 1988, c C-6, ss. 9(5) & 9(6); *Civil Code of Quebec*, SQ 1992, c. 64, arts. 538-42

⁶²⁹ Fiona Kelly has chronicled the scholarly literature on the heterosexism of family law with examples from Australia, England and Wales. *Infra* note 625. See also: Jenni Millbank, "The Limits of Functional Family: Lesbian Mother Litigation in the Era of the Eternal Biological Family" (2008) 22 *International Journal of Law, Policy and the Family* 149. and Therese Callus, "A New Parenthood Paradigm for Twenty-First Century Family Law in England and Wales?" (2012) 32 *Legal Studies* 347.

⁶³⁰ Angela Campbell, "Conceiving Parents Through Law" (2007) 21(2) *International Journal of Law, Policy and the Family* 242 at 259.

Perhaps unsurprisingly, when the intended fathers are two gay men who have conceived with a surrogate, the balance between competing genetic and intentional parental rights grows even more complex. In the United States a highly publicized case in the 1980s brought attention to the statutory gaps around surrogacy arrangements.⁶³¹ The *Baby M* case served as a catalyst to action for many state lawmakers, although there was little consensus on what such action should look like.⁶³² At present, U.S. laws around surrogate motherhood offer a patchwork of jurisdiction with some banning surrogacy contracts, others enforcing them, and still others having no laws at all.⁶³³

Extra-Reproductive Families Outside the Heterosexual Dyad

To return to the gay male couple from the example above, after the successful conception and birth of their child by an altruistic surrogate, it will be necessary to fill out a birth certificate and file a birth registration according to the provincial *Vital Statistics Act*. As mentioned, this process varies across jurisdiction in Canada, but in all Canadian provinces - whether there are specific laws around surrogacy or not - the birth mother will be considered to be the presumptive legal parent of a child.⁶³⁴ No Canadian jurisdictions allow a surrogate mother to relinquish parentage before the birth of the child. Legislation in British Columbia and Alberta, as well as

⁶³¹ This matter involved a custody dispute between a traditional surrogate and the commissioning family. The case brought national attention to the complex bioethics of surrogacy when the birth mother refused to relinquish her parental rights. See: *In the Matter of Baby M.*, 537 A.2d 1227 (N.J. 1987).

⁶³² Carla Spivack notes that in the wake of *Baby M* “there was a wide spectrum of views as to what kind of regime was called for, ranging from calls to criminalize the practice to urgings to protect such arrangements.” Carla Spivack, “The Law of Surrogate Motherhood in the United States,” 58 *Am. J. Comp. L.* 97-114 (2010)

⁶³³ *Ibid.*

⁶³⁴ As a point of interest, however, the recent B.C. *Family Law Act*, which came into force in March 2013, is unique in Canada in that for cases of surrogacy the intended parents may be the legal parents from birth. This marks a departure from the presumption of the birth mother’s parentage. In such a scenario all parties must have recorded their intentions in writing before the conception, the surrogate must provide written consent to the intended parents after the birth, and the intended parents must take the child into their care. If these requirements are met the intended parents are registered on the birth certificate, and no genetic link is necessary between the intended parents and the child. Where all parties consent after the birth, the process is administrative rather than judicial; a court declaration is not required.

regulations in Nova Scotia, lay out a process by which a birth mother may relinquish legal parentage to the intended parents under a surrogacy arrangement; in other jurisdictions, courts must rely on the best interests of the child when making parentage determinations in surrogacy situations.⁶³⁵ As the men interviewed for the Creating Our Families project were from Ontario, the focus will be on that provincial system of registration.

In 2004 in Ontario, a single gay male father was unable to register the birth of his daughter by surrogate without first obtaining a court order. Following application to the Superior Court of Justice he registered the child's birth in his name alone and obtained a declaration of parentage. He then sought the reimbursement of costs to obtain the declaration, as his situation was not provided for in Ontario's birth registration system.⁶³⁶ The court in *K.G.D. v. C.A.P.* recognized the inadequacy of the system and ordered the government to pay half the costs, but did not order a comprehensive remedy or legislative action.⁶³⁷

Thus the initial presumption remains that the surrogate is the mother, although she will not be necessarily named on the registration. According to Sara R. Cohen and Sherry Eve Levitan, two family lawyers with extensive experience managing surrogate contracts in Ontario, the standard process in such a scenario is to delay the birth registration.⁶³⁸ With the help of DNA evidence and sworn affidavits from all parties, an Ontario solicitor can file a court order to

⁶³⁵ Alberta specifically provides that a surrogacy contract is unenforceable and may not be used as evidence of the surrogate mother's consent after the birth. The Québec *Civil Code* provides that a surrogacy contract is null. See: *Filiation of children born of assisted procreation* (1991) RSQ.c C-I-1, s 541.

⁶³⁶ *K.G.D. v C.A.P* [2004] O.J. No. 3508.

⁶³⁷ *Ibid.* This case followed upon the successful petition by a heterosexual couple for the registration at birth of their twins by surrogate. In *J.R. v. L.H.*, the court found a declaration of parentage to be in the best interest of the twins, declared the intentional parents to be the children's only parents, and granted an order directing the Registrar General to register a Statement of Birth consistent with that declaration. The application was by consent. *J.R. v. L.H.*, [2002] O.J. No. 3998, [2002] O.T.C. 764, 117 A.C.W.S. (3d) 276.

⁶³⁸ Ellen K. Embury, "A national review of the law of parentage declarations", Published by Canadian Fertility Consulting on, December 10, 2013 . Accessed on June 14, 2014. <<http://fertilityconsultants.ca/blog/national-review-law-parentage-declarations-ellen-k-embury//>>

request that the intended parents be declared as the baby's legal parents.⁶³⁹ This avoids need for the replacement or amendment of documents and allows the registration and birth certificate to be issued in the names of the intended parents.⁶⁴⁰ The process may take in excess of six weeks, and requires independent legal counsel for the surrogates and intended parents.⁶⁴¹

Extra-reproductive projects exist within an ambiguous location in the law. The more they diverge from the two-parent heterosexual norm, the more they challenge fundamental notions of kinship and genetic belonging. In the above example of the gay parents, only one father of the child will be a biological relation. The recognition of the parental rights of a gay co-parenting couple both engages the genetic tie *and* diminishes its centrality to the formation of family. In this way assisted reproduction thus both reinstates *and* denaturalizes biological kinship, enacting a “dispersement” of kinship across the multiple agents who participate in the process of conception.⁶⁴² The non-genetic father is as nevertheless an equal actor in this extra-reproductive project, with his location as legitimate parent depending on a complex process of techno-bureaucracy, social recognition and purposive intent.

Politics of Queer Recognition

This process of recognition involves a demand for respectability and normalcy while also pressing at the bounds of acceptable kinship formation. Thus planned extra-reproductivity represents an instance of queering at the same time that it lodges a demand for normativity and inclusion within legal recognition. This queer dialectic sharpens when kinship dispersement

⁶³⁹ *Family Law Rules*, O Reg 114/99; *Child and Family Services Act*, R.S.O. 1990, CHAPTER C.11.

⁶⁴⁰ *Ibid.*

⁶⁴¹ *Ibid.*

⁶⁴² Marilyn Strathern, *Reproducing the Future: Essays on Anthropology, Kinship and the New Reproductive Technologies* (New York: Routledge, 1992); Marilyn, *supra* note 133; Strathern, "Displacing Knowledge: Technology and the Consequences for Kinship," in *Conceiving the New World Order* (Faye Ginsburg & Rayna Rapp eds., 1995).”, *supra* note 131.

involves a wide host of actors, such as with the gay couple and their gestational surrogate. When multiple adults may hold claim to a child the demand for normativity, for a politics of respectability, weighs heavily.

Laura Mamo has written about this process in reference to women in same-sex relationships:

Seeking recognition [as a lesbian mother] includes the intersubjective process of recognizing oneself as a parent, but it also includes being recognized by self and others as belonging to or connected with a child; as part of a family; as legible (and thereby legitimate) mothers, parents, and families in social interactions; as full citizens, via state benefits and entitlement; and as full participants in the polity or sociality.⁶⁴³

Perhaps as a result, those who pursue queerly reproductive projects at the edges of legible kinship very often enact a particularly conservative politics. The interviews I conducted with some gay male parents confirms the intensity of this demand for normalcy, for being “just like” any other family wishing to have a child. The petition for the approving gaze of the state accompanies a necessary subjectification of oneself as a “good parent” deserving of such approval, a strategy of normalization that underscores the call for inclusion. The rhetorics of ‘choice’ and ‘autonomy’ are key aspects of this strategy, as liberal subjects exercise their individual rights to (in the case of surrogacy) create a family which involves some element of a genetic tie. The transformation of gay male subjecthood into fatherhood through surrogacy requires, as Nikolas Rose and Paul Rabinow have discussed in the context of infertility, “the re-imagining of human capacities as open to re-engineering and enhancement by medicine.”⁶⁴⁴ Former pathways to fatherhood which may have been located through adoption or through heterosexual intercourse, in the context of reproductive technology and modern sexual

⁶⁴³ Laura Mamo, *supra* note 76 at 88.

⁶⁴⁴ Paul Rabinow and Nikolas Rose, “Biopower Today” (2006) *Biosciences* 1(2):195-217 at 208.

citizenship, may now be imagined through the privatized economies of surrogacy, hypermedicalization and techno-bureaucracy.

For example, in this passage, a gay couple from the study is discussing their decision to hire a surrogate rather than adopting.

Chad: Well, I guess the reason we went with assisted reproduction is because we originally looked at adoption and we talked to a counselor to have a Homestudy done, and she said that she would be happy to do a Homestudy, but she thought that we would be wasting our money because we didn't have a chance in hell in getting a child.

Rick: ...She just said you could go with the other type of [special needs] adoption and you're not going to be guaranteed a young child, you're not going to be guaranteed a healthy child. But you'll probably be successful in getting a child...which is what we sort of thought.

Chad: Well, if you get a...if you get a...if you get a uh...a child with a disability from natural causes at the hands of God then that's fine, but we didn't necessarily want to voluntarily sign up for that, it's a huge, huge cost commitment. And we didn't want to ride on the back of the bus just because we're gay.

Rick and Chad were both wealthy, white professionals in their 40s, and to some degree the conservative views espoused throughout this interview reflect their race and class privilege. Their ability to locate a willing surrogate, provide her with substantial reimbursement and fund multiple rounds of insemination was effectuated through a great deal of private capital. However they also faced substantial legal precarity through this process – a position of which they were very much aware. This was enhanced by their decision to arrange a traditional surrogacy arrangement, in which the surrogate's own eggs were fertilized.

Chad's speech betrays this pressure of claiming a normative right from the margins of acceptable kinship. Chad's refusal to "ride at the back of the bus" because of his sexuality draws intentionally from U.S. civil rights imagery, framing a demand for the achievement of his family aspirations in the language of social equality. This phrasing uses past struggles for race and

economic justice as a tool to lever his own privilege into being – a not uncommon strategy by mainstream LGBT activists seeking the normative recognitions of same-sex marriage.⁶⁴⁵ The claim to full citizenship, to a liberal equality to the same benefits and entitlements as all members of society, exerts a powerful drive on queer kinship projects pursued through AHR. That the state’s extension of equality might result in the intensification of normalization has not commonly been seen as a problem by the mainstream gay and lesbian movement. As Judith Butler explains, in respect to the gay marriage debates:

To be legitimated by the state is to enter into the terms of legitimation offered there and to find that one’s public and recognizable sense of personhood is fundamentally dependent on the lexicon of that legitimation. And it follows that the delimitation of legitimation will take place only through an exclusion of a certain sort, though not a patently dialectical one. The sphere of legitimate intimate alliance is established through producing and intensifying regions of illegitimacy.⁶⁴⁶

Butler is speaking in reference to the symbolic recognition of same-sex relations in the frame of legal marriage, and the potential for the further marginalization of illiberal queer subjects (i.e. polyamorists, those who practice BDSM, undisciplined sexual subjects). However the change to family law that gay male surrogacy implies, similarly involves a fundamental shift in the fabric of heterosexual kinship construction. While the potential naturally exists for the legitimation of certain queer family arrangements to exclude and minimize other forms, I believe the destabilization of the heterosexual family wrought by AHR offers an expanded field of family relations in which multiple kinships may take hold. However this process is necessarily

⁶⁴⁵ For a critique of this approach, see: Novkov, J. (2008), “The Miscegenation/Same-Sex Marriage Analogy: What Can We Learn from Legal History?” *Law & Social Inquiry*, 33: 345–386. For a meta-analysis of how arguments about same-sex marriage privilege some relationships while stigmatizing others and may justify discriminatory policies toward sexual minorities, including the use of race as a discursive tool, see: Cole, E. R., Avery, L. R., Dodson, C. and Goodman, K. D. (2012), “Against Nature: How Arguments about the Naturalness of Marriage Privilege Heterosexuality.” *Journal of Social Issues*, 68: 46–62.

⁶⁴⁶ Butler, Kinship, *supra* note 46 at 16.

contested, and existing in tension with the regions of illegitimacy against which such kinships are defined.

These are complex processes. Even in regard to the symbolic value of same-sex marriage, Butler acknowledges that one's political stance on the issue may be far from clear. For Butler, neither a permanent exclusion from the state nor a critical rejection of that state are viable options. Instead, she suggests that "it becomes increasingly important to keep the tension alive between maintaining a critical perspective and making a politically legible claim."⁶⁴⁷ In the context of AHR, then, it may be useful to keep a tension alive between the critique of reproductive normativity (and the incitement to 'good' sexual citizenship it entails) and the process of normalization under which queer families are subjectivated. This binary does not exhaust the possibilities, however; there are multiple spaces for non-normative and reproductive kinship which may refigure and complicate the dyadic two-parent family.

Even Chad and Rick discussed their complicated and ongoing relationship to their surrogate, who bore two children for the men over the course of three years. The continued role the surrogate played in their lives, as the genetic mother of two children with no legal mother, speaks to this tension between normativity and the potential to refigure dominant notions of kinship. These queer modes of family are also seen in the openness of lateral kinship forms, such as with Paula and Nicole and the dozens of donor sibs of their daughter discussed in Attachment Two.

Whether recognized, sidelined, ignored or abjected by law, a variety of novel family forms are being created through extra-reproductive arrangements in the clinic. Yet at present,

⁶⁴⁷ *Ibid* at 17.

heterosexual couples who are utilizing intra-reproductive material are somehow understood to co-exist in the same infertility space as the extra-reproductive gay couple and their entourage of reproductive labour. Both groups would walk into a fertility clinic, meet with the same counsellor, sign the same consent and release forms, and undergo a strict range of mandatory testing. As has been explored by this section, my two-pronged contention is that a) the needs of such groups are patently different, and b) the guiding discourse of 'infertility' is not a helpful descriptor for what either group is actually facing. To proceed with the misnomer of infertility only serves to shore up the naturalness of 'fertility' and reproduce the 'natural facts' of conception as an unmarked normative category.

By unpacking the columns of the clinical experience, this chapter has begun to open the closed figuration offered by medical infertility. This has clarified the role that idealized genetic kinship plays in structuring family outcomes and reproductive choices, despite the presence of reproductive technology which questions the centrality of such biological ties. Such a critique also sheds light on the normative pressures that structure extra-reproductive queer kinship, and sketches the role of law in approving certain models of parentage to the exclusion of others. The next chapter will continue the disaggregation of infertility by offering new conceptual categories to describe the clinical experience of AHR.

Chapter Ten: Creating New Conceptual Categories

Introduction

While the separation of intra- and extra-reproductive family projects helps to clarify many of the social and legal issues at play, it does not create any new models. In this chapter, therefore, I would like to propose new ways of thinking about ‘infertility’ that offers fresh vocabularies and conceptual horizons. The chart below revisits the framework developed in Chapter 9 and begins to open up some of these foundational categories.

Orthofertility: Interrogating Reproductive Supremacy

Once again we will start with the white column on the far left.⁶⁴⁸ Here we find heterosexual couples, as well as bisexuals and transpeople who are coupled with a reproductively aligned partner, all of whom are able to create children without reproductive assistance.

<i>*Natural/Non-Clinical*</i> INTRA-REPRODUCTIVE <u>ORTHOFERTILITY</u>	<i>*Artificial/Clinical*</i> INTRA-REPRODUCTIVE <u>PARAFERTILITY</u>	<i>*Artificial/Clinical*</i> EXTRA-REPRODUCTIVE <u>SYNFERTILITY</u> (UNPLANNED)	<i>*Artificial/Clinical*</i> EXTRA-REPRODUCTIVE <u>SYNFERTILITY</u> (PLANNED)
Heterosexual couples. Bisexuals and transpeople coupled with reproductively aligned partner.	Heterosexual couples. Bisexuals and transpeople coupled with reproductively aligned partner.	Heterosexual couples. Bisexuals and transpeople coupled with reproductively aligned partner.	Gay and lesbian couples. Single people. Bisexuals and transpeople coupled with a reproductively non-aligned partner. Older heterosexual couples. Multiple-parent families.

⁶⁴⁸ Note the identical sexual demographics in columns one, two and three. All consist of heterosexuals as well as bisexuals and transpeople with a reproductively aligned partner. It is only the final column that offers an exception to the reproductive alignment – I will return to this issue in more detail below.

This column tends to exist as an unremarkable category; the standard baseline for how children have been conceived since “time immemorial”.⁶⁴⁹ Yet in order to ‘make strange’ this most normative of reproductive categories, I would like to resist allowing it to reign as the champion of an unmarked fertility. This project finds inspiration with recent outsider scholarship that has sought to unmask the social construction of the norm.

Authors in whiteness studies, for example, have worked to locate the privileges that cohere to unmarked racial identifications. Whiteness studies has recognized the need to identify ‘white’ as a racialized category and challenged whiteness as a powerful symbol of privilege.⁶⁵⁰

In her seminal 1989 piece on whiteness, Peggy McIntosh writes how:

I have come to see white privilege as an invisible package of unearned assets that I can count on cashing in each day, but about which I was “meant” to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear, and blank checks.⁶⁵¹

That same privilege exists within the binary of ‘man’ and ‘woman,’ wherein one’s assigned gender at birth is expected to match up with one’s adult gender identification. Transgender activists and scholars have argued that this unproblematic vision is actually an idealized construct that depends on a static notion of sex and gender. They have drawn attention to the constructed nature of cisgendered bodies, and resisted the site of transgenderism as the proper location for gender pathology.⁶⁵² Without this critical analysis, the category of “transgender increasingly functions as the site in which to contain all gender trouble, thereby

⁶⁴⁹ As discussed above, this is the language used by McLachlin CJ in the *AHRA* reference case decision. *Supra* note 450.

⁶⁵⁰ See for example: Dyer, Richard: *White* (London & N.Y., Routledge, 1997); Delgado, Richard and Stefancic, Jean (eds.): *Critical White Studies* (Philadelphia, Temple University Press, 1997).

⁶⁵¹ McIntosh, Peggy, “White privilege and male privilege: A personal account of coming to see correspondence through work in women’s studies.” Working paper #189. (Wellesley, MA: Wellesley College Center for Research on Women., 1988).

⁶⁵² See for example: *The Transgender Studies Reader*, edited by S. Stryker and S. Whittle, eds. (New York: Routledge: 2006); Dean Spade, 2010. “Be Professional!” *Harvard Journal of Law and Gender*, 33:71-84.

helping secure both homosexuality and heterosexuality as stable and normative categories of personhood”.⁶⁵³

By noting the many privileges enjoyed by the unmarked fertility of heterosexual reproduction, I aim to join these scholars in attempting to make strange the privileges of the normal. As such, I have designated this intra-reproductive category as *orthofertility*, from the Greek prefix for ‘straight’. This identifies the orthodox modality of kinship construction in society and law, wherein the social parents and biological parents are naturally presumed to correlate. When orthofertility is recognized as one of merely a range of options, one may more readily track its normative power and the ways in which heterosexual coupling has assumed reproductive supremacy. Yet orthofertility is not the same as heterosexuality. They are often conflated, but in drawing attention to the constructed nature of dyadic genetic kinship it is important to remember that sexuality and sexual reproduction need not be in parallel.

First, as has been seen, the orthofertile also may include bisexuals and transpeople with a reproductively aligned partner. In fact, identical sexual demographics exist in columns one, two and three, with only column four offering an exception to this reproductive alignment. It is clearly not a question of *heterosexuality alone* that affords normative weight to orthofertility, but the manner in which sexual reproduction has historically been matched with heterosexual expectations for child-bearing and rearing. A bisexual woman and her male partner may not view themselves as properly heterosexual, but when they conceive through sexual intercourse it is under the rubric and privileges of orthofertility. The situation is more complicated for a transman and his gay male partner, for whom social approbation may weigh more strongly, but the intra-

⁶⁵³ Stryker, Susan. 2004. “Transgender Studies: Queer Theory’s Evil Twin.” *GLQ: A Journal of Lesbian and Gay Studies* 10(2):212-215 at 214.

reproductive privilege of their coupling will ensure that no other party may supplant either man's parentage claim without consent.⁶⁵⁴

Despite the configurations of bodies and sexual identities which may pursue orthofertile reproduction, its conflation with heterosexuality remains profound. For example in 2011 a transman named Paul, widely touted as "Britain's first male mother," was impregnated through sexual intercourse with his male lover Jason.⁶⁵⁵ Paul had neglected to take his hormone injections while on holiday, and after a difficult pregnancy in which both men struggled to come to terms with their impending fatherhood, the couple separated. The story garnered much attention in the press, with the vast majority of commentators attempting to reinstate Paul as a woman to restore the bounds of orthofertility as a properly heterosexual practice. Multiple media outlets ran an article on the pregnancy; the following is a small sample from the flood of (international) comments the story garnered on the *Daily Mail* website:⁶⁵⁶

So, if "Paul" really wants to be a man, why wasn't "he" having sex with women? And, if Jason is really a gay man, then why did he enjoy sex with "Paul"? They sound like a really confused heterosexual couple...

- Mimi, Syracuse, NY

So, a man and a woman were having sex in the way most men and women do, and the woman fell pregnant - what a surprise!

- MJ, Lisbon, Portugal

⁶⁵⁴ While a transgender man who gave birth to a child would be listed simply as a "parent" on the birth certificate, he will be listed as the child's "birth mother" on the birth registration because of the way the *Vital Statistics Act* is written. This is the case for all Canadian provinces including British Columbia and their recent comprehensive reform of family law. In their discussion of the new legal regime in British Columbia, Barbara Findlay and Z strongly recommend that, given the current language of the registration form, a transgender birth father seek a declaration of parentage or a stepparent adoption in anticipation of difficulty should the family plan to travel. This does not represent a challenge to the birth father's underlying parental rights, but is a pragmatic suggestion for clarity given the likelihood of the family encountering homophobic and transphobic jurisdictions. Findlay, *supra* note 616 at 6.1.24.

⁶⁵⁵ David Lowe, "Partner On UK's First Ever Male Mum, ", *The Sun*, March 11, 2012.

<<http://www.thesun.co.uk/sol/homepage/news/4186028/Partner-on-UKs-first-ever-male-mum.html>>

⁶⁵⁶ *Ibid.*

I have no issue with one sex changing to another sex if that's what they truly want, but until a woman changes FULLY completes their transformation to a man, they should not be classed as so. None of this half-hearted rubbish, if you want to have naturally conceived children, do it as a woman and then do your changes. The same stance goes for a man changing to a woman.

- mysslo, London, UK

There's nothing unnatural about a woman giving birth vaginally, completely natural, been doing it for centuries. In the human race only the female can give birth due to the reproductive organs she has, so this is [a man and a] woman that I hope are in love and will go out of their way to protect the children.

- Jo, Ware, Hertfordshire

If they're a gay couple, how come they had heterosexual sex for them to conceive?

- Ian Bygum, Up North, In't Yorkshire

Call me old fashioned, but Jason and Paul are a man and a woman who fell in love and had a baby. Shame no-one thought to tell them.

- cha cha, the town that time remembered

Here, the imagery of “naturally conceived” children is invoked alongside the location of Paul and Jason as a heterosexual couple, a “man and a woman who fell in love and had a baby.” The dictates of orthofertility, and the reproductive supremacy it commands, apply a powerful logic to Paul’s body, transforming him into a cisgender woman – and a confused one at that. The reproductive alignment between Paul and Jason is shunted back into a familiar heterosexual frame, and into the way the human race has “been doing it for centuries.” This rhetorical strategy is buttressed by naturalistic language and a common-sense attitude – an ‘old fashioned’ folksy wisdom that was rarely refuted within hundreds of comments on the titillating details of this case.

Interestingly, however, this strategy also places a normative demand upon heterosexual reproduction. For even as it polices the boundaries of orthofertility, demanding that all ‘naturally’ procreative sexuality be heterosexual, it also has the effect of containing the

heterosexual within the boundaries of orthofertility: As all intra-reproductive couples are properly heterosexual, so all heterosexual couples should be properly intra-reproductive. Thus it becomes difficult to imagine a heterosexual couple *who might not wish* to be orthofertile despite their desire for children; who might intentionally decide *not* to procreate through sex, even though they are able. This includes the reproductive imperative experienced by intentionally childless couples, as well as the presumption that children should be produced within the reproductive dyad. Why does the ideal mode of procreation involve the conception of a child through sexual intercourse? Why cannot a fertile body who wishes to parent seek out reproductive labour, or donor gametes, if the intention exists? The question is so contrary to orthofertile logic that it may seem odd to pose.⁶⁵⁷ Heterosexuality and orthofertility are resolutely fixed, making it awkward to think of them as decoupled.⁶⁵⁸

Response to what has been termed ‘social surrogacy’ is partly indicative of this dissonance.⁶⁵⁹ Citing career pressure, the pain of childbirth and the prospect of stretch marks,

⁶⁵⁷ After a surrogate gave birth to her twin daughters, U.S. celebrity Sarah Jessica Parker was accused in popular media of being ‘too posh’ to try to have a child ‘naturally’. She soon came out to defend herself, explaining that her and husband Matthew Broderick had “been trying to expand our family for a number of years and we actually have explored a variety of ways of doing so.” When pressed as to whether the couple had eventually been unable to reproduce through IVF, she replied: “Yeah, I mean, I couldn’t pretend otherwise.” As she went on to clarify, “It would be a complicated...It would be odd to have made this choice if I was able to, you know, have successful pregnancies.” <http://www.today.com/id/30832692/ns/today-today_entertainment/t/sarah-jessica-parker-opens-about-surrogate>

⁶⁵⁸ An exception might be the exhortation for genetic superiority that was exemplified by such social experiments as the Repository for Germinal Choice – a sperm bank in California that opened in the early 1980s. The Repository aimed at providing donor sperm from men of high IQ, professional attainment and education level and even included several Nobel Prize winners. One may imagine a heterosexual couple choosing the ‘superior’ Repository sperm to create their children, electing for a genetic hierarchy in which the social father was understood to have an inferior contribution to make. For more on this sperm bank in particular see David Plotz, *The Genius Factory: The Curious History of the Nobel Prize Sperm Bank* (New York: Random House, 2005).

⁶⁵⁹ I would locate the primary issue with ‘social surrogacy’ in a feminist concern with the exploitation of poor women’s bodies. In the past decade there has developed an important transnational critique of stratified reproduction and the role played by the reproductive systems of poor women in (perhaps most troublingly but not limited to) countries in the Global South. This analysis has drawn attention to international systems of capital, mobility, regulation, access and the commodification of female bodies. While not minimizing the critique of these reproductive economies, I would also suggest that amplified horror at the *elective* decision to hire a surrogate, rather than a decision out of reproductive *necessity* as with a heterosexual couple who cannot conceive, is rooted in the conceptual coupling of heterosexual coupling and orthofertility.

some women have chosen to avoid pregnancy and hire a surrogate not due to reproductive incapacity, but as an elective decision.⁶⁶⁰ In fact this may be growing more common, especially in locales where surrogate labour is relatively cheap and/or unregulated. A 2012 news article in *The Telegraph* of Calcutta, India, discussed the blossoming of local surrogacy markets and cited drought conditions in a nearby region as driving more women into surrogate labour.⁶⁶¹ While much Western scholarship on Indian surrogacy has focused on the transnational aspect of surrogacy markets and concerns over exploitation by wealthy tourists, reporter G.S. Radhakrishna quoted the State Health Secretary as saying that, out of the 50-100 infants delivered each month to surrogates, only about *five percent of births* are commissioned by foreigners.⁶⁶² The piece then quoted a fertility expert who discussed the phenomenon of social surrogacy by Indian women as a relatively commonplace practice:

“Most of the clients are women from well-to-do Indian families who want to avoid childbirth so that their lifestyle, or body shape, is not affected,” said Srinivas Prasad, a doctor at one of the city's top 15 fertility centres.⁶⁶³

While reproductive incapacity is generally viewed sympathetically, at least in Canada, the intentional choice to avoid pregnancy is viewed with suspicion at best. Even within the fertility industry, social surrogacy is often held at arm's length. Many fertility clinic websites are circumspect about appropriate reasons for considering surrogacy; some clearly state that they will not accept clients who are themselves able to carry a pregnancy.⁶⁶⁴ This rejection maintains

⁶⁶⁰ Tessa Mayes, “Career Women Rent Wombs To Beat Hassles Of Pregnancy” *The Sunday Times*, London, July 8, 2001. <<http://www.sunday-times.co.uk> 7-8-1>

⁶⁶¹ G.S. Radhakrishna, “Mom dumps surrogate baby, gets him back,” *The Telegraph*, Calcutta, India, January 29, 2012. <http://www.telegraphindia.com/1120129/jsp/frontpage/story_15065100.jsp#.UflzMm2KK0Y>

⁶⁶² *Ibid.*

⁶⁶³ *Ibid.*

⁶⁶⁴ Marcy Darnovsky, “Too Posh for Pregnancy? Are there good reasons and bad reasons for surrogacy?” *Genetic Crossroads*, February 8, 2012. <<http://www.psychologytoday.com/blog/genetic-crossroads/201202/too-posh-pregnancy>>

intact the appropriate link between heterosexuality and orthofertility, with reproductive transgressions viewed as a repugnant form of vanity, selfishness, luxury, or worse.

Of course the costs of social surrogacy are beyond the reach of many. There are strong economic reasons for a couple to choose orthofertility as an available option. In jurisdictions which do not offer subsidized access to AHR, financial considerations will have an enormous impact on how people approach reproductive strategies. However the normative weight of orthofertility currently plays a role even where cost is not the determining factor and reproductive technology is ubiquitous.

When it is assumed that orthofertility is always the best approach, the conceptual and practical application of other forms of reproduction is delimited. This maintains the conceptual tie between heterosexuality and orthofertility, as seen by the public insistence that Paul and Jason were a cisgendered male-female couple. At the same time, heterosexual individuals and couples *not* in an orthofertile situation may experience this idealized mode as abjecting, as a form of structural exclusion. By making orthofertility merely one of a range of fertility practices, it becomes possible to challenge the reproductive supremacy of this vaunted method of procreation and open the field for the following new modalities.

Parafertility: Intra-reproductive Family

The first new mode to be explored is located in column two of the chart below. This reproductive category encompasses what I am calling *parafertility*. It describes a fertility that lies not in *opposition* to orthofertility (the sterility of *infertility*) but rather sits *in parallel* to it. The term is derived from the Greek prefix *para-* meaning “alongside of; beside; near; resembling”.

<i>*Natural/Non-Clinical*</i> INTRA-REPRODUCTIVE <u>ORTHOFERTILITY</u>	<i>*Artificial/Clinical*</i> INTRA-REPRODUCTIVE <u>PARAFERTILITY</u>	<i>*Artificial/Clinical*</i> EXTRA-REPRODUCTIVE <u>SYNFERTILITY</u> (UNPLANNED)	<i>*Artificial/Clinical*</i> EXTRA-REPRODUCTIVE <u>SYNFERTILITY</u> (PLANNED)
Heterosexual couples. Bisexuals and transpeople coupled with reproductively aligned partner.	Heterosexual couples. Bisexuals and transpeople coupled with reproductively aligned partner.	Heterosexual couples. Bisexuals and transpeople coupled with reproductively aligned partner.	Gay and lesbian couples. Single people. Bisexuals and transpeople coupled with a reproductively non-aligned partner. Older heterosexual couples. Multiple-parent families.

The last section explored non-assisted intra-reproductive coupling as the idealized form of fertility – what the Mayo Clinic describes as “normal sexual intercourse”.⁶⁶⁵ As has been discussed, an important motivator behind the normalization of orthofertility is to have biological and social kinship align, with children produced as the ‘natural’ outcome when a man has sexual intercourse with a woman. My contention is that parafertility describes a nearly identical scenario, albeit one requiring a bit of assistance. The goal of this intra-reproductive form of assisted reproduction is to approximate the ‘natural’ reproduction of orthofertility, with biological father and biological mother matching up precisely with the categories of intended parent.

The last chapter detailed the experience of an imaginary heterosexual couple in the fertility clinic, who underwent an egg extraction and ICSI procedure in order to recreate the structure of the intra-reproductive family. This may be understood as an instance of parafertility.

⁶⁶⁵ See *supra* note 490 for a discussion of the definition of infertility. This issue has been thoroughly discussed in prior chapters.

The sperm and ova of the mother and father were both sourced from inside the parenting dyad, despite the substantial hardship and cost involved. Under conventional thinking, the focus rests primarily upon the complex technological intervention carried out within the space of the clinic - the diagnosis of infertility, the medical apparatus, and the reproductive expectations that unfold. (And certainly the couple, and the woman in particular, would be acutely aware of the materiality of these interventions.)

I contend, however, that the clinical/non-clinical dichotomy is not the only, and perhaps not even the most appropriate, vantage from which to understand this process. When focus is instead brought to bear on the actors, their gametes, and the legal outcome of their parenting project, it is clear that parafertility is very much in keeping with the standard heterosexual model of parentage. This sharpens awareness of the normative standards of orthofertile reproduction, which function to structure and inform the decisions made under the banner of parafertility.

This parafertile couple and their intra-reproductive genetics are able to benefit from the same privileges of parental recognition afforded to orthofertile couples. Simply put, parafertility does not pose a challenge to the family order as currently or historically figured in Canadian law. On the contrary, it is hard to imagine a case in which the presumptions of legal parentage would be *more* certain than in a laboratory setting!⁶⁶⁶ At the conclusion of successful parafertility treatment and pregnancy, a child will be born to two parents with whom she shares a biological connection. In the absence of death or divorce she will presumably be raised by these parents,

⁶⁶⁶ See *supra* note 605 for a discussion of medical error in donor insemination and the scandal that has surrounded Ottawa fertility doctor Norman Barwin. I would argue that such mix-ups feel so shocking not only because of a faith in the performance of medical expertise, but because of a deep attachment to parafertility as an approximation of orthofertility. The expectation that biological and social kinship will be aligned means that unintentionally giving birth to a stranger's baby represents the deepest sort of error, the most painful of errant biological outcomes. Compare this affective response with the distaste expressed toward couples who pursue social surrogacy, where parafertility is *not* the intentional outcome of reproductive assistance. The idealized operations of orthofertility loom across the other categories of the chart as a powerful standard for 'proper' reproduction.

and at some point they may (or may not) discuss the medical intervention that allowed for her conception.⁶⁶⁷

Certainly the child would not have been born without this intervention, but this is no Pandora's baby,⁶⁶⁸ no terrifying journey into the embryonic stuff and matter of life itself. While the cyborg spectre of test tube children may still hold some fears of the unnatural,⁶⁶⁹ in fact these are complex interventions made *wholly in the service of the natural*. In the 1970s when IVF first came on the scene it represented a potentially dangerous alchemy; a tinkering with life that seemed to open a slippery slope into a chimerical future where human clones would march in lockstep. As Robin Marantz Henig describes it, in her book on test tube babies and the reproductive revolution, "[i]n vitro fertilization was frightening because at the time anything seemed possible, the worst outcome every bit as likely as the best."⁶⁷⁰

Yet as Henig notes, nearly four decades later, IVF is considered a relatively simple and harmless procedure, a medical procedure with the same sort of risks and benefits as any other intervention.⁶⁷¹ The parafertile couple is merely using technological enhancements to produce the same genetic outcome that would have occurred via heterosexual coupling, masking the site of technological intervention and allowing the couple to proceed with the social rewards of orthofertility. This masking is often so complete that a vibrant industry exists to help parafertile parents tell their child they were not the product of 'natural' conception.⁶⁷² Books like *Mom*,

⁶⁶⁷ Heterosexual couples who require donor gametes and/or surrogate labour to procreate would not be classified as parafertile and will be discussed in the next section. Couples who experience a successful intra-reproductive birth through AHR represent the definition of parafertile reproduction.

⁶⁶⁸ Robin Marantz Henig, *Pandora's Baby: How the First Test Tube Babies Sparked the Reproductive Revolution*. (Houghton Mifflin.: Boston, 2004).

⁶⁶⁹ Davis-Floyd, Robbie & Joseph and Dumit (Eds), *Cyborg Babies: From Techno-Sex to Techno-Tots*, (Routledge, 1998), *supra* note 112.

⁶⁷⁰ Henig, *supra* note 668 at 266.

⁶⁷¹ *Ibid* at 242.

⁶⁷² To be fair, the majority of books are aimed at families who have used donor gametes and surrogates. This is because the farther one moves from the reproductive supremacy of orthofertility, the stranger appear the family

Johnny said I grew in a test tube!?: A guide to assist parents in explaining technological conception are part of a growing library of texts aimed at helping parents and their children in navigating the break from orthofertile privilege.⁶⁷³

By pulling back from the clinical/non-clinical divide, and the sweeping diagnostic of infertility upon which it rests, it is possible to draw some long-overdue distinctions. Understanding the constitution of paraferility allows us to question the fundamental binary of ‘natural’ versus ‘artificial’ that primes the infertility trap. This is a crucial move to help reduce the stigma and shame that attends parafertile heterosexual couples, who may experience the fertility clinic as a site of failed, malfunctioning sexuality.⁶⁷⁴ Indeed there is nothing damaged or broken about paraferility, and one may readily think of this process as travelling alongside of intra-reproductive coupling performed via sexual intercourse.

Parafertile couples simply require a reproductive boost which does not trouble the prevailing social order. The needless stigma that attends these discourses has made it difficult to mobilize political action in Canada and contributed to the lack of effective regulation around reproductive technologies. For example Preston Manning, former leader of the Reform Party, was a political insider to the long journey of the *AHRA* detailed in Chapters Five and Six. At a 2011 conference on the *AHRA* Supreme Court reference case, Manning specifically located this shame – and the chariness of politicians to address such a sensitive issue - as a barrier to the effective promulgation of statutory regulations in Canada.⁶⁷⁵ I believe the formulation of

formations created through AHR. However issues of ‘test tube’ births and other IVF procedures are certainly part of this literature, as well as standard clinical counseling to support parafertile parents in talking to their children.

⁶⁷³ Barbara Ann M. Messina, *Mom, Johnny said I grew in a test tube!?: a guide to assist parents in explaining technological conception*, (Pittsburgh, PA: Dorrance Publishing Co., 2004).

⁶⁷⁴ See in particular Chapter Eight’s discussion of “Reproductive Trauma and the Infertility Trap.”

⁶⁷⁵ Preston Manning, Discussion during Roundtable, *Reference re. Assisted Human Reproduction Act* Implications of the Supreme Court’s Decision Conference, University of Toronto, November 4-5, 2011.

parafertility is a first step toward reducing this stigma: This is not a wounded model, merely a parallel reproductive form that requires medical intervention and assistance.

Framing this as parafertility not only minimizes trauma for heterosexual couples and opens discursive space for political mobilization and action, it also allows us again to account for the *relational* character of reproduction, bracketed apart from a fixation on the heterosexist categories of male and female. For just as orthofertility must be decoupled from the heterosexual, so must parafertility. As is evident in the chart, parafertility is equally inclusive of trans and bisexual people who may be paired with a reproductively aligned partner. Unfortunately at present, the clinic is aggressively blind to non-heterosexual parafertility. The operations of orthofertile power that sought to reclaim Paul and Jason as a heterosexual couple apply in equal measure to parafertile families.

A painful instance of this normative disciplining was recounted by Kristin and Isabel, who talked about their initial intake at a clinic in Toronto. As may be recalled from earlier chapters, Isabel is a lesbian-identified trans woman and Kristin is her cisgendered female partner. They had presented themselves to the clinic as a lesbian couple, and here the women recount their experience seeking assistance to inseminate Kristin with Isabel's sperm.

Isabel: Well, I mean, there were tons of factual inaccuracies in all our documentation and everything. I mean, I had a health card that lists me as female correctly and on their charts they always had me listed as male. Which was, you know, and then so we told them that that's actually not correct according to my documentation and everything. And they...instead of apologizing or trying to remedy the situation, they were defensive about how difficult it would be for them to do that....to change their records and so on. So they wrote down, basically, that Kristin was a heterosexual woman – which she's not – and that I was...uh...the father...the potential father who has, you know (*incredulous*) sperm problems or something!

Kristin: Yeah, they wanted to treat us as a straight couple with male-factor infertility.

The healthcare practitioners of the clinic are riveted upon the heterosexual presumptions of intra-reproductive procreation. When reproductive alignment is present – either orthofertile or parafertile – the compulsion to label the couple as heterosexual seems nearly irrepressible. Even when Isabel confronts the clinic staff on their transphobic mislabeling, they prove unable to apologize or amend the records. These women have come to the clinic to manage their parafertility, and despite consistent and vocal self-advocacy are unable to chip away at the cemented presumptions of heterosexuality.

This is a reproductive heterosexism actualized through the medical apparatus of the clinic, not only through the willful mis-identification of Isabel's documentation, but in the inappropriateness of medical treatment provided. The women went on to explain how the clinic encouraged them to have sexual intercourse to inseminate, even though they had clearly sought out assisted reproduction and had not presented intercourse as an option:

Kristin: They were very also interested in us making an effort to get pregnant at home..um..which wasn't anything that we expressed an interest in.

I: Meaning through...some sort of coitus?

Isabel: She wanted us to...yeah...exactly.

Kristin: She wanted us to have sex and get pregnant...which...*(incredulous noises)*

Isabel: *(laughs)* We were...yeah...like...why were we at a fertility [clinic]...you know? Clearly, that...

Kristin: But they really consistently perceived of us as having...being a straight couple with male-factor infertility who needed to make lifestyle changes...‘Cause that's how their system is set up.

The experience of Kristin and Isabel in Toronto, as well as Paul and Jason in the UK, demonstrates that it is not enough merely to break open the clinical/non-clinical dyad and account for more reproductive options. It is also critical to strip the presumptions of

heterosexuality from both orthofertility *and* para fertility. As Kristin notes, the ‘system is set up’ with a presumption of heterosexuality – at least when it comes to para fertile couples - and this flawed perception was a source of great strain to both women, in addition to the pressures they already felt to successfully conceive. Trans-sensitive training and cultural competency for clinical staff has been recommended by some LGBTQ parenting organizations, and this is a useful palliative to reduce the discomfort of trans-identified people and their partners.⁶⁷⁶ However the foundational discourses of the infertility trap must also be identified in order to recognize the operation of the natural/artificial binary and shift the dominant paradigm of orthofertile reproductive supremacy.

By detaching heterosexuality from reproductive alignment and the variable modes of intra-reproductive fertility, space is created for the recognition of queer modes of reproduction that do not involve a male-female dyad. As with any challenge to a normative order, it may give rise to new systems of meaning as well as new forms of control. However a focus on relationality rather than the fixed gender of bodies has the capacity to offer an interesting refiguration of the ‘traditional family,’ while also diminishing idealization of the ‘natural’ as non-assisted reproductive coupling. When the divergence between avenues to family formation is marked by intra- and extra-reproductive arrangements, rather than clinical and non-clinical, it may even serve to minimize the traumas of the clinic and allay wounded heterosexuality. At the very least, it holds the promise of carving out room for queer bodies such as Kristin and Isabel, Paul and Jason.

⁶⁷⁶ The most active in this regard in Toronto has been the LGBTQ Parenting Network at Sherbourne Health Center, although the 519 Community Center has also done advocacy in this area.

Thus far, the terms orthofertility and parafertility have been developed to describe the two varieties of intra-reproductive arrangements. The next section will explore extra-reproductive arrangements and the ways in which these sub-categories can be rethought.

Introducing Synfertility

To account for extra-reproductive arrangements which do not involve the two-parent contribution of gametes, one last neologism is required: *synfertility*. This term takes the prefix *syn-* from the Greek for 'with' to describe the *collective* nature of sourcing gametes and reproductive labour from outside the dyadic family unit. It describes the quantitatively unique experience of extra-reproductive procreation, wherein one or more social parents may be lacking a biological connection to the child. Synfertility is captured in the third and fourth columns of the chart.

<i>*Natural/Non-Clinical*</i> INTRA-REPRODUCTIVE <u>ORTHOFERTILITY</u>	<i>*Artificial/Clinical*</i> INTRA-REPRODUCTIVE <u>PARAFERTILITY</u>	<i>*Artificial/Clinical*</i> EXTRA-REPRODUCTIVE <u>SYNFERTILITY</u> (UNPLANNED)	<i>*Artificial/Clinical*</i> EXTRA-REPRODUCTIVE <u>SYNFERTILITY</u> (PLANNED)
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Within synfertility we then can distinguish two further refinements: those parents who walk into the clinic with a *planned* synfertile parenting project - the reproductive outsiders of the fourth column; and those who must resign themselves to synfertility after medical diagnosis

indicates the sterility of one or both partners – the overwhelmingly heterosexual couples of column three. All synfertile parents create their families with gametes from outside the parenting dyad, and may also rely upon the reproductive labour of surrogates. The ways in which they engage with the clinic and the discourses of reproductive trauma may be very different, however.

Unplanned Synfertility

As has been seen, the infertility trap produces stigma from the division it creates between normal and pathologized forms of reproduction. This dull binary renders parafertility as the gold standard of the fertility clinic, and casts synfertility as a last resort when other forms of parafertile intervention have failed. It has been discussed how this model seeks to replicate the ‘normal’ process of reproductive heterosexual intercourse, with every degree of variance a further remove from the ideal. Thus, the intensity of stigma increases as one departs from parafertility into the realms of unplanned synfertility.

Within column three, for example, one might encounter a heterosexual couple who is unable to achieve conception after multiple rounds of IVF with their own ova and sperm, and who turn in eventual defeat to gamete donors or surrogate labour.⁶⁷⁷ This unintentionally synfertile couple bears the difficult burden not only of so-called infertility, but the confusion of kinship creation beyond genetic affiliation. Of all the reproductively aligned forms of fertility, this presents the greatest challenge to social parents who had also expected to share a biological tie.

⁶⁷⁷ This describes many couples seeking reproductive assistance, but it is difficult to track the incidence as parafertility IVF is currently collapsed with synfertility IVF as a clinical practice. For example a recent case before the Ontario Human Rights Tribunal has demanded state funding for IVF procedures, but without clarity as to whether this will also involve a need for donor gametes or surrogate labour. (See *infra* note 890 for a discussion of *Ilha v. Ontario (Health and Long-Term Care)* [2010] HRTO 594.) Given that a robust and controversial egg trade has developed in Canada around the production of donor ova, and the extreme scarcity of donor sperm, there appears to be many reasons to want to conceptually separate these different forms of reproductive assistance.

One such crisis point for clients is when the possibility of having their own, shared biological child has come to an end. After years of trying, couples must decide what path, if any, to take next. In the midst of grieving the dream of a genetically shared child, couples must face one of the hardest decisions they will ever have to make.⁶⁷⁸

Synfertility gains its affective power as a “crisis point” and “one of the hardest decisions” a couple may ever face through the fixation on orthofertility as an unquestioned ideal. The cultural dominance of compulsory heterosexuality and the norms which privilege orthofertile and parafertile kinships are pervasive; they are layered deeply in the foundational discourses of law, medicine and society, and even in sites (such as the fertility clinic), where reproduction is *explicitly structured* apart from a need for sexual intercourse.

Controversial legal disputes over parental rights in the field of reproductive technology are all instances of synfertility.⁶⁷⁹ When the clear lines of genetic affiliation are ruptured, and multiple parties may hold competing claims to parentage, law has found itself splayed across intended, genetic, gestational and custodial parents without clear guidelines for determination. As Janet Dolgin has described within a U.S. context:

Now, the society and the law must determine not only who is the mother, the father, or the baby, but what is a “mother,” a “father,” or a “baby.” The simultaneous challenge to the social facts of family and to the biological facts of family precludes certainty of almost any sort...By threatening central assumptions about the biological correlates of family – assumptions that until recently were rarely examined at all – the new reproductive technologies endanger the ideological framework within which family has long been understood.⁶⁸⁰

⁶⁷⁸ Jaffe, Janet and Diamond, Martha O. , (2011). *Reproductive trauma: Psychotherapy with infertility and pregnancy loss clients.* , (pp. 135-155). Washington, DC, US: American Psychological Association, *supra* note 510 at 135.

⁶⁷⁹ The exception that comes to mind is litigation between a husband and wife over the control of frozen embryos created through their intra-reproductive gamete contributions. Although presumably, if a dispute has arisen it is because the couple no longer plans to raise the child within their two-parent household, and they are therefore no longer pursuing a parafertile alignment between biology and sociality.

⁶⁸⁰ Dolgin, *Defining the Family*, *supra* note 13 at 134

However this threat to central assumptions of law and society is *not* posed by parafertility, as has been explored. While the two have long been conflated under the rubric of ‘new reproductive technologies,’ synfertility and parafertility in fact mark out distinct ontological relations with distinct legal ramifications. By removing the clinical/non-clinical boundary marker that has framed all forms of AHR as a challenge to the ideological framework of family, attention may be sharpened on the varieties of synfertility which actually pose a novel effect.

In fact it is unsurprising that the two have remained wed – the goal of reproductive technology has long been to naturalize the technological intervention itself. Reproductive technology has multiplied the ways through which human reproduction can occur, but it has not widely challenged existing scientific paradigms that explain the ‘biological facts’ of human reproduction.⁶⁸¹ Instead it uses existing paradigms of nature, as based in the heterosexual imaginary, demonstrating their accuracy by multiplying possibilities for control over the processes of reproduction.⁶⁸² The revolutionary aspect of AHR is thereby not found in its challenge to a contemporary scientific vision; on the contrary, “it is revolutionary because it actualizes that vision through the control and manipulation of biological processes previously understood as “natural” and impervious to human manipulation.”⁶⁸³

To this point, there has been no clinical requirement to disaggregate parafertility and synfertility as conceptual and ontological categories. The goal of ‘orthofertility-plus’ has dominated the clinic, offering a hyperboost to the natural world even as it avoids challenging the underlying ‘biological facts’ of heterosexual reproduction. AHR has been aimed at multiplying

⁶⁸¹ Dolgin, *Defining the Family*, *supra* note 13 at 137.

⁶⁸² *Ibid.*

⁶⁸³ *Ibid.*

possibilities for traditional reproduction, not creating new ontological formations altogether.⁶⁸⁴ In law and society, synfertility has also operated in an odd liminal space. On one hand, the loss of the biological anchor is recognized as a complex figuration of family wherein the biological facts appear to dim in significance.⁶⁸⁵ This is the site of cultural anxieties around reproduction and fears of an emerging army of surrogate handmaids, for example. Yet at the same time, the socio-legal changes wrought by reproductive technology have occurred under the aegis of the ‘traditional family’ and have not fundamentally rewritten (yet) family law and the assumption that human reproduction is the result of natural processes.⁶⁸⁶

The ontological relationalities of synfertility are thus stubbornly interpreted through the gaze of orthofertility, as “the social contours of family have been consistently defined through reference to the biological correlates of [heterosexual] familial relationships.”⁶⁸⁷ This has begun to shift in recent years, as seen with British Columbia’s new *Family Law Act* and select legal cases that are discussed in the final chapters of this dissertation.⁶⁸⁸ The *Act* in particular provides an impressively comprehensive guide to the multiplicity of ontological relations that may be

⁶⁸⁴ This can be seen in multiple locations, including the mis-gendering of trans parents back into heterosexual roles; the clinic’s resistance toward traditional surrogates; the desire to control the disclosure of donor identities (as is occurring through private spaces such as the Donor Sibling Registry); the complex techno-bureaucracies of the clinic when managing surrogacy arrangements; and the resistance to blending the sperm of two intended parents for insemination or embryo fertilization. These techniques were all discussed by Creating Our Family participants, and are all aimed at recreating and clarifying an explicitly two-parent orthofertile form of kinship construction.

⁶⁸⁵ Dolgin discusses in depth the cases *Johnson v. Calvert* and *McDonald v. McDonald*. *Johnson* involved a heterosexual couple, both of whom provided a gamete to be joined for gestation by a surrogate. *McDonald* involved a wife who gestated a donated ovum that was fertilized by her husband’s sperm. Dolgin shows how each of the opposing parties in these cases associate their position with one of ‘tradition’ and the ‘natural truth’ of the enduring committed relationship maintained by the claimant. The invocation of a claim to the ‘traditional family’ by gestational, genetic and custodial parents alike demonstrates the remarkable flexibility of the symbols of human reproduction and the power of ‘nature’ even when harnessed by claimants from very different angles of relation. Dolgin, *Defining the Family*, *supra* note 13 at 139-156.

⁶⁸⁶ For example, British Columbia’s recently redrafted *Family Law Act.*, as discussed above by Findlay, *supra* note 616.

⁶⁸⁷ Dolgin, *supra* note 13 at 149.

⁶⁸⁸ For example the 2007 Ontario case *A.A. v B.B.*, which is discussed at length at *infra* note 735 in Chapter 12.

created through AHR.⁶⁸⁹ I would argue, however, that this detail is only possible because of the drafters' specific attention to the queer kinships of *intentional* synfertility. It is precisely by taking up a queer perspective on the complex family forms made possible through AHR that legislation may be crafted to account for families created outside the heterosexual imaginary.

Intentional Synfertility

To return to the chart, it is in the multiple, ranging kinships of column four that procreation is actively and intentionally decoupled from sexual intercourse. When the queer families of column four are foregrounded, a different vantage point is gained upon the multiplied forms of reproduction made possible by AHR. These collective engagements from outside the parenting dyad are able to open the conceptual field, and hold potential to genuinely destabilize the biological correlates of heterosexual familial relationships.

Of course at the same time that novel forms of reproduction may be potentially destabilizing, their configuration and appropriation may uncritically recuperate class and race privilege and patriarchal power. These technologies are inseparable from the cultural matrix in which they are produced, and as such their operations are negotiated and constructed to uncertain outcome. What is clear, however, is that through the operations of synfertility it has become “increasingly visible that [kinship] is nothing but a process of social, cultural and legal *construction*; a construction which obviously cannot be reasonably legitimated by recurrence to an unchallenged consensus about its "natural" foundation.”⁶⁹⁰ Thus as intentionally synfertile families push themselves into law and the public order, a flood of questions about ‘natural’ mothers, fathers, sex and kinship enter the space of the heterosexual imaginary, affecting key

⁶⁸⁹ See Findlay, *supra* note 616 and a discussion of potential family formations under the new law.

⁶⁹⁰ Lykke, *Are Cyborgs Queer?*, *supra* note 81 at 8. Emphasis in original.

determinist key notions of ‘unalterable’ links between reproductive capacities, sexual desires and subjectivity.⁶⁹¹ As Dion Farquhar makes the point:

By separating parenting into genetic, biological and social-legal aspects, ARTs change and challenge the fetishizing of blood ties, the nuclear romance of reproduction and their concomitant sexual identities. They declare the constructedness of reproduction by posing alternative ways to conceive. Rather than condemn this...as a ‘reproductive brothel’...I would like to celebrate the diversity and oddities and exclusions that such a position denies.⁶⁹²

In this spirit, then, rather than take a techno-utopic stance on AHR, I suggest that the figuration of intentional synfertility may allow for a productive space in which to think through reproductive difference and potentially destabilize heteronormativity. The disaggregation of parentage into multiple categories of attachment reveals their inherent *constructedness*, and offers alternatives for family formation that remained previously unthinkable. However these technologies are not static objects, but are shifting historic practices that interact with and shape the groups and individuals built within and through them. As such it matters what groups are using them, when and why. What kinds of diversity, oddities and exclusions are being produced? What new forms of normativity and control are being generated? To begin to answer these questions, it may be helpful to look closely at the denizens of column four and the ways in which queer parenting projects are negotiating the spaces of the clinic and courtroom.

Queer Agents of Intentional Synfertility

To a large extent, planned synfertility describes the reality of assisted reproduction for gay and lesbian couples, single people, bisexuals and transpeople coupled with a reproductively non-aligned partner as well as multiple-parent families. These are the people whom Jenni

⁶⁹¹ *Ibid.*

⁶⁹² Farquhar, *infra* note 902 at 217.

Millbank has called ‘reproductive outsiders,’⁶⁹³ families excluded by the operation of two blunt categories of fertility – a *normal* positive ability and an *abnormal* deficiency that requires help – as well as by the reproductive supremacy afforded to genetic relations. I would also extend this category to include older heterosexual couples, who approach the fertility clinic with the intention of using gamete donors or surrogate labour to procreate. Cathy Cohen has shown how heteronormative systems of oppression exclude not only lesbians from the category of acceptable ‘normal’ femininity, but also single mothers, welfare recipients, women of colour, etc.⁶⁹⁴ By the same token, the ‘normal’ reproductive family is a heterosexual couple of natural child-bearing age who may conceive through sexual intercourse. The labor of the clinic is to repair the rupture in this ‘normal’ process through the application of heightened and directed forms of parafertility and (if necessary) by ameliorating the pain of unplanned synfertility.

Post-Menopausal Women and Reproduction

Like same-sex families and single parents, however, older heterosexual couples approach the clinic with an intentional project of reproductive assistance. Women past ‘natural’ childbearing age also fall outside acceptable models of kinship, with questions of access to AHR for post-menopausal women often the focus of fiery public debates, particularly in the early 1990s as countries moved to regulate access to and funding for reproductive technologies. For example, in 1993 former French Health Minister Philippe Douste-Blazy launched an effort to ban IVF for older women in France, and lobbied for a similar ban throughout the European Union.⁶⁹⁵ As Douste-Blazy saw it, older mothers represented a critical threat to the natural reproductive order and would be unable to care for their children in later life. In a radio interview

⁶⁹³ Jenni Millbank, “Reproductive outsiders: the perils and disruptive potential of reproductive coalitions” in *Queer theory : law, culture empire*, Robert Leckey and Kim Brooks, eds. (Abingdon: Routledge, 2010).

⁶⁹⁴ Cohen at *supra* note 168.

⁶⁹⁵ Susan Phillips, “Reproductive Ethics”, CQ Researcher, 4(13), April 8, 1994 • Volume 4, Issue 13.

from that time quoted in the *Washington Post*, he exclaimed, “I think it is absolutely shocking that a child can be 18 when his mother is 80.”⁶⁹⁶

The RCNRT in Canada reached a similar conclusion, when they recommended that “women who have experienced menopause at the usual age should not be candidates to receive donated eggs.”⁶⁹⁷ France ultimately limited infertility treatment to couples of reproductive age, as did places like the United Kingdom,⁶⁹⁸ although Douste-Blazy’s larger European Union campaign was unsuccessful. In countries like Italy, for example, the absence of regulations have made it attractive to older women from neighbouring countries who have been rejected by their home clinics.⁶⁹⁹

The demonization of unnatural childbearing in older women represents not an issue of sexual object choice, as it does for same-sex couples and single people, but a *temporal* rift in the

⁶⁹⁶ Interview quoted in “France to Seek Legislation Curbing In Vitro Pregnancies,” *The Washington Post*, Jan. 4, 1994.

⁶⁹⁷ Proceed with Care, *supra* note 320 at 593. In a later published exchange, Patricia Baird defended the Commission’s position as follows:

We based our recommendation that postmenopausal women not be eligible for IVF at this time on a fundamental principle concerning the appropriate use of finite societal resources. For postmenopausal women, successful implantation is only likely if eggs taken from young women are used. Since there is [sic] a limited number of eggs available, we recommended that women in the age group when it is usual to be fertile should have priority. Until the needs of women in that age group have been met, we recommended that women past menopause should not be eligible to receive donor eggs, thus depriving premenopausal women of treatment. In: Patricia Baird, “IVF for Postmenopausal Women, Canadian Medical Association Journal, Oct 1996;, 155 (7).

In response, Jennifer Parks argued that there was no sensible reason to discriminate against older women:

I maintain that there are no good *prima facie* grounds for denying all postmenopausal women access to IVF. If IVF is to be used in an evidence-based way, then we should assess each request for reproductive assistance on its own merits. If the evidence indicates that IVF would not be effective in a particular case, the patient seeking IVF treatment could be justly denied. I do not think that Baird gives a sufficient account as to why postmenopausal women should be denied IVF treatment, since a scarcity of resources does not in itself lead to this conclusion. *Ibid*, [The author responds:]

Perhaps due to the general failure to regulate AHR in Canada, no specific regulations or age restrictions currently apply, nor are there Canadian professional guidelines that stipulate an upper limit on the age at which women may access technologies to assist reproduction. For more on the current Canadian context see: Françoise Baylis, G.K.D. Crozier, “Postmenopausal Reproduction: In Whose Interest?” *Journal of Obstetrics & Gynaecology Canada* (2009) 31(5):457-458

⁶⁹⁸ Emily Jackson, *Regulating Reproduction*, *supra* note 213 at 203.

⁶⁹⁹ *Ibid*.

acceptable timeline of reproduction. In some respects, the social approbation of post-menopausal mothers holds an even more vigorous character than for lesbian mothers (for whom the immutability of sexual identity presumably applies). In a certain tenor of public debate, these are women who have *intentionally squandered* their reproductive capacity and now seek state assistance to reproduce. Nina Lykke describes the post-menopausal woman as a “monstrous figure” when she appears in public discussions around reproductive ethics and access to AHR. The “Career Woman” is “one who out of pure selfishness puts off having a child until it is nearly too late. Obviously, she is a bad and selfish person without the right maternal instincts. To her, whose life style is probably focused on consumption, a child is just consumer goods.”⁷⁰⁰

Post-menopausal women serve as a central location for cultural anxieties around the loss of ‘nature’ and the gendered expectations for childbearing as wrapped in the notion of infertility. They represent the transgression of a temporal boundary reflected through a misogynist logic of appropriate reproductive agency. A dichotomy is thereby formed between ‘normal’ women in an age-appropriate heterosexual relationship, and ‘queer’ women who are too old, too gay, too single, too selfish or too focused on their career to reproduce ‘naturally’. And critically it is *women* who experience this temporal boundary marker as social violence - older men entering fatherhood do not encounter the same uproar over their reproductive intent.

Describing a series of older men who uncontroversially fathered children with younger women - Charlie Chaplin became a father at 73, Sen. Strom Thurmond at 74, actor Anthony Quinn at 78 - *Washington Post* health columnist Abigail Trafford blames the censure being heaped on older mothers on sexism, as enacted through “the familiar and unscientific Double

⁷⁰⁰ Lykke, *Are Cyborgs Queer?*, *supra* note 81 at 14.

Standard.”⁷⁰¹ Thus when comedian Steve Martin recently fathered a child at age 67 with a much younger woman, it was to much benevolent acclaim, with online press exclaiming “Mazel Tov!” and wishing the new parents well.⁷⁰²

Of course older fathers may not require reproductive assistance, placing their sexual behaviour outside of regulatory limits. Nevertheless a misogynist logic underscores this political stance, with female bodies held as the focus of medical intervention and the affective site of blame for deferred reproduction. In piece typical of this censoring genre, entitled ‘Why Old-Age Parenting Is A Bad Idea,’ *Globe and Mail* columnist Margaret Wenté starts off in a mock huckster address to the women of Canada: “Are you too busy to have kids? No worries. Thanks to medical technology, having children in your 40s is no big deal... You could be warming baby bottles and having hot flashes all at the same time!”⁷⁰³ She goes on to outline the supposedly amplified dangers of post-menopausal reproduction, while intimating that pregnancy in older women is likely to result in a parade of horrors, including a higher likelihood of childhood autism.

After skimming past the American Society for Reproductive Medicine’s recommendation of an outside limit of 55 years for female reproduction, Wenté wrings her hands at the negative outcomes of older women seeking to conceive, including “hundreds of thousands of useless and

⁷⁰¹ Washington Post Health, Jan. 4, 1994, p. 6. ⁷⁰¹ Abigail Trafford, quoted in Phillips, *supra* note 695.

⁷⁰² This gushing prose is typical of news coverage at the time: “At 67 years old, Steve Martin is at last starring in his own real-life version of *Parenthood!* The *New York Post*’s Page Six reports that the beloved comic actor has quietly become a father for the first time, with his wife, Anne Stringfield, welcoming a child in December.” Justin Ravitz, U.S. Magazine, Feb 13 2013, “Steve Martin, 67, Becomes First-Time Dad, Wife Anne Stringfield Has Baby <http://www.usmagazine.com/celebrity-moms/news/steve-martin-67-becomes-first-time-dad-wife-anne-stringfield-has-baby-2013132>”, U.S. Magazine, Feb 13 2013. <<http://www.usmagazine.com/celebrity-moms/news/steve-martin-67-becomes-first-time-dad-wife-anne-stringfield-has-baby-2013132>>

⁷⁰³ Margaret Wenté, “Why Old-Age Parenting is A Bad Idea”, *The Globe and Mail*, March 30, 2013. <<http://www.theglobeandmail.com/globe-debate/margaret-wente-why-old-age-parenting-is-a-bad-idea/article10527549/>>

costly medical procedures, thwarted expectations, marital stress, heartbreak *and an epidemic of children with autism, learning disorders and perhaps even schizophrenia.*⁷⁰⁴ Were one to drift away from Wente's prose at this point – a forgivable lapse – a simple, blunt impression remains: selfish career women who were “too busy” to get pregnant during their natural childbearing years are endangering a whole generation of children.

Despite scores of studies, data remains unclear on the relationship between advanced parental age and the increased risk of some psychiatric disorders.⁷⁰⁵ The most recent and comprehensive study comes from Sweden, and tracked all individuals born in that country between 1973 and 2011 (a total of 2,615,081 people), comparing the mental health outcomes of children born to fathers 20 to 24 years old with those born to fathers 45 years and older.⁷⁰⁶ The study found a strong association between a father's age at childbearing and disorders including autism, attention-deficit/hyperactivity-disorder [ADHD], bipolar disorder, schizophrenia, substance abuse problems and low educational attainment.⁷⁰⁷ The researchers indicated that, for most of these disorders, prevalence increased steadily with paternal age: When compared to a child born to a father in his early twenties, a child born to a man of 45 years or older was 3.45

⁷⁰⁴ *Ibid.*

⁷⁰⁵ A number of studies have investigated this link, and while some correlations have been found with advanced maternal age, recent literature has focused on exploring the relationship of autism spectrum disorders with *de novo* mutations in sperm. See for example: Malaspina, D. “Paternal factors and schizophrenia risk: de novo mutations and imprinting.” *Schizophr. Bull.* 27, 379–393 (2001); Augustine Kong, et al. (2012) “Rate of de novo mutations and the importance of father's age to disease risk.” *Nature* 488: 471-475; Parner ET, Baron-Cohen S, Lauritsen MB, JÃ,rgensen M, Schieve LA, Yeargin-Allsopp M, Obel C. “Parental age and autism spectrum disorders.” *Ann Epidemiol.* 2012 Mar;22(3):143-50.; Croen LA, Najjar DV, Fireman B, Grether JK. “Maternal and paternal age and risk of autism spectrum disorders.” *Arch Pediatr Adolesc Med.* 2007;161:334-340.; Reichenberg A, Gross R, Weiser M, et al. “Advancing paternal age and autism.” *Arch Gen Psychiatry.* 2006;63:1026-1032.

⁷⁰⁶ D'Onofrio BM, Rickert ME, Frans E, et al. “Paternal Age at Childbearing and Offspring Psychiatric and Academic Morbidity.” *JAMA Psychiatry.* 2014;71(4):432-438.

⁷⁰⁷ *Ibid.*

times more likely to have autism, 13 times more likely to have ADHD and 24.7 times more likely to have bipolar disorder.⁷⁰⁸

Even Wentle gets around to this father-focused vein of research eventually. After laying the blame on careerist women for most of her column, she finally notes that some data has found causal links between older fathers and “the soaring incidence of autism and other brain disorders.”⁷⁰⁹ Wentle even quotes genetic researcher Dolores Malaspina and the move away from saddling post-menopausal women with guilt for having children late in life. As Malaspina says: “People have always focused on maternal age, but now we know that paternal age matters, too...This is a true paradigm shift.” Wentle immediately sidesteps this insight to zoom back into blaming older mothers, ending the piece with a prod to her (imaginary) daughter to stop dithering around with the business of baby-making and “get on with it.”

However impressive Wentle’s misogynist tunnel vision may be, the paradigm shift to paternal age as a potential contributing factor to childhood morbidity should not simply displace blame onto older men who father children. Indeed none of these results should be interpreted as placing blame on parents, cautions epidemiologist Michael Rosanoff. As the associated director for public health research at Autism Speaks, Rosanoff explains that the increase in autism risk is relatively modest and the “vast majority of children born to older fathers will not have any of these disorders.”⁷¹⁰ Here, the politics of blame colludes with the rejection of ‘unnatural’ synfertility to demonize older mothers for post-menopausal childbearing.

⁷⁰⁸ *Ibid.*

⁷⁰⁹ Wentle, *supra* note 703.

⁷¹⁰ Autism Speaks, “Study Ties Dad’s Age to Risk of Autism, Other Mental Disorders in Kids,” February 27, 2014 <<http://www.autismspeaks.org/science/science-news/study-ties-dads-age-risk-autism-other-mental-disorders-kids>>

Susan Drummond, in an opinion piece in the *Toronto Star*, suggests that age limits to reproductive assistance for women represent an arbitrary cutoff based more on discrimination than on concern for child or maternal health.⁷¹¹ The complexity of kinship and character of the environment in which a child will be nurtured should instead be the primary concerns for a compassionate provider of reproductive health care. As she maintains, “A less discriminatory test would focus on the thoughtfulness and care of parental plans for sheltering a child within a capricious world,”⁷¹² rather than the attainment of a physical age untethered from social context, embodiment and location.

Importantly, the demonization of post-menopausal women rests uneasily with the unqualified acceptance of other ‘unnatural’ aspects of modern medicine.⁷¹³ As Emily Jackson points out, while it might be ‘unnatural’ for a woman to have a child after menopause, it may be similarly ‘unnatural’ for a young woman who has suffered from ovarian cancer to subsequently bear children, and it is probably ‘unnatural’ for her to be alive.⁷¹⁴ Jackson suggests that rather than a blanket prohibition on post-menopausal reproduction, screening for potential risk factors and performing a careful medical assessment would offer a genuinely patient-centric response.⁷¹⁵

Clinical Pressures on the Intentionally Synfertile

While agreeing with Jackson’s compassionate stance, as well as the demonization experienced by reproduction outside of appropriate temporalities, I think it is helpful to conceptualize the atemporal and asexual reproductions of column four as similar in kind. I

⁷¹¹ Susan G. Drummond, “A principled limit to assisted reproduction and parental age” *Toronto Star*, May 2013. <http://www.thestar.com/opinion/commentary/2013/05/06/a_principled_limit_to_assisted_reproduction_and_parental_age.html>

⁷¹² *Ibid.*

⁷¹³ Emily Jackson, *Regulating Reproduction*, *supra* note 213 at 203.

⁷¹⁴ *Ibid.* Scare quotes mine.

⁷¹⁵ *Ibid* at 205. As she continues: “But even if we were to accept that having elderly parents is not ideal, few parents are able to offer their children a perfect upbringing, and the disadvantages of their advanced age might be balanced by the advantages of having more stable, experienced and economically secure parents.”

understand the abjection of post-menopausal women and the ‘unnatural’ character of this reproduction as also occurring within the frame of queer kinship. It represents an intentionally synfertile variance from the ‘normal’ model of procreation, as a reproductive project being pursued beyond the bounds set by idealized orthofertility.

Planned synfertility deviates from the central assumption derived from an orthofertile model: that *the superior form of reproduction draws exclusively upon the gametes of the intended parents*. Such an assumption operates in contrast to the ‘withness’ of extra-reproductive genetics that synfertility represents.

Orthofertility also assumes that an ideal parenting project involves two people, and that reproductive labour will be provided (wherever possible) by the intended parents. These are presumptions imported from an idealized heterosexuality without analysis or review of their application to AHR. And while some parents may indeed wish to perform reproductive labour and utilize their own gametes, as with the reciprocal IVF carried out by Paula and Nicole, these scenarios should not be taken for granted. Orthofertility crafts the foundational assumptions that the reproductive outsiders of column four must encounter when they seek out AHR, yet they may be deeply inappropriate for families constructed through intentional synfertility.

The inter-racial parenting project of Carol and Maricel was discussed in Chapter Nine, in regard to their struggle with Canada’s strict sperm importation regime. Carol, who is white, was prepared to be inseminated and have a child with her own eggs, while Maricel, who is from the Philippines, was unwilling to get pregnant. They thus decided to use a sperm donor of Filipino origin in order to reflect their family composition and ensure the child would also share a racial heritage with Maricel. However when it proved difficult for them to locate Canadian-compliant

Filipino sperm, it was assumed by the clinic that the best course of action would simply be for Maricel to carry the child. The women related their conversation with a doctor at their Toronto fertility clinic:

Carol: The solution was: “Why doesn’t Maricel try and get pregnant instead?”...”And then you can use a white donor and it won’t be a problem.”

Maricel: Yeah and they just said like, “Do you want to start the testing?” But we already told her in the beginning that I don’t want to be pregnant.

Carol: Yeah. That wasn’t an option for us.

Maricel: Because we already told her that, you know, it’s not even an option that I’m getting pregnant and then she’s coming back to me and saying they want to start all the testing and stuff.

Carol: Yeah it was interesting. Just because you have the capacity to you should. Like, why wouldn’t you, why do you want to go to all this trouble...

Maricel had been consistent with the clinic regarding her position. Yet once Health Canada’s restrictive importation regime threw a hurdle in the couple’s reproductive plans, it was immediately assumed that the work of pregnancy would shift from Carol’s body to Maricel’s. Her clearly articulated lack of consent was immaterial in the face of the orthofertile reproductive imperative. The bedrock of the clinic is constructed upon an expectation that family should be created through as many intra-reproductive ties as possible, with reproductive labour provided in whatever means available by the intended parents. It thus becomes inconceivable as to why Maricel would not want to provide her egg (and uterus!) if it proved difficult for Carol to access a desirable donor.

Maricel: It made me feel...awkward because she was kind of saying, "Well you can get pregnant and then it will be easier for you guys. Then why aren't you doing it?" But I didn't want to get pregnant.

I: So did you feel like you had to give a full explanation to her?

Maricel: Yeah, yeah. But I don't usually give explanations to people in that way (*laughs nervously*). Like, I just told her, "No." But you know that feeling, like, "Why aren't you doing it? You could do it and it would be easier." So...yeah.

Carol: And that's interesting too, because that's come up [again] since we've had the baby...Cause we went through all this trouble and we ended up getting our half-Filipino child...

Maricel: And I have to explain...

Carol: Yeah.

Maricel: So many times...that I don't want to get pregnant (*laughs nervously*).

Carol: Now people are like, "Well you went through all that trouble so next time why isn't Maricel just gonna do it?" And we're kind of like, "No. Next time we'll do it the same way. Cause it's important."

While the women's doctor clearly understands the heterosexual imperative for racial alignment – families *should* look like a racial blending of both parents – it is not clear to her why Maricel's body is not available to produce this ideal phenotypical mixture. Maricel's desire for motherhood did not include the conception and gestation of her child, and she was not willing to provide reproductive labour even though it may have been facially "easier" by the logics of the clinic.

The expectation that all female bodies are reproductive bodies is a central aspect of compulsory motherhood, and has long been critiqued as a cornerstone of the manifestation and institutionalization of male dominance over women and children.⁷¹⁶ Patriarchal ideology has

⁷¹⁶ Adrienne Rich, *Of Woman Born: Motherhood As Experience and Institution*, (W. W. Norton & Company: New York, 1976). Adrienne Rich has helpfully distinguished between the "experience of motherhood" as the affective

defined motherhood as the “instinctive vocation” of women, with structural and ideological pressures applied to ensure the reproductive function of female bodies.⁷¹⁷ Motherhood thus becomes a major and constitutive social role for women, with all women “socially defined as mothers or potential mothers.”⁷¹⁸ As Martha Fineman has framed it, motherhood is “[a] colonized [concept]...an event physically practiced and experienced by women, but occupied and defined, given content and value, by the core concepts of patriarchal ideology.”⁷¹⁹

These discourses remain potent in the clinic, as a location attuned toward the reproduction of orthofertility and steeped in the heterosexual imaginary. In an empirical study of nurses working with lesbian clients in professional practice settings, Judith A. MacDonnell has described how “discourses of compulsory heterosexuality and compulsory motherhood frame the nuclear family and many nursing programs.”⁷²⁰ Lesbian motherhood, however, may offer a challenge to this patriarchal mode, as it need not involve the reproductivity of female bodies. The parenting project envisioned by Maricel did not involve her pregnancy, yet this did not lessen her desire to become a parent. Nor did Carol anticipate that her partner would be sharing reproductive duties. On the contrary, Carol staunchly defended Maricel’s position as the women contemplated having their second child, insisting that they follow the same process again, “[be]cause it’s important.” The link between patriarchy, control over women’s bodies and

relationship between a woman and her children, and “motherhood as enforced identity and as political institution.” Thus the clinical discourses may have disciplinary effects and mediate access to reproduction for queer folks, but the *experience* of parentage need not be steeped in the patriarchal norms of orthofertility.

⁷¹⁷ Dorothy Roberts, "Racism and Patriarchy in the Meaning of Motherhood" *The American University Journal of Gender, Social Policy & the Law* 1, no.1 (1992) at 10.

⁷¹⁸ *Ibid.*

⁷¹⁹ Martha A. Fineman, *Images of Mothers in Poverty Discourses*, *Duke Law Journal* 274-295 (1991) at 289-90.

⁷²⁰ Judith A. MacDonnell (2006) “Exploring matrices of mothering and feminisms: Life history methodology as a venue for understanding complexities of mothering discourses for lesbian health advocates.” *Journal of the Association for Research on Mothering and Feminisms*, 8(1-2), 298-310 at 304.

reproduction that is figured by compulsory heterosexuality, and enacted through the bedrock of the clinic, has the potential for disruption...but at a cost.

This reproductive pressure was experienced as deeply unsettling for Maricel. For most of the interview she had been a quiet presence in the room, displaying a butch stoicism as her femme partner Carol recounted their experience in an animated fashion. Maricel's nervous laughter while recounting this part of their story spoke to her discomfort with the memory, and the awkward feeling she had experienced as the contours of her planned synfertility project abraded the normative expectations of the clinic. Interwoven by the legacy of patriarchal power over women's bodies, radical feminist interventions into reproductive technology, the paternalist recommendations of the RCNRT, limited contemporary reserves of non-white donors in Canada, and the production of strict Health Canada regulations on sperm importation, Maricel and Carol had found themselves securely ensnared in the infertility trap.

Fortunately, the women were able to extricate themselves from their medical providers in Toronto. They contacted a clinic in New York state, and arranged for it to receive the California donor sperm they had selected and set up insemination. This was a stressful endeavor, however, as the clinic was a three-hour roundtrip drive across the border. As they were not planning to inform Carol's employer about her pregnancy until it was well underway, the women were obliged to visit the clinic in the early morning before their work day began – a pre-dawn hustle they described as intensely nerve-wracking. The women told the border guards at every crossing that they were going shopping in the U.S., and were concerned about being flagged by customs for their regular monthly visits and hauled in for an interview. Maricel's visa for travel in the

U.S. was only for six months, and the precarity of her legal status, the fear of lying to border guards and the potential duration of their reproductive project caused her particular anxiety.

Maricel: Yeah so I didn't I didn't want to be like, what's it, *grilled*, at the border 'cause I didn't want them to find out what exactly we are doing. And since we've been doing it for like three consecutive months I was worried that it will show up and...It well, for [Carol] 'cause she's a Canadian citizen it doesn't matter but yeah. It was definitely a concern. (*laughs nervously*)

Despite these hurdles, the couple remained clear that their family plan involved Carol carrying the child through insemination with Filipino donor sperm. While their story had a happy resolution, recounted as their infant son cooed at the table, Maricel's discomfort at the clinical and legal apparatus remained affectingly stark.

Synfertility in Family Law

Synfertility is now an everyday occurrence at fertility clinics across the world, but it continues to be collapsed into the technological ambit of reproductive intervention and viewed as a poor cousin to clinically-assisted parafertility. The dominant model of *infertility* persists as the structuring frame, obliging that *synfertility*, that *witness* to be suppressed in order to preserve the sanctity of the imaginary heterosexual family. Yet *synfertility* is not merely a bad case of parafertility (or infertility for that matter): it represents a completely different biosocial formation.

While the empirical work of the Creating Our Families project focused on the clinical encounter and issues of access to reproductive technology, the complex kinship structures of *synfertility* are also starkly rendered in family law. The 'gayby boom' has not led to a profusion of three- or four-parent families, nor has it reshaped the terms in which reproductive technology is conceived; the scarce mention of LGBTQ parents by Canada's highest court in the *AHRA*

Reference case attests to the still-marginal character of queer parenting.⁷²¹ Nevertheless the legal landscape *has* shifted in response to synfertile families, albeit marginally, inducing both judicial rulings and statutory reform to, overwhelmingly, “solidify parentage within the same-sex nuclear family by extending the rights and responsibilities of parenthood to the spouse of the birth parent.”⁷²² Still the ideology of the heterosexual family remains dominant, and this can pose a hurdle for families built outside this model – even when they follow a two-parent structure.

Kyle and Micah, two transgender men that I interviewed, had conceived with a known donor, with Micah carrying the child and a friend providing the sperm. After the birth of their son, Harold, the men had planned a trip to the U.S. to introduce their baby to his great-grandparents, who had all booked flights in anticipation of the gathering. However the new parents encountered difficulty registering their names on the birth certificate form, which only had entries for ‘Mother’ and ‘Father/Other Parent’. As Micah was a birth *father*, they were unsure of how best to proceed. This was a matter of some urgency for the men, as they could not get a passport for Harold without his birth certificate, and the date of the family meeting was fast approaching. As Kyle explained, he was feeling a great deal of pressure during this period to get Harold’s paperwork in order, as “I had two octogenarians flying in from two other cities in six-and-a-half weeks to meet their great grandson for the first time.”

Micah had initially called around to sort it out and was told that both men needed to physically come into the Toronto office to discuss the matter.⁷²³ They arrived at the office with their ten-week old son, their documentation in order, and a printed copy of the Ontario Human

⁷²¹ As discussed at length in Chapter Six.

⁷²² Fiona Kelly, “One of these Families is Not Like the Others: The Legal Response to Non-Normative Queer Parenting in Canada” (2013) *15 Alberta Law Review* 1-22 at 2.

⁷²³ The two available offices were in Thunder Bay and Toronto. Micah described how he “had a conversation with them about how that was geographically privileging certain areas and not okay...[but] that didn’t go very far.”

Rights Commission's 'Policy on preventing discrimination because of gender identity and gender expression.' They encountered one employee after another with a sympathetic attitude but no idea how to address their situation.

Micah: Everyone was respectful and totally understood that this was a legitimate problem. "We see you and who you are." "We understand why this is difficult but nobody has ever told us how we answer this."

Kyle: ...And people kept saying, "I don't know if I have the authority to do that?"

Micah: "Okay, okay, so who does? If you don't, who might?"

Kyle: And so we just kind of got passed up the food chain to some degree.

After many hours at the office they were eventually sent home without resolution, and told to wait for a response from the next level of authority. Two days later they received a call from another government employee, and they had to start from the beginning and explain their situation once more.

Kyle: Government Employee #2 called back two days later and was like, 'Okay so walk me through this.' (*laughs*)

Micah: Which we did. And interestingly she called as Harold and I were heading out in the car for whatever reason. And we said, "Hang on a sec," and she had to listen to us get the baby ready and work through things and really sound like a normal, normal family with a new baby doing things that families with new babies do. Like, "Do you have the diaper bag and new hat?" and you know, "Can you carry the bucket out to the car?" 'cause I had a C section, and all of that stuff. So by the time we got to telling her the story she'd already had this, "Oh you really are a family, doing family things, with a baby that I can hear in the background." And we hadn't intended that as sort of normalization theatre.

Kyle: But I think it helped.

The woman they referred to as "Government Employee #2" told the men that she would send the registration forms to them directly, and they could simply "cross off Mother wherever it says Mother, fill in Father." However she was also hesitant in regard to her authority to sign off

on the doctored forms. Micah and Kyle described how the province's Assistant Registrar General was eventually brought in to consult on the case, and determine whether it would be necessary to file a court petition to allow Micah to file as the birth father.

Micah: And it wasn't intended as a threat, like "Do it or else we will take you to court." But I think they were like, "Ok, family. We understand great grandmothers. Like, Ok." And I will say that it also builds on the lesbian thing and two moms on the birth certificate, that's already in place, so it's not like it wasn't building on people's earlier court battles and struggles. But it was surprisingly easy in the grand scheme of things.

The men highlighted their sense of how the "normalization theatre" they had performed had advanced their case and placed them within a two-parent frame of legibility. Certainly the revision of Ontario's *Human Rights Code* to include protection from discrimination and harassment because of gender identity would not have hurt their case (nor did their strategy to bring a printed copy-in-hand).⁷²⁴ However they also spoke to how the bureaucratic recognition of a traditional form of family – great-grandmothers, family reunions – seemed to make their petition easier than it might have been. In light of the judicial successes of cases like *Rutherford* there was already a statutory frame in place to allow for two mothers to register, which they felt had laid a foundation for their two-father claim.⁷²⁵ All of these factors contribute to the normative framing of the queer ontology of synfertile parenting, a discursive maneuver that requires the performance of a certain type of 'normalization theatre' for inclusion into the privileged nuclear family of law.⁷²⁶

⁷²⁴ In 2012 "gender identity" and "gender expression" were added as grounds of discrimination in the Ontario *Human Rights Code*, RSO 1990, c H.19 RSS. The Ontario Human Rights Commission is currently updating its policy to reflect these codes. See also *supra* note 449 for a deeper discussion of recent legislative developments around gender identity and expression.

⁷²⁵ As noted above, the 2007 amendments to Ontario's *Vital Statistics Act* allows a non-biological parent to certify a birth certificate as the "Other Parent" as long as they are acknowledged by the biological parent and the father is unknown. Given that Micah and Kyle used a known donor, I am not sure how they circumvented this part of the *Act* and I did not inquire during the interview. See also *supra* note 623.

⁷²⁶ This process of discursive normalization was particularly strong in the *Rutherford* case, with the court deeply impacted by an affidavit filed by the child of two of the applicants. The plea by twelve-year-old S.R.E. is instructive

This contradictory and ambivalent subjectification may be understood within a long tradition of queer encounters with law. As Brenda Cossman rightly explains:

While the heteronormativity of law and the legal subject has been increasingly challenged, lesbians and gay men have been partially absorbed into dominant modalities of legal subjectivity. The complex processes of inclusion and exclusion have led to the emergence of new legal subjects who are both normalized and transgressive.⁷²⁷

In her piece on the role of the *Charter* in advancing gay rights claims in Canada, Cossman discusses at length the *Mossop* case – the first gay equality rights case to reach the Supreme Court.⁷²⁸ She describes the strategy adopted by these early litigants as a conscious attempt to disrupt the heteronormativity of law.⁷²⁹ *Mossop* was argued not on the equivalency of heterosexual relationship to same-sex relationships, but within a discourse of equality which aimed to avoid the sameness argument and refused to stake ground on, for example, the foundation of sexual monogamy.⁷³⁰ The litigants also advanced a sophisticated argument about intersectionality, insisting that discrimination on the basis of “family status” – the issue at the heart of the case – included discrimination against same-sex couples. As Cossman relates, the case “challenged the heteronormativity of dominant modalities of family and legal personhood, and it was partially successful in so far as the challenge made inroads in a strong dissent” by Justice L’Heureux-Dubé.⁷³¹

of this affective power of normalization and the weight it holds with the Court:

“I just want both my moms recognized as my moms...I would like my family recognized the same way as any other family, not treated differently because both my parents are women...I want my family to be accepted and included, just like everybody else’s family.” (*Rutherford*, *supra* note 623 at para 219)

The same passage was quoted in entirety in the decision *A.A. v. B.B.*, with Rosenberg J.A. explaining approvingly that, “An excerpt from the *M.D.R.* record dramatically demonstrates the importance of the Declaration [of parentage] from the child’s point of view.” (*A.A. v. B.B.*, *infra* note 735 at para 15..) This claim for formal equivalence, to be “just like everybody else” and “recognized the same way as any other family” has proved an effective strategy for gay and lesbian equality projects that seek state recognition within existing terms of reference.

⁷²⁷ Cossman, *supra* note 433 at 225.

⁷²⁸ *Mossop v. Canada (A.G.)*, [1993] 1 S.C.R. 554 at 555 [*Mossop*].

⁷²⁹ Cossman, *supra* note 433 at 227.

⁷³⁰ *Ibid.*

⁷³¹ *Ibid* at 228.

In the majority opinion, however, these transgressive elements were folded back into the normalizing field of heterosexual family relations. The opinion, which ruled against Mossop, operated to reinforce the heteronormativity of the dominant family by finding that family status did *not* include same-sex couples. Thus, as Cossman ultimately concludes, “the broader political message was a normalizing one of sameness and assimilation.”⁷³²

This tension between assimilation and transgression, normativity and disruption, also underscores the encounter of the synfertile family with law. Micah and Kyle were joyfully irreverent during our interview, and talked about their unconventional family arrangement involving a polyamorous relationship with multiple lovers in other cities. Micah described with relish the conception of their son, which had occurred in a hotel room in Baltimore while he was on a date with one of his lovers, a flight attendant. It turned out that the weekend of his date was at the same time as his ovulation, so Micah asked the sperm donor – who was, incidentally, a rabbi – if he could meet them at the hotel rendezvous.

Micah: And so I phoned the rabbi and said, “So, that’s the right weekend...” And he sort of said, “So are you coming?” And I said, “Well I actually already have this date in Baltimore with a flight attendant.”

Kyle: “So we were wondering if we could fly you there instead?”

Micah: And he was willing. So the rabbi and the flight attendant and I spent a weekend together in Baltimore. We talked about you know, having two hotel rooms on the same floor. The person I’m fucking and not sharing body fluids with and the person I am sharing body fluids with but not fucking.

This non-normative foundation of their parenting project did not pose a difficulty for the two men when it came to registering Harold. This was for a variety of reasons. Partially, it was because they were able to read as ‘family’ due to their normalization theatre and their reference

⁷³² *Ibid.*

to conventional intergenerational modes of care. It was also because of policies against discrimination based on gender identity as reflected in the Ontario Human Rights Code, and because of previous legislative victories and statutory amendments in Ontario giving rights to same-sex parents. However it was also large part because there was no strife in their relationship.

Had the determination over Harold's legal guardianship come to a custody battle, the details of their sexual escapades might not have been so benignly recounted. Their queer family project was thus discursively subsumed into the available legal categories of parentage, creating a functional equivalency between "birth mother" and "birth father" that belied the complex circumstances of Harold's creation.⁷³³

In fact there have only been two instances where Canadian law has legally validated non-normative queer families: the Ontario Court of Appeal decision in *A.A. v B.B.* and British Columbia's new *Family Law Act*.⁷³⁴ The latter has been discussed in Chapter 9 as a site of recent statutory reform. The former offers an interesting case on the three-parent model that has not yet been replicated in Canada, and was only possible in the first instance thanks to the lack of dispute between all parties. This parental stability offered room to challenge the limitations of the dyadic family model and open (albeit limited) space for queer family formations.

A.A. v B.B. involved a male sperm donor, a lesbian mother who carried the child, and her female partner, the non-biological mother of the child.⁷³⁵ The appellate judgment saw Rosenberg

⁷³³ Compare this with the functional equivalency of the arguments in *Egan*, another landmark Supreme Court case involving gay equality. These arguments were explicitly assimilationist and relied upon sexual monogamy to stress the enduring value of the relationship between Egan and his partner of more than forty years. The equivalence between same-sex and opposite-sex relationships have long relied upon this idea of private and monogamous love, even in cases where such a tie was not present. See also: Teemu Ruskola, "Gay Rights Versus Queer Theory: What is Left of Sodomy after Lawrence V. Texas?" (2005) *Social Text*, Vol. 23, Nos. 3-4.

⁷³⁴ Fiona Kelly makes this argument, and I think correctly. Kelly, *supra* note 722 at 7.

⁷³⁵ *A.A. v B.B.* [2007] O.J. No. 2

J. tracking between the poles of biological and social kinship in order to focus on the best interests of the child (D.D.). Ultimately the court decided that all three adults had an equal stake in raising this child, a judgment that adapted to the materiality of this queer family and its planned synfertility. In affirming the non-biological mother's legal parentage, the Appeals Court exercised its inherent *parens patriae* jurisdiction to remedy what it found to be a “legislative gap” in the current statute, the Ontario *Children's Law Reform Act*. According to Rosenberg J.:

It is contrary to D.D.'s best interests that he is deprived of the legal recognition of the parentage of one of his mothers. There is no other way to fill this deficiency except through the exercise of the *parens patriae* jurisdiction.⁷³⁶

This is one of the very few cases in Canadian jurisprudence in which the needs of the queer family were actually placed at the fore. Rather than a familiar routine to juggle the primacy of biology over sociality, the decision rested upon the best interests of D.D. not only as a queerly-conceived child but *specifically as a queerly-conceived child of reproductive technology*. This marks a sharp departure from the judicial logics discussed in previous chapters, which sought to recreate the heterosexual, two-parent family by whatever means necessary. With *A.A. v B.B.* the court recognizes a dispersed form of kinship which revolves around the nexus of sexuality and technology required to create a child with three parents. As Rosenberg J. noted, in regard to the rationale behind the *CLRA*:

The possibility of legally and socially recognized same-sex unions and the implications of advances in reproductive technology were not on the radar scheme. The Act does not deal with, nor contemplate, the disadvantages that a child born into a relationship of two mothers, two fathers or as in this case two mothers and one father might suffer. This is not surprising given that nothing in the Commission's report suggests that it contemplated that such relationships might even exist.⁷³⁷

⁷³⁶ *Ibid* at para 37.

⁷³⁷ *Ibid* at para 21.

This nexus of sexuality and technology, and the specific character of planned synfertility in creating queer families, are intrinsic to the court's recognition of D.D.'s three legal parents. This case was seen as a partial victory for many in the field of gay and lesbian rights, with Fiona Kelly and others critiquing the lack of a *Charter* claim and the court's invocation of *parens patriae* discretionary jurisdiction, thus limiting the scope of the judgment.⁷³⁸ This case also placed the onus of applying for third-parent status recognition on the non-biological parent (in this case the lesbian partner of the biological mother) and served to prioritize the donor's status as a natural father.⁷³⁹ Yet as Kelly continues, "[w]hile *A.A. v. B.B.* is the only decision of its kind and is not applicable outside of Ontario, or perhaps even beyond the individual facts of the case, it suggests that in families in which three adults agree they are all parents, the courts *may* be willing to give legal recognition to the arrangement."⁷⁴⁰

However I believe the significance of this decision is not reducible to a victory – partial or otherwise – for gay and lesbian equality. Extra-reproductive family-making extends beyond the LGBTQ community, and it is imprecise to frame these shifts in family law as belonging properly to gay or lesbian kinship formations. Nicole LaViolette is approaching this conclusion when she states that the *A.A. v. B.B.* “decision is more rightly situated in the developing caselaw on new methods of conception and parenting than in the context of lesbian and gay rights”.⁷⁴¹ However as this dissertation has argued, synfertility also involves a queer component of family construction which must be accounted for. It is not gay and lesbian rights *or* reproductive technology, but a queer form of technologically-assisted family composed in slantwise relation

⁷³⁸ Fiona Kelly, *Transforming Law's Family.: The Legal Recognition of Planned Lesbian Motherhood* (Vancouver: UBC Press, 2011); See also: LaViolette, Nicole, “Dad, Mom – and Mom: The Ontario Court of Appeal's Decision in *A.A. v. B.B.* (2011). *Canadian Bar Review*, pp. 665-689.

⁷³⁹ Kelly, *Transforming*, at 27.

⁷⁴⁰ *Ibid.*

⁷⁴¹ LaViolette, *supra* note 738.

to the heterosexual imaginary. The framework of planned synfertility allows for the reproductive frame to be opened beyond the dyad into multi-parenting arrangements, and recognizes the intentionality of all reproductive actors as well as the necessary patchwork of biology, genetics and social care they may provide. An actualized vision of planned synfertility thus has the potential for a tremendous and revolutionary impact on current conceptions of family law.

Conclusion

The increasing ubiquity of AHR demands new approaches to evaluate historic categories of parental affiliation and caretaking. British Columbia has been the first and only province to adopt sweeping reform in the light of synfertile families and the new forms of extra-reproductive kinship they represent. In the meantime, courts continue to place synfertile families within the bounds of existing family law, whether appropriate for their condition or not.⁷⁴²

Reproductive technologies were designed to enable greater conformity with the traditional family and recreate parafertile family forms, but the extra-reproductive alignments made possible by AHR have ironically undermined the basis of normative biological parenting. While the complex family forms that have emerged from synfertile arrangements – planned and otherwise – have reshaped the legal landscape of family, the normative two-parent model has proven extremely resilient. The processes of legal inclusion and exclusion which synfertile families must face, often brought to the fore in the midst of acrimonious legal battles, have engendered a steady reliance upon the dominant modalities of legal subjectivity.⁷⁴³ Thus even as

⁷⁴² For classic examples of this struggle with new family forms, see: Wadlington, Walter, “Artificial Conception: The Challenge for Family Law,” 69 Va. L. Rev. 465 (1983); Silva-Ruiz, Pedro F, “Artificial Reproduction Techniques, Fertility Regulation: The Challenge of Contemporary Family Law,” 34 Am. J. Comp. L. Supp. 125 (1986); Garrison, Marsha, “Law Making for Baby Making: An Interpretive Approach to the Determination of Legal Parentage,,” 113 Harv. L. Rev. 835 (1999-2000).

⁷⁴³ Cossman, *supra* note 433 at 225.

the queer ontologies of synfertile families have taken on rich social resonance and lived meaning,⁷⁴⁴ their legal recognition has occurred within a narrow frame of formal equality with orthofertile couples.

I argue that the traditional legal form of family should not be reinscribed atop the multiplied kinships of synfertility. Instead, the legal frame should be expanded and enlarged in step with the social and discursive forms that already exist. *A.A. v. B.B.* relied upon a best interests of the child analysis to determine that D.D. was better off with three legal parents. This is a narrow ruling that requires a stable and monogamous family form to demonstrate the solidity of home life.⁷⁴⁵ While Micah and Kyle were loving parents with a bright and active toddler in the home, they were also transgender men in a committed polyamorous relationship involving multiple international lovers. Judicial discretion is an unreliable tool to determine the new contours of legal parentage, particularly as *ad hoc* judicial decisions increasingly govern this area of family law.⁷⁴⁶ As Susan Boyd has warned, “[m]ore contested scenarios are bound to produce more ambivalent results.”⁷⁴⁷

The synfertility model offers a blueprint toward the engagement of more complex legal forms that does not implicitly privilege biological or sexual affiliates, but looks broadly to the host of actors involved in producing a child. It creates more space for contractual relations by expanding the imaginary of the legal family, and turning it away from biological lineage as the

⁷⁴⁴ Look to the complex and fragmented kinships described in Rachel Epstein, *Who's Your Daddy? And Other Writings on Queer Parenting* (Sumach Press, 2009).

⁷⁴⁵ Rosenberg J. noted in the very first paragraph of the judgment that “A.A. and C.C. have been in a stable same-sex union since 1990.” (at para 1). *A.A. v. B.B.*, *supra* note 735.

⁷⁴⁶ LaViolette, *supra* note 738 at 683.

⁷⁴⁷ Susan Boyd, “Gendering Legal Parenthood: Bio-Genetic Ties, Intentionality and Responsibility” (2007) 25 *Windsor Y. B. Access to Just. 63*”, *supra* note 71 at 84. As Ontario waits for a ruling in *X.X. v. Y.Y.* about the right of a known sperm donor to claim parental rights against the wishes of the intended parents, Boyd’s concerns appear especially prescient.

primary factor in kinship construction. Kinship is understood as relational and produced in various forms by the actors in each particular interrelation and assemblage. These are already extant social realities; the task for law is to legitimate these various forms by allowing for legal ties not bound by heterosexuality or patriarchy. Law must also actively engage by supporting the conditions for their production through funding and subsidized access to AHR, as will be discussed in Chapter 11.

The two-parent mode for parentage is no longer tenable as the singular form of relational care and family construction. However there is no guarantee that simply expanding the bounds of family to include multiple parental actors will lead to improved outcomes for parents or children. It is important to understand the patriarchal and heterosexist context in which these new social forms are emerging, and judiciously balance competing and multiplied claims to parenthood in light of the normative bedrock on which they stand.

Statutory amendment that allows for the contractual and intentional position of all parties to be laid out in advance may enhance the legal protection of synfertility projects. In the meantime, synfertile families are at the mercy of judicial discretion in a deeply heterosexist society. The threat to exclusive two-parent lesbian parenting posed by a known donor seeking custodial rights must be viewed not only from a utopian stance that welcomes the fragmentation of the parenting dyad. The embodiment, intention and lived reality of synfertile families matters, and neither biological nor sexual affiliates should be understood to automatically create a stronger kinship bond. Community may be multiplied, but any claims to parental rights must be evaluated with an eye to patriarchal, masculinist and sexist social norms.

Chapter Eleven: Financing Reproductive Assistance

Introduction

While questions of legal access to gametes and reproductive labour were touched upon in Attachments One and Two, this chapter will look in depth at economic barriers facing synfertile families and argue for the primacy of affordable access to AHR as a central plank of a platform of reproductive justice. It will begin by considering the role of financial investments in AHR more broadly, as reflected in the anti-commercialization tenets of the *AHRA* as well as the lucrative medical complex of what has been referred to as ‘Fertility Inc.’ It will then move on to explore the health and economic rationales for limiting multiple births in IVF as well as other forms of reproductive intervention.

This chapter argues that the primary focus on IVF funding represents a heterosexual focus on parafertility and does not reflect the experience of many LGBTQ people seeking access to AHR. It then considers the limited case law that exists around petitions for state funding of reproductive assistance, and demonstrates the assumptions that undergird these decisions. A queer lens will be applied to this investigation of judicial responses. It then looks to the provincial funding models advanced by a handful of Canadian jurisdictions, and considers the impact on LGBTQ people in particular.

Fertility Inc.

In a 2002 *New York Times* piece called ‘Fertility Inc.: Clinics Race to Lure Clients’ on the growing fertility industry and the competition for patients, Gina Kolata discussed the approach taken by some establishments to drum up business.⁷⁴⁸ She described the case of a recently-opened New Jersey fertility clinic which had hired a marketing consultant, founded weekly support groups for infertile couples, and flown in a sommelier from France to preside

⁷⁴⁸ Kolata, G. 2002. “Fertility Inc.: Clinics race to lure clients.” *New York Times*, January 1, 2002, D1, D7.

over a wine-tasting dinner to woo the support (and referrals) of local doctors. As Kolata explained:

They had little choice but to invest heavily in marketing, fertility experts agree. Infertility has become a big, fiercely competitive business, with a billion dollars in revenues and with more and more doctors fighting for a limited number of patients. The growth of the field has been fueled by rising success rates and increased demand from patients, many of whom pay tens of thousands of dollars out of their own pockets in hopes of having a child.⁷⁴⁹

This hyper-marketization of the industry has only continued since then. Fertility clinics are for-profit enterprises, buoyed by specialized diagnostic testing and expensive procedures like IVF and ICSI. Fertility Inc. is big business, valued at approximately four billion dollars in the U.S. alone.⁷⁵⁰ Competition remains fierce, and in the U.S. at least, a competitive market encourages inflating numbers by exaggerating estimates, using internal metrics of success, and transferring more embryos than might be ideally recommended to boost numbers.⁷⁵¹ As indicated by the *Joint Report of the Council on Ethical and Judicial Affairs and the Council on Scientific Affairs*:

Another troubling aspect of ART concerns promotion of these services. Fertility clinics sometimes claim inflated success rates in advertising. Providers have included data on outcomes in media promotion, in some cases giving exaggerated estimates of success or defining success differently from the accepted standard. Even if the figures are genuine, predictors are so mercurial in ART that a cited figure may not represent the chances of successful outcomes for the majority of patients. Furthermore, average success rates do not necessarily reflect the results of a specific clinic since outcomes are affected by the nature of the pathology (some types of infertility are more successfully treated than others) as well as the skill of the professional and technical staff.⁷⁵²

⁷⁴⁹ *Ibid.*

⁷⁵⁰ This number fluctuates widely depending on the source and the criteria used in assessing both domestic and international flows of finance in fertility markets. However four billion dollars annually in the United States is quite widely quoted as an average number. I could not find comparable statistics for Canada. See: Transparency Market Research “Infertility Drugs and Devices Market - Global Industry Analysis, Size, Share and Forecast, 2010 – 2017” ReleaseWire Via Acquire Media NewsEdge.

⁷⁵¹ Kolata, *supra* note 748. See also *infra* note 752.

⁷⁵² American Medical Association, “Issues of Ethical Conduct in Assisted Reproductive Technology,” A Joint Report of the Council on Ethical and Judicial Affairs and the Council on Scientific Affairs, June 1996.

This is of particular concern given the low success rate of the most expensive procedures, such as IVF, with success measured by the birth of a child. Despite being a technologically advanced treatment, IVF is often unsuccessful, with only a 25% to 30% chance of success per round of treatment.⁷⁵³ Patients thus often attempt multiple rounds of IVF, with some estimates indicating that more than half of patients will continue treatment until they have a birth.⁷⁵⁴ With the out-of-pocket cost of each round ranging between 10,000 and 15,000 dollars, this may soon become a very expensive enterprise for most families seeking treatment.⁷⁵⁵

At the same time, there is concern that an established trend for ‘money back guarantees’ may put the success of the clinic above the health of the pregnant body and any children that result.⁷⁵⁶ Jim Hawkins recently conducted an in-depth study of how fertility refund programs are presented to patients, noting that refunds represent an innovative financing tool that is virtually unparalleled in other areas of medicine.⁷⁵⁷ Hawkins reviewed and coded online information on refund programs offered by every U.S. fertility clinic with membership in the Society for Assisted Reproductive Technology (ASRM). He found that the majority of clinics failed to comply with professional self-regulations that mandate the disclosure of certain information about their refund program.⁷⁵⁸ Most clinics also often present information in a deceptive manner, or in a manner that exploits poor decision-making on the part of patients.⁷⁵⁹ For example, Hawkins found that only 14% of fertility clinic websites followed ASRM guidelines by stating

⁷⁵³ Hamilton, B. H. and McManus, B. “The effects of insurance mandates on choices and outcomes in infertility treatment markets.” (2012) *Health Econ.*, 21: 994–1016.

⁷⁵⁴ Malizia BA, Hacker MR, Penzias AS. “Cumulative Live-Birth Rates after In Vitro Fertilization” (2009) *New England Journal of Medicine* 360(3): 236–243.

⁷⁵⁵ *Ibid.*

⁷⁵⁶ Debora L. Spar, *The Baby Business: How Money, Science, and Politics drive the Commerce of Conception* (Harvard Business School Press: Boston, 2006).

⁷⁵⁷ Jim Hawkins, “Financing Fertility,” (2010) *Harvard Journal on Legislation*, Vol. 47, pp. 115-165.

⁷⁵⁸ *Ibid.*

⁷⁵⁹ *Ibid.*

that “the program is not guaranteeing pregnancy and delivery,” while only 2.2% of clinics complied with policy by making it “clear to patients that they will be paying a higher cost for IVF if they in fact succeed on the first or second cycle than if they had not chosen the shared-risk program.”⁷⁶⁰ As Hawkins argues, additional consumer protection regulations are necessary, given the regulatory vacuum that currently exists around refund programs and the evident failure of voluntary self-regulation.⁷⁶¹

As discussed in Chapter Six, both the U.S. and Canada are currently without comprehensive national or state/provincial regulation regarding the operation of fertility clinics. The few standards that do exist are mostly derived from research review boards or nonbinding ethics committee guidelines.⁷⁶² This lack of regulation has been of particular concern due to concerns over multiple birth pregnancies, which represent substantial and elevated health risks for both the pregnant body and infant.⁷⁶³ For example, twins are six times more likely to die in their first year of life than single children; for triplets, the risk of death increases twelve-fold. Twins are four to six times more likely than singletons to contract cerebral palsy.⁷⁶⁴ In Canada,

⁷⁶⁰ *Ibid* at 127.

⁷⁶¹ Hawkins argues that policymakers should require refund providers to make certain mandatory disclosures when presenting information about their refund programs. As he suggests, in the case of IVF refund programs, the law already has a structure to protect consumers—the same disclosure-driven regime used in other financial contexts. “Legislatures do not have to invent a new type of regulation to address the fertility industry’s innovative financing tools. They merely need to extend the same legal principles that already protect consumers in other contexts to protect consumers who are financing fertility. Without significant intrusion into the market, disclosure requirements would help potential participants make rational, informed decisions when evaluating the merits of refund programs.” *Ibid* at 163.

⁷⁶² *Ibid*.

⁷⁶³ Risks to the adult may include miscarriage, high blood pressure, kidney damage and post-partum hemorrhage requiring life-saving transfusions, while infants face greater likelihood of prematurity, low birth weight, respiratory distress, infections, hearing and vision problems, cerebral palsy and other irreversible neurological damage. Elizabeth Pector, “Ethical Issues of High-order Multiple Births,” (2005) *Newborn and Infant Nursing Reviews*, Vol 5(2), pp 69-76.).

⁷⁶⁴ *Ibid*.

IVF accounts for only one percent of all births but 17 percent of neonatal intensive care unit admissions.⁷⁶⁵

Increased Chance of Multiple Births

There are two forms of clinical intervention which may result in an increased chance of multiple births: ovarian stimulation and the intra-uterine insemination (IUI) of washed sperm via catheter; and all forms of IVF including ICSI.⁷⁶⁶ Ovarian stimulation with IUI represents a common intervention in the management of unexplained subfertility not only in North America but throughout the world, as its relative ease and non-invasiveness have made it a very popular option.⁷⁶⁷ It is also cheaper than IVF and a route pursued by many poorer families unable to pay for expensive rounds of IVF.⁷⁶⁸ One of the gay couples I interviewed had pursued ovarian stimulation + IUI with their traditional surrogate, and spoke approvingly of the lower cost, but most gay couples will be facing a scenario with a gestational surrogate and IVF. As discussed above, many lesbian women and transmen are immediately encouraged to begin rounds of fertility drugs upon entering the clinic, and will also face a greater likelihood of conceiving multiples than if ovarian stimulation drugs had not been prescribed.

At present, AHR multiple birth rates are currently around 30% per delivery, compared to an unassisted rate of 2%.⁷⁶⁹ This has been attributed to the difficulty of controlling the number of follicles produced during a round of ovarian stimulation drugs + IUI, and the practice of

⁷⁶⁵ The long-term cost of caring for twins, triplets, or higher-order multiples has been estimated as substantially higher than caring for a single child - at four, 11, and 18 times higher, respectively. See: Jessica Schmerler, "The More The Merrier: Limiting the Number of Embryo Implantations," *Yale Scientific Magazine*, May 9, 2012

⁷⁶⁶ *Ibid.*

⁷⁶⁷ Aboulghar M. "Controlled ovarian hyperstimulation and intrauterine insemination for treatment of unexplained infertility should be limited to a maximum of three trials." (2001) *Fertility & Sterility* 75(1):88-91.

⁷⁶⁸ *Ibid.*

⁷⁶⁹ Janvier A, Spelke B, Barrington K, "The epidemic of multiple gestations and neonatal intensive care unit use: the cost of irresponsibility" (2011) *J Pediatr* 159(3): 409-413.

transferring more than one embryo per cycle of IVF.⁷⁷⁰ Data from the U.S. indicates that all forms of IVF account for about 40% of multiple birth pregnancies, while ovarian stimulation + IUI accounts for a further 40%; the remaining 20% occur spontaneously.⁷⁷¹ For its part, Canada has posted one of the highest rates of multiple births from IVF in the world.⁷⁷²

Given the high cost of AHR, the low success rates and the lack of regulation on number of embryos transferred, it has become common in many clinics to ‘stack the deck’ and aim for successful pregnancy and birth on the initial rounds of IVF.⁷⁷³ As Janvier et al. explain, this is done in consultation with the prospective parents, as “[p]atients and their doctors choose the number of embryos to implant during a treatment, with a greater number of embryos providing both a higher birth probability and a higher chance of a multiple birth.”⁷⁷⁴

This is of apparent benefit to the patient, as it serves to reduce emotional, physical and financial strain by leading to an early conception and birth. It is also of apparent benefit to the clinic, as a successful pregnancy is the central mandate of reproductive assistance. Under the refund scheme described by Hawkins there may also be a financial incentive, as the up-front premium paid by all entrants to the refund plan is not refunded should the first round (or rounds) prove successful. As Hawkins describes, patients who invest in IVF refund programs and achieve a pregnancy in their first or second cycle may pay over \$10,000 more than if they had been on a cycle-by-cycle basis.⁷⁷⁵ Yet as he explains: “Because people are so happy to have a baby...they do not worry about the excessive costs incurred with the refund program and they do

⁷⁷⁰ *Ibid.*

⁷⁷¹ *Ibid* at 1.

⁷⁷² *Ibid.* This is changing with the institution of government subsidized IVF in Quebec, coupled with a mandatory policy of single-embryo transfer when clinically indicated for women under 36. The situation of Quebec will be discussed in detail shortly.

⁷⁷³ Again, the exception to this is the jurisdiction of Quebec, where public policy mandates a single-embryo transfer.

⁷⁷⁴ Hawkins, *supra* note 757 at 995.

⁷⁷⁵ *Ibid.*

not sue to recover these costs.”⁷⁷⁶ A powerful financial incentive thus exists on the part of the clinic to ensure that a successful birth is achieved on the first or second round; this makes the presence of unregulated multiple-embryo transfers all the more likely.

Some Canadian clinics have also instituted an American-style refund program in recent years. For example, NewLife IVF Canada in Mississauga, Ontario, offers a ‘Guaranteed Success Program’ for \$20,000 (*plus* additional costs such as medication, prescreening tests and cycle monitoring), promising a refund of \$15,400 if a live birth is not attained following three fresh IVF attempts and all frozen embryo transfers.⁷⁷⁷ However should a couple conceive upon the first IVF attempt - as with the U.S. model - the clinic retains the up-front investment and banks the entire payment.

While NewLife does not post their regular fees on the website, a clinic in Scarborough, Ontario, offers a similar IVF Guaranteed Pregnancy Program and lists both program *and* regular fees. According to the IVF Canada and the LIFE Program website, couples can enter the Program for a cost of \$22,000 plus medication, which includes a \$17,600 refund if they do not have a successful pregnancy.⁷⁷⁸ However a single round of out-of-pocket IVF is priced at \$6,000 (plus medication and testing, which may run as high as an additional \$14,000), meaning that a couple would have to undergo a minimum of four rounds of IVF for their investment to avoid loss; any fewer cycles and it is the clinic which gains. This appears to incentivize the clinic to ensure successful conception and birth in as few cycles as possible, making the suggested

⁷⁷⁶ *Ibid* at 985.

⁷⁷⁷ NewLife Fertility, ‘Guaranteed Success Program’. Accessed July 17, 2014
<http://www.newlifefertility.com/editor_upload/123_Guaranteed%20Success%20Program-website.pdf>

⁷⁷⁸ IVF Canada and the LIFE Program has little information about the specifics of the guaranteed program, but it would presumably follow the basic contours of the U.S. model as with NewLife.

transfer of multiple embryos a sound financial prospect. At the same time, Canadian clinics are not obligated to publish their success rates.

Clinical Success Rates

At present, both the U.K. and the United States require clinics to report how many pregnancies or births they produce per treatment. Yet despite the incorporation of American-style models of refund guarantees, and Canada's broad adoption of the for-profit business structure of Fertility Inc., this country lacks any independent source of information about which clinics might give patients the best chances of having a child.⁷⁷⁹

The AHRC would have collected and potentially published such data, but in the wake of its disbanding there is no federal agency tasked with monitoring reproductive health care outcomes. Canadians currently have no way to compare expensive out-of-pocket reproductive outcomes on a clinic-by-clinic basis.⁷⁸⁰ This is a problem not least because data from other countries indicates that clinics may range widely in terms of success, with a study from Australia and New Zealand reporting birth rates following fresh-embryo IVF treatment at different clinics ranging from 3.6% to 25.9% in 2011.⁷⁸¹ While these percentages gloss over potential differences in patient demographics and health, a similar 2010 study from Holland did adjust for individual patient attributes and found it made only a slight impact on final numbers.⁷⁸²

For its part, CFAS has argued against the publication of clinical success rates, suggesting that such data would be misleading to patients and may spur clinics on to dangerous medical

⁷⁷⁹ Tom Blackwell, "The fertility clinic guessing game: Canadians have no way to find out success rates of pricey IVF treatments", *National Post*, June 22, 2014. < <http://news.nationalpost.com/2014/06/22/the-fertility-clinic-guessing-game-canadians-have-no-way-to-find-out-success-rates-of-pricey-ivf-treatments/>>

⁷⁸⁰ *Ibid.* As Blackwell reports, "[h]ard evidence from other countries suggests that results can differ markedly from clinic to clinic."

⁷⁸¹ *Ibid.*

⁷⁸² *Ibid.*

practices in order to boost outcomes.⁷⁸³ As CFAS spokesman Al Yuzpe has argued, “It has dramatic implications on the financial health of that clinic...They feel themselves under immense pressure to distort their practices in ways that, as clinicians, they don’t want to do.”⁷⁸⁴

However it is precisely the conflict between a for-profit system and a patient-centered model of care which is the issue. For most of Canada, like in the U.S., the business of assisted reproduction remains extremely lucrative for practitioners; a recent Quebec lawsuit indicated that the director of a Montreal clinic was earning more than \$1.5 million per year as long ago as 2005.⁷⁸⁵ Amidst a hypermedicalized system of infertility which is growing increasingly marketized, Canadians find themselves in a mixed system of reproductive assistance – they are barred from a ‘consumer awareness’ model out of concerns that clinics may seek to increase their bottom line at the expense of patient health. Yet they are also faced with refund schemes that demand complex consumer acumen and negotiation to determine sound fiscal choices. At the same time, fertility clinics are reaping substantial profits without oversight or the need for transparency on their success rates.

IVF and Multiple Births in Canada

Canadian families paying out-of-pocket for IVF are thus faced with difficult decisions. They may opt-in to something like a refund guarantee program, without access to indicators of general clinical success or published data on success rates for their specific age and health range. Although one hopes not, they may also potentially encounter clinical pressure to transfer more than one embryo per cycle, with the goal of exiting the refund program early. Indeed such

⁷⁸³ *Ibid.* Blackwell reports that CFAS has stopped collating figures itself from clinics, handing over the job to BORN, an Ontario government-funded organization that addresses a wide array of birth-related issues, and has no mandate to release clinic information.

⁷⁸⁴ *Ibid.*

⁷⁸⁵ *Ibid.*

pressure may not even be necessary: studies show that 85% of parents planning to undergo out-of-pocket IVF - even after being counseled about the risks - still wish to minimize the stress, expense and difficulty and conceive twins.⁷⁸⁶

On the other hand they may also decide to pay for IVF on a per-cycle basis. As mentioned, the cost can run as high as \$20,000 per cycle. In this case, multiple-embryo transfers may also be indicated as a pragmatic choice for the prospective parents due to expense, time and emotional strain. When funding is provided by the government, however, the election of multiple-embryo transfers shifts dramatically. In 2009, before Quebec provided access to subsidized IVF, only two percent of couples elected for single-embryo transfer; when the cost was borne under universal coverage in 2011, however a full 32 percent of cycles in that province were elective single-embryo transfer.⁷⁸⁷

Fertility doctors themselves have been a powerful driver behind Quebec's policy shift. In a 2008 paper, three doctors from the University of Montreal calculated that a mandatory policy of single-embryo transfer would substantially reduce the number of babies admitted to neonatal intensive care units every year, result in fewer deaths, lower incidence of brain injuries and result in 42,000 less days of intensive care.⁷⁸⁸ Anne Janvier and her colleagues were adamant that the only way to lower Canada's level of IVF multiple births is to eliminate the "perverse economic incentives" that drive it.⁷⁸⁹ As they insisted, every time more than one embryo is transferred, "we

⁷⁸⁶ Canada, Ontario, *Raising Expectations: Recommendations of the Expert Panel on Infertility and Adoption*, (Toronto, ON, August: Ministry of Children and Youth Services, 2009). This statistic does not indicate whether the process includes payment per-cycle or payment in a refund program, although in both cases the financing would be on an out-of-pocket basis.

⁷⁸⁷ M.P. Vélez, M.P. Connolly, I.-J. Kadoch, S. Phillips, and F. Bissonnette, "Universal coverage of IVF pays off" *Hum. Reprod.* (2014) 29 (6): 1313-1319.

⁷⁸⁸ Janvier et al, *supra* note 769.

⁷⁸⁹ *Ibid.*

increase the risks to the mother, we increase the risks to the patients that don't even yet exist.”⁷⁹⁰

IVF with single embryo transfer has been shown to almost completely eliminate multiple pregnancies.

Yet with the exception of Quebec, there are no binding federal or provincial standards in Canada for how many embryos may be transferred during a cycle of IVF. In 2009, Canada's 28 private fertility clinics reported 1,274 multiple pregnancies, including 1,193 twins, 76 triplets and five quads; in the same year, Canada and the United States tied for the highest twin rate.⁷⁹¹ In 2010, however, Quebec began paying for up to six cycles of IVF with the proviso that only one embryo be transferred per cycle for most women.⁷⁹² The argument for public funding of IVF has taken on a distinctly economic cast; as framed by the Canadian Agency for Drugs and Technologies in Health, “there is a belief that the public funding of IVF with single-embryo transfer is a more sustainable strategy, as it offsets the downstream costs associated with the ramifications of multiple pregnancies.”⁷⁹³

Outside of Quebec, fertility clinics still commonly transfer two, three or more embryos in a single round of IVF; nevertheless the impact on national birth rates from Quebec’s policy alone been dramatic.⁷⁹⁴ In 2009, 32% of pregnancies achieved via IVF in Canada resulted in a multiple

⁷⁹⁰ *Ibid* at 5.

⁷⁹¹ As reported at the time by a team of Canadian OB/GYNs, “this similarity may be explained by the geographical proximity of the two countries and their similar standards in ART-related practices.” Cook JL, Collins J, Buckett W, Racowsky C, Hughes E, Jarvi K. “Assisted reproductive technology-related multiple births: Canada in an international context.” (2011) *J Obstet Gynaecol Can.* 33(2):159-67.

⁷⁹² Sharon Kirkey, “New guidelines say only one embryo should be transferred in young women undergoing in vitro fertilization,” *National Post*. June 4, 2013.

⁷⁹³ In Quebec and elsewhere in Canada, this has been seen as the best method to balance strained parental resources (and the concomitant push toward elective multiple-embryos transfers) and the health of adult and child, while locating a secure funding rationale for government. For an example of this economic rationalization, see: Canadian Agency for Drugs and Technologies in Health, “Assisted Reproductive Technologies in Canada,” *Health Technology Update*, Issue 10 - March 2009.

⁷⁹⁴ In 2009, Canada’s clinics had the following rates of IVF embryo transfer: in 13% of procedures a single embryo was transferred; in 58% of procedures two embryos were transferred; in 22% of procedures three embryos were transferred; in 7% of procedures four embryos or more were transferred. There is no data in Canada available on

pregnancy; by 2012, after Quebec had fully instituted its provincial reproductive assistance policy, this number declined by almost half to 18.4%.⁷⁹⁵

Ontario has recently made a similar move toward reducing the number of embryos transferred, with an April 2014 announcement that the provincial government will now fund one cycle of IVF treatment per patient.⁷⁹⁶ There are also plans to set up an advisory body to ensure the practice of medical standards, including single-embryo transfer for certain patients.⁷⁹⁷ The single-embryo standard has also been championed by CFAS.⁷⁹⁸

This singular attention to IVF, however, fails to attend to multiple births which occur through ovarian stimulation. While all 26 IVF centers accredited by the Canadian Andrology and Fertility Society must submit health reporting data on IVF deliveries to a national registry, they are not required to report on births through IUI + ovarian stimulation.⁷⁹⁹ This constitutes a significant gap in data reporting not least because it is far more likely to be the route that lesbians and transmen follow, as well as those few gay men with a traditional surrogate. Yet CFAS does

maximum numbers of embryo transfer, although in the following year a second category was added. In 2010 the numbers looked quite different thanks to the integration of Quebec's statistics and its provincially-mandated single embryo transfer for most cases. In 2010 CFAS reported the following statistics: in 24% of procedures a single embryo was transferred; in 52% of procedures two embryos were transferred; in 17% of procedures three embryos were transferred; in 5.3% of procedures four embryos or more were transferred, and in 1.6% of procedures five or more embryos were transferred. While the Quebec data had a great impact in reducing the number of two- and three-embryo transfers, it left unchanged the high-order transfers of four, five or more embryos (which remained stubbornly at 7%).

⁷⁹⁵ CFAS Media Release, "Human Assisted Reproduction 2013: Live Birth Rates for Canada", September 26, 2013.

⁷⁹⁶ Tom Blackwell, "Ontario to fund in-vitro fertilization with a caveat — one embryo at a time to cut risky multiple births." *National Post*, April 9, 2014. < <http://news.nationalpost.com/2014/04/09/ontario-to-fund-in-vitro-fertilization-with-a-caveat-one-embryo-at-a-time-to-cut-risky-multiple-births/>>

⁷⁹⁷ *Ibid.* However, as will be discussed in a moment, this number may vary widely based on indicators of patient health, age and presumed fertility.

⁷⁹⁸ In clinical practice guidelines released in June 2013, CFAS outlined the suggested number of embryos to transferred to minimize multiple pregnancies, with no more than a single embryo to be transferred for women under 35. For "poor prognosis" patients, the recommended maximum is two, while for women aged 40 to 42, the guidelines recommend a maximum of three or four embryos. For women older than 42, however, CFAS suggests that doctors consider transferring up to five embryos, depending on how many days after fertilization the embryos are transferred and the woman's prognosis for success. See: CFAS Media release, June 10, 2013, "Release, "Canadian Fertility and Andrology Society provides practitioners with clear guidelines for embryo transfer", June 10, 2013.

⁷⁹⁹ Janvier et al, *supra* note 769 at 1.

not track this data, despite indications that the procedure has a similar rate of multiple births as IVF. There is thus no way of knowing the effect that provincial health policy or enthusiastic drug prescription may be having on the multiples rate for some members of the LGBTQ community.

Heterosexual Focus on IVF

The focus on funding for fertility procedures has been primarily on treatments such as IVF, a medical technology that can fertilize an embryo with the genetic material of both intended parents. A central reason for this focus is the sheer cost of IVF, as a prohibitively expensive treatment for the patient and a potentially lucrative source of revenue for the for-profit clinic. This tension between economic efficiency and maternal health outcomes has led to a high incidence of multiple births and has formed an important rationale behind the drive for state funding and mandated single-embryo transfer in some provinces.

However I argue that IVF's status as the *sine qua non* of parafertile interventions is also a factor in its discursive primacy. Through procedures like ICSI, the heterosexual couple is able to procreate using their own gametes, achieving the gold standard of fertility treatment by paralleling 'normal' heterosexual coupling. IVF is used by a relatively small portion of LGBTQ parents-to-be, most notably gay men using gestational surrogates and lesbian couples undergoing reciprocal IVF.⁸⁰⁰ Yet the issue of public funding for IVF continues to be at the fore of mainstream discussion, rather than options like drug-free IUI or modified cycles of IUI.

Such discussion also obscures the fact that multiple birth rates are similarly high for procedures of ovarian stimulation + IUI. This less expensive procedure is still a major investment for many poor and queer families, and it remains priced out of the grasp of many

⁸⁰⁰ The process of reciprocal IVF is discussed at *supra* note 577.

more.⁸⁰¹ As seen in Chapters Eight and Nine, these procedures hold their own dangers due to hyperovarian stimulation and the recorded evidence of fertility doctors pressing fertility drugs onto lesbian and transgender bodies and couples. Priorities in access to state funding for reproductive assistance may therefore be quite different for subfertile heterosexual couples than for those with an inherently non-reproductive sexuality. Yet with the focus of heterosexual litigation and provincial funding schemes focused on IVF – rather than a broader agenda of accessibility, safety and affordability for all forms of AHR – the issue continues to be narrowly construed.

Each province mandates allowable forms health care coverage under the aegis of provincial insurance. In Ontario, for example, the costs of IVF were covered under provincial medical care from 1985 until 1994, when all IVF procedures - except “complete bilateral anatomical fallopian tube blockage that did not result from sterilization”⁸⁰² - were comprehensively delisted. Ontario has recently announced its intention to pay for a single round of IVF treatment, once again refocusing on one form of reproductive assistance to the exclusion of all others. The singular focus on expensive IVF treatment obscures the importance of this procedure as a primarily heterosexual modality of parafertility, as well as the financial concerns faced by people using other forms of reproductive assistance.

⁸⁰¹ As the Creating Our Families project showed, even wealthy white families experienced the out-of-pocket cost of AHR procedures like IUI and the purchase of anonymous donor sperm as a major financial outlay. The lack of a broader range of people of colour in our study, despite intensive recruitment and members of the research team belonging to targeted racialized communities, may speak to the unaffordable nature of these technologies for many.

⁸⁰² Ontario *Health Insurance Act*, R.S.O. 1990, Chapter H.6 at para 23 section 24(1) of Regulation 552, which reads in full that IVF is not an insured service “other than the first three treatment cycles of *in vitro* fertilization that are intended to address infertility due to complete bilateral anatomical fallopian tube blockage that did not result from sterilization”.

Impact of Quebec Legislation

The Quebec government began offering full funding for IVF treatments as well as other forms of AHR in mid-2010, making it the first jurisdiction in North America to do so.⁸⁰³ Quebec's provincial health care system now provides coverage for all services related to the medical aspects of ovarian stimulation, artificial insemination and three cycles of IVF, mandating in most cases a single embryo transfer for women under 36.⁸⁰⁴ The new plan also covers up to six 'natural' cycles (meaning a cycle in which ovulation occurs spontaneously, without being stimulated by medication) or modified natural cycles (meaning a cycle of ovarian stimulation through fertility drugs), which are aimed at producing only a single embryo.⁸⁰⁵ The plan will not pay for AHR services beyond three stimulated cycles or six natural cycles, although in the case of a live birth resulting from IVF, the patient is eligible for coverage for an additional three-cycle program.

The rate of multiple births in Quebec decreased sharply following the introduction of this policy, dropping from 29% in 2009 to six percent in 2011.⁸⁰⁶ This same period also saw a steep rise in the number of fresh IVF cycles performed, which leapt from 1,875 cycles in 2009 to 5,489 cycles in 2011.⁸⁰⁷ The public program has been far more popular than expected, increasing government costs per IVF treatment cycle from \$3730 to \$4759.⁸⁰⁸ However despite larger costs,

⁸⁰³ Manitoba introduced a 40% tax credit of up to \$8,000 for fertility treatment costs in 2010, and Ontario has previously offered three rounds of IVF treatment funding for women who have both Fallopian tubes blocked. New Brunswick has also promised a 50% rebate, up to \$5,000 a year, for those who need treatment. In April 2014, Ontario announced plans to provide limited IVF funding, with the province paying for one cycle of IVF for all patients. See: Kate Schwass-Bueckert, "Funding IVF will save provinces money: Advocates", *Toronto Sun*, August 11, 2011.

⁸⁰⁴ Multiple embryos may still be transferred under suboptimal conditions, due to age or other health indicators, but any physician who transfers more than one embryo must justify his or her choice. *An act respecting clinical and research activities related to assisted procreation*, 2010. (2009, c.30) – Coming into force of certain provisions of the Act. O.C. 643-2010, 7 July 2010. *Gazette Officielle du Québec*, July 21, 2010, vol. 142, No. 29.

⁸⁰⁵ *Ibid.*

⁸⁰⁶ Kathryn Doyle, "Insurance coverage of IVF may decrease multiple pregnancies" *Reuters Health*, May 14, 2014.

⁸⁰⁷ *Ibid.*

⁸⁰⁸ M.P. Vélez et al, *supra* note 787.

the “efficiency defined by the cost per live birth, which factored in downstream health costs up to 1 year post delivery, decreased from \$49,517 to \$43,362 per baby conceived by either fresh and frozen cycles.”⁸⁰⁹ As reported by a large comparative analysis conducted by physicians at the University of Montreal Hospital, “our study confirms that the implementation of a public IVF programme favouring eSET not only sharply decreases the incidence of multiple pregnancy, but also reduces the cost per live birth.”⁸¹⁰

Nevertheless, the program has been criticized for its overall burden on the health care system: while initially budgeted at \$30 million in 2010-11, the cost was close to \$70 million in 2013-14.⁸¹¹ The program had been driven by a goal of recovering \$100 million in overall health costs by reducing the cost of neo-natal care for multiple births, and while the cost per live birth did decrease, the overall demand for the service outweighed any savings. The Minister of Health for Quebec, Gaétan Barrette, has publically said that assisted reproduction is not an essential health service.⁸¹²

Barrette has also suggested that the program should be restricted to people with a diagnosis of ‘infertility,’ in specific reference to limiting access to the program by queer families. As he made explicit: “While single mothers and same-sex couples make wonderful parents, homosexuality is not an illness.”⁸¹³ The framing of medical infertility as a necessary condition for access to a taxpayer-supported reproductive benefit is of evident concern as the situation moves forward. Thus far, Barrette has spoken of considering two options for the future of the

⁸⁰⁹ *Ibid* at 1313.

⁸¹⁰ *Ibid*.

⁸¹¹ Kevin Dougherty, “Everything is on the table’ in IVF review: Barrette” *Montreal Gazette*, June 6, 2014. <<http://montrealgazette.com/news/everything-is-on-the-table-in-ivf-review-barrette>>

⁸¹² *Ibid*.

⁸¹³ Richard Vaughn, “Will LGBT People Be Banned from Québec’s Free IVF Program?”, *International Fertility Law Group*, June 10, 2013 at 4:11 pm. <<http://www.iflg.net/will-lgbt-people-be-banned-from-quebecs-free-ivf-program/>>

program: ending public funding in part or in whole; or introducing a new bill that would implement a series of recommendations made by a Quebec report released in summer 2014.

This report, by the Quebec's *Commissaire à la Santé et au Bien-Être*, is a comprehensive 386-page review of the province's reproductive assistance program. The report suggests that the program be maintained overall, but offers twelve recommendations aimed at streamlining and improving the process. These recommendations are focused on ensuring better health outcomes and cost controls, as well as allowing greater access to information, oversight of best practices, and generating social consensus around commercialization and ethically contentious issues such as surrogacy.⁸¹⁴

First, the Commission recommends a range of access restrictions for reasons such as elective fertility preservation and voluntary sterilization. This appears to include individuals who have undergone elective procedures such as tubal ligation or vasectomies.⁸¹⁵ However the proviso against fertility preservation due to "social reasons" is of particular concern to transgender women who may wish to bank their sperm before transition; whether this would be considered an elective procedure is not certain. Nor it is clear if a post-transition transgender woman with no viable sperm would be viewed as having undergone 'voluntary sterilization,' thereby rendering herself and (potentially) her partner ineligible for treatment. Given that the recommendations also suggest that "both partners be covered within the provincial health insurance program,"⁸¹⁶ it appears to model a two-parent dyad of intra-reproductive family formation that reflects orthofertile standards.

⁸¹⁴ Audrey L'Espérance, "Socializing Access to Fertility Treatments in Quebec?" *Impact Ethics*, June 19, 2014 <<http://impactethics.ca/2014/06/19/socializing-access-to-fertility-treatments-in-quebec/>>

⁸¹⁵ Vaughn, *supra* note 813.

⁸¹⁶ L'Espérance, *supra* note 814.

For this reason, as well as for the gatekeeping and heterosexist standards of the clinic mentioned in earlier chapters, there is also concern about the recommendation for psychosocial evaluation of intended parents before access to fertility services is granted. Similar to the controversial approach used in the U.K. to assess parental suitability, the Quebec report recommends that intended parents must complete and sign a declaration documenting past psychosocial issues such as addictions and matters of child welfare.⁸¹⁷ In a related matter, the report also suggests the development of a database that clinics can access to track patient contacts, clinical interactions and psychosocial assessments to ensure that patients are not “shopping around” for services that may have been denied elsewhere.⁸¹⁸

In its eleventh recommendation, the Commission calls for the funding of both open-identity and anonymous sperm.⁸¹⁹ At present, Quebec covers only the cost of anonymous sperm acquisition; however as discussed in Attachment Two, many lesbian families strongly prefer to use open-identity gametes. Assuming that same-sex couples are not barred from the program altogether, as Barrette has intimated, the funding of open-identity sperm donors would be likely to have a positive impact on queer families, and will open already-limited donor selections to a wider range of options. While there are no explicit recommendations on surrogacy, the Commission does suggest that the government deal with demands by single and same-sex parents for access to assisted procreation, and advises a public discussion on the legal, ethical, clinical and social aspects of surrogacy.⁸²⁰

⁸¹⁷ Pamela White, “Quebec’s Assisted Human Reproduction Program” Impact Ethics, July 15, 2014. As White describes, “Much ink has been spilt in the UK over the intrusion of the “nanny state” in family reproduction, and the recommendation to intervene in who is a “suitable” parent may be among the more contentious.”
<<http://impactethics.ca/2014/07/15/quebecs-assisted-human-reproduction-program/>>

⁸¹⁸ *Ibid.*

⁸¹⁹ *Ibid.*

⁸²⁰ Dougherty, *supra* note 811.

Perhaps controversially, the report recommends means tested payments, suggesting that users should pay a fee for the service based on their income.⁸²¹ It also suggests moving away from IVF as the first choice for a woman seeking medical assistance to conceive, instead favouring less invasive and less costly procedures, such as ovarian stimulation.⁸²² While based on primarily economic rationales, this may actually lead to a less medicalized model in which reproductive interventions are applied more sparingly. Rather than being driven by the logics of para-fertility, such a cautious approach may open the door to greater consultation and discussion before treatment is applied. Such an approach may also be used as a means to bar gay couples from accessing the program with gestational surrogates, however, as IVF with an egg donor would normally be the first stop for such intentionally synfertile families.⁸²³

There is also the danger that cost-cutting measures may be taken too far. A recent investigation of a fertility doctor in London, Ontario found evidence of professional misconduct in regard to repeated low-tech options. Dr. James Martin admitted to performing repeated intra-uterine insemination (IUI) treatments and prescribing high doses of ovarian-stimulation drugs, putting some patients in danger of serious complications.⁸²⁴ An expert report submitted to the College of Physicians and Surgeons hearing found that by persisting with the low-tech IUI

⁸²¹ Angelica Montgomery, “Assisted procreation should not be free, report says” *CJAD News*, June 6, 2014. The details of this scheme are not worked out, nor are thresholds suggested. <<http://www.cjad.com/cjad-news/2014/6/6/assisted-procreation-should-not-be-free-report-says/print>>

⁸²² Dougherty, *supra* note 811.

⁸²³ In early 2014, gay Quebec radio host Joël Legendre announced that he and his husband were expecting twins via a gestational surrogate. The couple had initially been denied access to the provincial funding scheme, but after a call to their local political representative, they were eventually accepted into the program. This marked the first time a gay couple has been extended funding support for IVF and surrogacy in Canada. This announcement has led to spirited debate in Quebec about the ethics and cost rationales of surrogacy, and especially as regards same-sex couples. Quebec Health Minister Gaétan Barrette has indicated that, in his opinion, this case represents a problem with Quebec’s IVF program, and that he intends to act following the release of the report of the Commissaire à la Santé et au Bien-Être. See: Ingrid Peritz, “Provincial health insurance makes in vitro twins a possibility for gay couple” *The Globe and Mail*, Apr. 24 2014. <<http://www.theglobeandmail.com/news/national/provincial-health-insurance-makes-in-vitro-twins-a-possibility-for-gay-couple/article18202256/>>

⁸²⁴ Tom Blackwell, “Ontario fertility doctor banned indefinitely from practising after being found guilty of endangering two patients” *National Post*, May 20, 2014. <<http://news.nationalpost.com/2014/05/20/ontario-fertility-doctor-banned-indefinitely-from-practising-after-being-found-guilty-of-endangering-two-patients/>>

method and delaying a move to IVF, Martin may have left some older women unable to get pregnant with their own gametes.⁸²⁵ Such women would certainly be left out under the Quebec recommendations: the government report suggested that fertility clinics adopt a moratorium on women over 42 who use their own eggs, as well as a general minimum and maximum age for the program.⁸²⁶

AHR Funding By Other Provinces

Other Canadian provinces have also recently launched a program of public contributions to IVF cycles, including Ontario and New Brunswick. The Ontario government announced in April 2014 that it will contribute to the cost of one cycle of IVF, exclusive of the expense of associated drug treatments. As Vanessa Gruben notes, the press release refers to single embryo transfer as the principal way to reduce multiple births, indicating that the government's new policy will likely include both a funding and a regulatory component.⁸²⁷ The Ontario policy is far more limited than Quebec's current model, however, and does not appear to include funding for donor gametes, IUI or other non-IVF services. While the contours of this program will become clear, Gruben rightly suggests that overall affordability is the key to sustainable practices in Ontario. As she says, "social policy regulating the price of fertility services is much needed and likely will be more effective than partial funding for one cycle of IVF."⁸²⁸

The press release also describes the creation of an advisory body to assist in the development of Ontario's funding program; Gruben suggests that such a body should include health care professionals who provide fertility services; those who have used fertility services to

⁸²⁵ *Ibid.*

⁸²⁶ White, *supra* note 817.

⁸²⁷ Vanessa Gruben, "Ontario's New Policy for Safe Fertility Services", *Impact Ethics*, April 23, 2014. <<http://impactethics.ca/2014/04/23/ontarios-new-policy-for-safe-fertility-services/>>

⁸²⁸ *Ibid.*

build their families; sperm and ova donors; women who have acted as surrogates; and adult children conceived using donated gametes.⁸²⁹ To this list I would add members of the LGB and T community as well as the adult children of queer parents conceived through AHR.

Following suit to these developments, New Brunswick announced in August 2014 the government's plan to offset the cost of AHR for eligible residents. The Special Assistance Fund for Infertility Treatment is a one-time maximum grant of \$5,000 to claim costs related to IVF or IUI as well as related pharmaceuticals.⁸³⁰ While there was no mention of limits on the number of embryos that may be transferred, or whether there will be a regulatory aspect to this policy, the full details of the program have yet to be released.⁸³¹

To qualify, however, applicants must “[h]ave been diagnosed by a physician with fertility problems and have received infertility treatment after April 1, 2014.” The medical model of infertility is again in place, channeling access to taxpayer-funded services through a diagnostic procedure squarely aimed at the heterosexual couple. Whether this will prevent access by same-sex couples and single people without a medical diagnosis of infertility remains to be seen. Rachael Johnstone has also pointed out that this announcement follows on the heels of another significant change in reproductive health in New Brunswick, and the closing of the province's only abortion clinic due to a lack of government funding.⁸³² As she explains:

If it were part of a larger commitment to create a spectrum of women's reproductive health services, the infertility fund could be laudable. However, when contrasted with the government's long held, paternalistic stance against the creation of substantive access to abortion, it suggests more alarming commitments. Validating the desires of women to

⁸²⁹ *Ibid.*

⁸³⁰ Service New Brunswick, “Infertility Treatment – Special Assistance Fund,” Provincial Website. <<https://www.pxw1.snb.ca/snb7001/e/1000/infoTe.asp>>

⁸³¹ Rachael Johnstone, “Privileging Infertility over Abortion in New Brunswick”, *Impact Ethics*, August 6, 2014. <<http://impactethics.ca/2014/08/06/privileging-infertility-over-abortion-in-new-brunswick/>>

⁸³² *Ibid.*

have children by investing money in expensive (often unsuccessful) treatments, while simultaneously denying the rights of those facing unwanted pregnancies by failing to provide relatively minimal financial support, suggests deeply troubling views of women's reproductive rights.⁸³³

The apparent adherence to a heterosexist model of infertility is also a cause for concern as New Brunswick ushers in this new funding regime, and the possibility for exclusion by same-sex couples, single people and multi-parent families seeking reproductive assistance.

This prioritization of IVF has also shaped the legal challenges that have argued for the public funding of reproductive assistance. Almost without exception, heterosexual couples have framed their claim for IVF funding within a perspective that depends on reading infertility as medical pathology.⁸³⁴ This approach rests upon the twin presumptions of 'normal reproduction' and 'failed reproduction' to stake a claim of discrimination. This position has the effect of privileging heterosexual forms of sex and erasing LGBTQ relationships from petitions for state recognition of reproductive needs. Emblematic of this privileging is one of the first appellate cases to petition for provincial funding to cover the costs of IVF and ICSI.

Cameron v. Nova Scotia

In *Cameron v. Nova Scotia* (1999), the appellants were a heterosexual couple who had not been able to conceive due to the husband's diagnosed "severe male factor infertility".⁸³⁵ Cheryl Smith and Alexander Cameron had undergone four unsuccessful cycles of ICSI and were seeking reimbursement of the medical hospital costs of these procedures from the Nova Scotia Health Care Insurance Plan.⁸³⁶ As such procedures were not covered under the Plan, the appellants also

⁸³³ *Ibid.*

⁸³⁴ Precisely two such challenges will be explored below.

⁸³⁵ 172 N.S.R. (2d) 227; [1999] N.S.J. No. 33 (N.S. S.C.) [hereinafter *Cameron (NSSC)*, cited to N.S.R.].

⁸³⁶ This matches with Hawkins' observation, that couples who successfully give birth to a child or children are too happy to sue for the reimbursement of costs, be it from a clinic operating a refund program or from a provincial government health plan. The unsuccessful nature of the cycles of ICSI claimed by the *Cameron* case is a constitutive part of the demand for state compensation. See: Hawkins, *supra* note 757.

sought a declaration that IVF and ICSI constituted insured services under the *Health Services and Insurance Act* of Nova Scotia.⁸³⁷ They advanced a two-pronged argument: first, that proper interpretation of the Act would include coverage for IVF and ICSI and thus their denial of funding was unlawful; and second, that the province's failure to provide coverage was a violation of their *Charter* rights. The couple argued that by virtue of a physical disability – infertility - they had experienced impermissible discrimination, as the lack of provincial coverage for ICSI represented a breach of the equality provisions of Section 15 of the *Charter*.⁸³⁸

At the trial court level, the justice addressed the plaintiffs' argument that such reproductive procedures are "medically required" and on a par with other health interventions covered by law.⁸³⁹ He found that they were not, despite being "medically indicated," and furthermore that the *nature of the treatments* was the basis of the province's decision not to fund them, not the *personal characteristics* of a potential user.⁸⁴⁰ As such the treatments simply failed to meet the province's criteria for coverage, liberating the court from the need to invoke a *Charter* analysis.⁸⁴¹

Upon appeal, the court was unanimous in concluding that the case should be dismissed. Interestingly, Chipman J.A. rejected the trial court's finding that procedures such as ICSI are not medically required, arguing that procedures aimed toward the non-medical end of human

⁸³⁷ R.S.N.S. 1989, c. 197.

⁸³⁸ Section 15 of the *Charter* reads: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." *Charter*, *supra* note 281.

⁸³⁹ *Cameron (NSSC)* at paras 240-241. As Barbara von Tigerstrom rightly points out in a comment on the case, the description of a procedure as "medically necessary" is critical in Canada because it determines, through its inclusion in the *Canada Health Act* and provincial health insurance legislation, what services must be insured under public health plans. See: Barbara von Tigerstrom, Equality Rights and the Allocation of Scarce Resources in Health Care: A Comment on *Cameron v. Nova Scotia*, 11 Const. F. 30 (1999-2001) at 34.

⁸⁴⁰ *Ibid*, *Cameron (NSSC)* at paras 241-243.

⁸⁴¹ *Ibid*.

reproduction “*could* qualify as medically necessary”.⁸⁴² However give the costs, success rates and risks of ICSI and IVF in particular, such procedures were not shown in this case to be medically required.⁸⁴³ He then deferred judgment as to which procedures *might* be deemed medically necessary in the future in the hands of policy administrators, recognizing the flexible and ongoing contestation over the allocation of limited health care funds.⁸⁴⁴

As for the *Charter* argument, Chipman J.A. found that there was indeed a distinction being drawn between the “fertile” and the “infertile,” with the latter category affirmatively constituting a form of disability.⁸⁴⁵ Although he recognized infertility as an enumerated ground for constitutional protection, and the presence of discrimination in limited provincial funding for AHR services, Chipman J.A. nevertheless found such discrimination to be justified by Section 1 of the *Charter*.⁸⁴⁶ The objective of the Plan was to provide broad public health care with limited financial resources, directing the court to apply deference to difficult decisions over allocation. He also noted that their equality guarantees were only minimally impaired, as the appellants’ focus had been exclusively on securing access to IVF. Chipman, J.A. determined that denial of public funding for IVF did not therefore constitute undue hardship because it “denies to the infertile funding for only two procedures, leaving them not only the full panoply of medical services available to all, but a number of specific procedures available for their condition.”⁸⁴⁷

Chipman J.A. relies heavily upon a discourse of wounded heterosexuality to draw the

⁸⁴² 177 D.L.R. (4th) 611; [1999] N.S.J. No. 297 (QL) [hereinafter *Cameron (CA)*], cited to D.L.R.] at para 85.

Emphasis in original.

⁸⁴³ *Ibid* at 90.

⁸⁴⁴ *Ibid* at 237-238.

⁸⁴⁵ The concurring opinion by Bateman J.A. did not find that infertility is a disability or that the restriction of health care funding for assisted reproduction in this case constituted *Charter* discrimination. Instead, she concluded that the suffering experienced by infertile people was not comparable to the experience of disability and the marginalization faced by people with other forms of impairment.

⁸⁴⁶ *Ibid*.

⁸⁴⁷ *Ibid* at 244.

infertile into the category of disability. As he claims, “the infertile have been shown to suffer pre-existing disadvantage, vulnerability, stereotyping and prejudice. They have been portrayed, and seen themselves portrayed as, having undesirable traits or lacking those traits which are worthy.”⁸⁴⁸ Fascinatingly, he equates the stigma experienced by infertile heterosexuals with the stigma faced by gays and lesbians.

Quoting approvingly from *Vriend*, which involved the dismissal of a gay teacher, Chipman J.A. explains that “even if the infertile are less stigmatized than, for example, gays and lesbians, what must be considered is the effect of the law drawing a distinction based on their characteristics.”⁸⁴⁹ He then underlines a passage from the *Vriend* decision to highlight the potential for discrimination against infertile people, emphasizing that: “Compounding that effect is the implicit message conveyed by the exclusion, that gays and lesbians, unlike other individuals, are not worthy of protection.”⁸⁵⁰ Drawing an analogy to the “implicit message” potentially conveyed by Nova Scotia’s health care plan - that infertile people, like gays and lesbians, are not worthy of protection - he concludes that infertile people are vulnerable to discrimination.⁸⁵¹

The use of a gay and lesbian judicial victory to highlight the vulnerability of infertile heterosexuals is an interesting move. Chipman J.A. draws upon the wounded heterosexuality of the clinic to analogize the experience of gays and lesbians with infertile people, but *not* as similarly non-reproductive – as might be expected - but as an abjected category of social exclusion. In the process, he fails to consider how gay and lesbian people might themselves be viewed through the model of medical infertility being applied to categorize infertile people as

⁸⁴⁸ *Ibid* at 194.

⁸⁴⁹ *Ibid* at 198. Emphasis in original.

⁸⁵⁰ *Ibid* at 198

⁸⁵¹ *Ibid* at 199.

disabled.

This remarkable oversight is further compounded in the concurring reasons by Bateman J.A., when she analyzes whether or not equal protection for infertile people has been denied in a discriminatory manner. As she explains, policies excluding funding for certain treatments or procedures may indeed discriminate, but must be linked to the nature of the service and not the personal characteristics of a particular social group:

If, for example, it was the government's policy not to fund any medical services for the infertile (assuming them to be “disabled”), without regard to the nature of the service, it is likely that such a policy would be seen to promote the view that such persons were less worthy of recognition or value as a human being or as a member of Canadian society. Such would likely be the case, as well, **with a policy that denied all medical treatment specific to gays or lesbians** or all treatments which only women required.⁸⁵²

Quite astonishingly, Bateman J.A. echoes her colleague's use of the historic marginalization of gays and lesbians (not to mention women) as a rhetorical lever to highlight the vulnerability of infertile heterosexuals. In the process she apparently fails to notice that an imagined policy that might deny treatment to all gays and lesbians could be the variety of reproductive services she had precisely under scrutiny.⁸⁵³ Instead her attention remains with the location of reproductive impairment within a medicalized framework of disability. By adhering to a strictly medical model, both Chipman J.A. and Bateman J.A. allow an uncontested relationship between the pathology of infertility and the definition of disability to remain uncontested by the court.⁸⁵⁴

⁸⁵² *Ibid* at 285.

⁸⁵³ Chipman J.A. uses gay and lesbian equality as a rhetorical tool for a third time in the judgment, when he describes how the province's health policy “denies to the infertile a major component of the array of services available to ameliorate their condition. They are, to paraphrase the court in *Vriend*...still denied a treatment which ‘may be the most significant for them.’” *Ibid* at 204.

⁸⁵⁴ For an excellent analysis of the problematics of this alignment from a critical disability perspective, see D. Gilbert and D. Majury, “Infertility and the Parameters of Discrimination Discourse”, in D. Pothier and R. Devlin

The *Cameron* appellate ruling displaces a concern with the social dimension of disability in favour of a strictly biological modality. It constitutes disability as a failure located in the abnormal body, rather than understanding disability as a social construction in conflict with normalizing regimes.⁸⁵⁵ Discrimination is here sited in the failure of the state to assist in achieving heterosexually reproductive outcomes, rather than questioning the medical diagnosis of infertility itself. This decision also conflates the two claimants as a single infertile heterosexual unit, despite the fact that it was only the male experiencing an issue of subfertility.⁸⁵⁶ This failure to apply a gendered analysis to the case is in keeping with the dyadic model of orthofertility and the host of expectations that fuel the heterosexual imaginary.

It is also notable that Chipman J.A. tacks back and forth between dismissal and approval of the possibility of intentional synfertility for the couple. When reviewing the trial court judgment, he states that he was not impressed by “the suggestion that the availability of other choices to the condition of childlessness such as donor insemination, adoption or simple acceptance was in itself a convincing reason for deeming IVF and ICSI to be not medically necessary.”⁸⁵⁷ This appears to be a recognition of the critical role of para-fertility in recreating the model of dyadic heterosexual parenthood. Yet in concluding that the violation of the appellants’ *Charter* rights is only minimally impaired by the funding scheme, he determines that this is because “it denies to the infertile funding for only two procedures, leaving them not only the full

eds., *Critical Disability Theory: Essays in Philosophy, Politics, Policy and Law* (UBC Press: 2006).

⁸⁵⁵ *Ibid.* See also: Judith Mosoff, “Reproductive Technology and Disability: Searching for the “Rights” and Wrongs in Explanation” (1993) 16 *Dalhousie L.J.* 98.

⁸⁵⁶ Gilbert and Majury, *supra* note 854.

⁸⁵⁷ *Cameron (CA)* at para 86.

panoply of medical services available to all, but a number of specific procedures available for their condition.”⁸⁵⁸

Yet the decision has already described the range of parafertile procedures the couple underwent, including surgery on the male appellant, three cycles of intrauterine insemination of the female appellant and the removal of fibroids from her uterus.⁸⁵⁹ It was only after these failed that the couple sought out ICSI as a last resort.⁸⁶⁰ What procedures remain? One must conclude, then, that the “number of specific procedures available for their condition” involves the synfertile donor insemination that only recently failed to impress the court.

This incoherence is not only due to sloppy analysis, as has been discussed by other commentators,⁸⁶¹ but also because court lacks the necessary vocabulary to describe the deviations from orthofertility that it contemplates. The analysis also leaves uninterrogated the correlation between stigma and non-reproductive alignment. The heterosexual parent who finds themselves infertile and reliant upon assisted reproduction tends to experience this biological limitation as deprivation. And importantly, it is because of this deviation from the 'natural' mode of reproduction (and the trauma and loss that results) that a legal claim of discrimination may be launched, triggering a demand for state involvement and compensation. Since *Cameron*, this script has been followed by other petitions for the government subsidy of reproductive assistance.

⁸⁵⁸ *Ibid* at para 244.

⁸⁵⁹ *Ibid* at 3.

⁸⁶⁰ After their male factor infertility was diagnosed, the Camerons underwent a suite of procedures including surgery on the male appellant, three cycles of intrauterine insemination of the female appellant and removal of fibroids from her uterus (myomectomy). Only when these failed were the appellants referred by their physicians for ICSI. *Ibid* at para 3.

⁸⁶¹ Von Tigerstrom, *supra* note 839; Gilbert and Majury, *supra* note 854.

Terry Buffett v. Canadian Forces

In 2006, a landmark human rights challenge was won by Canadian soldier Terry Buffett, who successfully claimed that his wife's IVF cycles should be funded under the Army's medical plan.⁸⁶² The grounds for the case started back in 1997, when the Canadian Forces (CF) agreed to cover the IVF treatment of a female officer. A year later Buffett applied to have his wife's IVF treatment receive similar coverage.⁸⁶³ When he found himself denied, Buffett filed a grievance arguing this restriction was discriminatory and based on gender. In 2001 his filing was denied by the Canadian Forces Grievance Board, which noted that dependents are not covered under the CF health policy, justifying the refusal of Buffett's IVF request as a reasonable limit under s.1 of the *Charter*.⁸⁶⁴

Buffett filed a complaint with the Canadian Human Rights Tribunal in which he claimed that this refusal constituted adverse differential treatment based on his disability (male factor infertility), his sex, and his family status, in breach of s.7 of the *Canadian Human Rights Act*.⁸⁶⁵ The Tribunal ruled in favour of Buffett, concluding that infertility constituted a disability within the meaning of the *Canada Human Rights Act*, with its diagnosis as a medically treatable illness allowing for his claim under s.7.⁸⁶⁶ The decision of the Tribunal, under direction from Justice Hadjis, hinged upon the distinction between procedures that *reverse infertility* and procedures that *induce or assist conception*. As the former can be characterized as medical procedures, and therefore are covered under the CF's medical plan, it was determined that “CF members with

⁸⁶² *Terry Buffett v. Canadian Forces* [2006] CHRT 39.

⁸⁶³ *Ibid.*

⁸⁶⁴ *Ibid* at para 35.

⁸⁶⁵ *Canadian Human Rights Act, An Act to extend the laws in Canada that proscribe discrimination* (R.S., 1985, c. H-6). Section 7 provides that: “[i]t is a discriminatory practice, directly or indirectly, ... (b) in the course of employment, to differentiate adversely in relation to an employee, on a prohibited ground of discrimination.”

⁸⁶⁶ *Buffett, supra* note 862 at para 105: Quoting from Hadjis J.: “In light of the foregoing, I am satisfied that Mr. Buffett's infertility constitutes a disability within the meaning of the *Act*.”

male factor infertility should receive substantively equal benefits as either CF members with double fallopian tube obstruction, or all female CF members, as the case may be.”⁸⁶⁷

According to Hadjis J., substantively equal benefits may include not only treatment for male infertility for an Army officer, but also IVF treatment for the non-enlisted marital partner, making the Canadian Forces responsible for a style of publicly funded IVF that at that time was not available through any provincial health care plan in the country.⁸⁶⁸ This 'additional' benefit was deemed necessary to equalize the gap between female factor and male factor infertility, for as the expert medical witness at trial testified: medical treatment for both male *and* female infertilities was required to normalize the pregnancy rates to about 30 percent per cycle.⁸⁶⁹ As Hadjis J. concluded:

Thus, in order for male CF members to receive a benefit that is equal to the benefit being offered to female members with bilateral fallopian tube obstruction [leading to female infertility], IVF treatments with ICSI [male infertility treatment] would need to be made available to them.⁸⁷⁰

While this judgment affords a greater claim to reproductive services for male CF members, it is at the cost of a deeply rigid and binary model of not only sexual partnership but parenthood. Indeed the language of the case is oriented fully toward a dyadic heterosexual structure of coupling, with Hadjis J. remarking how “assisted conception procedures are different from all other medical procedures...in that, by biological necessity, two individuals must be involved.”⁸⁷¹

⁸⁶⁷ *Ibid.* at para 123.

⁸⁶⁸ Nisker, J. “Socially based discrimination against clinically appropriate care” CMAJ. 2009 Nov 10;181(10):764

⁸⁶⁹ *Buffett, supra* note 862 at paras 58-59.

⁸⁷⁰ *Ibid* at para 60.

⁸⁷¹ *Ibid* at para 52.

In case the gender of those two individuals was not evident, the judgment details at length the requirement for a male-female model of both medical infertility and the resultant claim to CF benefits. In the paragraph below, which I have quoted at length, one finds it difficult to imagine a single male who wishes to use the services of a gestational surrogate. Nor is it easy to imagine a lesbian couple in which the non-CF member wishes to have IVF treatments in order to conceive.⁸⁷² The wording of the judgment is so tightly structured, and so resoundingly built upon an orthofertile framework of parenthood, that only the 'disability' of infertility is conceptualized as a medically necessary procedure under the bounds of CF health care funding. The single father and lesbian couple have no grounds for claim here:

The CF's health care policy is structured in such a way as to provide the female member who has a form of female factor infertility with a publicly funded service that will afford her the opportunity to have a child. *Physiologically, this procedure can only be completed with the contribution of a person of the opposite gender. The CF funds the service for the female member, even if the opposite-gender contribution comes from a non-member of the CF.* On the other hand, the CF does not provide the equal benefit to a male member with male factor infertility, merely because the contribution from the opposite-gender non-member is much more medically complex. And yet, the same physiological reality exists that conception can only occur with the participation of both partners.⁸⁷³

Under this strictly intra-reproductive reasoning, while a female heterosexual CF member with a male partner will be eligible for treatment and insemination with her partner's sperm, a lesbian CF member will not be able to claim the same coverage. Now it may be that a further court challenge by a lesbian member of the Armed Forces is required to advance this claim on discriminatory grounds; but as the results of the case depend on the existence of medical

⁸⁷² The Canadian Armed Forces was compelled by a 1992 Federal Court order to repeal the policy barring homosexuals from the Canadian military as a violation of the *Charter*. By the time of the *Buffett* ruling, gays and lesbians had been serving in the Armed Forces for fourteen years. See: *Douglas v. Canada* (T.D.), [1993] 1 F.C. 264.

⁸⁷³ *Buffett*, *supra* note 862 at para 53. Italics mine.

infertility, it is only in the absence of 'normal' conception that such procedures are deemed medically necessary. If one callously wishes a bilateral fallopian tube obstruction upon the non-CF member of the imaginary lesbian couple, then she might have a claim to these services. But in the absence of an 'infertility problem' this case provides no reasonable grounds for a claim.

When medical necessity is strictly equated with reproductive impairment, *and* the focus remains on expensive ICSI and IVF procedures that challenge limited health care allocations, little room remains for queer families to stake a claim for state support. Critically, while these cases have focused on heterosexual couples and the diagnosis of infertility, they have laid the conceptual bedrock for litigation advanced by same-sex couples as well. The leading Ontario case launched by a gay couple to claim some of the expenses of assisted reproduction demonstrates some of the restrictions imposed by the narrow argumentative ground carved out by *Cameron and Buffett*, and the ways in which they fail to align with queer parenting projects.

Toronto (City) v. Toronto Professional Fire Fighters' Association

In the arbitration hearing *Toronto (City) v. Toronto Professional Fire Fighters' Association*,⁸⁷⁴ two grievances were filed on behalf of a married gay male couple to claim the drug costs required for their gestational surrogate and egg donor under the City's drug benefit plan (one member of the couple was a firefighter and city employee). Although fertility drugs were covered under the City's plan, their claim for the cost of the drugs had been denied. The City justified this denial on the grounds that the plan covers the employee, his or her spouse (whether same-sex, heterosexual, common-law or married) and dependent children; it does not cover third parties, such as the gestational surrogate and egg donors in this case.

⁸⁷⁴ 2009 CanLII 28639 (ON LA)). [hereinafter referred to as *Toronto Professional Fire Fighters' Association*.]

The Fire Fighters' Association [Association] filed a policy grievance against the City. In an individual grievance filed on behalf of the firefighter, the Association claimed his right to be free from discrimination in employment on the basis of sex and sexual orientation. In line with the jurisprudence set by *Cameron* and *Buffett*, as well as the dominance of the medical model of analysis, in a separate policy grievance the Association also asserted that the benefit plan discriminated against a separate category of persons "on the basis of disability."⁸⁷⁵ However as will be discussed, even this claim by the Association was carefully contextualized by the social reality of the men.

It is notable that the grievance did not seek the reimbursement of costs for IVF coverage, but merely drug cost benefits allowable under the existing plan. Thus the challenge was not to determine whether a procedure was medically necessary and should be newly included within health coverage (as with *Cameron*) but to determine whether it was a substantively equal benefit according to an existing plan (as with *Buffett*). The court sought to determine whether discrimination had occurred in the distribution of substantively equal benefits, and, if so, what the grounds of such discrimination might be.

The Association's submission claimed that to be unlawful, discrimination need not be intentional or express, but can be unintentional and indirect. The submission thus contended that the denial of coverage in this case represented a "classic case" of "adverse effect" discrimination, as an apparently neutral rule regarding the limitation of funding for procedures of assisted conception to marital partners serves to prevent access by surrogates, therefore excluding gay

⁸⁷⁵ In the Ontario anti-discrimination context, the right to equal treatment upon enumerated grounds is grounded in s.5(1) of the provincial *Human Rights Code*. *supra* note 555.

men from health funding explicitly meant to provide for AHR.⁸⁷⁶ As the Association insists, “it is solely because of the gay male firefighters’ sex and sexual orientation – namely the reality of being in a same sex relationship with two men – that they cannot achieve conception without reliance on a female surrogate and egg donor.”⁸⁷⁷ Thus, the Association submitted that discrimination is based on the intersecting grounds of sex and sexual orientation, and the City’s response failed to account for “the contextual reality of the grievor’s life as a gay man”.⁸⁷⁸

In line with these intersecting grounds, the Association submitted a qualified definition of infertility as a person “who, as a result of *the nature* of her or his infertility, is incapable of conceiving a child without the use of reproductive technologies involving a female surrogate and/or egg donor (to whom the [fertility] drugs are prescribed)”.⁸⁷⁹ This moves away from a strictly biological frame to a more relational inquiry, where the focus is not on determining the *individual cause* of reproductive incapacity but evaluating the *contextual setting* of a synfertility project. This move avoids focusing on the medical diagnosis of infertility in order to stake a claim for reproductive impairment as a disability. Instead it takes up an embedded understanding of reproductive alignment, arguing that it is discriminatory to deny the cost of fertility drugs to “gay male firefighters who, *as a result of their sexual orientation and sex*, are partnered with another man and are therefore biologically incapable of conceiving a child without the use of reproductive technologies”.⁸⁸⁰ This definition does not rest upon an individualized medical pathology, but upon the constitutionally protected grounds of sexual orientation and sex and the sexual object choices that follow from queer relations.

⁸⁷⁶ *Toronto Professional Fire Fighters’ Association*, *supra* note 874 at para 41.

⁸⁷⁷ *Ibid* at para 44(27).

⁸⁷⁸ *Ibid* at para 44(29).

⁸⁷⁹ *Ibid* at para 20. Emphasis mine.

⁸⁸⁰ *Ibid*. Emphasis mine.

Finally, the Association argues that this policy is discriminatory not simply because it may adversely impact people in same-sex relations, but because it also treats different types of same-sex relationships differently. Heterosexual male firefighters, heterosexual female firefighters, *and* lesbian female firefighters who require reproductive assistance can receive reimbursement for the fertility drugs, whereas gay male firefighters and their reliance upon a surrogate and egg donor are denied reimbursement. This is similar to the reasoning applied in *Buffett*, wherein the procedures available to a female CF member were not available to a male CF member. However in this case, it is not an equivalent parafertility but the complex synfertilities of surrogate labour that create the grounds for discrimination. The Association's attention to the socially embedded context of reproductive alignment allows them to advance a complex argument for reimbursement that accounts for the synfertility of the men.

Despite the Association's careful attention to the contextual reality of a planned gay parenting project, the arbitrator's decision reflected a painfully thin vision. Arbitrator Goodfellow begins his decisions with the distinction between two categories of employees who may be discriminated against under the current provisions: 1) those whose infertility can only be overcome through the use of surrogates to whom fertility drugs are prescribed; and 2) gay males who are not infertile but who engage surrogates to whom fertility drugs are prescribed.⁸⁸¹ From the start, Arbitrator Goodfellow rejects the socially embedded model of reproductive alignment in favour of a medical model of infertility. He asserts that "[t]here is no dispute that infertility is a disability," explaining that there are many causes and types of such infertility, "some of which are 'treatable' by the 'sufferer' taking fertility drugs and some of which are not."⁸⁸² He thus frames the employees of both categories as reproductively disabled, despite the use of scare

⁸⁸¹ *Ibid.*

⁸⁸² *Ibid.*

quotes to indicate that gay reproductive non-alignment might not actually be a malady from which one suffers (and that being gay is not something one would wish to consider ‘treatable’!). Arbitrator Goodfellow is admittedly constrained by the terms of the drug program, which require evidence of adverse treatment upon a prohibited ground to stake a claim of discrimination. In the policy grievance filed by the Association the ground is disability, with adverse treatment comprised of drug payment for some infertile persons but not for others.

Within these terms, however, Goodfellow must read gay reproductive non-alignment as disability, and he makes repeated reference to the individualized character of infertility as experienced by “a disabled person.”⁸⁸³ Thus the negotiated benefit of the plan, as he concludes, attaches to the employee as well as their spouse and dependent children. However these benefits encircle only properly disabled bodies within the bounds of the sexual dyad, not the synfertile character of surrogacy and egg donation. Only those forms of ‘disability’ that are treatable through drugs are covered, and only within the sexual family unit. As he concludes, “[w]hat the plan does not do...is enable a disabled person who is covered by the Plan to, in effect, contract out that benefit to a third party”.⁸⁸⁴

Because this conceptual rubric cannot account for the contextual experience of the gay couple, Goodfellow relies solely on the benefit of the drugs to alleviate medical infertility. This framing of infertility as disability reflects the norms of the insurance industry,⁸⁸⁵ as well as the increasing medicalization of reproductive bodies. By narrowing his judgment to the issue of negotiated drug benefits to treat disability, rather than the ontological difference that synfertile families may present, Goodfellow is able to produce the following reasons:

⁸⁸³ *Ibid.*

⁸⁸⁴ *Ibid.*

⁸⁸⁵ *Ibid* at para 33(i).

...the plan does not discriminate against infertile employees *in the provision of the benefit*: fertility drugs. Such drugs continue to be available to them. They are simply of no value in dealing with their particular form of infertility.⁸⁸⁶

The problem here is viewed not as located in the definition of either infertility or disability, but with the *particular* form of disability-as-homosexuality that the two men are facing. When he then turns to the specific issue of discrimination based on sex and sexuality, Goodfellow is able to neatly extend his line of reasoning to conclude that the drug plan benefits make the drugs *available*, they are simply not *efficacious* because the two men are not properly disabled.⁸⁸⁷ By divorcing the men from their social and relational context, Goodfellow is able to examine their individual bodies in isolation, allowing him to make the observation that “we are dealing here with a claim for the cost of fertility medication advanced on behalf of a fertile male whose partner – who is also covered by the plan – is also fertile.”⁸⁸⁸ This dogged reliance on the fertile/infertile binary as constructed within a framework of disability ignores the intersectional factors of sex and sexual orientation that make their claim necessary in the first place.

Finally, in noting that “the obstacle to conception in this case is that [the fire fighter’s] partner is male” Goodfellow closes the book on their lived reality, remarking that “unlike at least some forms of ‘disability’ (including some from which males can suffer), this is not an obstacle that the City’s drug benefit plan or, indeed, any drug benefit plan, is capable of overcoming. What is missing in this case is a member of the opposite sex.”⁸⁸⁹ Thus a same-sex relationship is figured as a biological ‘obstacle’ outside the bounds of the drug treatment benefits available to assist conception, with those very bounds defined by their adherence to a rigorously heterosexual and orthofertile model.

⁸⁸⁶ *Ibid* at 29.

⁸⁸⁷ *Ibid*.

⁸⁸⁸ *Ibid*.

⁸⁸⁹ *Ibid*.

Queer Folks and Access to Reproductive Funding

So where does this leave intentionally synfertile families? The reviewed case law has indicated limited utility for the medical model of infertility, which is deployed to make a claim of discrimination based on disability.⁸⁹⁰ This equation, in which assisted reproduction is always incumbent upon an underlying medical problem (infertility) which requires medical intervention and public funding (as a disability), works to pathologize the provision of AHR and construct reproductive assistance as a remedy for abnormality. This is an individualized frame that depends on a host of assumptions about intra-reproductive orthofertile families, and has difficulty accounting for the collaborative synfertility of queer parenting projects.

However some of the legal strategies pursued by the Toronto Professional Firefighters Association in their grievance submissions offer a promising response. The submissions rejected a biological frame of reproduction in favour of a more relational inquiry. Rather than seeking to determine the individual cause of reproductive incapacity, the analysis focused on evaluating the contextual setting of a given reproductive project. This moves away from the infertility trap and the problematics of the medical model of disability as grounds for a discrimination claim. Instead this approach pursues an embedded understanding of reproductive alignment.

⁸⁹⁰ This is also the case for the more recent human rights challenge launched by Ana Ilha and her husband Amir Attaran, a professor at the Faculty of Law and Department of Epidemiology at the University of Ottawa. In 2009 they filed a complaint with the Human Rights Tribunal of Ontario against the Ontario Ministry of Health, alleging that the province's failure to publicly fund IVF treatments amounts to discrimination. *Ilha v. Ontario (Health and Long-Term Care)* [2010] HRTO 594.

As reported in a *National Post* article about the couple's frustration with IVF treatments in Ontario being publicly funded only for women with blocked fallopian tubes, Ilha said about her inability to conceive: "It's not cancer, but it is a disability...And if it is funded for a particular group, it should be funded for other groups that have the same diagnosis." (Quoted in Natalie Alcoba, "Should the State Be Funding In-vitro Fertilization?", *National Post*, August 21, 2009. <<http://www.nationalpost.com/m/story.html?id=1917858>>).

The discrimination claim is thus grounded in a contextual analysis that seeks an explicit accounting of the sexual orientation and sex of synfertile families.⁸⁹¹ It becomes easier to make a claim for the public funding of reproductive assistance based not on disability, but on a contextual analysis that accounts for synfertile couples who are not reproductively aligned with their partner. Such an argument does not rest upon medical pathology, but upon the constitutionally protected grounds of sexual orientation and sex and the sexual object choices that follow from queer relations.

The discussion from Quebec shows that, for the first time in Canada, an open regime of state-funded reproductive assistance has provided support for all manner of queer families, including a gay couple and a gestational surrogate. By not hinging access to AHR upon a medical diagnosis, the province has avoided the infertility trap and made wide-ranging access a possibility. However there have also been critical limitations, including the program's refusal to fund open-identification donors and the invalidity of surrogacy contracts in Quebec. Nevertheless the program has met public health goals by reducing the number of multiple births, and provided access to AHR that is not contingent upon psychosocial gatekeeping or the presence of reproductive pathology. Unfortunately this all seems set to change in the near future.

To date, however, no other province in Canada offers this sweep of coverage, under the rationale that AHR is not medically necessary and therefore does not oblige the state to provide subsidized access.⁸⁹² Yet reproductive technologies can only be framed as medically

⁸⁹¹ This follows the three-step analysis for a claim under s.15(1) of the *Charter* set out in *Law v. Canada* (1999), wherein inquiries are to be undertaken using a comparative approach, taking account of contextual factors including the claimant's characteristics or circumstances, the ameliorative purpose or effects of the impugned provision and the nature of the interest affected. Such an analysis is also purposive, requiring the claimant to show that the purpose of s.15 has been infringed by the impugned law.

⁸⁹² Edward Hughes, "Access to effective fertility care" (2008) 30 (5) *J Obstet Gynaecol Can.* 389-390. Hughes cites a recent letter written to the British Columbia Ministry of Health which received the following reply: "the Medical

unnecessary within a heterosexual model that understands 'normal' reproduction as orthofertile reproduction. By prying apart the categories of what is considered 'essential' care and what is considered 'elective', it is possible to reveal powerful bioethical assumptions about what a healthy (heterosexual) populace requires. When the field is broadened to include synfertility as well as parafertility, this drastically opens the conceptual rubric for all manner of families.

By centering the experience of the queer reproductive family and rejecting the limits of the infertility trap, I believe that one may more readily demand access to state-led subsidies that can help mitigate the ruthless logics of privatization. The uneasy hybrid of Canada's fertility industry – as an unregulated, for-profit, opaque, private and yet occasionally publically funded regime – should not be based upon efficiency goals that replicate corporate modalities to the exclusion of broad social welfare. This includes both an attention to reducing multiple-embryo transfers, as well as care for ensuring sustained access by queer families and single people who do not fit a medical model of infertility.

By rejecting a market-based approach to health care, not only queer people but all users of reproductive assistance are able to voice a concern for reproductive outcomes that can account for their specific needs. As it stands, the infertility trap holds the potential for very real consequences upon the reproductivity of LGBTQ people. Quebec stands at the cusp of radically reframing its funding model, while the newly announced plans in Ontario and New Brunswick are restricted to a single round of IVF and/or couples with a medical diagnosis of infertility. While there is still no public funding for reproductive procedures in most of Canada, the tide appears to be turning. Certainly the past decade has seen vociferous debate about the wisdom of

Services Plan relies on the advice of the medical profession in determining the medical necessities of procedures. To date, there has been *no indication from the medical profession that it considers IVF to be medically necessary.*” While both of these examples refer narrowly to the practice of IVF, they are exemplary of provincial approaches to the funding of AHR more broadly. Emphasis mine.

including AHR procedures within provincial insurance plans.⁸⁹³ The tenor of such debates may indicate the future direction of reproductive funding, if LGBT advocates and voices continue to remain silent.

Columnist Margaret Wenté again offers an example of how current discourses exclude and marginalize queer perspectives, this time in a *Globe and Mail* editorial on the decision to publicly fund IVF treatment in Quebec. In the piece, Wenté roundly criticized the Quebec Health Minister at the time, lamenting the drain on public monies now that provincial “government will start funding in vitro fertilization for people who can’t conceive *normally*.”⁸⁹⁴ It is not a stretch to imagine how a professional muckraker like Wenté might read the situation faced by Maricel and Carol in the previous chapter. Despite her (presumably) functional uterus, Maricel was unwilling to be inseminated and it was her partner Carol to whom the labour of reproduction fell. The women were fortunate in that Carol did not require IVF, merely a wider range of donor sperm options, but if Carol had needed a donor egg, the apparent obstinacy of a lesbian co-mother like Maricel may have been thrown into relief. A commentator such as Wenté would surely have little difficulty in placing Maricel’s ability to exercise reproductive control over her body in tension with the taxpayer-funded provision of IVF.

When the underlying framework of assisted reproduction is a heterosexual model, it is impossible to imagine *why a reproductive body might decide not to reproduce* while still wishing to engage in a parenting project. Where might we find a rationale for the public funding of expensive egg donation and IVF procedures for a subfertile lesbian, when she has a female

⁸⁹³ For example the *Raising Expectations* report, which concluded that the high cost of assisted reproduction services is compelling Ontarians to make unhealthy choices about their own health, the health of their children, and the sustainability of the entire health care system. *Raising Expectations*, *supra* note 786 at 22.

⁸⁹⁴ Margaret Wenté, “In Quebec, infertility is now a disease,” *The Globe and Mail*, July 20, 2010. <<http://www.theglobeandmail.com/news/opinions/in-quebec-infertility-is-now-a-disease/article1645305/>>

partner with the biological capacity to get pregnant through donor insemination? Framing her rejection of pregnancy as a 'choice' rather than a fundamental expression of her gender identity casts the issue as one of individual caprice. Maricel's decision appears a peevish whim, except when read through a queer lens wherein a woman may *not* want to get pregnant, may *not* want to adopt, but may still wish to parent a child that is biologically linked to both her partner and her own heritage. This is a vision of synfertility that is unreadable through the narrow conceptual framework of the infertility trap, where the instrumentalist logics of the health marketplace remain powerfully buttressed by the reproductive logics of orthofertility.

Should Canadian provinces one day decide to broadly subsidize these procedures, it is uncertain what normative expectations will be applied to people in their position, although the recent fracas over the gay radio host and Quebec's funding of his gestational surrogate provides a clue.⁸⁹⁵ The effacement of alternative modes of kinship occurs because synfertility has not been seen as a valid and intentional form of family creation. When the singular lens of AHR is trained on producing parafertility within a heterosexual imaginary, it limits the options for other family arrangements to take place. Instead, debate focuses exclusively upon an imaginary privatized, heterosexual family making specific, individualized claims (either just or unjust, depending on one's ideological stance) upon a distributive state.

I do not of course deny the validity of medical risks to heterosexual women, and agree that greater access to safe IVF, including single embryo transfer, results in improved health outcomes for mother and child, as well as reduced expenses for the state. But this debate represents only part of the picture, and yet it has dominated national discussion. What I am

⁸⁹⁵ See discussion earlier in this chapter about the Quebec government's intent to retract public funds for gay surrogacy projects. While the era of public funding for AHR is still in its infancy, a cost-benefit analysis working in tandem with heterosexist rationales is not hard to anticipate.

interested in is the continued polarization between the 'ordinary' families who can conceive 'naturally' and the 'exceptional' cases who are plagued by the 'abnormal' disease of infertility and require public funding to safely produce offspring.

As explored throughout this dissertation, this conceptual natural/artificial binary works to create reproductive stigma while effectively erasing LGBTQ people from the discussion. It is this foundational discursive frame of natural/unnatural, normal/abnormal and the excision of queer embodiments which prevents broader discussions. The explicit incorporation of a medical model of infertility in New Brunswick is thus cause for concern, as are recent comments by the current Health Minister for Quebec. This is the wrong direction to be moving in, as the current Quebec model of funded reproductive assistance has allowed LGBT people, single people, poor people and subfertile heterosexuals to work toward actualizing their parenting plans. This has also allowed people seeking IVF to avoid deliberations over multiple embryo transfer, which places the intended parent(s) in an impossible bind wherein the best interests of their unconceived child must be weighed against the chance of not conceiving a child at all.

Yet these progressive moves cannot be stripped from the fact that Quebec is the first province in Canada to take these measures, not to mention the first jurisdiction in North America. The rationale here, I would argue, primarily fulfills not social goals of safe medical treatment nor even economic goals of fiscal management, but solidly nationalist goals of population expansion. A declining birthrate and clearly stated provincial aim to maintain 'a distinct society' practically mandate the free provision of procreative technologies. At the same time, this explicitly natalist reckoning is framed by the recent debates in Quebec on “reasonable

accommodation” for racial and ethnic minorities, and haunted by xenophobic fears and discourses of Quebecois purity.⁸⁹⁶

Dorothy Roberts has written persuasively of the connections between racial inequality, access to reproductive technology and social trends toward privatization. Her work in *Killing the Black Body* described the workings of a “reproductive caste system” which contrasted policies that punish the childbearing of poor black women with the high-tech fertility industry that promotes childbearing by more affluent white women.⁸⁹⁷ There is also a growing international component to this analysis. Cross-border reproductive travel has increased the potential for racialised exploitation as people move out of cautious and prohibitive jurisdictions into more permissive jurisdictions, where they may acquire treatment more quickly or substantially reduce costs.⁸⁹⁸ Yet Quebec’s provision of accessible reproductive assistance for all families, despite its uneasy foundations upon pro-natalist policy, served poor, queer and racialized families as well as wealthier white families on the top of the reproductive hierarchy. I believe this is the right model.

The empirical research of the Creating Our Families study backs up this concern for the effects of reproductive stratification. Despite a central methodological goal of recruiting LGBTQ people of colour and those living outside major urban centres, our research sample nevertheless consisted of predominantly white, same-sex partnered, urban women with relatively high levels of education and income.⁸⁹⁹ While additional research is required to more fully identify barriers to access, our sense is that this demographic reflects the predominant

⁸⁹⁶ This and related ideas of homonationalism and the biopolitics of queer reproduction will be developed more fully in future work.

⁸⁹⁷ Roberts, *Killing the Black Body*, *supra* note 469 at 246–93.

⁸⁹⁸ Richard F. Storrow, “Travel into the Future of Reproductive Technology”, 79 *Univ. of Missouri-Kansas City Law Rev.* 299 (2010).

⁸⁹⁹ Lori Ross et al., *supra* note 233.

users of AHR services from within LGBTQ communities in Ontario. As our study concluded:

It is notable that despite the relatively high levels of education and income within our sample, one of the most common concerns expressed by our participants was the financial inaccessibility of AHR services.⁹⁰⁰

This data points strongly to the importance of state-funded medical care and the need for reproductive support to ensure that AHR does not remain a remote technology out of the reach of poor, queer and racialized communities.

⁹⁰⁰ *Ibid.*

Chapter Twelve: Family, Contract and Queer Parenthood

New Models for New Times

This dissertation has traced the figure of the queer family as an empirical location to bring conflicting discourses of nature and culture into conversation. It has sought to track the paths through which relationality is recognized and privileged in law, with a focus on reproductive technologies and the new biosocial forms of kinship which are created. It has given specific attention to family arrangements which involve the sourcing of gametes or reproductive labour from outside the sexual dyad – a formation referred to as ‘extra-reproductive’ family – and tracked these families through the medico-juridical forms of power in operation at fertility clinics and in family law.

It has also involved a historical component, looking at the impact feminist scholars have had on the development of AHR-related legislation in Canada. It explored the strand of radical feminism which rejected reproductive technology as an instantiation of patriarchal control over women’s bodies, and the influence this mode of thinking had on Canadian feminists seeking to respond to and influence newly developing state policy. It also explored the impact this strategy of ‘governance feminism’⁹⁰¹ had on a report issued by the Commission on New Reproductive Technologies and later iterations of a federal bill. It has traced feminist concerns that their ideas had been absorbed without political context, and looked specifically at the impact on sperm regulations and commercial surrogacy bans as they affected lesbian and gay prospective parents.

It then relied upon empirical data to show how queer families are being medicalized and pathologized in the fertility clinic, and paid special attention to the construction of ‘infertility’ as

⁹⁰¹ Halley, *supra* note 434.

a normalizing mode rooted in heterosexist and biologically essentialist modes of thought. It suggested that the ‘infertility trap’ is a central agent in developing and sustaining the reproductive traumas of the fertility clinic, and looked at the effect this formation has on non-normative families seeking reproductive assistance. Finally it moved to create a new conceptual framework for the multiple forms of intimate affiliation being produced through assisted and non-assisted means, and rejected techno-mediated kinship construction as an exceptional form of family creation.

This dissertation has argued that the privileging of nature functions to affirm the heterosexual imaginary. Thus technologically-assisted reproduction needs to be understood not in opposition to ‘natural’ modes, but as a form of power operations that represent much more than the neutral application of reproductive tools. Indeed, the very idea of ‘natural’ maternity relies on the construction of ‘unnatural’ modes as its constitutive other. As Dion Farquhar rightly argues:

“Unitary” maternity is a political category, a historically constructed and weighted polemical inscription of a formerly naturalized “experience” as something it was not, and could not have been, before discourse invested it as such. The purported universality and fixity of the category of unitary maternity is called into question *at the same time* it is named and called into existence – by its difference from an other, technologically distributed, maternity...Technophobic naturalizing discourses operate by positing a pre-technological, protected idyll...Reproductive technologies thus create a nostalgia for projections about what might have been *before* present regimes of fragmentation.⁹⁰²

Reproductive technologies thereby pose a challenge to the “romanticized holism” of unified maternity, demonstrating the political character of the intra-reproductive family, as well as its socially constructed nature. AHR is thus not really a fragmentation of a formerly unified whole, as the unitary frame was already a fiction. I contend that the romanticized holism of

⁹⁰² Dion Farquhar, *The Other Machine: Discourse and Reproductive Technologies* (New York: Routledge, 1996) at 214.

orthofertility is soothed in the clinic by recourse to parafertility. The easy recognition of parafertile family forms in law also operates to mask the constructedness of this unitary ideal, and claim a universality for the mechanics of intra-reproductive family formation. Synfertile families may appear to fragment the ‘natural’ family, but in fact they merely draw attention to the political character of the heterosexual imaginary and the legal recognitions that flow from its limited vision. The dispersed kinships of synfertility make it difficult to naturalize this ‘idyllic’ mode as a pre-cultural frame of reproduction.

This dissertation has also sought a corrective to much writing about AHR and its binary figuration of nature/culture. For even when providing a sophisticated analysis of the operations of technology and social power, feminist theorists have demarcated the ‘technological’ space of the clinic from the supposed ‘natural’ world of sexual reproduction. This boundary marker between artificial and natural may be critiqued, but it is still understood to have material effects in its uncoupling of sexual intercourse from reproduction.⁹⁰³ Indeed it is precisely this innovation – the breach between sex and conception - which is thought to represent the central disruption posed by reproductive technologies. While I am a great admirer of her work, Farquhar’s writing is nevertheless instructive in this regard, when she argues that:

By definitively separating sex from reproduction, reproductive technologies break the naturalized assumption that reproduction is heterosexual and heterosocial. By fetishizing the social criteria of ‘the [heterosexual] couple,’ medical discourse *invokes* the heterosexist standard only to *disrupt* it by its asexual and third-party donor interventions.⁹⁰⁴

⁹⁰³ See for example, Susan Boyd at, *supra* note 71: “Sexuality and procreation have increasingly become uncoupled both technologically and socially, and ‘baby making of all sorts, including the hi-tech and clinical kind, has increasingly occurred outside heterosexual marriage.” At 3, quoting Maureen Sullivan, who herself makes the same point in: Maureen Sullivan, *The Family of Woman: Lesbian Mothers, Their Children, and the Undoing of Gender* (Berkeley: University of California Press, 2004) at 1. See also Cahn, *supra* note 23.

⁹⁰⁴ Farquhar, *supra* note 902 at 211-212.

I respectfully disagree. It is only synfertility that performs this break from the naturalized assumptions of heterosexuality. The clinical intervention of paraferility – a form of intra-reproductive family construction that operates in parallel to un-assisted reproductive coupling – does not in fact trouble the heterosexual and heterosexual model that Farquhar describes as broken. Paraferile interventions in the clinic actually perform reparative work to wounded heterosexuality, and do not separate sexual affiliates from their intended reproductive outcomes. By refusing the natural/artificial dichotomy which has long structured the discussion about reproductive technologies, I have sought to disaggregate various forms of clinical activity and demonstrate their very different effects in law.

Privileged Families of Law

This final chapter revisits the discussion in the opening pages, and the discussion of shifting family forms in Canadian law. It argues that law, like medical discourse, also reflects a privileging of nature and an idyllic attachment to heterosexual coupling as the pre-eminent mode of family formation.⁹⁰⁵ This is why paraferile families, who precisely approximate the parental modes of orthofertile reproduction, are so easily welcomed into an untroubled presumption of parentage and the heteronormative family order. It is only the synfertile family, and the extra-reproductive character of their family formation, which pose any potential for rupture. These are the intimate modes which have troubled legislators and challenged courts to account for their configuration.

⁹⁰⁵ There is a rich tradition of feminist legal scholarship on the gendered nature of family law, and the ways in which patriarchal modes of power have been reinstated in the modern era through a formalistic gender neutral stance. See for example: Jamil Zainaldin, “The Emergence of a Modern American Family Law: Child Custody, Adoption and the Courts, 1796-1851” (1979) *Northwestern University Law Review* 73; Martha A. Fineman, *The Neutered Mother, the Sexual Family, and Other Twentieth Century Tragedies* (New York: Routledge, 1995); Mary L. Shanley, “Unwed Fathers’ Rights, Adoption, and Sex Equality: Gender-Neutrality and the Perpetuation of Patriarchy” (1995) *Columbia Law Review*, Vol. 95, No. 1; Laura Belleau, “Farewell to Heart Balm Doctrines and the Tender Years Presumption, Hello to the Genderless Family” (2012) *Journal of the American Academy of Matrimonial Lawyers*, Vol. 24 Issue 2.

The legal family is an overdetermined site of social and economic organization that has long been understood as being founded upon a very traditional, culturally specific, heterosexual, middle-class familial ideology.⁹⁰⁶ As Martha Fineman has argued, our “societal and legal images and expectations of family are tenaciously organized around a sexual affiliation between a man and woman,” flattening other forms of familial arrangement so that “[f]ormal, legal, heterosexual marriage continues to dominate our imagination when we confront the possibilities of intimacy and family.”⁹⁰⁷ Even legal reforms aimed at expanding the family to include unmarried heterosexual couples or same-sex couples do not challenge the primacy of the sexual family, as “[b]y duplicating the privileged form, alternative relationships merely affirm the centrality of sexuality to the fundamental ordering of society and the nature of intimacy.”⁹⁰⁸ At a deep level, then, the legal category of family is “equated with the paradigmatic relationship of heterosexual marriage”⁹⁰⁹ and exerts a powerful subjectivating force through its ability to absorb other (appropriately) sexual forms into its fold. It reflects the foundational primacy of the orthofertile pair-bond and the ‘natural’ union of two sexually-affiliated adults even when expanding its bounds to include non-reproductive same-sex couples.

Indeed while same-sex marriage was anticipated by many as having the capacity to dislodge this normative frame, this has not been the outcome. Through the rubric of ‘sexual citizenship,’ Brenda Cossman has written on how by encouraging the “right” choices to become “good” citizens, the state intimately interlaces sex with belonging and sexual freedom with self-governance. This allows for members of previously disparaged sexual identity categories, such

⁹⁰⁶ Susan Boyd and Claire Young, “From Same-Sex to No Sex”? Trends Towards Recognition of (Same-Sex) Relationships in Canada,” *Seattle Journal of Social Justice* 1(3) (2003): 757-793.

⁹⁰⁷ Martha A. Fineman, “The Sexual Family” in *Feminist and Queer Legal Theory: Intimate Encounters, Uncomfortable Conversations*, Martha A. Fineman, Jack E. Jackson and Adam P. Romero (eds.) (Famham, Surrey, GBR: Ashgate Publishing Group, 2009) at 45.

⁹⁰⁸ *Ibid.*

⁹⁰⁹ *Ibid.*

as gays and lesbians, to manage their sex lives appropriately and be included within the liberal state. As Cossman says, “to the extent that we conduct ourselves as ethical sexual subjects, through appropriate sexual practices, choices and desires, we may be constituted and reconstituted as eligible for sexual citizenship.”⁹¹⁰

As other Canadian legal feminists have argued, the failure of the same-sex marriage campaign to critique the mechanisms of formal equality and provide an analysis of gendered inequality has simply reconstituted the two-person marital family as the fundamental social institution *par excellence*.⁹¹¹ Shelley Gavigan’s work has drawn attention to the discursive construction of ‘legitimacy’ in regard to the children of lesbian couples, and the presumption that same-sex marriage was required to remove the stigma of ‘illegitimacy’ that otherwise would attach.⁹¹² This language invokes old categories of family law, long since repudiated and repealed, and reinstates them as relevant signifiers for the formal legal equality of same-sex couples.⁹¹³ Thus the process of same-sex equality partially depends on reforming and reinstituting the language of normalcy, encouraging legal convention and the dyadic structure of marriage – or what Hester Lessard has referred to as the equality formalism of “marriage fundamentalism.”⁹¹⁴

In the context of embryo management and their potential designation as property, Jennifer Nedelsky has argued that, in choosing an operational legal category to work with, “perhaps the most important starting point of inquiry is what the presumptions are, what will

⁹¹⁰ Cossman, *supra* note 205 at 206.

⁹¹¹ Susan Boyd, “Contradictions and Challenges in Canadian Family Law,” (2007), *thirdspace: a journal of feminist theory & culture*, volume 7, issue 1.

⁹¹² Shelley Gavigan, “Equal Families, Equal Parents, Equal Spouses, Equal Marriage: The Case of the Missing Patriarch.” In Sheila McIntyre and Sandra Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms*. (LexisNexis Canada Inc., 2006) at 336.

⁹¹³ *Ibid.*

⁹¹⁴ Hester Lessard, “Charter Gridlock: Equality Formalism and Marriage Fundamentalism.” In Sheila McIntyre and Sandra Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms*. (LexisNexis Canada Inc., 2006) at 292.

require justification, what norms will have to be argued against, what values will be taken as given.”⁹¹⁵ This is precisely the concern I have with the legal category of ‘family’ and its site as a discursive and ontologically normativizing force. In Chapter Two, I posed the following questions:

Is the family a strictly legal concept, and one which only finds culturally legible form through the categorizations of law? If so, might the queer family represent not only the breakdown of the symbolic heterosexual order, but also a rupture in the ways in which ‘family’ has assumed a coherent legal form? Might the queer family, in its material form and inherent non-reproductivity, represent an oxymoron with which the law cannot grapple? And ultimately, is it possible for law to adapt, or must it seek to reinstate existing heterosexual modes of nature/culture upon the palimpsest of the queer family?

At the conclusion of this investigation, I believe that the synfertile family does represent a potentially transformational rupture. However due to the impossibility of finding other models for kinship affiliation reflected in law, it has been difficult to account for the extra-reproductive nature of these parental alignments. At the same time, the legal order remains gendered, classed, abled and raced in ways that make deviations from that norm precarious. The familiar language of ‘legitimacy’ thus becomes available to lesbian couples seeking to make their claim for formal recognition to the state, as well as the claim by a twelve-year girl that her lesbian mothers are “just like everybody else’s family.”⁹¹⁶ It is through reinstatement of the two-parent norm – even when those parents are gleefully polyamorous transmen – that subjects may stabilize their parenting projects. The subjectification may occur with conscious awareness, as through the production of a form of ‘normalizing theatre’ that enacts familiar family tropes, but it must occur nevertheless.

⁹¹⁵ Jennifer Nedelsky, “Property in Potential Life? A Relational Approach to Choosing Legal Categories” (1993) 6:2 Can JL & Jur 343 at 350-51.

⁹¹⁶ Gavigan, *supra* note 912; Rutherford, *supra* note 623.

Thus it appears a fraught mission to try and infuse the abstracted form of legal family with complex embodiments of synfertility. Family as a legal category may not be the right place to stake queer claims of affiliation.⁹¹⁷ Indeed Richard Storrow has chronicled the various bodies of law which have been applied to sort out the parentage issues that arise of assisted reproduction, with some courts presuming the matter is “best addressed through the application of adoption law, marital presumptions of legitimacy or equitable estoppel, [while] legislatures addressing assisted reproduction have fashioned unique statutes to resolve these issues.”⁹¹⁸ As he notes, the overall tendency has not been toward coherent and clear criteria, although it has skewed to policies that favor restriction instead of expansion of the legal definition of family.⁹¹⁹

Intentional Parenthood and the Law of Contracts

Storrow is also one of many legal scholars who have called for a central role for intentional parenthood in breaking free of traditional definitions of family and recognizing alternative family forms.⁹²⁰ As he argues, intentionality can serve as a “tie-breaker” between contending indicia of parenthood; in the heterosexual context of gestational surrogacy in which he writes, the primary modes are genetic and gestational contribution.⁹²¹ By developing a theory of parentage that focuses on those who intended to raise the child, such analyses hope that a more flexible mode will emerge to ameliorate the ideological conservatism of assisted reproduction law.⁹²² Contract law has thus proved an attractive terrain for scholars in this vein,

⁹¹⁷ This is not least because of the singular focus on human reproduction. Queer people without children may also constitute and self-identify as family, as might a gay man and his cat. For fascinating work on inter-species relationships that are well beyond the scope of this dissertation, see: Donna Haraway, *When Species Meet* (Minneapolis: University of Minnesota Press, 2008).

⁹¹⁸ Richard Storrow, “Parenthood By Pure Intention: Assisted Reproduction and the Functional Approach to Parentage” 53 *Hastings L.J.* 597 2001-2002 at 599.

⁹¹⁹ *Ibid.*

⁹²⁰ *Ibid* at 641.

⁹²¹ *Ibid.*

⁹²² *Ibid.*

although the focus has remained almost exclusively on heterosexual families and the confusions of unplanned synfertility.

For example Marjorie Maguire Shultz has proposed that legal rules governing assisted reproduction must include an enhanced role for intention. She argues that law should recognize “the importance and the legitimacy of individual efforts to project intentions and decisions into the future”⁹²³ as long as such intentions are deliberate, explicit and bargained for. As intention plays a key role in projects of assisted reproduction, Shultz sees a natural fit between contractual perspectives, doctrines and concepts, and the solution of legal issues raised by modern reproductive technologies.⁹²⁴ To bring these solutions to bear, Shultz argues for a new “meta-rule” that would make bargained-for intentions determinative of legal parenthood.⁹²⁵ As she maintains:

Where arrangements involve several persons, where the opportunity for planning and deliberation exists, where reliance is weighty, where expectations are substantial and their validation is personally and socially important - as is true of reproductive agreements - contracts offer a means of arranging and protecting these various interests. If we are to construct legal policies that effectuate intention in assigning legal parenthood, contract law can contribute a set of principles and rules attuned to the problems of private ordering.⁹²⁶

However as Nedelsky reminds us, “The choice of legal category is a strategic one. And the first step of the strategy is to ensure that the category will facilitate, rather than obstruct, the outcomes we most care about.”⁹²⁷ Is contract law the right legal mode through which to effectuate the recognition of the synfertile family?

⁹²³ Marjorie Maguire Shultz, “Reproductive Technology and Intent-based Parenthood: An Opportunity for Gender Neutrality”, 1990 *Wis L. Rev.* 297 at 302.

⁹²⁴ *Ibid* at 303.

⁹²⁵ *Ibid*.

⁹²⁶ *Ibid* at 397.

⁹²⁷ *Ibid* at 354.

Susan Drummond has recently argued for the utility of enforceable gestational carrier contracts, and suggested that intended parents should prevail over gestational carriers in the event of disputes over parentage following the birth of a commissioned child.⁹²⁸ Given the lack of federal and provincial legislation around AHR in Canada (as has been discussed at length), Drummond suggests that private law offers a deft mechanism to respond to the complexities of extra-reproductive family formation. Her attention is specifically on gestational carriage contracts, which she recommends treating as “analogously to domestic contracts – i.e., that they will be enforced unless they fail to meet context specific limitations on the validity of contract, such as unconscionability, fraud, error, or duress, that take into account the unique settings of physical intimacy in which they are conceived.”⁹²⁹

In her view, the combination of failed legislation, weakly enforced criminal provisions and an emerging professional model of surrogate labour demands a response that can account for the contemporary realities of gestational carriage. After a thorough review of theoretical and empirical literature, Drummond concludes that provincial governments would be well advised to create legislative and regulatory frameworks under which gestational carriage contracts are enforceable.⁹³⁰ However she distinguishes between the existing family law model of domestic contract and her proposed gestational carriage contract. As she explains, family law legislation places a variety of limitations on the sort of contractual arrangements that may be entered into as a mechanism to enforce standardization and avoid “default legislative regimes”.⁹³¹

⁹²⁸ Susan G. Drummond, “Fruitful Diversity: Revisiting the Enforceability of Gestational Carriage Contracts” (2013). *Osgoode CLPE Research Paper No. 25/2013* at i.

⁹²⁹ *Ibid* at 62-63.

⁹³⁰ *Ibid* at 54.

⁹³¹ *Ibid* at 47.

Cases like *Doe v. Alberta*, for example, have drawn clear limits on the contours of this [heterosexual] standardization in setting the role of intention in the determination of parentage.⁹³² Jane Doe and John Doe were unmarried cohabitants in a sexual relationship. While Jane Doe wished to have a baby, John Doe was not prepared to father a child nor take on any parental rights or obligations. Jane Doe thus sought out anonymous donor insemination at a clinic, and the couple continued their cohabitation. When Jane Doe gave birth to a child in August 2005, both she and John Doe sought a declaration in the Alberta Court of Queen’s Bench that they had the right to enter into an express, binding contract detailing their agreement that she was the sole parent of the child and he had no parental rights or obligations.⁹³³

The court dismissed their application, ruling that intent was relevant but not determinative in this case, as the applicants could not “by agreement preclude the possibility that a Court may sometime in the future find John Doe to stand in the place of a parent.”⁹³⁴ Their claim was dismissed upon appeal, with the court ruling that due to his ongoing sexual relationship with the mother, John Doe had evidenced a “settled intention” to stand in the place of a parent.⁹³⁵ Despite their attempt to negotiate a contractually binding agreement outside the bounds of the traditional two-parent family, the court applied existing family law doctrines to collapse the Does back into the stable roles of mother and father. As Brenda Cossman has argued, when trying to structure an intimate life outside the assumptions of the nuclear family, and particularly in the context of parenting, a reliance on contract may in fact be suboptimal.⁹³⁶

⁹³² 2005 ABQB 885, 390 A.R. 227 [*Doe v. Alberta* (Q.B.)], aff’d 2007 ABCA 50, 404 A.R. 153 [*Doe v. Alberta* (C.A.)], leave to appeal to S.C.C. refused.

⁹³³ *Ibid.*

⁹³⁴ *Doe v. Alberta* (Q.B.) *ibid* at para 23.

⁹³⁵ *Doe v. Alberta* (C.A.) *ibid* at para 22.

⁹³⁶ Brenda Cossman, “Parenting Beyond the Nuclear Family: *Doe v. Alberta*”, (2007) 45 *Alberta Law Review*. 501 – 513 at 511.

Drummond acknowledges the controversy that followed the *Doe v. Alberta* ruling, and the limits it set on the role of intention in the establishment of parentage, yet remains optimistic about the capacity of private contract to manage the particularities of family relations.⁹³⁷ I am convinced by her reasoning in distinguishing between a gestational carriage contract and the John and Jane Doe scenario of domestic contract, in which a “settled intention” to parent may develop within an integrated family. A gestational carrier contract such as she envisions would ensure only *one* set of custodial parents on the scene, and therefore avoid the risks of functional parent-like relationships as contemplated by the court in *Doe v. Alberta*.

Drummond attends explicitly to the ways in which assisted reproductive technologies have expanded the role for intention and contract as family forms have developed outside of normative heterosexuality – and in particular for same-sex families and single parents.⁹³⁸ She makes a sustained argument on behalf of the utility and flexibility of contract law, as well as its increasing validity in the realm of intimate ordering, consciously rejecting the universalizing pull of commercial contract jurisprudence and its language of commodification and market value.⁹³⁹ Indeed the emotional language of commercial contract has long coloured discussion of surrogacy by radical feminists and their descendants; the very idea that a child may be seen as a “product” by her commissioning parents – a quotation that Drummond attributes to Francois Baylis – holds its direct antecedent in FINRRAGE and the prohibitionist stance of the RCNRT.⁹⁴⁰

⁹³⁷ Drummond, *supra* note 928 at 45.

⁹³⁸ *Ibid* at 49.

⁹³⁹ *Ibid* at 52. Drummond argues that that the public/private conceptual divide can create a “romantic fog” about the family, which remains oblivious to the fact that much of family law is aimed at the *breakdown* of intimate relationships.

⁹⁴⁰ *Ibid*. Baylis is quoted in Tom Blackwell, “Couple urged surrogate mother to abort fetus because of defect” *National Post*, Oct 6, 2010. <<http://news.nationalpost.com/2010/10/06/couple-urged-surrogate-mother-to-abort-fetus-because-of-defect/>>

To return to and rephrase Nedelsky's clarifying question, then: will reliance upon contract law in managing the parentage claims of synfertility facilitate or obstruct the outcomes we most care about? Despite the rigid reformulation of the heterosexual family in cases like *Doe v. Alberta*, Drummond is optimistic that increasing latitude has emerged for individuals to reformulate and transform fundamental aspects of the social order.⁹⁴¹ Yet in her own analysis, she distances her gestational carrier model from domestic family contracts. She is particularly concerned with the supervisory reach of the court as regards custody, and its latitude to review contracts not only for adequacy but in light of the best interests of the child.⁹⁴² As an example of this troubling judicial scope, Drummond also notes that it remains possible for a court to impede divorce proceedings if a judge determines that child support arrangements are insufficient.⁹⁴³

In framing her contractual model away from this overburdened domestic weal, Drummond distinguishes gestational carrier contracts as a *sui generis* form of contract.⁹⁴⁴ This jettisoning of the domestic contract in favour of a new model makes strategic and intellectual sense, and offers a useful tool for gay couples thinking of commissioning a surrogate. But I cannot help wondering where this leaves Jane and John Doe. Their intentional parenting project was one of synfertility, in which the ongoing relationship (or lack thereof) of non-genetic and non-biological parents is not as easily severed by the relinquishment of a newborn infant. Does “the flexibility of individual tailoring”⁹⁴⁵ which she rightly touts also extend to synfertile families? Or will judicial latitude and the best interests of the child standard, when applied in a

⁹⁴¹ *Ibid* at 53.

⁹⁴² *Ibid*. Courts have historically been unwilling to recognize the validity of contracts related to children on the basis that they are contrary to public policy. The concern is that a contract will overturn the child's best interests, the sole criterion upon which parenting decisions are supposed to be based.

⁹⁴³ *Ibid*.

⁹⁴⁴ *Ibid* at 54.

⁹⁴⁵ *Ibid*.

heterosexist and orthofertile society, consistently thwart attempts to create families outside the nuclear parenting norm?

Contextual Purposive Intent of the Synfertile Parent

Of course this also raises the question as to whether such flexibility is even necessary. Certainly the empirical evidence from the Creating Our Families study indicated that many people *were* planning to parent in exclusive two-person family units. Indeed, many lesbians and trans-identified couples had *intentionally* chosen anonymous donor sperm to avoid legal battles with known donors, in step with the legal advice offered at LGBTQ parenting workshops and queer community-based organizations (at least in Toronto). Their construction of a two-parent family was conscious and strategic, designed to minimize potential future hassles by aligning with a standard domestic paradigm. Yet nearly as many reported feelings of frustration and anger with the operations of the clinic, and a profound sense of alienation at the hypermedicalization of queer bodies. Might an ability to create flexible parenting contracts and structure their intimate lives outside the traditional two-parent framework, allow queer people to more easily create families without a necessary reliance upon donor anonymity?⁹⁴⁶

Put another way: What if synfertile families were not shunted into a normative mode by the operations of law and clinic alike? What kinds of families might emerge? It may well be the very same two-parent models. However it may also take the form of complex and gradated kinships with multiple family modes and categories. For example the vernacular term “spunkle,” commonly used to describe a known sperm donor in an avuncular family role, indicates that there may be existing social categories that could be reflected in a fractured model of family law

⁹⁴⁶ Drummond’s proposal of gestational carrier contracts explicitly requires an egg donor and the process of IVF to make such an arrangement, in fact, gestational. While the negotiation of a traditional carrier contract may be more disposed to conflict, there are certainly examples of traditional carriers in a quasi-parental relationship in Canadian case law. See for example *D.W.H. v. D.J.R.*, 2009 ABQB 438.

no longer reliant upon an exclusive dyadic structure. Here we may take up Fineman's call to move beyond the sexual family, through the creation of domestic units for childbearing and childcare that do not rely upon adult sexual partnerships nor a two-person framework. Such contracts, ranging from single parent to multi-parent households living together or apart, have the potential to genuinely shift the heterosexist matrix of family law. At the very least, I believe we need a relational analysis in domestic contract that can account for individual modes and desires for family formation, *and* for the structural inequalities that permeate society. The idea of *contextual purposive intent* may move us closer to this goal.⁹⁴⁷

The concept of contextual purposive intent was recently advanced by Nancy Kim at the California Western School of Law to more accurately describe the embedded sociocultural matrix of contract law.⁹⁴⁸ In her first paper on the subject, Kim introduces the idea of contextual purposive intent as a concept both necessary to determine *why* a party intended to enter into a contract – examining a party's reason or motive for entering into an agreement – as well as the relevant circumstances both at the time the contract was made as well as those arising after contract formation.⁹⁴⁹ According to Kim, this approach helps to bring to the surface concepts of fairness and substantive justice that are latent in many of the defense doctrines.⁹⁵⁰ This matters because, as she explains:

The primary objective of contract law is not, however, to standardize contracting behavior. Perhaps the single most acknowledged justification for contract enforcement is

⁹⁴⁷ Nancy S. Kim, "Mistakes, Changed Circumstances and Intent" (2007.) *Kansas Law Review*, Vol. 56, No. 3, 2008. 473 (which lays out the conceptual groundwork for contextual purposive intent).

⁹⁴⁸ This is part of a larger "expanded intent analysis" which would require courts to consider facts within their cultural context. Kim includes three new categories in her expanded intent analysis: volitional intent ("volitional in this regard is more than an absence of physical coercion; it means willingness to enter into the contract"), cognitive intent ("does not refer to what a party actually knows (or does not know)...[it] takes into account what the parties *considered* at the time the contract was made"), and contextual purposive intent, which is considered in detail below. *Ibid* at 480-481.

⁹⁴⁹ *Ibid* at 481.

⁹⁵⁰ *Ibid*.

that contracting promotes individual autonomy or the “will of the parties.” Yet, the parties to a contract are not always “reasonable,” or at least not reasonable as such a term may be understood by a decisionmaker with a different background and experiences. People, even where they are reasonable, are not always reasonable in the same way. Parties often do not always share the same assumptions, experience, cultural or social values, bargaining power or access to information, either with each other *or with the decisionmaker or hypothetical reasonable person*. Thus, even if we were to accept dynamic contract law's view of contractual intent as purely subjective, we must still resolve the issue of *how* we should analyze such intent.⁹⁵¹

Her framing recognizes the subjective character of the ‘reasonable person’ standard – a legal fiction that has been critiqued as derived from the cultural lexicon of the dominant group in society, and staunchly reliant upon the supposed neutrality of the judiciary as decisionmaker.⁹⁵² This judicial neutrality has been challenged in Canadian law, but remains a powerful ideological force in American jurisprudence.⁹⁵³ As Deborah Waire Post has argued, “While there is an emerging consensus that cultural competence is a skill and ethical obligation of practitioners, it is much harder to find articles promoting a judicial ethic of cultural competence.”⁹⁵⁴ As a corrective, Kim attempts to develop a language that takes into account three levels of culture and law: the cultural context that is present in a particular dispute; the ideological and cultural

⁹⁵¹ *Ibid* at 515.

⁹⁵² Deborah Waire Post, “Cross-Cultural Readings of Intent: Form, Fiction, and Reasonable Expectations” (2011) *Wake Forest L. Rev. Online* 94 at 95-96.

⁹⁵³ Carol A. Aylward, *Canadian Critical Race Theory: Racism and the Law* (Halifax: Fernwood Publishing, 1999). Aylward argues that, in contrast to the U.S., Canadian lawyers seldom make arguments based on principles of colorblindness. Through of an analysis of a case from Nova Scotia, Aylward recounts how appellants persuaded the Supreme Court of Canada that the frame of reference for a “reasonable person” would shift depending on cultural context. For a black judge, an objective stance would not be colorblind but would be informed of the prevalence of racism in Canadian society. See *infra* note 979 for a discussion of this case and its potential applicability to contextual purposive intent within a Canadian context.

⁹⁵⁴ Post, *supra* note 952 at 94. Post notes that American scholarly traditions of critical legal theory and critical race studies have produced biting critiques of the ‘colorblind’ nature of U.S. judiciaries, and particularly of the Supreme Court. See for example: Neil Gotanda, “A Critique of ‘Our Constitution is Colorblind’” 44 *Stanford Law Review* 1, 2–3 (1991); Dwight L. Greene, “Justice Scalia and Tonto, Judicial Pluralistic Ignorance, and the Myth of Colorless Individualism in *Bostick v. Florida*” 67 *Tulane Law Review* 1979, 1980–81 (1993). For a recent work on ‘colorblindness’ in the Canadian criminal justice system see: David M. Tanovich, *The Colour of Justice: Policing Race in Canada* (Irwin Law, 2006).

content of contract theory; as well as the culture and institutional norms that are internalized by the judiciary.⁹⁵⁵

In her second paper on the subject, Kim applies her theoretical framework to two case studies regarding issues of nationhood and gender, exploring the cross-cultural readings which might emerge from an expanded intent analysis.⁹⁵⁶ Kim begins with a contractual intent dispute involving two Korean claimants in a California appellate court, which was dismissed by the judge for a variety of contextual factors, not least because the contract was signed in blood after heavy drinking in a sushi bar.⁹⁵⁷ Kim argues that the strict application of objective consideration doctrine ignored Korean cultural expectations, such as the fact that Korean businessmen typically conduct business under precisely these circumstances, with business relationships in Korea based upon personal relationships that are “integrally related” to the consumption of large quantities of alcohol.⁹⁵⁸ As well, the drawing of blood may be understood within Korean cultural norms as “a way to show sincerity rather than evidence of extreme intoxication, mental instability or coercion.”⁹⁵⁹

Thus when viewed in cultural context, the circumstances under which the blood contract was made are not unusual and do not raise the same suspicions that they do without an understanding of the business and social norms guiding the parties’ conduct. Instead of pressing this encounter into a dominant Western mode that is inappropriate for the situation, Kim calls instead for a “contextual purposive intent” that would require courts to consider facts in cultural context and include the social identities of the parties to the contract. This approach recognizes

⁹⁵⁵ Kim, *supra* note 947.

⁹⁵⁶ Nancy S. Kim, “Reasonable Expectations in Sociocultural Context, 45 Wake Forest L. Rev. 641, 659 (2010).

⁹⁵⁷ The parties had been drinking heavily at a sushi bar, after which one produced a pin and pricked his finger to write a promissory note, in Korean, in blood.

⁹⁵⁸ *Ibid* at 655.

⁹⁵⁹ *Ibid* at 657.

the relationship between the individual and the collective, provides focus and direction appropriate to the specific context, and references the expectations and beliefs of the cultural community from which the dispute arises (in this case the Korean or Korean American community).⁹⁶⁰

Kim then turns to a treatment of a case involving the disposal of frozen embryos upon marriage dissolution. Arthur (Trip) Witten and Tamera Witten had undergone *in vitro* fertilization during their seven-and-a-half year marriage without success.⁹⁶¹ As part of the clinical process, the couple had signed an “Embryo Storage Agreement” that required the signed agreement of *both* parties for the transfer, release or disposition of any cryopreserved embryos that might be created. Trip then filed for divorce, and Tamera requested that she be awarded the 17 stored embryos that remained as part of dissolution proceedings. Trip refused to allow her access and asked the court to enforce the mutual consent provision in the Agreement.

The judge relied on the enforceability of the Agreement and held that written consent was required from both Tamera *and* Trip to release the embryos, holding that “agreements entered into at the time in vitro fertilization is commenced are enforceable and binding on the parties, subject to the right of either party to change his or her mind about disposition up to the point of use or destruction of any stored embryo.”⁹⁶² Kim argues that this ruling failed to take into account the gendered nature of IVF as well as the parental expectations of the female party. As she asserts:

The gender neutral language belies that only one of the parties - the woman - will have endangered her health in vain...The contemporaneous mutual consent model ignores the difference in nature of the contributions of a man and a woman in the in vitro fertilization

⁹⁶⁰ *Ibid.* See also Post, *supra* note 952 at 98.

⁹⁶¹ *In re the Marriage of Witten*, 672 N.W.2D 768, 772-73 (2003).

⁹⁶² *Ibid.* Quotation marks removed.

process. The woman will *always* suffer more physical pain and risk more to her health than the man. To assume equality in this context ignores the disparate nature of their participation in the *in vitro* process.⁹⁶³

Kim refuses the neutral equivalence between Trip and Tamera in this context, arguing that Tamera's greater investment of time, physical hardship and medical risk is not on the same footing as Trip's provision of a semen sample. She also notes that Trip did not want to destroy the embryos, but merely prevent Tamera from utilizing them to get pregnant. Thus Trip's ability to "change his mind" about the disposition of the embryos and maintain them in stasis is validated by the court, while Tamera's consistent and unchanged intention – that of using the process of *in vitro* fertilization to have a child – is disregarded. As Kim describes: "[T]he court recognizes Trip's ability to change his mind - something that is generally not recognizable in other contracts - as worthy of protection and prioritizes that over the expectation and reliance interest of Tamera, thus utterly disregarding the physical suffering experienced by her."⁹⁶⁴ This disproportionate investment in reproductive labour has been called a matter of "sweat equity" by Robyn Ikehara, who argues that women should be awarded greater dispositional authority than men when a contractual gap (in this case, divorce) exists within such disputes, as women have borne a greater physical burden and relied heavily to their detriment.⁹⁶⁵

By applying her expanded doctrine of contractual intent, Kim argues that the gendered character of the situation must be engaged, recognizing the differently weighted investments that each party holds in the outcome. Tamera's willingness to undergo the physical hardship of IVF and her continued commitment to the reproductive project indicates that she holds the contextual

⁹⁶³ Kim, *supra* note 956 at 31. Emphasis in original.

⁹⁶⁴ *Ibid.* As Kim notes, this frames the relevant issue as one involving Trip's right to change his mind, rather than Tamera's interest in using the embryos. The judge declines to consider the issue as one involving a contractual gap, even though the agreement did not specifically address what would happen in the event of a divorce.

⁹⁶⁵ Robyn L. Ikehara, "Is Adoption the "New" Solution for Couples in Dispute Over Their Frozen Embryos?" 15 *Southern California Law Review* 316-318 (2006).

purposive intent to become a parent. It is clear *why* she entered into the contract, and her reasons or motives for entering into the agreement have not changed, despite shifting circumstances since the time the contract was signed. Trip, on the other hand, appears to lack such intent, with his participation in the creation of embryos conditioned by an expectation that the couple would remain together. He apparently had not considered what might happen should the relationship end, and if this consideration had been raised, Trip would presumably have specified that his consent rested on the continuation of their relationship, or he would have declined to enter into the agreement altogether. Thus, argues Kim, “because Trip lacked contextual purposive intent, the agreement between Tamera and Trip should not be enforced unless there is a strong public policy compelling enforcement.”⁹⁶⁶

By adding this contextual element to their adjudication of contract disputes, the court may enhance their understanding of what ‘reasonable expectations’ might be in a given situation. It allows a judge to view the contracting situation from the standpoint of the parties, not merely from his or her own vantage point.⁹⁶⁷ It complicates the idea of an ‘objective’ standard unaffected by race, class, sexuality, gender or other social factors,⁹⁶⁸ and allows contract law to be analyzed within a socio-cultural context that considers the intentions and purposive motives of the disputants, as well as the social environment in which these decisions are being made.

I believe this sensitivity to the social identities of the claimants in contract disputes may also offer an important corrective within the domestic contractual arrangements of family law. This socio-cultural framing is neatly able to capture something of the tension between dominant models (of the legal family) and the intentional complexity of many queer reproductive projects

⁹⁶⁶ Kim, *supra* note 956 at 34.

⁹⁶⁷ *Ibid* at 35.

⁹⁶⁸ *Ibid* at 36.

(via synfertility). Intentional synfertility is a *purposive* form of kinship that expects to locate procreation outside the marital bed, and as such involves a different contextual frame than the two-parent model of orthofertile coupling. By considering the contextual purposive intent of Jane Doe, for example, the judiciary may have acknowledged the social pressures to conform to a dyadic model of heterosexual coupling, the refusal of both her and John Doe to equate the sexual tie with a reproductive imperative, and the contextual purposive intent of John Doe himself as a determined non-participant in this parenting project. This would have allowed the couple to navigate their intimate lives at a distance from the orthofertile heterosexual framework, via judicial recognition of the complex and purposive motivations of intentional synfertility.

Contextual Purposive Intent in Canada

While writing against the limitations of U.S. jurisprudence, the different legal context in Canada may make it easier to argue for a subjective review of contractual disputes. There is precedent for decisionmakers to avoid the charge of judicial bias when they apply their knowledge of identitarian or differently-lived experience, allowing for specific socio-cultural factors to be contemplated by the court. In *R.D.S. v. The Queen*, for example, the Supreme Court of Canada reviewed a challenge to a racialized judge who had acknowledged the presence of pervasive structural racism in Nova Scotia in her reasons for decision on a children's court criminal matter.⁹⁶⁹ A black youth had been charged with assaulting and resisting arrest by a police officer in Halifax, with the youth and the officer the only two witnesses to the alleged crime. Their accounts of the events differed widely.⁹⁷⁰ The only African-Canadian judge in Nova Scotia, Corrine Sparks, had presided over the case, and made remarks in her judgment that spoke

⁹⁶⁹ *R.D.S. v. The Queen*, [1997] 151 D.L.R. (4th) 193.

⁹⁷⁰ Shin Imai helpfully discusses this case in an article on legal pedagogy and the teaching of race-conscious lawyering. Shin Imai, "Counter-Pedagogy for Social Justice: Core Skills for Community Lawyering" (2002) 9 *Clinical Law Review*, 195.

to the racialized character of the criminal justice system. As she explained her reasons for acquitting the youth:

I am not saying that the officer overreacted, but certainly police officers do overreact, particularly when they are dealing with non-white groups... I believe that probably the situation in this particular case is the case of a young police officer who overreacted. I do accept the evidence of [R.D.S.] that he was told to shut up or he would be under arrest. It seems to be in keeping with the prevalent attitude of the day.⁹⁷¹

The approach of Judge Sparks was challenged in the lower courts, with a claim that her attention to the “attitude of the day” described above, and her reference to the well-documented history of “racism” in Nova Scotia in another passage, could have been seen as having affected her approach to the evidence, and in particular the evidence of the white arresting officer.⁹⁷²

The lower courts agreed with this analysis, accepting the claim of a reasonable apprehension of bias in Judge Sparks’ language.⁹⁷³ Upon appeal the Supreme Court reversed the lower court rulings, and in a joint judgment, Justices McLachlin and L’Heureux-Dubé said:

[W]hile judges can never be neutral, in the sense of purely objective, they can and must strive for impartiality. [The test for bias] therefore recognizes as inevitable and appropriate that *the differing experiences of judges assist them in their decision-making process and will be reflected in their judgments*, so long as those experiences are relevant to the cases, are not based on inappropriate stereotypes, and do not prevent a fair and just determination of the cases based on the facts in evidence.⁹⁷⁴

As they continued:

The reasonable person must thus be deemed to be cognizant of the existence of racism in Halifax, Nova Scotia. It follows that judges may take notice of actual racism known to exist in a particular society. Judges have done so with respect to racism in Nova Scotia.⁹⁷⁵

⁹⁷¹ Quoted in *ibid* at 7.

⁹⁷² *Supra* note 969 at 485; *R. v. S. (R.D.)*, [1995] NSJ No. 184 (NSSC); *R. v. S (R.D.)*, [1995] 145 N.S.R.2d 284 (NSCA).

⁹⁷³ For an interesting discussion of this case in relation to Australian jurisprudence, see: Reg Graycar and Jenny Jane Morgan, “Feminist Legal Theory and Understandings of Equality: One Step Forward or Two Steps Back?” (2000) *Thomas Jefferson Law Review*, Vol. 28, No. 3.

⁹⁷⁴ *R. v. S. (R.D.)*, [1997] 3 S.C.R. 484 at para 29.

⁹⁷⁵ *Ibid* at paras 47-48.

This landmark decision thus established the rules for determining reasonable apprehension of bias in the court system by judges, and was the first to develop a framework for the application of social context in judging. In a published discussion that followed the ruling, Justice L’Heureux-Dubé said, in specific reference to the judgment: “Judges should not aspire to neutrality. When Judges have the opportunity to recognise inequalities in society, and then to make those inequalities legally relevant to the disputes before them in order to achieve a just result, then they should do so.”⁹⁷⁶ Thus, ethical judiciaries have a responsibility to recognize inequalities in society, understand how these inequalities may play out in the disputes before them, and apply their understanding of structural and systemic injustice to the facts of the case.⁹⁷⁷ They may bring their own lived experience to the matter, as with Judge Sparks and her presumably first-hand experience with racism and sexism in Nova Scotia; or they may educate themselves on pervasive forms of social discrimination and seek to apply a context-specific analysis that takes into account the barriers faced by different socio-cultural groups. This ruling thereby provides at least partial grounds for the subjective and ethical judgment necessary to allow courts to adjudicate claims of contextual purposive intent. Unfortunately, the legacy of the decision has not made a deep impact upon the Canadian legal landscape.

To mark the 15th anniversary of the *R. v. R.D.S.* decision, McGill University convened an interactive seminar in late 2012, hosted by Esmeralda M.A. Thornhill, Professor at the Schulich School of Law at Dalhousie University.⁹⁷⁸ In a radio interview with a McGill student radio show

⁹⁷⁶ Quoted in Graycar and Morgan, *supra* note 973 at 415. See also: Justice Claire L’Heureux-Dubé, “Reflections on Judicial Independence, Impartiality and the Foundations of Equality,” 7 CIJL Y.B. 95, 106 (Jan. 1999).

⁹⁷⁷ The retreat to ‘impartial objectivity’ when it comes to historically subordinated groups has been referred to as “pluralistic ignorance” by critical race theorists. It refers to the “erroneous cognitive beliefs shared by one group regarding other individuals or groups.” Greene, *supra* note 954 at 1981. As Post clarifies: “More precisely, it is ignorance of the particular facts, the lived experience of subordinated communities, which can or should be used to judge the reasonableness of the interpretations, choices, and judgments made by members of that community.” *Supra* note 952 at 95.

⁹⁷⁸ “*R. v. R.D.S.* Revisited After 15 Years” was a CRLT Think Tank Seminary hosted in November 2012 by the

following the seminar, Thornhill criticized the ways in which the ruling has failed to shift the practice of Canadian law despite its initial promise. While the judgment had been highly significant at the time, and generated a flurry of scholarship in the first few years after coming down,⁹⁷⁹ Thornhill felt that its promise had been “far from being fulfilled.”⁹⁸⁰ As she explained, as the first Canadian case to usher in social context education for judges on the basis of lived race and gender identity, it was important “not only for all people of African descent, but for all women.”⁹⁸¹ However as Richard Devlin has reported in relation to *R. v. Hamilton*,⁹⁸² a 2004 case from Ontario that involved a context-specific analysis of social injustice and racialized oppression, when trial judges have tried “to tailor their responsibilities to the realities of systemic and intersectional inequality” the results have not been promising.⁹⁸³

The case Devlin describes was a criminal issue, as was the original matter in *R. v. R.D.S.* And indeed it may be that the institutional norms of criminal courts lend themselves toward more

Black Law Students Association of McGill, the Human Rights Working Group, and the McGill Centre for Human Rights and Legal Pluralism. The event featured Dr. Esmeralda M.A. Thornhill, Professor at the Schulich School of Law, Dalhousie University & O'Brien Fellow in Residence, McGill Centre for Human Rights & Legal Pluralism.
⁹⁷⁹ The case generated a great deal of scholarship in the first two years after it was released; since then it has not played a major role in Canadian legal analysis with the exception of the work of Richard Devlin. For an example of this initial flurry of scholarship see: Carol A. Aylward, "Take the Long Way Home' *R.D.S. v. R. The Journey*" (1998) 47 U.N.B. L.J. 249; Christine Boyle et al., "*R. v. R.D.S.*: an editor's forum," *Case Comments* (1998) 10 Can. J. Women & L. 159; April Burey, "No dichotomies: reflections on equality for African Canadians in *R. v. R.D.S.*" (1998) 21 Dal. L.J. 199; Richard F. Devlin, 'We Can't Go On Together with Suspicious Minds: Judicial Bias and Racialised Perspective in *L v. R.D.S.*' (1995) 18 Dalhousie L.J. 408.; Richard F. Devlin & Dianne Pothier, "Redressing the imbalances: rethinking the judicial role after *R. v. R.D.S.*" (1999-2000) 31 Ottawa L. Rev. 1; Patricia Hughes, "*S.(R.D.)*: A New Direction in Judicial Impartiality?" (1998) 9 N.J.C.L. 251, 261; Allan C. Hutchinson & Kathleen Strachan, "What's the difference?: interpretation, identity and *R. v. R.D.S.*" (1998) 21 Dal. L.J. 219-235; David C. Paciocco, "The Promise of *R.D.S.*: Integrating The Law of Judicial Notice and Apprehension of Bias" (1998) 3 Can. Crim. L. Rev. 319, 345; Sherene Razack, "*R.D.S. v. Her Majesty the Queen*: a case about home" (1999) 9 *Constit. Forum* 59; Jennifer Smith, "*R. v. R.D.S.*: A Political Science Perspective" (1998) 21 Dal. L.J. 236-248.

⁹⁸⁰ LegalEase, "Race, Gender, and Social Context," Episode 40 (Dec 2012) on CKUT 90.3FM.

⁹⁸¹ *Ibid.*

⁹⁸² (2004), 72 O.R. (3d)

⁹⁸³ The case involved two black female drug couriers who had been apprehended on suspicion of smuggling cocaine from Jamaica. Both pled guilty and the trial judge imposed a twenty-month conditional sentence on one woman, and a twenty-four months less a day conditional sentence on the other. The trial judge justified his decision by an analysis of the interlocking and systemic dynamics of poverty, race and gender. The Ontario Court of Appeal overturned the decision and determined that the trial court was in error to do so. See: Richard Devlin & Matthew Sherrard, "Big Chill: Contextual Judgment after *R. v. Hamilton*" (2005) 28 *Dalhousie L.J.* 409 at 413-414.

impartial forms of justice due to factors such as sentencing principles and floodgate concerns.⁹⁸⁴ Might the latitude for subjective adjudication be different in a non-criminal context? It is important to note that family courts are *already attuned* to context-specific adjudication and more likely to readily manage the issues of subordinated cultural and social communities. By the same token, contract law is already a wing of jurisprudence built upon context-specific inquiry. Thus, the disposition of domestic contracts may offer a ripe nexus to reinvigorate the principles of social context education, and encourage renewed judicial sensitivity to issues of race, gender, class and sexuality as laid down with so much promise in *R. v. R.D.S.* I believe the paradigm of contextual purposive intent, and its parallel decree for attention to subordinated cultural and social factors, may provide a helpful platform to explore issues of substantive justice that would otherwise remain buried within contractual dispute adjudication. It would allow an analysis of the best interests of the child not grounded upon abstracted notions of wellbeing, but – as with *A.A. v. B.B.* – a context-sensitive determination that sought to respond to the queer relations already in existence.

What might the institutionalization of a judicial treatment of contextual purposive intent look like in relation to synfertility? The resolution of (for example) contractual disputes over parentage in regard to two lesbian parents and their known sperm donor, would first suggest a deep and careful analysis of the conditions under which the donor agreement was made.⁹⁸⁵ It would seek to determine *why* all parties intended to enter a contract – examining their reasons or motives – as well as the relevant circumstances both at the time the contract was made as well as those arising after contract formation. These relevant circumstances might include the ideological dominance of the two-parent family in Canada, the cost and difficulty of obtaining

⁹⁸⁴ *Ibid* at 415-416.

⁹⁸⁵ This is the precise scenario faced by *W.W. v. X.X. and Y.Y.*, a case currently pending in Ontario courts. See also Kelly, *supra* note 625.

anonymous donor sperm through a clinical encounter, a tradition of informal parenting arrangements within queer communities, the vulnerability of lesbian co-mothers given the heterosexual imaginary and its affective attachments to the biological tie, the vulnerability of single men as fathers, and the different standards and expectations of care commonly applied to fathers versus mothers.⁹⁸⁶

It would also include a temporal analysis, seeking to understand how conditions have changed since the contract was formed. Was the child already born? If so, what was her relation to the multiple caregivers and what kinds of community was she nurtured by? Did the lesbian couple have a contextual purposive intent to create an exclusive two-parent family given the forces of structural homophobia and the uncertainty of fertility law? What was the contextual purposive intent of the known donor and has this intent shifted? If so, why? Such a perspective would explicitly account for race, class, sexuality, gender and other social factors, and place the domestic contract within a socio-cultural context that considers the individual motives of the disputants, as well as the systemic factors and – importantly - the institutional legal environment within which such decisions are being made.

Wrapping Up

In this last chapter I have circled back to the start of the dissertation, unpacking the legal construction of ‘family’ in Canadian law, and arguing for a model of contextual purposive intent that can take into account the fractured and the conventional modes through which synfertile families are being created. Although the recent revisions to British Columbia’s *Family Law Act*

⁹⁸⁶ In regard to the last point, Joanna Radbord has argued that, as our culture still expects that women will assume primary responsibility for childcare, “relatively lesser contributions by men are often lauded as exceptional parenting.” While she is critical how this plays out in the same-sex context, with biological mothers expected to carry a heavier load than her co-mother due to the heterosexist frame of equivalency, I believe the frame also snaps back to the male-female dyad when a known sperm donor is on the scene. Thus even small contributions by a ‘Donor Dad’ may be seen to be highly laudable by a court. Joanna Radbord, “GLBT Families and Assisted Reproductive Technologies,” Paper presentation at the CBA 2010 Canadian Legal Conference in Niagara, Ontario.

offer a promising foundation for queer family structures outside the dyad, the ongoing and mutable nature of family forms created through AHR suggests that flexible solutions may give the greatest latitude – and protection – to non-traditional families.

Even within the LGBTQ rubric are many potential forms of family requiring many different forms of reproductive intervention: a contractual legal order that allows for sociocultural variance and intention appears to offer the strongest encouragement. This is at odds with the model of LGBTQ liberation followed by, for example, the same-sex marriage movement, which has sought inscription in the federal legal regime and validation by the symbolic weight of the marriage institution.

The contractual mode I envision draws from private law for the variation of intent, but relies upon a public model of state funding in order to actualize such intent. In an era of austerity and neoliberal retraction, such demands on the state may seem overbroad. However I believe that a Quebec-style model of universal access is possible, once the critiques of the infertility trap and the clinical push toward parafertility are modulated. When intra-reproductive models are not privileged as the ideal modality, it is possible that some heterosexual couples may opt for less expensive and invasive procedures, such as, for example, choosing donor insemination through IUI rather than the difficult process of ICSI. However given the power of orthofertility as a normative modality, it is also possible that a moderate user fee program may need to be instituted, involving a graduated system of payment based on income. To avoid a stratified system of reproductive hierarchy it is critical that poor people and, especially, poor and racialized queer people be able to access reproductive assistance if desired. By setting a payment threshold of (for example) \$200,000 in combined household monthly income, after which a

marginal fee would apply, wealthier families can help to subsidize the cost of treatment for poorer households.

The framework I have developed rejects the medical model of infertility to launch disability claims, and instead looks to the embedded ontology of queer lives. It offers room for constitutional protections grounded on sex and sexual orientation, while remaining vigilant against the individualized character of liberal rights claims. It also seeks to understand the relationality of reproductive bodies and intentions. As Roxanne Mykitiuk has argued, it is important to keep an account of the embodied, integrated subject tightly on hand:

In place of the abstracted, disembodied, rational, universal rights bearing, contracting, possessive individual at the centre of liberal discourse, I want to know what a social order that takes embodiment seriously would look like. If the structures and practices of liberal theory have been founded on a conception of person with an absent body, I want to know what a social theory centered around embodied persons would look like.⁹⁸⁷

I have sought to develop a relational engagement with reproductive bodies, creating new taxonomies and challenging others. I have framed synfertility in particular as a relational concept, and a way to focus on nurturance, need and responsibility as a way to track biological and social ties of care as effected through biotechnology. This strategy aims to remain responsive to complex sociocultural needs as emerging from queer families, and rejects a static federal model as the guardian of reproductive outcomes. Such a contractual model also presents an opportunity for queer families to develop, in all manner of forms, around the rearing and care of children.

It is through having children that queer families have become part of the discussion and, importantly, case law, with precedents such as *Rutherford* and *A.A. v. B.B.* The many

⁹⁸⁷ Mykitiuk, *supra* note 212.

contradictory aspirations of queer family life should not be shoehorned into an orthofertile model, but must be allowed sufficient plasticity through room for individual negotiation and the prioritization of synfertile pathways. Rather than have each province consolidate family law norms through statutory reform that insufficiently reflects queer realities, it is far preferable to allow these multiple modes to grow and transform the social landscape upon which they rest. Room must be provided for the complex ways in which reproductive technologies and the family structures they engender both “trouble the normal” and reinforce the normalization of traditional gender, sexuality and family constructs.⁹⁸⁸ That said, the recent statutory model from British Columbia does hold promise, and appears to have been developed with the needs of synfertile families explicitly in mind.

The federal structure of the *AHRA* emerged from radical feminist concerns around reproductive technology and a mode of governance feminism which hinged upon a criminal law power and a top-down mode of centralized control. Chapters Five and Six described how queer reproductive needs were sidelined or transformed through the process of governmentalization and the filtering of the RCNRT report through decades of legislative development. In its final form, the *AHRA* was not only unconstitutional, but woefully inadequate to meet the needs of communities on the ground. Virtual silence on the needs of LGBTQ people has continued into the present day and debates in Quebec over IVF funding, with the exception of a high-profile surrogacy case involving a gay celebrity. Rather than provincial edicts to replace the flawed form of the *AHRA*, which may fail to account for the richness of synfertility, careful attention to the contextual purposive intent of queer families themselves appears to offer a helpful way forward.

⁹⁸⁸ Mamo, *supra* note 76 at 6.

Importance of Developing New Models

Biotechnologies are no longer science-fiction innovations that beckon from the lurid realm of dystopian fantasy. While Margaret Atwood's cautionary fable 'The Handmaid's Tale' may have fanned the flames of apprehension back in the 1980s,⁹⁸⁹ it is no longer the case that assisted reproduction represents an unnatural form of cybernetic baby-making. I argue that in order to ensure that proper connections are made in an era of AHR, we must create new maps, vocabularies and legal orders. What might appear to be emerging freedoms and choice offered by new technological practices are concurrently forged *within* power relations, not outside them. As Mamo has remarked, "[t]his idea marks much of feminist technoscience studies approaches: the meeting of bodies with technological and scientific practices are part of culture and power; they do not exist outside of culture and power."⁹⁹⁰

I have thus devoted a substantial portion of my project toward exploring the relations of power and culture created through medical infertility as the dominant clinical model. As I have argued, this is no benign conceptualization, but one that structures the entire system of reproductive possibility within Canadian law and medicine. This in turn depends on a normative vision of the Canadian family that rests at the heart of gendered systems of social reproduction.

Without new vocabularies and imaginaries to support the creation of queer families, it will remain impossible to interrogate the legal and discursive ground upon which such reproductive projects are being pursued. These conceptual limits are no trivial matter; if the only strategies pursued by queer parents and activists toward legal recognition follow the explicit modeling of heterosexual families, options *will* be restricted.

⁹⁸⁹ Busby, *supra* note 263.

⁹⁹⁰ Mamo, *supra* note 76 at 10.

This dissertation has therefore sought to bring aspects of AHR into relief that have remained undertheorized and empirically bereft. My project takes up queer uses of AHR as a fresh lens through which to view the complex kinships, legal relations and biosocial assemblages generated by reproductive technology. Twenty years ago, Marilyn Strathern's work used the scrim of AHR to pry apart the ways in which culture and nature are connected in Euro-American understandings of (heterosexual) kinship. This analytical approach – questioning suppositions about the connection between natural facts and social constructions – has inspired the analysis of law, biotechnology and kinship taken up by this dissertation.

I have applied the central insights of queer theory's critique of heteronormativity to constructionist concerns about family law, reproductive technologies and the role played by contemporary forms of kinship in Canada. In the process, I have brought a multidisciplinary theoretical approach into conversation, reading it through queerly theoretical traditions, while drawing upon empirical research and critical legal studies to survey the queer landscapes of assisted reproduction.

Future Landscapes

Reproductive technologies will only grow more common, and synfertility in particular, requiring a paradigmatic shift of both vocabulary and understanding. By refusing the infertility trap of the clinic, it becomes possible to open legislative and adjudicative processes to a much wider range of options. For as has been thoroughly discussed, current clinical discourse relies upon the binary of infertility to create 'normal' and 'failed' modes of reproduction. It is only by understanding how infertility works to stigmatize and obscure the workings of the clinic that one may see how these aberrations are produced. And in a move that I think will reduce stigma for all, we can then demonstrate how infertility operates to privilege certain parafertile bodies with a

recognizable family form (heterosexual, partnered) even as it seeks to obscure the reproductive failing of those very same bodies.

This elaborate operation for the benefit of grieving heterosexual couples effectively denies the ontological experience of prospective queer parents, as this dissertation has explored through empirical data. Gay and lesbian bodies, and trans bodies in particular, must face not only the stigma of wounded heterosexuality, but also their dislocation as sexual and gender minorities who do not conform to a rigid para-fertility. Even when small concessions are made within the clinic, such as trans-sensitive training or the inclusion of LGBT-friendly brochures or information, this fails to shift the overall institutional culture. For example despite the increasing use by many clinics of abstract terms like “spouse” and “parent” on their intake forms, such apparently neutral modes remain bracketed within the framework of the dyadic orthofertile family.

Clinical interventions will continue to create offspring that baffle legal norms of parentage and affiliation unless we revise our approach to the ways these technologies are being utilized and, by extension, the legal effects being created. More nuance is required to disaggregate the application of fertility technologies and think through the ramifications of the narrow categories of infertility we have, frankly, quite exhausted over the past thirty-odd years. As long as we continue to proceed down the same worn path we will be unable to account for the complexity of these kinship formations. It has been difficult to develop legislation around reproductive technology in Canada, largely because of uncertainty about what may result. Decades after the formation of the RCNRT we are still hardly closer to a functional regulatory solution for all Canadians. By re-examining the language being used to name these issues, and the conceptual frameworks being

applied both before conception and in determining parentage, we may avoid the circular logic that has continued to get us nowhere.

In thinking more critically about the structure of 'infertility' and seeking to challenge its monolithic form, the hope is to begin to more adequately recognize the variable needs of all parafertile and synfertile families seeking AHR. Once this quantitatively different model is understood, we can perhaps begin to think through the whole regulatory and clinical apparatus that supports the infertility industry, and question those choices made in the name of preserving the sanctity of heterosexual reproduction. I believe this process will help to remove some of the stigma of AHR, open the discussion, and allow a transparency into the conduct of assisted reproduction. It also makes it possible to lodge a claim for queer reproductive justice against the ruthless certainties of biological determinism.

New family forms have posed a difficult challenge for Canadian law and resultant issues of parental presumption, custodial rights and biological relation have been a site of uncertain outcome for queer families. I have instead sought to propose a conceptual refinement that will move us closer to allowing fertility clinics, individuals, families, legislators and judicial authorities alike to reconceptualize the issues at stake when families are built through assisted reproduction.

Appendix A: Selected Demographic Characteristics of Participants

Variable	N = 66 (%)	Notes
<u>Gender Identification</u>		
Female (cisgender)	48 (72.7)	
Male (cisgender)	9 (13.6)	
Trans man/FTM spectrum	7 (10.6)	
Trans woman/MTF spectrum	2 (3.0)	
<u>Sexual Orientation</u>		
Lesbian	21 (31.8)	-1 also identified as queer
Queer	18 (27.3)	
Gay	11 (16.7)	- 2 also identified as queer
Bisexual	11 (16.7)	-1 also identified as queer/pansexual
Two-Spirit	1 (1.5)	- also identified as bisexual
Straight	2 (3.0)	- both identified as trans
Other	2 (3.0)	- included: homoandrophilic, fluid/no label

<u>Cultural/Racial Background</u>		- 1 missing - Participants could select more than one so frequencies do not total 100%
White	48 (72.7)	
Mixed	8 (12.1)	
Black/African/Caribbean	6 (9.1)	
Aboriginal	3 (4.5)	
South Asian	2 (3.0)	
Other	3 (4.5)	
<u>Relationship Status</u>		- 2 missing - Participants could select more than one so frequencies do not total 100%
Legally married	37 (56.1)	
Common-law	20 (30.3)	
Partnered	2 (3.0)	
Multiple partners	1 (1.5)	
Single	6 (9.1)	
Divorced	1 (1.5)	

<u>Region in Ontario</u>		-Subregions of Ontario as per the Ontario Ministry of Community and Social Services (2011)
Toronto region	34 (51.5)	
Southwest	10 (15.1)	
Eastern	9 (13.6)	
North Eastern	4 (6.1)	
Hamilton/Niagara	3 (4.5)	
Central East	2 (3.0)	
Central West	2 (3.0)	
Northwest	2 (3.0)	
<u>Highest Level of Education</u>		- 3 missing
High school	1 (1.5)	
College	7 (10.6)	
University	24 (36.4)	
Postgraduate	31 (47.0)	
<u>Household Income (CAD)</u>		- 3 missing
Under \$20,000	1 (1.5)	
\$21,000-\$35,000	2 (3.0)	

\$36,000-\$50,000	4 (6.1)	
\$51,000-\$65,000	6 (9.1)	
\$66,000-\$80,000	15 (22.7)	
\$81,000-\$100,000	8 (12.1)	
Over \$100,000	27 (40.9)	
<u>Age</u>		
26-30	7 (10.6)	
31-35	22 (33.3)	
36-40	21 (31.8)	
41-45	15 (22.7)	
45-50	1 (1.5)	

Appendix B: Interview guide.

Creating Our Families (COF): A Pilot Study of the Experiences of Lesbian, Gay, Bisexual, and Trans People Accessing Assisted Human Reproduction Services in Ontario

1. We recognize that LGBTQ people have a tradition of creating a “chosen” family, which is different from the standard notion of heterosexual families. Could you describe what your family looks like now?

2. Tell me about how you (you and your partner, your co-parent) came to the decision to have kids.

In this study, we’re interested in hearing about peoples’ experiences with assisted human reproduction, or AHR, services. AHR services include things like donor insemination, *in vitro* fertilization, egg donation, and other services that are typically offered through fertility clinics, doctor’s offices and sperm banks.

3. How did you come to consider AHR services as a possibility in building your family?

a. Did you consider or try any other options for having children?

b. When you were making your decision to use AHR services, where did you go for information about AHR? (How did you find out where to go for information? Was there any particular information you couldn’t find or had difficulty finding? Did you come across any specific information for LGBT people about AHR?)

c. (*If used services*) What services, processes or programs did you make use of? (Who used them? You, your partner, your co-parent, a donor, a surrogate, someone else?)

4. What did you imagine [the service] would be like?

a. Were you looking forward to your first visit? Feeling apprehensive? Did you have any specific worries or concerns?

5. (*If they accessed any services, otherwise skip to question 10*): Tell me about the first steps you took when you decided to access AHR services.

a. How did you get a referral?

b. How did you decide which AHR clinic to work with? (Did you have a choice?)

6. Tell me about your first interactions with [the service].

a. Did you feel welcomed, uncomfortable, etc.?

b. Did they have any LGBT-specific resources?

7. Tell us about the process after that.

a. What providers were involved in your care?

b. Who went with you to your appointments?

c. Can you remember a particularly good or bad experience with your provider or clinic that you would like to share with us?

d. Thinking back on your experiences, would you say you faced any particular challenges or difficulties in accessing AHR services? (Were these barriers related to your sexual orientation or gender identity? How?)

e. Was there anything that happened during the process that was really helpful to you?

f. *[If applicable-FERTILITY INTERVENTIONS]* Was it ever recommended that you take fertility drugs, or have any other interventions related to your fertility? How did you feel about that? (Did you feel like you were given a choice whether or not to have these interventions? Did you have all of the information you needed to make a decision? Did you feel like you were in control of your care?)

g. *[If applicable-COMING OUT]* How did you decide whether or not to out yourself to your AHR service providers? (At what stage did you decide to come out? Did you come out to everyone or only to some providers? What kind of reactions did you get when you came out? Did you ever feel you had to conceal your sexual orientation, gender identity or family configuration? Why did you feel that way? What was that like for you?)

h. *[If applicable-LEGAL ISSUES]* Were there any legal issues that arose?

i. How were you able to manage the costs you incurred?

8. Were you offered or required to have a counseling visit prior to receiving AHR services? (If yes, did you have one?)

a. What was your experience with the counseling process?

b. What did you talk about?

c. Was there anything about the counseling session that was particularly helpful?

d. Anything that seemed unhelpful or inappropriate to you?

e. *[If applicable]* Was there any concern expressed about having different-sex role models for your children?

9. (For those who did not use services, otherwise skip to question 12): So I understand from the information you gave us over the phone that you ultimately did not use AHR services. Can you talk about the factors that led to that?

a. Did you choose not to use services, or was that decision made for you by someone else? (Who? Why?)

b. Were there any issues specifically related to your sexual orientation or gender identity?

c. Were there any issues related to cost of services? Other practical issues?

10. Did you continue to try to build a family after AHR services were no longer a possibility for you?

a. (If yes) How did you go about doing that?

b. (If no) Why did you decide to stop?

11. Thinking back on your experience, do you feel that you had any unique experiences or needs related to your identity as a *insert relevant identity/ identities* (lesbian, gay man, bisexual person and/or trans person)?

a. What about other identities that are important to you? (probe: age, race/ethnicity, social class, disability)

b. (If participant lives outside of the GTA/Ottawa): Do you think there is anything unique about your experiences with AHR services because you live here? (Did you have to travel to access services? How far? What was that like for you?)

12. Based on your experiences, if you had five minutes with someone who could really make change in the AHR system, what would you recommend to them?

13. Is there anything we haven't covered that you feel is important for us to know about?

Appendix C: Socio-demographic questionnaire.

The following questions will ask you about your age, education, employment, relationship status, etc. This information will be used to get a big-picture idea of the people who participated in this study. All information provided by you will remain confidential.

1. How old are you?

- 16 – 25
- 26 – 30
- 31 – 35
- 36 – 40
- 41 – 45
- 45 – 50
- 50 – 60
- Over 60

2. What is your current relationship status? Please select all that apply.

- Legally married
- Common law/living with a partner
- Partnered / not living together
- Multiple partners
- Single
- Separated
- Divorced
- Widowed
- You don't have an option that applies to me

3. How do you describe your sexual orientation?

4. How do you describe your gender identity?

5. Do you identify as a person living with

a) a disability

- Yes
- No

and/or b) a chronic illness?

- Yes
- No

IF Yes a) What is the nature of your disability? _____

b) What is the nature of your health condition? _____

6. Have you tested positive for HIV?

IF Yes Did you learn of your status before or after considering AHR?

7. Do you currently have children?

- Yes

No

IF Yes a) How many in total?

b) How many are living with you?

c) How old are they?

8. Where were you born?

Canada

Outside Canada

9. If you were born in Canada, please skip to question 11. If you were born outside Canada, in which country were you born?

10. How many years have you lived in Canada?

11. How do you define your cultural and/or racial background?

12. What is your current employment status?

Full-time employed

Part-time employed

Student

Not employed

Retired

On disability

On maternity/parental leave

You don't have an option that applies to me

13. How would you describe your highest level of education?

Less than high school

High school some or completed

College some or completed

University (e.g. BA, BSc) some or completed

Post Graduation (e.g. MA, MSc) some or completed

14. What is your approximate household income?

under \$20,000

\$21,000–\$35,000

\$36,000–\$50,000

\$51,000–\$65,000

\$66,000–\$80,000

\$81,000–\$100,000

over \$100,000

Thank you for your participation

Appendix D: Written consent form

INVESTIGATORS

Lori Ross, PhD, Centre for Addiction and Mental Health

Leah Steele, MD, PhD, Centre for Addiction and Mental Health

Rachel Epstein, MA, LGBTQ Parenting Network, Sherbourne Health Centre

Stewart Marvel, MA, LL.M., Osgoode Hall Law School, York University

Study Sponsor: Canadian Institutes for Health Research

Introduction

You are being invited to participate in a research project. This consent form provides all of the information about this research project in order to assist you in deciding whether or not you wish to participate.

Before agreeing to participate in this research study, it is very important that you read and understand all of the information on this form. If you have any questions after you have read the form, you will be given as much time as you like to discuss them with the study investigator. You should not sign this form until you are sure that you understand and agree to all of the information about the research it provides.

Purpose of this Research

- Research on families formed through Assisted Human Reproduction (AHR) services (e.g., cycle monitoring, donor insemination, egg retrieval, sperm collection, in vitro fertilization, surrogacy) has focused on heterosexual relationships. However, there has been little research on the experiences of lesbian, gay, bisexual, and trans (LGBT, please see Glossary at the end of this form) people who use AHR services, or who have considered using these services, but have decided not to. The few available data suggest that LGBT people may face significant barriers to AHR services.
- The goal of this research is to understand the experiences of LGBT people who access, attempt to access, or have considered accessing AHR services in Ontario since January 1st, 2007.
- Part of this goal will be to explore the impact of the Assisted Human Reproduction Act (AHRA) on LGBT people in Ontario.

Description of the Research

Who will be participating in this study?

People who identify as LGBT and have used, considered using, or tried to use AHR services in Ontario since January 1, 2007.

If I choose to participate, what will I be asked to do?

1. Carefully read, consider, and sign this consent form. Once you have read and signed the consent form, you can return it to the interviewer. You will be given a copy to keep.
2. Take part in a one hour interview in which you will be asked to tell your story of using or attempting to use AHR services, or of considering but choosing not to use these services.
 - We will make an audio recording of the interview. However, if you do not wish to be audio recorded, please let the interviewer know and he/she will take written notes of the interview.

During the interview you will be asked to provide details about your decision to use or not to use AHR services, and your related and/or resulting experiences.

The total interview will not take more than 1 hour. You can take a break from the interview any time you like, and if you are unable to finish the interview at the scheduled time, your interviewer will offer to schedule another time to finish the interview with you.

3. Fill out a short, demographic questionnaire.

Potential Harms (Injury, Discomforts or Inconvenience)

There are no known harms associated with participation in this study.

It is possible that some of the questions you are asked may cause you to feel upset. If you feel upset, the interviewer can provide you with contact information for community support and/or mental health agencies that may be able to help you. You will also be encouraged to discuss any concerns you have with your family doctor. If you are uncomfortable with any of the questions or want to stop at any time during the interview, let the interviewer know.

Potential Benefits

You will not directly benefit from participating in this research study.

Confidentiality and Privacy

Your participation in this research is confidential. Your responses to the questions in the interview will be available only to the study investigators listed at the top of this consent form, and specific trained research staff who are bound to our research protocol and confidentiality agreement.

Study investigators are required to report to the authorities if it is clear that you or someone else is at risk of immediate danger, or if they have any reasonable suspicions of neglect and/or physical or sexual abuse of a person less than 18 years of age. Other than these legal exceptions, your responses to the interview will not be available to any individuals or organizations outside of the research team.

No information that reveals your identity will be released or published without your consent. Your responses and information will be held in strict confidentiality, and will be protected to the limits of the law.

All data will be safely stored in a locked facility and only research staff will have access to this information.

If you wish to participate in this study, but require anonymity of your records, you may select the option for anonymity on the signature page of this document (page 6). If you select this option, we will ensure the following:

o Once the interview is completed, we will remove from all transcripts and notes any information that may identify you and your family.

o We will remove and/or delete all reference to your participation in this project so that none of your identifying data remain on record with us.

Compensation

You will be compensated \$25.00 for your participation. Even if you choose to withdraw from the study before the end of the interview, you will still be compensated.

Participation and Withdrawal

- You can choose not to participate in any part of this research study, and you can choose not to answer any questions you are asked as part of the interview.
- If you choose to participate in this study, you can stop your participation (i.e., withdraw from the study) at any time without any effect on the care you receive. In addition, you do not lose any of your legal rights by signing this consent form. Your decision not to participate, or to withdraw your participation, will not influence the nature of your relationship with the researchers, Sherbourne Health Centre, CAMH, York University or any other group associated with this project, either now, or in the future.
- If you decide to withdraw from the study before the end, the investigators will ask you if they can still use the data you have provided to them to whatever extent possible. Should you say no, we will destroy your data.

Contact Information

- If you have any questions about your rights as a research participant in this study, you may contact Dr. Pdraig Darby, Chair, Research Ethics Board, Centre for Addiction and Mental Health, at 416-535-8501 ext. 6876, or Ms. Alison Collins-Mrakas, Senior Manager and Policy Advisor, Office of Research Ethics, York Research Tower, York University at 416-736-5914.
- If you have any questions about this research or your participation in this study, please contact the Principal Investigator, Dr. Lori Ross, at (416) 535-8501 ext. 7383, or Secondary Investigator, Stewart Marvel, at (647) 669-4144.

ATTACHMENT ONE

Listening to LGBTQ People on Assisted Human Reproduction:

Access to Reproductive Material, Services and Facilities

Introduction

In the wake of the December 2010 Supreme Court decision on the constitutional legitimacy of the *Assisted Human Reproduction Act* [AHRA],¹ Canada finds itself facing continued regulatory uncertainty in the area of reproductive technology. While next steps have yet to be defined by both provincial and federal authorities, this lacuna is of particular importance to lesbian, gay, bisexual, trans, two-spirit and queer (LGBTQ) people in Canada.²

¹Reference re *Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 SCR 457 [AHRA Reference]. Also see *In the matter of a Reference by the Government of Quebec pursuant to the Court of Appeal Reference Act, R.S.Q., c. R-23, concerning the constitutional validity of sections 8 to 19, 40 to 53, 60, 61 and 68 of the Assisted Human Reproduction Act, S.C. 2004, c. 2*, 2008 QCCA 1167, 298 DLR (4th) 712 [Quebec Reference].

²Lesbian is a term for a female whose primary sexual orientation is to other women. Gay is a term for a male whose primary sexual orientation is to other men. This term is sometimes used by lesbians (i.e., gay woman). Bisexual is a term for a person whose sexual orientation is directed towards individuals of more than one sex or gender, though not necessarily at the same time. Trans is an umbrella term referring to people who do not embrace traditional binary gender norms of masculine and feminine and/or whose gender identity or expression does not fit with the one they were assigned at birth; it can refer to transgender, transitioned, transsexual, and genderqueer people, as well as some two-spirit people. Transgender is a term used by individuals who falls outside of traditional gender categories or norms. It literally means “across gender,” and conveys the idea of transcending the boundaries of the gender binary system. It however is not necessarily a desire to be of the “opposite” sex. A transsexual is someone who feels their gender identity does not match the sex that they were assigned at birth. Many transsexual people choose to go through sex reassignment, including hormone treatment and surgeries, so that their sex and gender identity match. Transition refers to the process of changing from the sex one was assigned at birth to one’s self-perceived gender. It may involve dressing in the manner of the self-perceived gender, changing one’s name and identification, and undergoing hormone therapy and/or sex reassignment surgeries to change one’s secondary sex characteristics to reflect the self-perceived gender. Two-Spirit is an English language term used to reflect specific cultural words used by First Nations people who have both a masculine and a feminine spirit or to describe their sexual, gender and/or spiritual identity. Queer is a term that has traditionally been used as a derogatory and offensive word for LGBTQ people. Many have reclaimed this word and use it proudly to describe their identity and/or as an umbrella term for LGBTQ people or communities. Some people use ‘queer’ as a way of identifying their non-heterosexual orientation yet avoiding the sometimes strict boundaries that surround lesbian, gay, bisexual and trans identities. ‘Queer’ can also signify one’s rejection of heteronormative sexual identities, normative gender constructions, or essentialist identity politics. Please note that because ideas and attitudes are constantly changing within LGBTQ communities and among society at-large, these definitions may be used differently by different people and in different regions. Many of these terms have been adapted from the following sources: Barbara AM, Doctor F, Chaim G. Glossary. In: *Asking the Right Questions 2: Talking about sexual orientation and gender identity in mental health, counselling and addiction settings*. rev. ed. Toronto, ON: Centre for Addiction & Mental Health, 2007:55-60; Bauer GR, Hammond R, Travers R, Kaay M, Hohenadel KM, Boyce M. “I Don’t Think This Is Theoretical; This Is Our Lives”: How Erasure Impacts Health Care for Transgender People. *J Assoc Nurses AIDS C* 2009;20(5): 348-361; Green E, Peterson EN. LGBTQI Terminology. Available at: <http://www.lgbt.ucla.edu/documents/LGBTTerminology.pdf>

LGBTQ people are uniquely dependent on assisted human reproduction [AHR] services to create biologically-related children, with estimates suggesting that LGBTQ people represent 15-30% of clientele at some urban fertility clinics.³ Yet in a lengthy 167-page decision, the Supreme Court justices make only a single mention of LGBTQ users of AHR services. The reasons written by Chief Justice McLachlin failed to discuss LGBTQ people at all, while the judgment written by LeBel and Deschamps JJ. paused briefly to note that AHR “represents the only option for homosexuals who wish to reproduce.”⁴

In this chapter, I argue that the present legal regime has been crafted with scarce consideration of the reproductive needs of ‘homosexuals,’ let alone other members of the LGBTQ spectrum. Despite this omission, LGBTQ people in Canada who wish to become parents remain heavily dependent upon both adoption and AHR services.⁵ These are bureaucratically onerous and/or expensive options, leaving LGBTQ communities vulnerable to legislative gaps and judicial decisions which do not account for their unique realities.⁶ The

Accessed January 8, 2012.

³ Epstein R, The AHRA/LGBTQ Working Group. *The Assisted Human Reproduction Act and LGBTQ Communities*. Toronto, Ontario; 2008.

⁴ Decision of LeBel, Deschamps, Abella and Rothstein JJ, written by LeBel and Deschamps: “Rather, both those who testified before the Baird Commission and those who participated in the parliamentary debates acknowledged that the development of assisted human reproduction amounts to a step forward for the constantly growing number of people dealing with infertility. *Moreover, it represents the only option for homosexuals who wish to reproduce.* The risks for the health and safety of people who resort to these technologies do not distinguish the field of assisted human reproduction from other fields of medical practice that have evolved after a period of experimentation, such as that of organ transplants or grafts.” Italics added. Reference re *Assisted Human Reproduction Act*, 2010 SCC 61, [2010] 3 S.C.R. 457 at para. 254.

⁵ For more information about LGBTQ people’s experiences with adoption, see: Ross, L.E., Epstein, R., Anderson, S., Eady, A. (2009). Policy, practice and personal narratives: Experiences of LGBTQ people with adoption in Ontario, Canada. *Adoption Quarterly*, 12(3/4), 272-293; Ross, L.E., Epstein, R., Goldfinger, C., Yager, C. (2009). Policy and Practice regarding lesbian, gay, bisexual, transgender, transsexual and Two-Spirit adoption in Ontario. *Canadian Public Policy*, 35(4), 451-467; Ross, L.E., Epstein, R., Goldfinger, C., Steele, L.S., Anderson, S., Strike, C. (2008). Lesbian and queer mothers navigating the adoption system: the impacts on mental health. *Health Sociology Review*, 17(3): 254-266. For a discussion of how lesbian and bisexual women are navigating the provision of AHR services, see: Lesbian and bisexual women’s recommendations for improving the provision of assisted reproductive technology services. *Fertility and Sterility*, 86(3), 735-8; Ross, L.E., Steele, L., & Epstein, R. (2006). Service use and gaps in services for lesbian and bisexual women during donor insemination, pregnancy and the postpartum period. *Journal of Obstetrics and Gynaecology Canada*, 28(5), 505-11.

⁶ As an example, trans people have only recently gained recognition of their gender identity as an enumerated

AHRA Reference case once again emphasizes this gap,⁷ leaving increased legal uncertainty alongside the virtual erasure of LGBTQ people in Canada from the discussion of how and why AHR technologies are to be used in the future.

Legal uncertainty unduly impacts those with already precarious claims on the state, not least because the construction of dominant legal categories as neutral and universal actually obscures their historical particularism. When litigants challenge this abstracted form of legal rights and advance contextual narratives based on culture, race, or sexuality, Canadian courts have historically found such claims difficult to manage.⁸ As Hester Lessard explains, the supposed formal equality of access to rights “has no content other than the highly abstract content of entitlement to respect by the state for one’s status as a rights holder, and it contemplates an individual who is simply and fundamentally a rights-holding self, with no

grounds for discrimination in provincial and territorial human rights legislation. The Northwest Territories was the first jurisdiction to add “gender identity” to its human rights legislation in 2002 (*Human Rights Act*, SNWT 2002, c 18, s 5(1)). Manitoba added “gender identity” to its Human Rights Code in June 2012 as did Ontario, which also added “gender expression.” *Human Rights Code*, CCSMch175, s 9(2)(g), as amended by *Human Rights Code Amendment Act*, SM 2012, c 38, s 5(2); *Human Rights Code*, RSO 1990, c H. 19, s1, as amended by *Toby's Act (Right to be Free from Discrimination and Harassment Because of Gender Identity or Gender Expression)*, 2012, SO 2012, c 7, s 1. Prior to these amendments, the grounds of “gender” under the Ontario Code in particular had been held to include “gender identity”, but recent developments now make the legislation explicit. The term “gender identity” refers to a person’s own identification of being masculine, feminine, male, female, or trans. Gender identity is unrelated to sexual orientation; not all trans people identify as lesbian, gay, bisexual, or queer. Gender expression is the public expression of gender identity; actions, dress, hairstyles, etc., performed to demonstrate one’s gender identity.

⁷*Supra* note 3.

⁸ In regard to LGBTQ rights, *Mossop v. Canada (A.G.)*, [1993] 1 S.C.R. 554 demonstrated the limited success of litigants’ arguments which intentionally sought to avoid the normalizing weight of Canadian family law. As Brenda Cossman writes, “the [*Mossop*] case represented an interesting attempt by the litigants to frame the issue in the discourse of equality, while consciously trying to mitigate the sameness argument. In a conscious attempt to disrupt the heteronormativity of law, Mossop and the intervenors supporting his claim tried to limit their reliance on sameness arguments and the heterosexual equivalency of same-sex relationships. Even in arguing for a functional equivalency approach, Mossop himself refused to make arguments on the basis of sexual monogamy...*Functional approaches to the family are invariably measured against a set of norms about what families do or ought to do.*” In Brenda Cossman, *Lesbians, Gay Men*, and the Canadian Charter of Rights and Freedoms, 40 Osgoode Hall L. J. 223 (2002) at 226-227. This ‘set of norms’ is thereby rooted upon the heteronormativity of law - the assumption, in individuals or in institutions, that everyone is heterosexual, and that heterosexuality is superior to homosexuality and bisexuality. “Heteronormativity refers to the privileging of heterosexual relationships and identities through the establishment of said relationships and identities as the norm by which all others are evaluated.” Hylton, M.E. (2005). Heteronormativity and the experiences of lesbian and bisexual women as social work students. *Journal of Social Work Education*, 41(1), 67-82 at 69.

defining attributes, history, economic status, or social location.”⁹

In the case of AHR, these abstracted forms of entitlement are embedded deeply within the normative presumptions of heterosexual coupling.¹⁰ As was clear in the *AHRA Reference*, the infertile heterosexual couple is contemplated as the exemplary user of AHR services. Other dependent populations, including non-partnered men or women, are either ignored (as in the McLachlin C.J. decision), or marked only in passing (as in the LeBel and Deschamps JJ. ruling). This judgment, like so many others, is based upon the assumption that cisgender,¹¹ heterosexual couples constitute the norm, with all other demands for reproductive technology to be understood within this guiding frame. The SCC ruling assumes that LGBTQ people’s needs are *similar in kind* to those of cisgender, heterosexual couples, if perhaps more starkly rendered. Reproductive assistance may thereby constitute a necessary rather than occasional requirement for “homosexuals who wish to reproduce,” but the mechanics and legal considerations are basically the same. Thus, LGBTQ people’s concerns warrant no more than a passing acknowledgement, as the universality of the heterosexually reproductive family can accommodate all forms of socio-biological kinship – scientifically-aided or otherwise.¹²

This chapter aims to challenge such a perspective and demonstrate the specific character

⁹ Hester Lessard, “Mothers, Fathers, and Naming: Reflections on the Law Equality Framework and *Trociuk v. British Columbia (Attorney General)*” (2004) 16(1) Can. J. Women & the Law 165-211 at 176. In discussing the usage of abstract terms like “spouse” and “parent” within liberal legal discourse, Lessard notes that such apparently neutral categories participate in “eliding actual systemic differences in the positioning of social groups” despite a promise of theoretical inclusiveness. Such legal categories are an ideological reflection of dominant *social* norms and therefore implicitly privilege those individuals with a convergent understanding of historically specific family forms. See also Shelley Gavigan, “Legal Forms, Family Forms, Gendered Norms: What Is a Spouse?” (1999) 14 *Canadian Journal of Law and Society* 127.

¹⁰ For a more substantive discussion of this point, contact Lori E. Ross (l.ross@utoronto.ca), who together with the Creating Our Families research team (see note 14) is preparing a manuscript for publication entitled “Reframing assisted human reproduction: Reflections of lesbian, gay, bisexual, trans and queer people in Ontario, Canada.”

¹¹ Cisgender refers to a person whose gender identity matches the gender they were assigned at birth; someone who is not trans.

¹² For a philosophical meditation on the psychic lives of those who live outside of normative kinship, with specific reference to children born through donor insemination, see Judith Butler (2002) ‘Is Kinship Always Already Heterosexual?’ *Differences: A Journal of Feminist Cultural Studies* 13(1): 14-44.

of LGBTQ parenthood realized through AHR services. I argue that LGBTQ people are involved in a particular kind of reproductive project, and one that has been misread under the common banner of ‘infertility’ which currently drives the law and science of AHR.¹³ I write as a member of a qualitative, community-based study that has aimed to shed light on the experiences of LGBTQ people in Ontario who have used or considered using AHR services to have biologically-related children. Representing to our team’s knowledge the largest project of its kind, this pilot study was conducted collaboratively by researchers at the Centre for Addiction and Mental Health, the Sherbourne Health Centre and Osgoode Hall Law School.¹⁴

Although there are other areas of law that impact how LGBTQ people access and use AHR services, this chapter will take up the pressing consideration of access to reproductive material, services and facilities.¹⁵ Our team’s research shows that questions of access hold unique challenges for LGBTQ people accessing AHR, few of which are settled within Canadian case law or legislation. These are areas characterized both by restrictive law crafted without LGBTQ

¹³While this chapter will apply a specifically queer lens to analyze the weakness of infertility as a diagnostic, we are not the first to question the utility of the term. For a discussion on the shortcomings of ‘infertility’ as a conceptual rubric for both demographers and reproductive endocrinologists, see: Gurunath S, Pandian Z, Anderson RA & Bhattacharya S. (2011). Defining infertility—a systematic review of prevalence studies. *Human Reprod Update* 17(5): 575-588.

¹⁴This chapter was developed based on a Canadian Institutes of Health Research-funded study “Creating Our Families: A pilot study of the experiences of lesbian, gay, bisexual and trans people accessing assisted human reproduction services in Ontario” (FRN-103595). The study was developed in 2009 by Lori E. Ross (Re:searching for LGBTQ Health, Centre for Addiction & Mental Health), Leah S. Steele (St. Michael’s Hospital), and Rachel Epstein (LGBTQ Parenting Network, Sherbourne Health Centre). Stu Marvel joined the project in 2010 as a Co-Investigator and contributed to data collection. Lesley A. Tarasoff, MA, led participant recruitment and screening and completed the analysis of participant demographic data. Scott Anderson, MHSc, assisted in the development of the study, and datejie green, BA(Hons.), led data collection. Other staff and students from the Re:searching for LGBTQ Health team also contributed to this project (see www.lgbtqhealth.ca). In line with community-based research principles, this study was guided by an advisory committee of AHR service providers and service users. Cf: Israel BA, Schulz AJ, Parker EA, & Becker AB. (1998). Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health. *Annual Review of Public Health, 19*, 173-202. In total, 66 LGBTQ people from across Ontario were interviewed about their experiences with AHR services. I would like to thank the Creating Our Families (COF) research team for their comments on this piece, and the COF study participants for sharing their stories with us.

¹⁵ The other three areas of law which exert a differential impact on LGBTQ people are: access to reproductive funding; determinations over the legal parentage of donor-conceived offspring; and the rights of donor-conceived offspring to knowledge of their birth.

people's needs in mind, as well as unclear or vague jurisprudence that presents particular jeopardy for LGBTQ couples and individuals.

Indeed the Canadian Bar Association [CBA] has explicitly recognized the special requirements of LGBTQ people in relation to AHR. In a submission to Health Canada, the CBA noted that while the availability of fertility services impacts all segments of the population, “limits to that availability are likely to systemically discriminate against single people, and the lesbian, gay, bisexual and transgendered communities, who more often rely on assisted reproductive technologies to have children.”¹⁶

It is particularly distressing to witness the virtual elision of LGBTQ people from judgments such as the Supreme Court decision, as the statement of principles laid out in the *AHRA* explicitly aims to prevent discrimination against persons who seek to undergo AHR procedures, “including on the basis of sexual orientation and marital status.”¹⁷ This provision flows directly from the concern of the Royal Commission on New Reproductive Technologies [the Baird Commission] on prevailing discrimination against lesbians and single women in Canadian society. In its 1993 report, the Baird Commission expressed the strong view that:

it is wrong to forbid some people access to medical services on the basis of social factors while others are permitted to use them; using criteria such as a woman's marital status or sexual orientation to determine access to donor insemination, based on historical prejudices and stereotypes, amounts to discrimination as defined under human rights law and contravenes the Commission's guiding principle of equality.¹⁸

It is the contention of this chapter that such a *Charter*-backed guarantee must remain at the fore as federal and provincial jurisdictions alike now move to draft new legislation concerning

¹⁶ Canadian Bar Association, *Reimbursement of Expenditures under the Assisted Human Reproduction Act*, Ottawa: 2007. The CBA policy position paper makes a series of recommendations to Health Canada, urging for greater flexibility and the avoidance of narrow definitions for the reimbursement of gamete donors or surrogates. At 2.

¹⁷ *Assisted Human Reproduction Act*, SC 2004, c 2 [AHR], s. 2(e).

¹⁸ Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report*. Ottawa, 1993 at 278.

AHR.¹⁹ This position is bolstered by the *Canadian Human Rights Act*, which was amended in 1996 to explicitly enumerate sexual orientation as a prohibited ground of discrimination, following the declaration by Parliament that gay and lesbian Canadians are entitled to “an opportunity equal with other individuals to make for themselves the lives they are able and wish to have...”²⁰

Thus, in this chapter, I aim to outline gaps and limitations of the current regulatory framework and offer suggestions to ensure more equitable access and utilization of AHR services by LGBTQ people in Canada. The arguments are bolstered by empirical research that speaks to the lived realities of this legal uncertainty, and draws upon data from the ‘Creating Our Families’ study to demonstrate how reproductive law impacts LGBTQ people in distinctive ways.²¹ The chapter details the valences of fertility law as applied to LGBTQ families and concludes by suggesting possible areas of policy development and judicial analysis. By highlighting these areas of inequality and differential access to reproductive justice, the hope is that next steps concerning AHR legislation will proceed by taking into account the specific concerns of LGBTQ parents and parents-to-be.

LGBTQ access to reproductive material, services and facilities

This area of law may be characterized in terms of *access to reproductive material, services and facilities*. This includes access to human gametes such as sperm and ova, as well as the access of commissioning or intended parents to reproductive surrogates, either traditional or

¹⁹*Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11[Charter].

²⁰*Canadian Human Rights Act*, RSC, 1985, c H-6, s. 2, as amended by SC 1996, c 14, s 1.

²¹ While the points made herein are broadly applicable for LGBTQ people in Canada, it is important to note that the majority of participants in our qualitative study were aged 31-40 years, married or in a common-law relationship, white, university educated, and had an annual household income of greater than \$66,000 CAD (i.e., they are not necessarily representative of the larger LGBTQ population).

gestational.²² It also includes access to fertility clinics and gamete banks, which draw upon reserves both domestic and imported, as well as assisting individuals to freeze and store their own gametes (eggs, sperm, and embryos).

Access to third-party reproductive material is a crucial issue for LGBTQ people who wish to have biological children. Lesbians require sperm donation, gay men require ova donation (as well as a reproductive surrogate), bisexuals may require sperm or ova, and trans people may require sperm, ova and/or a surrogate, depending on the particulars of their situation.²³ While some lesbians, bisexuals and trans people may avoid the clinical system entirely and pursue home-based solutions with known donors (the infamous ‘turkey-baster’ method), this is not an option for many cisgender gay men.²⁴ When creating children with third-party gametes, LGBTQ parents-to-be must first determine whether they will select known or unknown gamete donors—each choice leads to very different legal pathways.

In this section, I outline five mechanisms of existing legal doctrine which infringe upon

²²A note on definitions: A *gestational surrogate* is a person who volunteers to have an embryo implanted in the uterus and carry the pregnancy on behalf of the intended parent or parents. A gestational surrogate is not genetically related to the resultant baby. A *traditional surrogate* on the other hand is someone who volunteers to conceive through insemination and carry the pregnancy on behalf of the intended parent or parents. A traditional surrogate contributes half the genetic complement of the resultant baby.

²³ Of course these situations may prove more complex, with lesbian and bisexual couples or individuals also requiring an egg as well as a surrogate, and gay men also requiring a sperm donor. The scenarios listed above represent the minimum of third-party gametes required by LGBTQ parents-to-be.

²⁴ For example, a 2011 study of thirty gay men who used AHR services concluded that, “gay men increasingly seek parenthood through assisted reproduction using an oocyte donor and a gestational carrier.” Dorothy A. Greenfeld, EmreSeli, 2011 ‘Gay men choosing parenthood through assisted reproduction: medical and psychosocial considerations’ *Fertility and Sterility* 95(1): 225-229 at 226. A preference for gestational surrogates – not least because of uncertainty over maternal parentage – means that gay men may find themselves completely reliant upon AHR services and the legal uncertainty this entails. For example, a U.S. study of gay fathers included a couple who were obliged, due to legal barriers to surrogacy in their state of residence, to hire “an egg donor from one state, a surrogate mother from another state, a surrogate agency in another state, the paternity clinic in a fourth state, [while they] were in a fifth state.” Dana Berkowitz and William Marsiglio, ‘Gay Men Negotiating Procreative Identities’, *Journal of Marriage and Family* 69 (May 2007): 366–381 at 377. Another gay father in the U.S., who had opted for a traditional surrogate because of the difficulty of accessing gestational services, mused that, “We were lucky that there was never a question for our surrogate of her role in the children’s lives, but as I look back, we were taking quite a risk. If she had changed her mind, or fought for custody, I suspect that our stable home life would’ve been disrupted in a homophobic system that would not have recognised my partner and I as the real parents.’ Quoted in Arlene Istar Lev, 2006, ‘Gay dads: Choosing surrogacy’, *Lesbian & Gay Psychology Review* 7(1), at 73.

or negatively impact the access of LGBTQ people to reproductive material, service and facilities.

One: Restricted access to legal means of gamete acquisition

The acquisition of ova and gametes is strictly regulated in Canada, and under the *AHRA* it remains a criminal act to privately purchase human reproductive materials.²⁵ Section 7 remained unchallenged in the reference case, and continues to prohibit the purchase of sperm or ova from Canadian donors. This legislation works in concert with Health Canada regulations around the transport, freezing, handling, purchase, and cross-border traffic of human gametes, most notably the *Processing and Distribution of Semen for Assisted Conception Regulations* [*Semen Regulations*].²⁶ Together, the *Semen Regulations* and Section 7 of the *AHRA* constitute the legal terrain for all Canadians seeking to gain access to third-party semen and ova.²⁷

Canada's legislation concerning gamete donation is currently among the strictest in the world.²⁸ This has limited the available supply of Canadian-donated sperm both anonymous *and* known.²⁹ The supply of anonymous semen is throttled by an onerous threshold for donation that

²⁵ While there have so far been no prosecutions under the prohibited sections of the *AHRA*, the Act prescribes a maximum penalty of \$500,000 and ten years imprisonment. *Supra* note 17.

²⁶ The *Processing and Distribution of Semen for Assisted Conception Regulations* SOR/96-254 was enacted under the *Food and Drugs Act*, R.S.C. c. F-27 [*Semen Regulations*]. The *Semen Regulations* came into force in June 1996, and are aimed at reducing the likelihood of infectious disease transmission. They set up a range of stringent health and safety requirements for the semen used in assisted reproduction.

²⁷ Although amendments to s.10 of the new *AHRA* have been made under s. 716 of the *Jobs, Growth and Long-term Prosperity Act*, SC 2012, c. 19, such provisions are not yet in force.

²⁸ Canada's sperm regulations are stricter than those enacted within many US jurisdictions, which makes it difficult for Canadians to import sperm from other countries. As reported by the Sperm Bank of California, a large semen distributor located in Berkeley, California: "Shipping semen samples to Canada is restricted because *Health Canada* has instituted strict regulations on donor testing that are not tenable for most US sperm banks to follow. However, we are able to sell sperm to recipients in Canada if they register with a US medical professional, cross the border to receive shipments and inseminate in the US." Promotional material, Sperm Bank of California. Italics in original.

²⁹ While Canadians are able to import sperm from other countries the regulations on allowable imports are strict, as indicated in the footnote above. This combination of restrictive domestic legislation and high international standards may collude to unduly impact certain people, and in particular those seeking sperm from a specific non-White racial background. For example, our interview participants included an interracial lesbian couple who were unable to find Filipino sperm within the limited Canadian stock. They selected a Filipino donor from U.S. sperm bank reserves, but encountered significant barriers when attempting to import the specimens due to its partial non-compliance with *Health Canada* regulations. Despite repeated attempts to import an available Filipino donor, the couple was

prevents gay and bisexual men from donating, while all known donors who are not also sexual partners, as we will see below, must navigate the secondary directives of the *Semen Regulations*.

Canada's restrictive donor legislation has an accentuated impact on LGBTQ people. It was estimated in 2011 that there are only approximately 35 active sperm donors in the entire country; numbers are even more uncertain regarding ova donors.³⁰ In order to meet demand, sperm is being imported from abroad, with some commentators estimating that 95% of Canadian needs for donor sperm are being met by sperm banks located outside of the country.³¹ Evidence suggests that LGBTQ people are drawing upon a relatively small pool of available anonymous donors, making it possible for related *donor sibs*³² to be concentrated within urban LGBTQ communities.³³ Our team's research suggests that LGBTQ people are far more likely to be utilizing the same donor and learning of the shared biology of their children through queer community ties. For example, one lesbian couple from our study attended a queer prenatal yoga class in Toronto, where they met another set of lesbian parents who had conceived with the same anonymous sperm donor. The women subsequently connected with fifteen more *donor sib*

ultimately prevented from bringing the desired samples into Canada and were obliged to physically drive across the border into the U.S. for insemination.

³⁰ Note that this number emerges largely from popular media not scientific sources, and a May 2011 article written by Toronto journalist Danielle Groen who investigated the status of ReproMed as Canada's last domestic sperm bank. Groen interviewed a number of clinical practitioners including the medical director of ReproMed, Dr. Alfonso Del Valle, who offered the following statement: "Before these laws came into place, we would have 100 donors at any given time...As it stands now, we must scramble to have 30 or 35 donors active." Groen also interviewed Samantha Yee, a social worker at Mount Sinai's Centre for Fertility and Reproductive Health, who corroborated this scarcity by remarking: "People are very surprised at how few donors there are in the Canadian catalogue." As of the time of writing, Groen's article is hosted on the ReproMed website. See: Groen, Danielle, Down for the Count: There are only 35 sperm donors left in all of Canada. Holy mama, we've got a problem, *The Grid*, May 2011. <http://www.thegridto.com/city/local-news/down-for-the-count/>

³¹ Tom Blackwell, Limit pregnancies by same sperm donor: fertility experts, September 8, 2011, *National Post*. <http://news.nationalpost.com/2011/09/08/limit-pregnancies-by-same-sperm-donor-fertility-experts/>

³² *Donor sibs* is a colloquial term used to discuss the other children who are the offspring of one's sperm donor. It is not universally applied, but those that utilize it seek to describe the genetic relationship between their children and other offspring of the same donor, which may not translate into a social relationship. Hertz, R. and Mattes, J. (2011). Donor-Shared Siblings or Genetic Strangers: New Families, Clans, and the Internet. *Journal of Family Issues*, 32(90):1129-1155 at 1136.

³³ For an in-depth analysis of this looming impact upon queer people in Canada, please see Stu Marvel, *Tony Danzais My Sperm Donor?: Queer Kinship in Canadian Fertility Law*, *Canadian Journal of Women and the Law* (2013).

parents through online media and Facebook, most of whom were other lesbian couples.

These tight networks pose particular problems for lesbians, trans men and queer people of colour, who have limited options in terms of semen donors:³⁴

“...the sperm supply is quite limited in Canada. There’s not tons of it ... [especially] for people from other um like ethnic minorities If you’re not looking for a white donor you have to look a little bit harder” (Carol,³⁵ a bisexual woman who conceived a child with her lesbian partner using anonymous donor insemination; in their case, they had to go to the U.S. to find a donor who matched their ethnic background).

Gay and bisexual men are also restricted by the ban on commercial transactions of donor ova, and, if pursuing gestational surrogacy, must first locate an altruistic donor willing to undergo the invasive process of egg extraction.³⁶ While there are options for purchasing donor ova from the United States and elsewhere, these are expensive avenues that channel legal uncertainty around the permissibility of cross-border gamete purchase.³⁷ Most of the gay men we interviewed felt that payments to egg donors and surrogates should be legal, though regulated, with additional legislation required to protect both ova donors and commissioning parents.

Two: Known semen donors who are not sexual partners are viewed as anonymous third-party donors

Due to reasons such as cost, convenience, shared parenting arrangements and intentional kinship creation, some people prefer to carry out assisted conception with a known donor rather

³⁴ *Ibid.* Also see: Ross, L.E., Steele, L., Epstein, R. (2006). Lesbian and bisexual women’s recommendations for improving the provision of assisted reproductive technology services. *Fertility and Sterility*, 86(3), 735-738.

³⁵ All names have been changed.

³⁶ For an investigation of how Canadians are accessing donor ova and the attendant medical risks to donors, see Motluk A. (April 2010). The human egg trade. How Canada’s fertility laws are failing donors, doctors, and parents. *The Walrus*, 30-37.

³⁷ Susan Drummond (2013) “Fruitful Diversity: Revisiting the Enforceability of Gestational Carriage Contracts” Osgoode CLPE Research Paper No. 25.

than purchasing anonymous sperm from a sperm bank.³⁸ For the purposes of the *Semen Regulations*, “assisted conception” refers to “a reproductive technique performed on a woman for the purpose of conception, using semen from a donor who *is not her spouse or sexual partner*.”³⁹ This definition places *all* donor semen in the same category, meaning that an anonymous vial ordered online will be treated with the same dispassionate rigor as a donation from a brother-in-law, a childhood friend, or an intended father in a multi-parent arrangement.

In practice, this means that known donor semen is subject to the same testing and quarantine requirements as anonymous donations. Even if a known donor has a clean bill of health and all parties agree to use a fresh specimen that has been tested and washed in the laboratory prior to insemination, the *Semen Regulations* prohibit the use of fresh sperm *unless there has been a sexual relationship* between the donor and the person being inseminated. Instead, the sperm sample must be frozen for a minimum of 180 days for infectious disease screening, with the donor’s blood extracted and tested both at the time of sample provision, and six months later when the semen is thawed and finally inseminated. This same routine must be replicated for any subsequent specimens the donor may produce.⁴⁰ This is a costly and time-consuming process that treats a known donor, who is often a close friend or member of a partner’s family, with the same epidemiological suspicion as an anonymous stranger.

For example, I interviewed a female couple, Tonya and Jacqueline, who had decided to

³⁸While Canadians cannot *privately* transact the purchase of human sperm under criminal penalty, they may purchase donor semen from licensed sperm banks. While this article will not explore the ethical hypocrisy of allowing payment for commercially-traded gametes from other legal jurisdictions, it does call into question the *AHRA*’s interdictions against payment for human reproductive material. This ban originates in the wording of the Baird Report, which stated: “To allow commercial exchanges of this type [buying and selling embryos, use of financial incentives, etc.] would undermine respect for human life and dignity and lead to the commodification of women and children” *supra* note 18 at 718.

³⁹*Supra* note 26, at s.1. Emphasis added.

⁴⁰Health Canada, Health Products and Food Branch Inspectorate, *Guidance on the Processing and Distribution of Semen for Assisted Conception Regulations* (GUIDE-0041) (September 1, 2004).

avoid the clinic altogether after being faced with these protocols.⁴¹ Tonya was planning to be inseminated with Jacqueline’s brother’s sperm, in order to foster genetic alignment in their family and create a child that would resemble both of its mothers. The couple sought out the assistance of a local fertility clinic to help with the process and carry out standard testing for both Tonya and Jacqueline’s brother. However, once they encountered the six-month quarantine period and associated costs mandated by the *Semen Regulations*, they decided to carry out the whole process at home. As they described, while their initial preference was for the clinic to manage the collection of Jacqueline’s brother’s semen, the known donor fees and procedural hurdles proved a frustrating barrier:

Jacqueline: I’m serious, like I’m still angry to this day about, about that clinic experience. Cause I think that a lot of people that are going in with known donors or friends, they virtually put a barrier up and it makes so that if you want an anonymous donor it’s already out of the price range but if you have a known donor or you want to co-parent or anything like this, it just makes the cost even more and for the average family it’s already expensive, so can you imagine what it does if they’re going to store this stuff for six months and do these extra procedures... financially [it] can be impossible for some families.

Another female couple interviewed had also opted to use home insemination with a known donor. They explained that “a big part” of their decision to avoid the clinical system was due to the required freezing of third-party donor sperm. They were both in their mid-thirties and did not feel that they could afford the additional delay in moving forward with insemination. Instead, they wanted to begin trying for a child as soon as possible to fit their biological and professional timelines. Bev, one of the women, had the following to say about the *Semen Regulations* and its restrictions on third-party donors: “Trust women. Let them make decisions about their own bodies and their own safety rather than trying to impose safety standards that assume that women who are trying to get pregnant are incapable of rational decision-making.”

⁴¹ All participant names have been changed.

It is important to note that these regulations do allow women seeking insemination by a male *sexual partner* to bypass quarantine requirements. Women in opposite-sex relationships may use fresh semen from a conjugal partner without delay, thereby avoiding the six-month waiting period as well as fees associated with the storage of donated semen. Indeed, should a lesbian or bisexual woman walk into a fertility clinic and falsify a sexual relationship with her male companion, she can also request immediate insemination without the requirements of freezing or quarantine.⁴² Rachel Epstein, writing on behalf of the LGBTQ/AHRA Working Group, a collective of Toronto-based service providers and researchers concerned with issues of access to AHR services, put the matter of harm as follows:

While we understand that the intent of this practice is to protect people from undetected risks, in fact there are no fewer risks in being inseminated with the sperm of someone one is having sex with, than there is being inseminated with the sperm of a known donor one has been inseminating with. The risks are the same. If one is willing to assume the risk of insemination from a sexual partner, one should also be able to assume the risks of insemination from a known donor. The situation outlined above has put people who are using known sperm donors in the position of lying when they approach fertility clinics. If they present their donors as sexual partners, they can access the services they require. If they tell the truth, they are denied. As well this means that in the case of a lesbian couple, the non-birth parent is left out of the process, which results in undue hardship to her. She is left out of the very personal and significant process of her child's conception.⁴³

In other words, a woman may assume the 'risk' of being inseminated by her sexual partner, but not the 'risk' of being inseminated by a loved one with whom she is not having intercourse. The *Semen Regulations* presume an anonymity and mistrust of the 'stranger danger' of contamination that is simply not the case with a known sperm donor. This is a definition crafted with cisgender, heterosexual couples firmly in mind, and one which is unable to account for the complex realities

⁴² Epstein, AHRA/LGBTQ Working Group *supra* note 3 at 6.

⁴³ *Ibid* at 7. There is also the related issue of custody, should a known donor choose to later claim legal parentage of the child. The documentation from a fertility clinic in which a known donor was masquerading as a sexual partner would have the known donor registered as "partner." This may make it more difficult for the mother to prove intent in case of custodial challenge.

of LGBTQ kinship arrangements.

Three: Gay men and HIV-positive men require Special Dispensation to be known donors and are barred entirely from anonymous semen donation

The *Semen Regulations* also incorporate a document entitled the *Technical Requirements for Therapeutic Donor Insemination* [Directive],⁴⁴ which excludes a comprehensive range of prospective donors determined to be in the ‘high-risk’ category or considered genetically unfit. These exclusions include men over 40 years of age and “men who have had sex with another man, even once, since 1977.”⁴⁵ Thus, even when presenting with a known third-party donor and attempting in good faith to follow the dictates of the *Semen Regulations*, a lesbian will find her donor in the ‘high risk’ category and be prevented from readily using sperm if it is from a gay or bisexual friend. Yet our interviews indicate that many lesbians, bisexuals and trans men would like to use sperm from a cisgender male or trans woman⁴⁶ friend, and in some cases this may even lay the groundwork for an intentional multi-parenting arrangement.⁴⁷

One lesbian couple we interviewed was prevented from using a known donor on the grounds that he was gay, and found themselves presented with confusing and contradictory information. At the clinic they were told that, as a gay man, their chosen donor would not be

⁴⁴Health Canada, *Technical Requirements for Therapeutic Donor Insemination* (Ottawa: Canada, July 2000).

⁴⁵*Ibid.* at ss. 2(1)(c). A challenge to the constitutionality of this policy in specific relation to blood donations by men who have since 1977 had sexual relations with other men was dismissed by an Ontario court in 2010, determining that the *Charter* did not apply as the respondent was a private rather than a governmental entity. See *Canadian Blood Services v. Freeman*, 2010 ONSC 4885, 217 CRR (2d) 153. See also: *infra* note 54 on the latest position of Canadian Blood Services.

⁴⁶Trans woman: a male to female transsexual (MTF); someone who was assigned as male at birth and identifies as female. Trans man; a female to male transsexual (FTM); someone who was assigned as female at birth and identifies as male. While hormone replacement therapy and surgical treatments will lead to loss of reproductive potential in male to female transsexuals, if they have stored spermatozoa before starting hormonal therapy these gametes may be used in the future. See also: De Sutter, P. (2001). Gender reassignment and assisted reproduction: Present and future reproductive options for transsexual people. *Human Reproduction*, 16(4), 612-614.

⁴⁷*AA v BB*, 2007 ONCA 2, 83 OR (3d) 561 is perhaps the most well-known Canadian example of a case in which a man was actively co-parenting with two lesbian women, wherein the court awarded joint parental rights to all three parties. See also: *C.(M.A.) v. K.(M.)*, 2009 ONCJ 18, 94 OR (3d) 756 for a more contentious example, in which the parental rights of a lesbian couple were challenged by the gay man who was also the sperm donor.

eligible to donate:

Justine: They [said we] would have to do a year quarantine, then that would include several samples throughout that year to be tested We actually had confided in one of the nurses that Rob [our known donor] was gay and they said that he they wouldn't even been able [to do it]... His donation would not be taken at all.

Frustrated by the extended quarantine period and complex regulations regarding gay men as donors, this couple eventually used an anonymous donor. Justine described their exasperation at the situation:

Justine: I mean we wanted to use Rob. I mean that was our first choice and we weren't able to...

Interviewer: But the nurse was discouraging.

Justine: Yeah, very discouraging in that sense. She said that they probably wouldn't even test him If they know. And it's like, well what does it matter? What, I mean what does it? You're testing for HIV anyway. Is it just a given because he's gay he's gonna have it? No. It's I mean it's a given that he's gonna have sex with men, yes. ... If you answer honestly as a gay man, yeah, you're basically excluding yourself. Do you lie? I mean is that what we've come to now is that for Rob to be able to, you know, to donate he has to lie about who he is? I don't think that's right.

As Epstein suggests, this equivocation between gay men and risky sexual practice is inaccurate, not to mention, “steeped in the homophobic and discriminatory view that ‘gay’ men are synonymous with HIV/AIDS.”⁴⁸

For a gay man who is excluded under the Directive's criteria but wishes to donate there is recourse. After first testing negative for infectious diseases such as HIV and hepatitis, he may apply for special authorization from his doctor under the Donor Semen Special Access Program (DSSAP). If the DSSAP is granted, he may then undergo the six-month semen testing and quarantine period.

In 2007, the Ontario Superior Court of Justice ruled on a challenge to the constitutionality

⁴⁸ See Epstein, AHRA/LGBTQ Working Group *supra* note 3 at 7. *Sexual orientation* is a term for the emotional, physical, romantic, sexual and spiritual attraction, desire or affection for another person (e.g., gay, straight, bisexual, lesbian), whereas *sexual identity* refers to one's identification to self (and others) of one's sexual orientation. Sexual identity is not always the same as sexual orientation and/or sexual behaviour (what people do sexually).

of the *Semen Regulations*. The lesbian applicants in *Susan Doe v. Canada*⁴⁹ had argued that considerations such as conceptions of autonomy and community values played an important part in determining their reproductive choices, and the donor exclusion list posed a discriminatory barrier not experienced by heterosexual couples or donors. In the judgment, Dambrot J. maintained that the donor exclusions as listed did not discriminate against lesbian women or gay men. According to the Court, the scheme was based on differential treatment not sustained on prejudice, stereotyping or historical disadvantage. Using a classical liberal approach to the rights set forth in the *Charter*, Justice Dambrot concluded that any differential treatment was justified by the original intention of the regulations.⁵⁰ As these regulations were predicated upon a protectionist health approach to reproductive matters, by which there is a necessity to protect the public from acquiring infectious diseases, the health protectionist argument overrules other considerations. This is despite the fact that health approaches to reproductive matters and HIV transmission have changed dramatically since the U.S. Centers for Disease Control first developed these guidelines in 1994.

At time of writing, HIV-positive men are banned from anonymous third-party sperm donation. Surrogacy is also not currently an option in Canada for HIV-positive single men or HIV-positive men in a same-sex couple, despite a large body of evidence suggesting that reproductive technologies can allow HIV-affected men to safely conceive.⁵¹ Indeed, a 2007 multicentre study on inseminations of women with HIV-positive semen reported that when using

⁴⁹*Susan Doe v. Canada (Attorney General)* (2006), 79 OR (3d) 586, 25 RFL (6th) 384 (SCJ), aff'd 2007 ONCA 11, 84 OR (3d) 81.

⁵⁰ For an extended treatment of the case, see the unpublished LLM thesis 'Doe v. Canada: Lesbian women, assisted conception, and a relational approach to rights' by Sandra Dughman (University of Toronto, 2009).

⁵¹ According to recently-approved Canadian HIV Pregnancy Planning Guidelines, "as all fertility clinics should be operating using Canadian Standards Association procedures for universal precautions and infection control, *there are no scientific grounds on which to refuse services to people living with HIV*" Emphasis in original, Mona R. Loutfy et al., Canadian HIV Planning Pregnancy Guidelines, *J Obstet Gynaecol Can*, June 2012; 34(6):575-590 at 587.

current sperm-washing technologies, “the calculated probability of HIV contamination is equal to zero.”⁵² The recommendation of the research team, based on this and other correlate studies, is that, “it is neither ethically nor legally justifiable to exclude individuals from infertility services on the basis of male HIV-infection.”⁵³

Advances in technology have minimized the risk of infectious disease transmission and ask that we revise the terms of protectionist arguments like *Susan Doe v. Canada*. In light of the onerous burden the Directive places upon gay and bisexual men and HIV-positive men, as well as the recipients of their donor sperm, we may ask what public interest is truly being served by continuing to uphold these outdated standards.⁵⁴

Four: The criminalization of commercial surrogacy

While some heterosexual couples may seek out surrogacy options, gay men who desire to create a genetically-related family without the involvement of a female co-parent, will require the services of a reproductive surrogate, as may some bisexual and trans-identified couples and individuals.⁵⁵ This places gay men in a situation of complex dependency and engagement with the bodies willing to bear their children. Our team’s research makes clear that Canada’s

⁵²This was the first multicentre study of the use of sperm washing in HIV-1-serodiscordant couples, the largest series published to date, and the first with sufficient case numbers to confirm the safety and efficacy of assisted reproduction where sperm washing was used as the primary means of avoiding HIV infection in the female partner. Bujan L, Hollander L, Coudert M et al. Safety and efficacy of sperm washing in HIV-1-serodiscordant couples where the male is infected: results from the European CREATE Network. *AIDS* 2007; 21: 1909–1914 at 1909. Also see: James D.M. Nicopoulos, Paula Almeida, Maria Vourliotis, Rebecca Goulding, and Carole Gilling-Smith, A decade of sperm washing: clinical correlates of successful insemination outcome. *Hum. Reprod.* (2010) 25(8): 1869-1876; Lynn T. Matthews and Joia S. Mukherjee. Strategies for Harm Reduction Among HIV-Affected Couples Who Want to Conceive. *AIDS Behav.* 2009;13:S5-S11.

⁵³*Ibid* at 1913.

⁵⁴Canadian Blood Services has publicly acknowledged that these criteria may be outdated in regard to blood donation, and in a 2009 media statement on their website declared: “We openly recognize and empathize with those for whom the MSM [men who have sex with men] deferral policy has a negative impact... Canadian Blood Services has the will to work towards change to the MSM deferral policy.” *Canadian Blood Services reaches out to affected MSM policy communities*, July 30, 2009. <Accessed at <http://www.bloodservices.ca>>

⁵⁵ See *supra* note 23 on the multiplicities of embodiment and kinship formation within LGBTQ communities.

criminalization of commercial surrogacy has exerted a powerful impact on gay men hoping to create biologically-related children, as legislative hesitancy to address the bioethics of surrogacy has created uncertainty around allowable reimbursement for surrogate expenses.⁵⁶

Surrogacy refers to the practice whereby, through prior arrangement, a woman carries and gives birth to a child that she does not intend to parent.⁵⁷ Instead, parenting responsibilities are assumed by the intended or ‘commissioning’ adults. Surrogacy may be either *traditional*, wherein a surrogate uses their own egg as fertilized by donor sperm, or *gestational*, in which the surrogate is implanted with an egg and sperm to which they have no genetic ties.⁵⁸

Two sections of the *AHRA* come to bear on surrogate transactions. Section 6 prohibits the payment or advertisement of payment to surrogate mothers or intermediaries, and places a minimum age restriction of 21 years on potential surrogates. The maximum criminal penalty for transgressing Section 6 is \$500,000 and ten years imprisonment.⁵⁹ Section 12 recognizes, however, that some reimbursement of expenditures is necessary on the part of surrogates (and gamete donors), and makes allowance for their limited compensation.⁶⁰ This was one of the few sections of the *AHRA* to withstand constitutional scrutiny by the Supreme Court, and was

⁵⁶ Eight years after the *AHRA* received Royal Assent, key sections of the Act that survived the constitutional challenge and remain *intra vires* are still not in force. See *infra* note 60 for Health Canada’s position on allowable expenses under s. 12. See also *infra* note 69 for a position that challenges the presumed exploitation and corrosive power dynamic of paid surrogacy arrangements.

⁵⁷ Trans men may of course also act as surrogates, however we know of no such cases to-date.

⁵⁸ See *supra* note 22 for a detailed description of different types of surrogacy.

⁵⁹ To-date, no charges have been laid under Section 6 since it came into force in 2004. However a recent investigation of Leia Picard, CEO of Canadian Fertility Consultants, may indicate a renewed interest in enforcement. RCMP officers raided Picard’s offices in February 2012 and seized computer equipment and files, investigating alleged violations of Section 6’s prohibition against commercial payment for eggs, sperm and the services of a surrogate. See: Tom Blackwell, ‘Ontario fertility raid linked to U.S. ‘baby-selling’ scandal’, *National Post*, March 5, 2012. Accessed online August 3, 2012 <<http://news.nationalpost.com/2012/03/05/ontario-fertility-raid-linked-to-u-s-baby-selling-scandal>>.

⁶⁰ Section 12 is not yet in force and Health Canada has not yet issued regulations. They have provided the following clarification into this regulatory vacuum: “Regulations regarding reimbursement are currently being developed to clarify what types of expenditures will be allowed and how the activity will be licensed. Until the licensing scheme and regulations are in place, donors may be reimbursed up to the actual amount of their legitimate expenditures without a licence.” Health Canada, *Frequently Asked Questions*, Accessed online August 3, 2012 <<http://www.hc-sc.gc.ca/hl-vs/reprod/hc-sc/faq/index-eng.php>>.

deemed an important safeguard to public morality in the reasons of McLachlin C.J.; its constitutionality was subsequently affirmed by the swing vote of Cromwell J.⁶¹

As Health Canada has not yet promulgated regulations for Section 12 the details of allowable compensation are uncertain. At this point, all that commissioning parents know is that receipts must be kept, and that a surrogate must not be reimbursed for the loss of work-related income incurred during her pregnancy unless “a qualified medical practitioner certifies, in writing, that continuing to work may pose a risk to her health or that of the embryo or foetus.”⁶² Thus, a strictly altruistic system is being enforced in Canada, as surrogates are not legally entitled to claim remuneration beyond out-of-pocket expenses and may only be compensated for missing work if their health is at risk.

But what kinds of expenses for reproductive labour may be compensated? Prenatal yoga classes? Childcare? Vitamins? Health Canada has taken the position that all ‘reasonable’ expenses incurred in the course of donation or surrogacy may be reimbursed, without actually defining what reasonable entails.⁶³ This remains a confounding area of law, as indicated by our research participants:

Interviewer: When you say mandating of payment, what do you mean?

James: I think it should be better worded ‘cause ‘reimbursement for expenses’ for me was never very clear and I don’t think anybody really understands it. If it’s sort of the middle of the road before you say “Yes you can pay” or “No you can’t pay” if that’s the way it’s gonna have to be, it’s okay I guess but I-I don’t understand why they can’t make it clearer (A gay man, who with his partner, now

⁶¹In regard to the validity of impugned provisions of the *AHRA* in upholding the criminal law power and protecting public morality, McLachlin C.J. reasoned as follows: “In summary, morality constitutes a valid criminal law purpose. The role of the courts is to ensure that such a criminal law in pith and substance relates to conduct that Parliament views as contrary to our central moral precepts, and that there is a consensus in society that the regulated activity engages a moral concern of fundamental importance.” (*supra* note 1 at para 51). The Chief Justice also drew specific attention to the role of s.12 in preventing Canadian morality from ‘crossing the line’ into commercialized reproductive activities: “This [s.12] is the line that prohibits that which is considered inappropriate commodification, and permits that which is considered acceptable reimbursement. *Threat of drawing this line raises fundamental moral questions.*” [emphasis added] (*supra* note 1 at para 111.)

⁶²*AHRA* s.12, ss. 1-3, quoting s. 12(3)(b).

⁶³Sherry Levitan, ‘Surrogacy in Canada’, Accessed June 23, 2012 <<http://www.fertilitylaw.ca/surrogacy.shtml>>.

has two children via anonymous egg donor and gestational surrogate).

At present, only the intended parents may reimburse a surrogate for expenses. They are left to their own devices in determining the ‘reasonableness’ of expenditures in accordance with contracts between the parties. In practice, this is generally done in consultation with a lawyer, who is an intermediary third party that *may* be paid for their services in helping negotiate the surrogate contract, despite regulatory uncertainty around acceptable contractual boundaries.⁶⁴

Other third parties who may receive compensation currently include fertility physicians, gamete banks and pharmaceutical companies, although none are allowed to help connect potential surrogates and parents. Sally Rhodes-Heinrich, who helms the popular website *Surrogacy in Canada*, warns about this ban on intermediaries: “I think you will see more disasters and tragedies in surrogacy if you don’t have people who do some preliminary screening, people who are educating and providing support.”⁶⁵

This selective approach to compensated support and professional advice is not only paternalistic, but privileges an educated class of practitioners – doctors, lawyers and pharmaceutical firms – over the actual surrogates being commissioned. One’s legal counsel may be remunerated for their labour, but not the surrogate at the center of the transaction. Concerns over the commercialization of trade in reproductive labour have represented a central thrust of the *AHRA* since its inception in the Baird Report.⁶⁶ Arguments over the moral validity of

⁶⁴ With regard to the promulgation of regulations under Section 12, Toronto lawyer Sherry Levitan writes, “It’s been eight years, and I don’t expect to see them in my lifetime. ...All I can do is lay it out for a client, and they can tell me where their comfort level is.” In Michael McKiernan, ‘Fertility lawyers press ahead despite legal vacuum’, July 09, 2012, *Law Times*, <http://lawtimesnews.com/Focus-On/Focus-On-Fertility-lawyers-press-ahead-despite-legal-vacuum>

⁶⁵ Tom Blackwell, ‘Canada’s murky legal world of surrogate-consultants and human-egg buyers’, March 9, 2012, *National Post*. Accessed August 3, 2012 online: <http://news.nationalpost.com/2012/03/09/canadas-murky-legal-world-of-surrogate-consultants-and-human-egg-buyers/>

⁶⁶ As Maneesha Deckha argues convincingly, anxiety over a potential marketplace of human commodities is one of the two central factors that have propelled the *AHRA*. The other is what she terms “species anxiety”, or “the phobia that individuals manifest at the thought of the human body intermingling with another species at the reproductive, genetic, cellular, or other body part level.” In Deckha, M. (2009). *Holding Onto Humanity: Commodification and*

commercial surrogacy have raged for decades, only growing more complicated in recent years with the globalization of reproductive surrogate markets into locations such as India, Thailand and Eastern Europe.⁶⁷

While some feminist commentators have argued that practices such as commercial surrogacy serve to embody and institutionalize the patriarchal domination of women, others have sought to understand surrogacy within terms of women's agency and the difficulties of contractual decision-making.⁶⁸ These are complex issues as surrogacy arrangements differ significantly depending on geographic, economic and social conditions.

Drawing from a meta-analysis of research on surrogacy in Canada, the United States and the United Kingdom, a 2010 study by Karen Busby and Delaney Vun interrogates the assumed power differentials of surrogacy and presumptions of exploitation.⁶⁹ As they report, "empirical research concerning women who become surrogate mothers in Britain and the United States does not support concerns that they are being exploited by these arrangements, that they cannot give

Species Anxiety in Canada's Assisted Human Reproduction Act, *Unbound: Harvard Journal of the Legal Left*, 5(1), 21-54 at 22.

⁶⁷ For discussions of reproductive tourism and the bioethical and feminist issues at play within the globalization of commercial surrogacy, see: Blyth E, Farrand A. 2005. Reproductive tourism—a price worth paying for reproductive autonomy? *Crit. Soc. Policy* 25:91–114; Jones CA, Keith LG. 2006. Medical tourism and reproductive outsourcing: the dawning of a new paradigm for healthcare. *Int. J. Fertil.* 51:1-5; Storrow RF. 2005. Quest for conception: fertility tourists, globalization and feminist legal theory. *Hastings Law J.* 57:295–330; Storrow RF. 2005. *The Handmaid's Tale* of fertility tourism: passports and third parties in the religious regulation of assisted conception. *Tex. Wesleyan Law Rev.* 12:189-211.

⁶⁸ For examples of the radical feminist view, see: Gena Corea, *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs* (New York: Harper & Row, 1985); Janice Raymond, *Women as Wombs: Reproductive Technologies and the Battle over Women's Freedom* (New York: Harper, 1993); Jocelyn Scutt, ed., *The Baby Machine: Reproductive Technology and the Commercialisation of Motherhood* (London: Merlin, 1990). For commentators that argue for more nuanced views of women's autonomy and choice, see: Rosalind Petchesky, "Reproductive Freedom: Beyond 'A Woman's Right to Choose'," *Signs* 5.4 (1980): 661-685; Judith Lorber, "Choice, Gift, or Patriarchal Bargain? Women's Consent to *in vitro* Fertilization in Male Infertility," *Hypatia* 4.3 (1989): 23-36; Marilyn Strathern, *Reproducing the Future: Anthropology, Kinship and the New Reproductive Technologies* (Manchester: Manchester University Press, 1992); Sarah Franklin, *Embodied Progress: A Cultural Account of Assisted Conception* (London: Routledge, 1997).

⁶⁹ Busby, Karen & Delaney Vun, "Revisiting the Handmaid's Tale: Feminist Theory Meets Empirical Research on Surrogate Mothers," 26 *Can. J. Fam. L.* 13 (2010).

meaningful consent to participating, or that the arrangements commodify women or children.”⁷⁰

Instead, Busby and Vun call for a more nuanced legal regime to ensure that women who enter into altruistic *or* paid surrogacy contracts will receive the full protection of the law.⁷¹

By the same token, Toronto lawyer Sara Cohen poses the following question on her website: “If women obtain medical advice, independent legal advice and psychological counselling and choose to engage in surrogacy or egg donation, why should the state protect them from themselves when they do not need or want protecting?”⁷² Indeed, a number of the gay male couples we interviewed commented on the perceived independence of their surrogates, while also lamenting the lack of guidance around how to navigate this complex social experience.

“‘Should we buy her something nice?’ You know what I mean? You don’t know what to do; it’s like uncharted territory” (Paul, a gay man, who with his male partner, are in the process of having a child via anonymous egg donor and gestational surrogate).

What is clear is that Canadian laws prohibiting commercial surrogacy are having a real and disproportionate effect on LGBTQ people, and are developing without consideration of the reproductive dilemma faced by gay men in particular. The indeterminacy of guidelines for reimbursement has not halted the practice, but has piled on greater anxiety to an already fraught and emotional process.

Brad: “...I think the whole ambiguity of the process scares people. I think even being in the process you kind of feel like you’re doing something wrong I think if it’s very clear then people will know that it is legal and you’re paying someone to, you know, help you with your...
James: Have your child.

⁷⁰*Ibid* at 46. This is substantiated by other studies carried out in English-speaking countries, including Bree Kessler’s estimation that military wives accounted for 50% of gestational surrogate carriers at clinics in Texas and California in 2008. Kessler, Bree. “Recruiting Wombs: Surrogates as the New Security Moms.” *Women’s Studies Quarterly*. 2009 (37: 1&2): 167-182

⁷¹*Ibid*. at 55.

⁷² Sara Cohen, ‘Dear Margaret, it’s me, Sara’, *Fertility Law Canada*, April 5, 2012, <<http://www.fertilitylawcanada.com/1/post/2012/04/dear-margaret-its-me-sara.html>>

Brad: Because I still have people saying to me: ‘Ooh isn’t that illegal?’” (A gay man, who with his male partner, has two children via anonymous egg donor and gestational surrogate).

Recent research indicates that paid surrogacy is still occurring; it has merely been driven underground.⁷³ While broad empirical data is scarce, it appears that after the *AHRA* criminalized the domestic practice of commercial surrogacy, people simply turned online to locate surrogates – many of whom are located in the U.S., where paid surrogacy is legal.⁷⁴

“... people were putting up information—‘I’m ready to be a surrogate’ or ‘I’d like to be a surrogate’ or ‘Are you looking for eggs?’ or whatever. So there were certain sites that I would go and visit and click on certain areas and email people and have information. The majority of them were in America though...” (Brad, a gay man, who with his male partner, now has two children via anonymous egg donor and gestational surrogate).

For the time being, the uncertainty of Section 12 may actually be of benefit as it allows surrogates to be compensated within a broadly defined ‘gray area.’ However this indeterminacy also contains its own stresses, and relies upon the hypocrisy of allowing some industries and professionals to benefit financially from surrogate arrangements, while others can not. If and when Section 12 regulations are promulgated, I believe it is of paramount importance that LGBTQ people’s concerns and the voices of actual Canadian surrogates be taken directly into account.⁷⁵

⁷³ CBC News Online – ‘Paid surrogacy driven underground in Canada: CBC report.’ Wednesday, May 2, 2007 | Accessed at <http://www.cbc.ca/health/story/2007/05/01/surrogates-pay.html>; Shireen Kashmeri, *Unraveling Surrogacy in Ontario, Canada: An Ethnographic Inquiry on the Influence of Canada’s Assisted Human Reproduction Act (2004), Surrogacy Contracts, Parentage Laws, and Gay Fatherhood*. Unpublished MA thesis (Concordia University, 2008).

⁷⁴ There are a large number of online resources designed to connect surrogates with intended parents, many of which specifically target Canadians. While none of the following websites explicitly detail the illegal fees one may be expected to pay when hiring a surrogate, many of the forums and classified ads do discuss the transfer of payment. To list just a few: Surrogate Mother (<http://www.surrogatemother.com/>), Surromoms Online Classifieds (<http://www.surromomsonline.com/classifieds/index.htm>), Canadian Surrogacy Options (<http://www.canadiansurrogacyoptions.com/>), In Vitro Fertilization New Jersey (<http://www.ivfnj.com/html/can-patients.html>), Circle Surrogacy Online (<http://www.circlesurrogacy.com/index.php/en?lang=gb-en>), Surrogacy in Canada Online (<http://surrogacy.ca/>). See also Motluk *supra* note 36.

⁷⁵ Cf. the AHRA/LGBTQ Working Group submission to Health Canada at *supra* note 3.

Five: Legislative uncertainty impacts access to service at fertility clinics

At present, there is no consistency of formal qualifications for health professionals performing controlled AHR activities as laid out in the *AHRA*.⁷⁶ Nor is there a consistent standard of practice to which clinics are held – either federally or provincially. There is no mandatory license or accreditation required for private fertility clinics, and in the absence of binding clinical practice guidelines for the provision of reproductive care, it is left to individual clinics or practitioners to set their own fees and standards.⁷⁷ As the Ontario Expert Panel on Infertility and Adoption concluded in 2009, “Without mandatory provincial accreditation, there are no common provincial standards for clinic operations, the services they should offer nor the prices that clinics should charge for their services.”⁷⁸

However while fertility clinics are largely self-regulated, medical practitioners such as reproductive endocrinologists, nurses, and other health professionals are members of regulated professions and required to meet the standards of practice set out by their regulatory colleges. Fertility counselors represent an important exception to this rule, as there is no agreement among those in the field concerning the minimum qualifications necessary to provide appropriate AHR counseling services.⁷⁹

While there have been attempts made to develop national standards for fertility practice,

⁷⁶As detailed in the *Guidelines for Qualification and Responsibilities for Each Assisted Reproductive Technology Laboratory Professional Position in Canada*, prepared by a committee of the Canadian Fertility and Andrology Society [CFAS]. While organizations like CFAS are working to develop standardized guidelines for mandatory application across Canada, this has not yet been implemented.

⁷⁷ While national accreditation for assisted reproductive technology does exist in Canada (see *infra* note 82), it is not mandatory. Suggested clinical practice guidelines for reproductive endocrinology and infertility have been advanced by the Society of Obstetricians and Gynaecologists of Canada, but as of writing these are not binding in any province or territory. See: http://www.sogc.org/guidelines/index_e.asp#REI

⁷⁸*Raising Expectations: Recommendations of the Expert Panel on Infertility and Adoption*, Ontario Ministry of Children and Youth Services, (Toronto, Ontario: Summer 2009) at 100.

⁷⁹Canadian Fertility and Andrology Society, *Assisted Human Reproduction Counselling Practice Guidelines*, December 2009. Accessed online: http://www.cfas.ca/images/stories/pdf/csig_counselling_practiceguidelines_december_2009.pdf

the *AHRA* ruling has made it virtually impossible for binding regulations to be promulgated at a national level.⁸⁰ The bulk of controlled activities regulated under the *AHRA* are now contained under the provincial power in matters of health, although provisions outlining consent to use and allowable compensation for gamete donors and surrogates are still validly enacted at the national level.⁸¹ Clinics may choose to be accredited by Accreditation Canada,⁸² but “the clinics and physicians’ offices that provide assisted reproduction services are not required to be accredited and information about their practices and success rates is not easily available.”⁸³

In the absence of definitive standards for fertility clinics, the Canadian Fertility and Andrology Society [CFAS] has developed clinical practice guidelines for physicians as well as guidelines and standards for certification for other fertility-related service providers such as counselors. While LGBTQ people’s perspectives are beginning to find small purchase in CFAS, their draft clinical practice guidelines do not account for any breadth of experience or embodiment; instead lesbian couples (the only mention of LGBTQ people), when present, are compared solely against a heterosexual norm. For example, while the CFAS guidelines on Assisted Human Reproduction Counselling Practice do refer specifically to lesbians and single women, the text quickly reassures that lesbians “do not differ from heterosexuals in their

⁸⁰Constitutional expert Peter Hogg made this remark during a conference held at the University of Toronto, “*Reference Re Assisted Human Reproduction Act: Implications of the Supreme Court’s Decision*,” November 4-5, 2011, University of Toronto.

⁸¹ Under Section 92(7) of the *Constitution Act, 1867* the provincial level of government is granted exclusive authority over the “establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals”. In practical terms, the awards the majority of legislative power in the area of health care to the provinces. The *AHRA* Reference decision has maintained Section 8 and s. 12 *intra vires* the federal government.

⁸² Accreditation Canada is a national organization that helps health service organizations to improve the quality of care and service they provide to their clients. They have developed ‘Qmentum’ standards at a system-wide level for Leadership for Assisted Reproductive Technology, and service excellence standards in the following three areas: Assisted Reproductive Technology Standards for Clinical Services; Assisted Reproductive Technology Standards for Laboratory Services and Assisted Reproductive Technology Standards for Working with Third Party Donors. None of these standards are publically available without fee.

⁸³*Supra* note 78at 96. This is not to suggest that no standards are in place. Health Canada regularly inspects the offices and clinics of all physicians who are distributors of semen. Physicians are required to meet certain minimum requirements in terms of documentation of compliance with the technical specifications.

parenting skills.”⁸⁴ While the intention is surely one of comfort to the (presumptively) heterosexual reader, once again this discourse revolves around a conceptual model that presumes a heterosexual couple as the exemplary AHR clientele. The CFAS guidelines also fail to include any discussion of gay men, bisexuals or trans people.

Although I do not intend to stake a claim here for the exceptional character of lesbian parenting, it *is* important to note that even well-meaning reassurances serve to mask substantial differences between heterosexual and LGBTQ AHR clients. These differences begin at the clinic’s front door. In contrast to cisgender, heterosexual couples, who tend not to solicit fertility services until a problem is discovered, LGBTQ prospective parents generally seek out clinical advice quite early in their journey to conceive. Yet despite the large numbers of LGBTQ people now utilizing fertility clinics, the overwhelming presumption for new clients is that a reproductive pathology is present. Clinics structured around the heterosexual model of fertility are geared at alleviating ‘infertility’⁸⁵ in conjugal partners, and often mandate a series of intrusive, sometimes painful and laborious diagnostic testing before service provision can even begin.⁸⁶ One of our research participants put it this way:

I think not having access to sperm is a really different thing than trying to get pregnant with sperm and having trouble, right ... the idea that queerness in and of itself, like being a lesbian in and of itself is a fertility problem is ridiculous and the fact that people are kind of going through the same measures as folks who have tried less in invasive ways to get pregnant... *I think it needs a whole re-think in order for it to really make sense to everybody who is accessing it [AHR*

⁸⁴Canadian Fertility and Andrology Society, Counselling Special Interest Group, *Assisted Human Reproduction Counselling Practice Guidelines*, (December 2009) at 11.

⁸⁵ In a recently published glossary of AHR terms, Zegers-Hochschild et al. define “infertility (clinical definition) [as] a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse”. In ‘The International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO) Revised Glossary on ART Terminology’. *Fertility and Sterility*, 92(5), November 2009 1520 at 1522. This standard, heterosexist definition cannot account for many forms of sexual behaviour among LGBTQ people, which may be regular and unprotected but will never result in a pregnancy. When this model of infertility is in play, LGBTQ people fall out of the diagnostic system.

⁸⁶As there are no standard practices across fertility clinics in Canada (or even across a single province) each clinic will differ on what it determines to be mandatory testing.

services]” (Miriam, a single queer woman who ultimately avoided AHR services and conceived outside of the clinic with known donor sperm, emphasis added).

There are also gate-keeping and bureaucratic elements that hamper LGBTQ people from carrying out their reproductive intentions. For instance, Epstein and colleagues note that:

In very recent history some Canadian fertility clinics required psychiatric assessment of lesbians before they were granted access to donor insemination services. We also know of at least one Toronto physician who required lesbians requesting access to donor insemination to write a “letter to the doctor” in order to convince him that they should be granted access to services. Other clinics and physicians simply denied access to lesbians and single women.⁸⁷

Sadly, trans people are now, in some instances, facing similar gatekeeping decisions with regards to their access to AHR services, and are having to debunk arguments about their rights and abilities to parent.⁸⁸

Further, many of the ‘Creating Our Families’ study participants noted that fertility clinic intake forms did not account for their particular identities and family configurations, nor did the clinic environment include representations of their identities and families. The presumptions of heterosexuality and infertility saturate the clinic, placing cultural as well as substantive barriers in the path of LGBTQ people seeking AHR services.⁸⁹ As national guidelines for AHR clinicians, nurses and counselors are being produced, it is vital that LGBTQ voices are part of the discussion. Increased cultural competency and sharpened awareness of the specificity of LGBTQ people’s needs are badly needed at this critical juncture of legislative development.

Conclusion

⁸⁷Epstein, *supra* note 3 at 3.

⁸⁸ See for example William Buckett, Infertility Treatment for Non-Traditional Families, Fall 2011, Infertility Awareness Association of Canada. Accessed at: <http://www.iaac.ca/content/infertility-treatment-non-traditional-families-william-buckett-md-mrcog-fall-2011>

⁸⁹For a more detailed discussion of the barriers that LGBTQ people commonly experience when accessing AHR services, as well as recommendations to counter such barriers, cf.: L.E., Steele, L., Epstein, R. (2006). Lesbian and bisexual women’s recommendations for improving the provision of assisted reproductive technology services. *Fertility and Sterility*, 86(3), 735-738; Also see *supra* note 3.

The AHRA Reference decision has left Canadians with more uncertainty than clarity. What has not changed, however, is the sidelining of LGBTQ people in how AHR services are being legislated and regulated. LGBTQ people now comprise a significant proportion of fertility clinic client traffic, and the numbers are only poised to grow. Outdated understandings of ‘infertility,’ discriminatory treatment of known sperm donors, limited sperm reserves, misinformation about the ‘risk’ of HIV-positive sperm donors, and vague and poorly-defined commodification concerns in relation to surrogacy must be revised to conform with contemporary realities. These are dusty approaches based on outdated science, limited empirical data and discriminatory assumptions.

This chapter has explored the many ‘grey areas’ that plague Canadian legislation concerning access to reproductive material, services and facilities. The standards of clinical practice that exist are based on the dyadic cisgender, heterosexual family norm. As queer intentional parenting arrangements move farther from the normative ideal, they find themselves in ever more precarious and uncertain territory.

Despite explicit reference in the preamble of the *AHRA* to the importance of preventing discrimination “including on the basis of sexual orientation and marital status” our team’s research has shown that LGBTQ people seeking AHR services are not being adequately served by the present legal regime. This chapter has highlighted five areas of law that require immediate and comprehensive attention in order to guarantee equitable access to AHR services for LGBTQ people. While our team’s research has begun to explore these issues and is the first study of its kind to include the voices of GBQ men and trans people, this analysis will be broadened and enriched by accounts from a greater number of gay men and trans people, as well as by those from low-income and racialized people, single parents, surrogates, donors and their families,

people living with disabilities and First Nations people seeking AHR. Until these voices are heard, many residents of Canada who rely on AHR will continue to wade through a regulatory regime inappropriately designed for the normative white, cisgender, financially-resourced heterosexual couple. Despite *Charter*-backed guarantees of equality and access, judicial decisions such as the *Reference re Assisted Human Reproduction Act* have been unable to account for the cultural specificity and community values of LGBTQ people in Canada. A re-evaluation of reproductive values is required as we move forward to ensure equitable access to AHR services for all those in Canada who wish to become parents.

ATTACHMENT TWO

Semen Donation and Lesbian Motherhood

Introduction

This paper expands on Attachment One with a focus on the Canadian legal regime of anonymous sperm donation for the purposes of assisted human reproduction. It remains attentive to the impact of this regime on LGBTQ people, as a population uniquely reliant upon reproductive technologies to have biologically-related children. This paper also utilizes empirical data to track multiple gaps in Canada's current legal structure, and explores how the use of donor gametes is impacting fundamental notions of kinship, community and lateral relation.

As I will argue, pressing regulatory issues exist regarding access to donor sperm, many of which exert a pronounced impact on LGBTQ families. I will provide a brief background to current law and policy, building off the accompanying dissertation, and use empirical data to flesh out a series of interlocking concerns. Attention will be paid to the question of setting enforceable limits on the number of children which may be produced from any single donor, and the need to track donor information through both federal and international registries. I will then use the central thread of a case study from the Creating Our Families research project to illustrate the ways in which a lesbian couple has navigated these regulatory gaps. The experience of these women – who used a donor they jokingly chose because of his resemblance to 1980s television star Tony Danza¹ - will help to clarify some of the specific concerns affecting queer parenting communities across North America. I will situate these findings within

¹ In keeping with the privacy protection of all participants in the study, I have also changed the name of the actor to whom the women referred.

the framework of Canadian AHR law and current clinical practice. Finally, I will highlight the new kinship potentials which may emerge for LGBTQ and heterosexual families alike, and suggest a variety of recommendations for future policy development.

Background to Canadian Law on Assisted Reproduction

The Assisted Human Reproduction Act

The history of the *Assisted Human Reproduction Act* is covered in Chapters Five and Six of my dissertation, as well as the confusion caused by s. 12. As may be recalled, this was one of the few parts of the *AHRA* to withstand the scrutiny of the Supreme Court reference decision, as the section which controls the reimbursement of expenditures incurred by donors and surrogate mothers based on the criminal prohibitions laid out in ss.6 and 7 of the *Act*.² While section 12 mandates a tough criminal penalty for the payment of human eggs or sperm and commercial surrogate arrangements, including a maximum fine of up to \$500,000 and ten years in jail, this section has never been proclaimed into force nor have any regulations been promulgated.

Although the federal agency charged with enforcing the *AHRA's* provisions long wallowed in a state of bureaucratic inertia, and has now been abolished altogether, the severity of the punishment has been sufficient to exert a dampening effect on Canada's domestic supply of third-party gametes.³ While this paper will focus on the impact of federal regulations on donor sperm, it is important to keep in mind that payment for ova donors and surrogacy arrangements also face criminalization in Canada.⁴

² *Assisted Human Reproduction Act*, SC 2004, c 2 [*AHRA*].

³ The fear of criminal penalty has been enough to bring clinics across the country into line with the new guidelines. I will explore in detail the waning supply for domestic sperm in Canada and the multiple pieces of Health Canada legislation that have discouraged local donors and banks. For the impact on egg donors in particular see: Alison Motluk, "The Human Egg Trade: How Canada's fertility laws are failing donors, doctors, and parents", *The Walrus* (April 2010) 30.

⁴ See for example the 2013 conviction of Leila Picard for arranging surrogacy contracts and payment to Canadian

Semen Regulations and Directives

Federal legislation around sperm donation involves a high standard of testing. Potential sperm donors must satisfy stringent screening criteria, and semen samples are subject to strict serological and microbiological testing.⁵ This began in 1996, when Health Canada issued regulations mandating a range of standard health requirements for the processing and distributing of semen used in assisted conception [*Semen Regulations*].⁶ Four years later, the *Semen Regulations* were tightened after a woman undergoing donor sperm insemination became infected with *Chlamydia trachomatis*.⁷ The revised policy, however, proved too onerous for most clinics to manage: Before 2000, Canada had more than one hundred clinics across the country distributing or collecting sperm; once the stricter regulations were advanced, most clinics found it impossible to comply and simply dropped out of sperm collection. Those that did remain soon struggled to recruit altruistic donors in the wake of the criminal penalties outlined by s.7 in 2004, and the number of domestic sperm banks flatlined.⁸

At the time of research, Canadians had access to just three Health Canada accredited sperm banks. Of these, two import sperm from abroad and only one collects sperm from Canadian men for national distribution.⁹ The combined force of the *Semen Regulations*, *Directive* and *AHRA* has throttled the supply of domestic sperm for AHR, and obliged most

surrogates.

⁵ Haimant Bissessar, *Altruism By Law*, Infertility Awareness Association of Canada, Summer 2005. <<http://www.iaac.ca/en/117-835-altruism-by-law>>

⁶ As was argued in Chapter Five, the strict processing requirements may be seen as a result of recommendations made by the RCNRT after speaking with grassroots women's networks providing access to fresh sperm, as well as the HIV crisis and concerns for its impact within (in particular) lesbian communities.

⁷ Health Canada, *Technical Requirements for Therapeutic Donor Insemination* (Ottawa: Health Canada, 2000) [*Directive*].

⁸ *Infra* note 14.

⁹ While there are two Canadian sperm banks that collect semen domestically, only ReproMed provides commercial access to donor sperm on a national level. The other bank, Procrea, is located in Montréal and has a limited number of donors available locally. *Infra* note 23.

Canadians to look abroad for donors. Yet even this is not always straightforward. As Canada's sperm regulations are stricter than those enacted within many other jurisdictions, limits are placed upon the specimens Canadians may import across the border.¹⁰ (This issue will be discussed below in reference to the scarcity of donors of colour.) As of the writing of this piece, there were 53 available Canadian donors from a population of approximately 34 million people, up slightly from 35 donors at approximately the time of research.¹¹

Simply put, the unpaid rigour of screening and specimen banking has presented a barrier to most prospective donors. The following describes the donor screening process at the nation's lone remaining sperm bank, ReproMed. Housed in a fertility clinic near Toronto, ReproMed is carefully compliant with the *AHRA*, *Semen Regulations* and the *Directive*, meaning that all potential donors must undergo the following:

On their first visit to the clinic, men must provide detailed answers about their lifestyle, sexual behaviour and family history reaching back three generations. They must sign a release of information form to their personal medical files, and a consent form releasing all rights regarding the disposal and results of insemination. They must then pass a personal interview to

¹⁰ As reported by the Sperm Bank of California, a large semen distributor located in Berkeley, California: "Shipping semen samples to Canada is restricted because *Health Canada* has instituted strict regulations on donor testing that are not tenable for most US sperm banks to follow. However, we are able to sell sperm to recipients in Canada if they register with a US medical professional, cross the border to receive shipments and inseminate in the US." "Shipments and Pick Ups" *The Sperm Bank of California*, Reproductive Technologies, Inc. <<http://www.thespermbankofca.org/content/shipments-and-pick-ups>>.

¹¹ Note that this number emerges from popular not scientific media. The article was written by Toronto journalist Danielle Groen who investigated the status of ReproMed as Canada's last domestic sperm bank. Groen interviewed a number of clinical practitioners including the medical director of ReproMed, Dr. Alfonso Del Valle, who offered the following statement: "Before these laws came into place, we would have 100 donors at any given time...As it stands now, we must scramble to have 30 or 35 donors active." Groen also interviewed Samantha Yee, a social worker at Mount Sinai's Centre for Fertility and Reproductive Health, who corroborated this scarcity by remarking: "People are very surprised at how few donors there are in the Canadian catalogue." As of the time of writing this article is hosted on the ReproMed website, offering strength to the quotations and data gathered therein. See: Danielle Groen, "Down for the Count: There are Only 35 Sperm Donors Left in all of Canada. Holy Mama, We've Got a Problem", *The Grid* (19 May 2011) <<http://www.thegridto.com/city/local-news/down-for-the-count/>>.

determine motivations for donation and provide a semen specimen. They must not have ejaculated for a minimum of three days and maximum of five days before providing this sample, marking a mandatory abstinence period that will be standard for all collections. A week later the men must return to the clinic to provide a second specimen and have blood drawn to conduct serology/virology screening. The third weekly appointment involves the provision of another semen specimen. During the fourth appointment, after providing the requisite specimen, the donor must undergo extensive physical exams with the Medical Director, who will also review the previous blood and semen samples for infectious and genetic disease.¹² Only at this point does a donor learn if he is actually eligible to participate in the program, on the merit of an appropriately risk-free medical, social and genetic history.

Those men who are accepted must agree to provide a weekly semen specimen at ReproMed's Mississauga premises on the western edge of Toronto, always maintaining abstinence for at least three days before the appointment and for no more than five days. They must have a blood specimen drawn every thirty days, and are asked to complete a Kiersey Temperament Report and provide social data about hobbies, skills, education, and interests, as well as providing childhood photographs. In some cases they may be asked to write essays and record sound files about themselves, with the intent of providing consumers with information about their physical features, family history, educational history, skills & abilities, preferences, personality traits, anatomical features, and medical history.¹³ A laudable goal, yet all

¹²*Ibid.*

¹³ ReproMed does not use a staggered pricing scheme or minimum height and education, but this is not the case with most U.S. sperm banks. For example Fairfax Cryobank, headquartered in Fairfax, Virginia, has offered a "doctorate program" which provides sperm from donors who have doctoral degrees or are pursuing them. Medicine, dentistry, pharmacy, optometry, law, and chiropractic all count as premium "doctorate" sperm, with an appropriately high price tag. David Plotz, "The Genius Factory", *Slate* (7 June 2005) <http://www.slate.com/articles/life/seed/2005/06/the_genius_factory.html>. See also: Haimant Bissessar, *Donor*

requirements must be fulfilled altruistically under present Canadian law. Donors may only be reimbursed a small fee for their trouble. ReproMed, however, applies a price tag of nearly \$700 per vial of washed sperm. Perhaps unsurprisingly, donor recruitment numbers are low.

In a 2008 study, ReproMed confirmed that of 301 men who contacted the bank in response to an advertisement seeking donors, only three were determined to be eligible according to medical, social and genetic standards (set by the *Semen Regulations and Directive*); and of those only *one* man was willing to donate without compensation (as dictated by ss. 7 and 12).¹⁴ This represents a fractional 0.3% recruitment rate, as compared to recruitment rates between 60% and 70% in France over a 15-year period (1980–1995) and 20% to 30% in the UK.¹⁵ The confluence of Health Canada regulations, extensive social data collection and the criminalization of compensation for gamete donation has had a chilling effect on Canadian sperm donation, resulting in a contracted local market that depends heavily upon the import of sperm from abroad.¹⁶ It has been estimated that a full 95% of the donor semen now being used in Canada is international, shipped in either through national distributors or by ReproMed itself.¹⁷ While this phenomenon affects all Canadians seeking donor sperm it is exerting a disproportionate effect on LGBTQ prospective parents.

Sperm: Why the High Cost and Low Supply?, Infertility Awareness Association of Canada, Fall 2010
<http://www.iaac.ca/en/515-405-donor-sperm-why-the-high-cost-and-low-supply-by-haimant-bissessar-fall-2010>

¹⁴ Alfonso P. Del Valle et al., “Anonymous semen donor recruitment without reimbursement in Canada” (2008) 17 Supplement 1 *Reproductive BioMedicine Online* 15.

¹⁵ *Ibid.*

¹⁶ To clarify this point: Canadians may go abroad to utilize donor sperm outside the reach of Health Canada regulations, but when importing sperm into Canada all domestic standards must be met.

¹⁷ Rosanna Hertz and Jane Mattes, “Donor-Shared Siblings or Genetic Strangers: New Families, Clans, and the Internet” (2011) 32:9 *Journal of Family Issues* 1129. Note this number was produced in popular not scientific media. I have seen estimates ranging from 80-95%, although those articles which come in on the lower end tend to be riddled with factual errors. Given its national publication I have opted to go with Blackwell's estimate, *supra* note

Case Study: Tony Danza and the Lesbian Mothers of Facebook

To understand how this legislative tangle impacts queer parents, it will be helpful to turn to a case study from the Creating Our Families project, and the story of a pregnant lesbian couple who responded to the research call. During our interview, Paula and Nicole¹⁸ candidly discussed the factors at play in their choice of donor sperm. A vital consideration highlighted by dozens of participants in the study was the uncertainty of Canadian family law in regard to known donor arrangements, obliging many to opt for the anonymity of the sperm bank in order to avoid potential custody battles down the road.¹⁹

When asked to describe how they eventually settled on an anonymous donor, Paula and Nicole were forthright about their concerns with asking friends and family, and the uncertainty this might bring:

Paula: We talked about friends.

Nicole: Yeah. There were one or two friends that we thought about using...but they both kind of wanted to be...they would have wanted more of a co-parenting relationship. Which seems really nice but I don't think either of us were really interested in that.

Paula: Yeah. And when we were concerned about money, we thought about maybe using my biological family member's sperm. He and I were quite close, we actually do kind of look alike. But he's kind of changed along the years and now he is a lawyer and um we, just because there's not a lot of precedent, like legal precedent, about the rights of queer parents. If it ever happened that he decided that he wanted to have more of a relationship with his child...it was scary.

¹⁸ Not their real names. Paula and Nicole were both cisgendered white women who identified variously as queer and lesbian. They have generously given consent to have their story drawn out from the interviews and highlighted.

¹⁹ Although the jurisprudence is scarce, Angela Cameron, Vanessa Gruben, and Fiona Kelly have written about four Canadian cases that address the legal status of known donors in queer families, all of which involved a contestation of parentage between the sperm donor and lesbian parents. Of these cases, three awarded some degree of parental or visitation rights to the sperm donor against the wishes of the intended lesbian parents. As the authors note, these cases "support the false notion that a known sperm donor in a parenting role, or contact by a donor, can only be a welcome addition, not an intrusion into a lesbian family." Angela Cameron et al, "De-Anonymising Sperm Donors in Canada: Some Doubts and Directions" (2010) 26 Canadian Journal of Family Law 95 at 124. See also the case: *W.W. v. X.X. and Y.Y.*, 2013 ONSC 1509

Nicole: Some judge looking at it seeing this guy that is a successful lawyer versus...

Paula: Two queer women.

Nicole: Us.

Paula: You know just fear of that.

Once Paula and Nicole had decided upon a sperm bank, they narrowed their options to three anonymous candidates and eventually selected a man resembling a popular actor from American television: the hunky sperm of “Tony Danza” as they jokingly referred to him. After a successful conception, they grew curious about the possibility of other children conceived through the same donor. Like most Canadians, they had chosen to import sperm from the U.S., and they began to try and find out more about other families who had used the same donor.

At present neither Canada nor the U.S. has an official national donor registry, and thus no way to determine where sperm ends up or how many children might be created from a single donor. However in May 2012, ReProMed instituted a private, pay-access site for parents who had conceived children from the pool of Canadian donors offered through their facilities. As the site describes, for the cost of \$135: “Users may voluntarily register their children in a database that other users (who have also conceived children from the same donor) can access. If a user wishes to make their contact information public, mutual communication may commence amongst families.”²⁰ ReProMed has launched access to this voluntary registry in two phases – the first for children conceived after January 1st, 2005; the second phase for children conceived after January 1st, 2002.

²⁰ “Frequently Asked Questions” *ReProMed Sibling Registry*, <<http://www.repromedsiblingregistry.ca/home.html>>.

The Donor Sibling Registry

While the makings of a Canada-wide registry operated under federal authority were outlined in the impugned provisions of the *AHRA*, this was never enacted due to Quebec's constitutional challenge.²¹ The desire for information about donor sperm users and providers continues, and ReproMed's recent initiative presumably aims to help fill this gap – at least for the 5% of Canadians that actually use Canadian sperm. For everyone else, including for Paula and Nicole, ReproMed's registry appears to have been modeled upon a for-profit organization that emerged in the United States in September 2000 to address the same failure of health information tracking. The Donor Sibling Registry [DSR] is a privately-run and membership fee-supported international network that aims to educate, support and connect donor families.²² The DSR invites users to look up a sperm donor by using the donor register number provided by the sperm bank or clinic, in order to pull up a page where other users, offspring and even donors themselves are posting and seeking to connect.

Through the DSR, Paula and Nicole were able to connect with a variety of people both

²¹ Section 17 of the *AHRA* would have established a national health information registry under the management of a federal agency, Assisted Human Reproduction Canada, to record information relating to donors, patients using donated gametes and donor-conceived offspring. Section 17 was one of several declared unconstitutional by the Supreme Court of Canada in December 2010. *Supra* note 8 at s 17.

²² The DSR was created by a biological mother named Wendy Kramer and her donor-conceived son Ryan. As no public outlet existed for contact between people born from anonymous sperm donation, the site was started to help facilitate such connections. According to the site: "The DSR averages more than 10,000 unique visitors to the site each month and is a worldwide organization, matching people in the US, Austria, Denmark, England, Canada, Australia, Cayman Islands, Bolivia, Brazil, Finland, France, Portugal, Puerto Rico, Germany, Hong Kong, Israel, Luxembourg, Dominican Republic, Estonia, Korea, Malta, Philippines, Spain, Turkey, Greece, New Zealand, Norway, S. Africa, Sweden, Ireland, Columbia and Switzerland." The site proudly announces that it has helped to connect more than 8902 half-siblings (and/or donors) with each other, with a total number of registrants, including donors, parents and donor-conceived people, at 34640. The membership fee is \$75 dollars per year or \$175 for permanent membership, allowing the user to add a posting and/or to contact others. As to the 2.6 million dollars already generated by this site, Kramer lists a variety of expenses as rationales why this is 'not simply a website'. This includes various banking fees, website managers, graphic design, mental health counselors, office support, attorney fees, travel, rent, etc. The Donor Sibling Registry (2013) <<https://www.donorsiblingregistry.com/about-dsr/membership-details>>.

in the US and Canada, and as Paula confirmed: “The majority of it is single women and queer couples.” Her observation is consistent with a 2010 Canadian study, which estimated that same-sex couples represent 55% of demand for donor insemination, with a further 23% coming from single women and just 22% on the part of heterosexual couples.²³ While the study offered no details on how many of the single women may also be lesbian or bisexual, nor on how many of the participants were trans-identified, it is evident that queer people represent the majority users of donor sperm in Canada. Indeed this number may be even higher, as the report encompassed only those people who inseminated through formal channels; it did not seek to estimate home insemination with known donors outside the clinical system.²⁴ Even using conservative data, it is clear that queer couples like Paula and Nicole find themselves at the forefront of anonymous sperm-donor use, as they explore how networks like the DSR are changing familial connectivity and awareness of other children born from the same donor sperm.

After Paula and Nicole had been emailing through the DSR for some time, one of the other parents suggested they create a Facebook group for the children conceived by ‘Danza sperm’ where they could post pictures and information. At the time of our interview this Facebook page had a membership of sixteen people. Nicole estimated that about ten children were either born or about to be born, and of that number there were three others in Toronto alone. It wasn't only through the Internet that connections were made, however. Paula and Nicole shared a remarkable story about meeting one of the other Toronto couples in their queer

²³ JM Bowen *et al*, “Altruistic Sperm Donation in Canada: an Iterative Population-based Analysis” Submitted to Assisted Human Reproduction Canada (AHRC). Programs for Assessment of Technology in Health (PATH) Research Institute. Hamilton, ON. [20 May 2010].

²⁴ There is a rich tradition of the ‘turkey baster’ method of low-tech home insemination in the lesbian community. See how-to guides such as: Stephanie Brill, *The New Essential Guide to Lesbian Conception, Pregnancy and Birth* (New York: Alyson Books, 2006); Marie Mohler and Lacy Frazer, *A Donor Insemination Guide: Written by and for Lesbian Women* (New York: Alice Street Editions/Harrington Park Press, 2002).

prenatal class. As Paula related: “We were just talking and realized that we used the same donor and...their friends actually were the other couple that we connected to [on Facebook].” Through a chance encounter in a queer parenting program, and an online social networking site, Paula and Nicole stumbled upon three donor sib²⁵ families living in the same city.

As they described these connections, the women were visibly excited about the idea of “recreating family” and developing a “new version of extended family” that their child could choose to access. The biological connection with donor sibs represented an extended network the women imagined would only be there if their daughter so desired. As Nicole said, “obviously...it’s for our child. If they don’t want to be friends with any of these people anymore then okay, then we’re not going to force anything on them.”

Importantly, these lateral relations were not seen as supplanting existing ties with Nicole and Paula’s families of origins. Indeed, the women noted with wry humour that their daughter would have no choice when it came to “holidays with grandma and grandpa.” The tension between biological and social kinship is one familiar to adoptive parents, as well as step-siblings and half-siblings related through divorce, remarriage, infidelity, or any number of configurations of intimacy. Similarly, donor sibs also exist outside conventional reproduction narratives, and as sociologists Rosanna Hertz and Jane Mattes assert, they are thereby adding “a new contour to

²⁵ Rosanna Hertz and Jane Mattes discussed the language used by parenting communities emerging around donor sibling networks, based on a survey of 587 single mothers who had used donor sperm. As Hertz and Mattes report: “Since there is no separate nomenclature for discussing the other children who are the offspring of one’s sperm donor, *donor sibs* is a colloquial term. Not everyone uses this term. Sibling presumes a relationship that in the case of donor siblings is problematic. In genetic terms, children who share the same donor are half-siblings; yet in this case half-sibling is a blood relationship that may or may not become a social one as well.” *Supra* note 17 at 1138. In recognition that “sibling” implies primarily a social grouping and often an expectation of childhood co-habitation, this article uses the term *donor sibs* to differentiate from *siblings* understood in the more conventional sense. As relations mediated through biotechnology the donor sibs radiating from a single point will be enmeshed within a shared genetic hub, but this blood tie may have little relation to the affective bonds of family and intimacy which actually figure within a child’s life.

the definition of kinship.”²⁶

And Baby Makes Three...Hundred?

Despite the careful distinction made by Nicole and Paula between families of care (non-optional) and families of incidental genetic connection (optional), it remains to be seen how extricable these categories will be in practice. In their research on donor sibs, Hertz and Mattes tracked parents who connected online to other parents who had used the same donor. As they explain, there are “a growing number of unrelated parents who share biogenetically related children who have begun to organize into more or less durable clans...large groups composed of several smaller families.”²⁷ It is my contention that queer communities are positioned at the core of these new clan structures.²⁸ Paula and Nicole described the happenstance of connecting with three other Toronto families parenting the donor sibs of their own child. But how many more might there be?

Despite strict regulations about how sperm is to be processed, Canada has no binding regulations to cap the number of inseminations from a single donor. Nor are there independent watchdogs to ensure compliance even if such regulations existed. ReproMed is instead self-regulating, although it promises to *attempt* to set allowable family limits according to the following internal guidelines: “ReproMed attempts to limit Donors to three live births per region

²⁶ Hertz and Mattes, *ibid* at 1130.

²⁷ *Ibid*.

²⁸ This contention also echoes works of queer anthropology such as Kath Weston’s *Families We Choose*, a landmark text which traced the networks of community and family-making among San Francisco gay men and lesbians people in the 1980s. Kath Weston, *Families We Choose: Lesbians, Gays, Kinship* (New York: Columbia University Press, 1991). See also complementary and contemporary texts by Ellen Lewin and Margaret Sullivan, among others. Cf: Maureen Sullivan, *The Family of Woman: Lesbian Mothers, Their Children, and the Undoing of Gender* (Berkeley: University of California Press, 2004); Laura Benkov, *Reinventing the Family: The Emerging Story of Lesbian and Gay Parents* (New York: Crown Publishers, 1994); Ellen Lewin, *Lesbian Mothers: Accounts of Gender in American Culture* (Ithaca, NY: Cornell University Press, 1993); Amy Agigian, *Baby Steps: How Lesbian Insemination is Changing the World* (Middletown, CT: Wesleyan University Press, 2004).

of 100,000 populations. Siblings of the same patient using the same Donor are considered one live birth.”²⁹ It has been pointed out by an article in the Canadian press that this could entail as many as many 75 consanguineous offspring in a city the size of Toronto.³⁰

Yet given the negligible supply of Canadian donors, the mechanisms through which ReproMed attempts to limit births in local markets is not really the issue. Even if there were domestic legislation around allowable family limits, it is not clear how such laws would impact cross-border donor sperm traffic, given the enormous quantity shipped in from abroad. The majority of the sperm currently being used by Canadians originates in the United States, where donors are compensated around \$100 per specimen and the supply has historically been much more robust.³¹ Allowable family limits are similarly unregulated and left to the discretion of each clinic.

The next section aims to answer the question of how many families might be in Paula and Nicole’s ‘clan’. By analyzing current sperm bank policy and best-practice guidelines, as well as anecdotal information that pivots around the DSR, a picture will be drawn of the potential for lateral donor sib relations. The policy of Fairfax Cryobank is taken to be instructive in this regard.

Analyzing Sperm Bank Limits on Successful Births from a Single Donor

Virginia-based sperm bank Fairfax Cryobank boasts on their blog that they have been

²⁹ “Donor FAQ”, ReproMed <http://www.repromed.ca/donor_faq>.

³⁰ Tom Blackwell, “Limit Pregnancies by Same Sperm Donor: Fertility Experts”, *National Post* (8 September 2011) <<http://news.nationalpost.com/2011/09/08/limit-pregnancies-by-same-sperm-donor-fertility-experts/>>.

³¹ As reported by journalist Danielle Groen: “The majority of the sperm comes from America and, to a lesser extent, Denmark—both countries have a bounty of donors, likely because they compensate those donors for their samples, at about 100 bucks a pop. But we’re shelling out for their largesse, as imported sperm costs patients up to 35 per cent more than the homegrown stuff.” *Supra* note 20.

“covering over 80% of the Canadian sperm market for a decade”.³² While this number is unverified there is no doubt that Fairfax represents a major international player in the export of donor sperm. On the Fairfax website under a heading that says 'Read Before You Buy', the following limitations are advertised as being placed on donor births:

“Fairfax Cryobank limits the total number of births for any donor based on the application of several criteria. Specifically, a donor's sales will cease when either of the following criteria is reached:

1. When 25 family units (children from the same donor living in one home) have been reported in the US.³³ International distribution stops when 15 family units have been reported. After the family unit limits have been met, vials will only be distributed for sibling pregnancies.
2. Total number of units sold reaches our designated limit (actual numbers are not disclosed)”³⁴

Here, “family unit” refers to a family with one or more children conceived by sperm from the same donor. (Thus Nicole could give birth to eight children conceived by their ‘Danza sperm’ and still count as one unit for the purposes of donor limits.) Disregarding the occasional set of octuplets, the promise of a maximum of 25 family units appears to place a reassuring limit upon the number of children produced by a single donor.³⁵ Certainly it is higher than in the United Kingdom, where the Human Fertilization and Embryology Authority regulates and inspects clinics to ensure that sperm or eggs from a single donor are used to create no more than ten families.³⁶ Just across the English Channel, the governments of Sweden and Spain have set a

³² Irena, Laboratory Staff “International Role of Fairfax Cryobank” *Cryo Blog*, (16 February 2011), Fairfax Cryobank <<http://www.fairfaxcryobank.com/blog/?p=110>>.

³³ This number was adjusted from 30 to a lower limit of 25 during the course of this chapter’s writing and editing.

³⁴ This is an exact quote from the Fairfax website, parenthetical clause and all. “Limitations on Donor Births” *Let Us Help You Get Started* (2013), Fairfax Cryobank <<http://www.fairfaxcryobank.com/ReadFirst.shtml>>.

³⁵ Thus, eight children born to the same mother from a particular sperm donor would constitute one family unit. By the same token, one child born to a single mother from a particular sperm donor would also constitute a family unit.

³⁶ Human Fertilisation and Embryology Authority, *Family Limit for Donated Sperm and Eggs* (11 February 2011) <http://www.hfea.gov.uk/docs/Factsheet-Family_limit_2011_02_11.pdf>.

maximum limit of six families per donor, while France caps at five and the Netherlands extends to twenty-five.³⁷

What is astonishing is the vast population disparity among countries with relatively similar limits. For example, the population of Germany (82.6 million) is approximately ten times the population of Austria (8.1 million), yet they both cap at 10 families.³⁸ Were the Austrian population-to-donor-families ratio to be taken as baseline, this would raise the German cap to 100 families. Even more puzzling is the disparity across continents, where India, with a population of more than 1 billion people has *also* set its national donor limit at 10 families. The seemingly arbitrary nature of these guidelines is partially because they *are* arbitrary, with limits set in an era before widespread access to donor semen was common. As Neroli Sawyer and John McDonald report, the data used to inform the numbers “range from 1956 to the late 1970s, with many of the values having changed or become obsolete.”³⁹ Given the US population of approximately 294 million, therefore, a cap of 25 family units may actually seem relatively reasonable.

Unfortunately there are at least four problems with this policy. The most obvious is that this limit applies only within the US. In the same section, however, Fairfax does specify its international regulations on donor limits, promising that caps are in place to a total of 15 additional family units worldwide. Thus a single donor may produce children within 25 U.S. families and 15 families located in other countries (for our purposes we will assume they are all

³⁷ Neroli Sawyer and John McDonald, “A review of mathematical models used to determine sperm donor limits for infertility treatment” (2008) 90:2 Fertility and sterility 265-271 at 266.

³⁸ *Ibid.*

³⁹ *Ibid.* at 275.

in Canada) to a total of 40 family units, which again might appear quite modest considering the global scale.

There is, however, a critical flaw in this accounting: the means by which sperm banks track such information. The monitoring of donor-conceived births at Fairfax is dependent upon – as it is at all sperm banks – the goodwill of former clients. The families and doctors themselves must access the reporting page on the Fairfax website or call in to an operator to report a birth. The tracking of 40 family units is carried out not by the clinic performing due diligence, but by families who have conscientiously filled out an online questionnaire.

The American Society of Reproductive Medicine (ASRM) recently addressed a survey of more than 5000 sperm bank users which highlighted the difficulty of ensuring reporting compliance. As the ASRM confirmed, 35-40% of respondents indicated they had not or did not plan to report their pregnancy back to the sperm bank.⁴⁰ The survey authors concluded that this lack of reporting “poses a significant challenge to sperm banks” and “does not allow for accurate pregnancy tracking to limit the number of family units per donor.”⁴¹ If we take the low range of these numbers, and assume that 35% of families do not intend to report their pregnancy, that ramps up the numbers for potential offspring considerably. Given the maximum of 40 North American family units, and the current average U.S. birth rate of 2.01, one might reasonably estimate that each of those families will have two children from a single donor.⁴² This would produce a grand total of 80 children conceived from the same donor, assuming full reporting.

⁴⁰ M A Ottey and S Seitz, “Trends in Donor Sperm Purchasing, Disclosure of Donor Origins to Offspring, and the Effects of Sexual Orientation and Relationship Status on Choice of Donor Category: a Three Year Study” (2011) 96:3 Supplement Fertility and Sterility S268.

⁴¹ *Ibid.*

⁴² In fact this number may be higher due to the common incidence of multiple births with AHR and the fact that sperm bank tabulations only account for successful live births.

However as not all families report their births, when we take the 80 children that are reported (by 65% of families) and account for the children that we know remain unreported (by 35% of families), we end with a total of 123 children potentially created from a single donor.

Enter the American Reality Show

Based on the anecdotal information that exists, such a number seems probable, if not likely. In late 2011 the *Boston Globe* ran an article on an attorney named Ben Seisler who had donated steadily to a sperm bank for three years during law school. Seisler eventually registered on the DSR and found 70 children that had been created with his sperm.⁴³ Through his calculations (although this logic is never explained), Seisler estimates that “I have reason to expect between 120 and 140 [children].”⁴⁴ This estimate is very much in alignment with the numbers produced by the thought experiment above.

A total of 123 donor sibs spread across the world may represent a large number, certainly, but perhaps not staggering in its ramifications. But recall this is only a clarification of the *first* part of Fairfax's policy. In the absence of self-reporting on the part of individual families, Fairfax then pledges to limit the sales of a single donor's sperm once the “[t]otal number of units sold reaches our designated limit (*actual numbers are not disclosed*)”⁴⁵. Here lies the third problem with present standards: a failure of transparency and accountability. While all North American sperm banks profess adherence to guidelines limiting the number of births from a single donor, there is neither binding regulation nor government oversight to ensure

⁴³ Linda Matchan, “Who’s Your Daddy? As Kids Conceived with Donated Sperm Grow Up, Life May Get Complicated for Donors”, *The Boston Globe* (15 September 2011) <http://articles.boston.com/2011-09-15/community/30161121_1_donor-sibling-registry-sperm-donor-donor-conceived>.

⁴⁴ *Ibid.* Seisler's story, and others like it, are the fuel for a new reality documentary special called “Style Exposed: Sperm Donor” which aired Sept. 27, 2011 on the Style network. The show engineers encounters between Seisler and selected offspring conceived through his sperm.

⁴⁵ This “actual numbers not disclosed” qualification exists in the original text on the Fairfax website. Emphasis mine. *Supra* note 34.

compliance in either country. On the contrary, there is a powerful financial incentive for sperm banks to draw maximum profit from each donor. Potentially, the bank is limited only by the physical volume of sample collected from any given donor.

Serial Donors at Multiple Clinics

The fourth problem is the most speculative, even as it poses the most exponential challenge to these figures. For even if one imagines a best-case scenario in which clinics, sperm banks and clients alike are rigorous about reporting and enforcing family caps to a federally mandated limit, a critical issue remains: There is no guarantee the donor will restrict his activities to a single clinic. Because donors are paid in the U.S., there is greater incentive for the same man to donate multiple times, and the large number of clinics collecting donor sperm makes serial donation accessible.

As with the case of Ben Seisler, a man donating over the course of only three years to a single clinic can feasibly produce 123 offspring. Now imagine that Ben moves around, decides to visit different clinics, maximizes his return on donation for commercial or narcissistic or altruistic motivation (or a mix of all three), and generally becomes something of a 'career' donor. Over the course of two decades Ben may end up donating to five or six clinics before he is forty – only a slightly far-fetched scenario given the span of time under discussion.⁴⁶ Assuming it is only five clinics, and that each clinic utilizes his sperm to maximum limits, based on the previous calculations a single man could father up to 615 offspring. Six hundred and fifteen

⁴⁶ The recent media attention paid to Trent Arsenault, a self-professed 'donorsexual' is indicative of how serial sperm donation can actually drive one's sexual animus. A 36-year-old Silicon Valley computer security specialist, Arsenault asserts both his virginity and his single-minded attention to providing sperm: "I've committed 100 percent of my sexual energy for producing sperm for childless couples to have babies. So I don't have other activity outside of that." While certainly an extreme case, Arsenault's story highlights the ways in which sperm donation can become an all-consuming task. David Moye, "'Donorsexual' Virgin Father of 14 Kids, Answers Your Questions", The Huffington Post (3 February 2012) <http://www.huffingtonpost.com/2012/02/03/trent-arsenault-donorsexual-sperm-donor-video_n_1251595.html>.

children! In the wildest of these scenarios, Paula and Nicole may expect to help their eighteen-year-old daughter navigate the complex consanguinity of 614 donor sibs in the social media connectivity of 2029.

The intent is not to conjure up a nightmarish scene of cloned child armies at the gate, but merely to demonstrate that the present legal regime is poised to have unintended consequences.⁴⁷ And as has been discussed, lesbian and bisexual women represent the majority users of anonymous donor sperm in Canada. When these families are feeling pressured to select anonymous donors for fear of contested parentage, and their access to available donors is slimmed to a bare handful, they become subject to the vagaries of a market with unclear outcomes. What seems likely, however, is that a confluence of demand, scarcity, legislation (both stringent and absent), uncertain parentage under family law, international borders, kinship, technology and sexual identity is poised to hold a concentrated impact on queer communities. These are lateral blood relations imbricated by connections of queer family, infertility and community practice, none of which are traceable under current federal policy in the U.S. or Canada. These developments are likely to be even more pronounced for LGBTQ people of colour, due in part to the limited reserves of semen from non-European donors.

Exacerbated Impact on Queers of Colour

As the Creating Our Families project made clear through interviews with queers of colour seeking donor semen, many people found their options acutely narrowed in regard to

⁴⁷ I realize that these are sensational numbers at the outer limits of statistical probability, but they are not impossible. For example Toronto-area filmmaker Barry Stevens has claimed to have up to 1,000 donor sibs through a donor who provided specimens to a sperm bank for three decades. His donor sibs are spread across the U.S., Canada, Europe and beyond and Stevens' work to locate these relations has formed the basis of his two documentary films on the subject.

potential race-matched donors.⁴⁸ For example, one couple I interviewed was seeking a Filipino donor, for which their nurse helpfully offered a mixed “Korean/Turkish” specimen as the closest they had to offer(!). The women ended up selecting a Filipino donor from a California clinic, but were eventually obliged to drive to New York state for insemination after the samples were barred from import for failing to meet all Health Canada requirements.

Once again, an examination of Fairfax's policy proves instructive. A January 2012 search of their databases for sperm available for import into Canada shows a stock of 39 donors total. This number is comprised of 24 donors of various European heritages and 15 of either non-European and/or multiracial backgrounds. Seven donors were categorized as broadly “Asian”, including two men of self-identified Chinese heritage, as well as one Korean, one Persian, one Taiwanese, one Sri Lankan and one Iranian donor.⁴⁹ Thus a lesbian couple of South-East Asian origin might find themselves uncomfortably restricted to the single available Sri Lankan donor. A search under the “Black” category locates just one donor of African-American origin, while “Latino” also offers up one donor, of Ecuadorian/Spanish ancestry. There are six men identified as “Mixed”, and as it happens on the site every multiracial donor counted one half of their ancestry as European. The other half was listed as variously Israeli, Mexican, Black, First Nations and Bengali, all categorized as “Ethnic” factors. Such ratios were typical across all three accredited sperm banks available to the prospective Canadian family.⁵⁰

Options are further narrowed if the parents wish to select an Open-ID donor – meaning that any children conceived through that donor will have to the option of learning the donor’s identity when they reach 18 years old. In every Creating Our Families interview I conducted

⁴⁸ The issue of “race-matching” and its location within the nature/culture binary will be discussed in Chapter Nine.

⁴⁹ All described racial and national categories are as indicated on the website.

⁵⁰ While there is more volume available to Canadians across the span of the Fairfax, Can-Am Cryobank and ReproMed donor catalogues, the racialized proportions remain constant.

where we discussed the topic, respondents had intentionally selected an Open-ID donor. However within donor catalogues such men represent, at most, a third of available options. For example at the time of writing, just ten of ReproMed’s 53 Canadian donors are Open-ID – a bit less than 19%. All of them are white.

Thus when queer folks of colour do wish to have an Open-ID donor reflect their racial background or the racial background of their partner, they will likely need to look outside Canadian borders. As with the couple seeking a Filipino donor, they will encounter the rigorous protocols of the *Semen Regulations* and may find their chosen samples are barred from importation. Additional barriers may then be faced in the form of precarious visa status, the U.S. health care system, expenses and requests for time off from employers with whom one does not wish to share an intended pregnancy plan.⁵¹

Queer Communities of Blood and Affiliation

The children of queer parents are more likely than other donor-conceived offspring to cross paths with their donor sib biological relations, either knowingly or unknowingly. The intersections of community and queer maternity were seen in Toronto with donor sib parents meeting by chance at a queer yoga class. Queers of colour may well belong to specific parenting communities situated at the intersections between race and sexual orientation and/or gender identity, such as the series of groups that spun out of the Asian Pacific Islander Lesbian Bisexual Queer women and Transgender Coalition (APIQWTC) in San Francisco. One of these, called Queer Parents for the Love and Advocacy for our Youth (QPLAY), was co-founded in 2008 by a Filipina lesbian and mother named Joy Caneda to create a support network for LGBTQ families living in San Mateo County, California. QPLAY seeks to offer children an opportunity to meet

⁵¹ These were all reported as concerns by Carol and Maricel, the couple seeking Filipino donor sperm. Please see further discussion of their case in Section Three.

other children growing up within queer families. As Caneda puts it:

Many of our children are kids of color, mixed descent or racially mixed families and may face racial/ethnic discrimination in addition to homophobia and heterosexism. However, we are working to overcome these challenges for our families and children. We are forming a collaborative network of groups to address the needs of our families throughout the Peninsula. We will continue our fun social activities. This has been important way for many of our families to have our kids meet others with similar family backgrounds and to have support as queer parents.⁵²

When children are created from limited non-white semen reserves and raised in concentrated urban areas within groups of racial affinity, it is likely that at least some will share a donor sib relation. Even more so when Open-ID requirements are layered atop already scarce options for ‘ethnic’ semen donors.

Not all queer parents rely upon anonymous sperm donors, of course. Nor are all children of LGBTQ parents created through reproductive technology. However when queer couples and individuals *do* find themselves seeking non-white donor sperm, the overrepresentation of lesbians as users of third-party semen deepens the likelihood of queer enclaves relying upon the same sources to conceive their children. This magnifies the possibility of consanguinity among queer families of colour and the potential for a wholly new set of donor-conceived taboos around queer intergenerationality.⁵³ As the children and parents of groups like QPLAY meet and share spaces to support each other, they will be among the first to grapple with this new set of challenges. When donors are uncertain, and semen can be

⁵²Joy Caneda, “Where Are We in the Peninsula?” (2010) 15:4 *Our Family Coalition Newsletter* at 11 <<http://www.ourfamily.org/sites/ourfamily.org/files/sitefiles/OFCNewsletter10Fall.pdf>>.

⁵³ By which I mean the vertical child-adult-elder structures of biological reproduction which have long typified heterosexual kinship. This emphasis on intergenerationality is in contrast to queer affective communities based not upon children or elders, but on peer-group relations considered to be ‘chosen family’. These may also represent vital sources of support and friendship, but my interest here is in drawing attention to multiple generations of queer family created through biological reproduction and the ramifications for these emerging forms of genealogical family-making.

indefinitely frozen, potentially *any* other queer spawn⁵⁴ could be a biological relation. Without a way to track the genetic backgrounds of these children, the intergenerational impact on queer communities and likelihood of accidental consanguineous reproduction is positioned at a high order of magnitude.

Yet while such projections may readily conjure the specter of incest - and perhaps it is this taboo which will eventually goad regulatory agencies into action – it represents one of many potentially shifting notions of kinship.⁵⁵ Even non-amorous relationships may pose a confounding matter for donor sibs, as one may encounter hundreds of genetic relations through clan networks of parents and children. Certainly there is no reason to presume this will be a necessarily bad thing. On the contrary, it may offer exciting and powerful connections; it may recreate many of the ways we conceive of biological identity; it may shift our present focus on vertical kinships to more lateral frameworks and it may fundamentally challenge what it means to ‘father’ a child. It may also end up having little effect at all. However it *is* clear that queer people, and in particular those who rely upon donor sperm to create their families, will be at the vanguard of whatever is coming.

⁵⁴ One of the challenges of working with new paradigms involves creating and adopting new vocabularies. To add to the recent definitions of fertility law and donor sibs, we have *queer spawn* (also spelled *queerspawn*). This is an increasingly popular term to describe the children produced through queer kinships, and is often adopted by the children themselves. See for example the documentary film 'Queer Spawn' by Anna Boluda as well as the radio project and sound archive 'Queer Spawn Diaries' about adults with queer and trans parents by Nava EtShalom and Chana Joffe-Walt. See also: Jamie K. Evans, '*A Queer Spawn Manifesto: Empowerment and Recognition*' in Rachel Epstein, ed, *Who's Your Daddy? And Other Writings on Queer Parenting* (Toronto: Sumach Press, 2009).

⁵⁵ The fright around accidental consanguinity is a cultural formation that finds its exaltation in the incest taboo. This norm has not remained stable across time or culture. In ancient Greece, for example, marriages were allowed between a brother and sister if they had different mothers, while half-sibling marriages were also found in ancient Japan. Contemporary Swedish law, on the other hand, allows marriage between two consenting adults even if they are siblings. The taboo against incest is steeped in heterosexual and Oedipal fears, with actual genetic impact on offspring up for debate. In particular, Judith Butler's work to redefine Antigone as the "postoedipal" subject has helpfully argued for forms of sexual alliance and political agency beyond the incest taboo. Cf: *Judith Butler, Antigone's Claim: Kinship between Life & Death* (New York: Columbia University Press, 2000).

Discussion

This chapter has sought to lay out some of the particularized concerns affecting LGBTQ people using third-party donor sperm in Canada. It has been interested in tracking how lateral kinships may form through multiple donor sibs, and the ways in which this exerts a differentiated impact on LGBTQ communities and especially on queers of colour. It has explained how the entwined regulatory force of the *AHRA*, *Semen Regulations* and the *Directive* have restricted the available supply of Canadian sperm donors, to the point that an estimated 95% of the semen used for AHR is now sourced from outside the country. Among other concerns, including the strictness of protocols around importing sperm into Canada, recent empirical research has indicated a narrowing of available selections for people seeking a non-white donor.⁵⁶ At the same time, uncertain laws around parentage and the custodial rights of known donors have inclined many families to choose anonymous donors rather than inseminating with a friend or partner's family member. This is a particularly precarious decision for queer couples, who have traditionally fallen outside of normative models of childrearing. As same-sex couples and single women are estimated to constitute the largest demographic of users of third-party sperm donation for use in AHR, this places them disproportionately at the fore of any legal gaps that may exist. And gaps there are.

The lack of a formal national donor registry to track health information of donors, families and the donor offspring produced constitutes a serious lacuna. The gutting of the *AHRA* means that such a registry is no longer in the works, while the shuttering of Assisted Human Reproduction Canada has closed the doors on Canada's only federal voice on reproductive issues (as muted as that voice may have been). While Toronto's ReproMed sperm bank has

⁵⁶ See in particular the experience of the lesbian couple seeking a Filipino donor, discussed above, who were recommended a "Korean/Turkish" donor as the closest the clinic had to offer.

attempted to compensate for this shortfall in health reporting information by instituting a voluntary pay-access sibling donor registry, it only covers those select donors who originated in Canada. As this represents less than 5% of all Canadians using donor semen, this cannot present a satisfactory solution to the problem of donor tracking. The for-profit Donor Sibling Registry in the U.S. aims at providing an international forum for donor sibs, donors and parents to connect online, but it is also voluntary, for-profit and operating outside of government regulation.

The failure to institute a national tracking mechanism for donor health information constitutes a serious omission, even as the utility of such a registry is limited by the fact that Canada sources the majority of sperm from abroad. Health Canada regulations around altruistic sperm donation have throttled domestic supply, forcing reliance upon commercially-sourced sperm reserves from countries like the U.S. and Denmark. This prevents local capacity to track the donors and donor sibs of Canadian families, even as the government professes a moral ideal that eschews the exchange of payment for human reproductive material. This is a foundational hypocrisy that is harming Canadians seeking health reporting information on their donors and children, and one which unduly impacts LGBTQ people using donor gametes.

Recommendations for Legal and Policy Development

The first step in addressing this hypocrisy should be to examine the *Semen Regulations* and *Directive*. Policymakers must aim to remove barriers to donation on the part of known donors and HIV donors, and remove the criminal penalties to match paid donation regimes as in the semen-exporting countries from which Canada receives its stock. Canada currently has one of the lowest donor recruitment success rates in the world, and a domestic pool of 53 active donors for a population of approximately 34 million people. The regulations affecting known donors must also be overhauled to allow for less stringent quarantine and processing procedures.

When couples and single people elect to inseminate with known donors, they should be afforded the same streamlined process available to women inseminating with sexual partners. Each province must clarify the parentage rights of known donors, allowing for the intention of the social parents to prevail. This may include non-exclusive parenting arrangements that incorporate more than two legal parents if desired by the intended caregivers.⁵⁷

As ReproMed is currently the only national distributor for Canadian sperm, its online donor registration system should be expanded and made available to donors as well. The stripping of the *AHRA* and close of the AHRC has made the development of a federal health registry on donors unlikely, rendering private models currently in operation the most practical outlet for consolidation and expansion. Health Canada must support ReproMed to work in concert with the fertility clinics of other donor-export nations, and particularly the U.S., to institute an international database of gamete donors and health reporting information. At the same time, it is also critical to develop federally-mandated guidelines for donor limits on family units. These must not be steeped in heterosexual presumptions, but should remain responsive to the requirements and compositions of LGBTQ communities and their reproductive needs.

Issue with Donor Limits on Family Units

At present, all North American sperm banks promise compliance with some form of regulation on donor limits, most commonly the ASRM allowable birth/donor distribution rate. This calculus sets family limits as standing at 25 births/donor per 800,000 in a circumscribed population, i.e., *the population surrounding the location where donor inseminated births are reported as occurring*.⁵⁸ A “circumscribed population” is here defined as a limited geographic

⁵⁷ The discussion of multiple-parent arrangements and parenting formations through AHR is discussed in Chapter 10.

⁵⁸ The American Society for Reproductive Medicine, “Guidelines for Sperm Donation” (2002) 77:6 Supplement 5 443

area as drawn from the field of clinical research. Unfortunately there is a problem with utilizing geography as the key demographic indicator. In the *Handbook of Research Methods in Clinical Psychology*, authors George C. Tremblay and Barbara Landon discuss the definition and clinical assumptions underlying the “circumscribed population” framework. They offer instead the concept of “community” as a corollary in relation to harm reduction and prevention:

First, [we discuss] the concept of community – some circumscribed population of individuals who share certain characteristics...the very act of defining communities is a necessary step in developing an understanding of risks faced by their inhabitants. Definitions of community usually imply a geographic boundary, but may, for some purposes, derive from other shared characteristics such as ethnicity, sexual orientation, or the experience of a traumatic event.⁵⁹

This perspective helps to uncover the range of assumptions bundled into the apparently benign association of “population” with “geographic location.” Such a definition assumes that each individual: A) will maintain a static location, B) will find their primary social allegiance through spatial relationships such as neighbours, C) are not pulled by vectors of identity along race, sexual orientation or (the obvious) materialities of assisted reproduction, and D) do not have access to non-physical communities such as those offered by the Internet. Yet as has already been seen with Paula and Nicole and their startling proximity to donor sibs of their child, both online communities *and* local geographies provide categories of belonging. The example of QPLAY in San Mateo county demonstrated even more complex intersectional allegiances upon lines of race, sexuality, parenting and location. The failure of ASRM's imaginary “circumscribed population” of ostensible (white) strangers is inescapable in light of

Fertility and Sterility 2. See also: Practice Committee of the American Society for Reproductive Medicine and Practice Committee of the Society for Assisted Reproductive Technology, “2008 Guidelines for Gamete and Embryo Donation: a Practice Committee Report” (2008) 90:5 Supplement Fertility and Sterility S30 at S36.

⁵⁹ George C Tremblay and Barbara Landon, “Research in Prevention and Promotion” in Michael C Roberts and Stephen S Ilardi, eds *Handbook of Research Methods in Clinical Psychology* (Oxford, UK: Blackwell, 2003) 354 at 362-3.

the complex formation of actual social communities.

Sexual orientation and communities of practice around queer parenting are drawing people together in more concentrated streams than presumed by the anonymity of geographic population. This means that the donor sibs of queer parents are far more likely to encounter each other than in the objectively envisioned “circumscribed population” of a geographic radius. This is to say nothing of the online communities being created around donor insemination and the role of new media in connecting geographically disparate groups. In developing new regulations it is critical to discard the idea of a “circumscribed population” based purely on geography. This is a dated model that relies on an understanding of geographic proximity to the exclusion of other crucial social vectors, including ethnicity, race, sexual orientation, the trauma of infertility or social media as vehicles through which people develop communities of connection and belonging.

New criteria to determine appropriate donor insemination limits in light of queer family-making is required, with emphasis on racial diversity, sexual orientation and demand for Open-ID donor options. As these regulations are being developed, however, it is imperative that Canada not mandate a blanket restriction requiring all families to select Open-ID donors. The *Pratten* case argued in British Columbia would have required that provincial legislation provide mechanisms by which adult donor-conceived children can locate identifying information on their anonymous donors.⁶⁰ It also was widely expected to institute a mandatory Open-ID policy in Canada, potentially limiting not only domestic donors but also that large pool of gametes imported into Canada from other nations. Yet as discussed above, at time of writing just ten of ReproMed’s 53 Canadian donors are Open-ID, and all of them are white. For prospective

⁶⁰ *Pratten v British Columbia (Attorney General)*, 2011 BCSC 656; *Pratten v British Columbia (Attorney General) et al.* 2012 BCCA 480.

parents already facing narrow options, a policy of mandatory Open-ID would create unacceptable limitations. In the absence of other revisions to existing jurisprudence, not least a clarification of the parental rights of known donors, *Pratten* would merely have compounded existing legal precarity; once again this would have been most keenly felt by LGBTQ people and queers of colour.⁶¹

Finally, an enhanced regulatory enforcement regime is necessary to ensure that reproductive technologies are being appropriately provided and accessed. As discussed in Chapter Six, there is no consistent set of formal qualifications or standard of practice to which fertility clinics are held, as well as no licensing or accreditation required. Mandatory provincial accreditation is necessary to standardize clinical services, protocols, operations and prices.

Every province and territory in Canada has its own rules, requirements and processes for medical licensure; in Ontario, for example, all doctors must receive their certificates of registration from the provincial College of Physicians and Surgeons of Ontario [the College]. The College is charged with investigating complaints about doctors on behalf of the public and is also responsible for conducting disciplinary hearings when doctors may have committed an act of professional misconduct or incompetence. To date, the College has held only two disciplinary hearing to review the conduct of a fertility specialist operating at a private fertility clinic.⁶² One doctor in question was suspended for professional misconduct for three months and levied a fine

⁶¹ Pratten was denied leave to appeal by the Supreme Court of Canada.

⁶² In this case, a doctor had a sexual relationship with his receptionist, and after the relationship was terminated, the woman became an anonymous ovum donor in his fertility practice for two separate families. The receptionist was able to gain access to the recipient's files and learn the identity of at least one ova recipient. The doctor in question was found to have taken insufficient care to conceal patient identities, constituting a violation of their guaranteed anonymity. In: *Auyeung (Re) The Discipline Committee of the College of Physicians and Surgeons of Ontario in the Matter of a Hearing directed by the Complaints Committee of the College of Physicians and Surgeons of Ontario*. Release of Written Decisions Date: August 10, 2006.

of \$2,500.⁶³ The other case involved a doctor in London, Ontario who was investigated in regard to professional conduct and banned indefinitely from practicing fertility medicine in May 2014.⁶⁴ No other fertility specialist has received formal reprimand from the College.⁶⁵

Professional boards such as the provincial Colleges of Physicians and Surgeons must collaborate with bodies such as the Canadian Fertility and Andrology Society to develop and enforce donor cap regulations at each individual clinic, and work with the newly-created international donor registry to ensure that successful births are enumerated. This important responsibility can no longer be left to the self-reporting goodwill of families and their physicians. Effective regulatory oversight must take into account the specific needs of LGBTQ people, as major consumers of reproductive technology, and work with grassroots organizations, donor-conceived family organizations and community-based advocacy groups to ensure inclusive and fair policy that meets the requirements of all families across Canada.

Conclusion: Queer Families on the Frontlines

In concluding this chapter I would like to return to the story of Paula and Nicole. As the lived lives at the heart of this paper, I believe they demonstrate the importance of creating a policy regime that can account for queer subjects in both law and conception. Their limited

⁶³ *Ibid.*

⁶⁴ A recent investigation of a fertility doctor in London, Ontario found evidence of professional misconduct in regard to repeated low-tech options. Dr. James Martin admitted to performing repeated intra-uterine insemination (IUI) treatments and prescribing high doses of ovarian-stimulation drugs, putting some patients in danger of serious complications.

⁶⁵ There were two other hearings that involved an obstetrician-gynecologist and therefore indirectly impacted female fertility, but these both concerned community practitioners who did not specialize in assisted reproduction. In the first, an obstetrician-gynecologist pled no contest to the charge of incompetence incompetent in his management of 47 patients between 1992 and 2001. The Committee revoked his license to practice. *Wai-Ping (Re) The Discipline Committee of the College of Physicians and Surgeons of Ontario in the Matter of a Hearing directed by the Complaints Committee of the College of Physicians and Surgeons of Ontario*. Release of Written Decisions Date: March 11, 2004. In the second, an obstetrician-gynecologist faced complaints about his treatment of 37 women and was found to have failed to meet the standard of practice in his care of six of the women. *Vaidyanathan (Re) The Discipline Committee of the College of Physicians and Surgeons of Ontario in the Matter of a Hearing directed by the Complaints Committee of the College of Physicians and Surgeons of Ontario*. Release of Written Decisions Date: July 7, 2006.

options as Canadians using federally-regulated donor sperm obliged them to select a U.S. candidate who may be utilized by dozens, if not hundreds of other families across the globe. As white women they had access to the largest pool of potential donors, yet as lesbians they were also the largest client base of third-party donor semen; as queer folks they exist in a community of sexual practice in which lateral kinships between half-siblings are far more likely; and as Torontonians they are members of Canada's largest LGBTQ population.

The complex web of legal regulation that ensnares their experience with assisted human reproduction has not been able to offer Paula and Nicole any certainty about how many other families may be giving birth to donor sibs of their child, nor has it been able to provide a legislative mechanism to track these children as they grow into adults. In our interview, Nicole told me how the fertility clinics are not impressed by such independent initiatives as the Donor Sperm Registry “because they want everything...wrapped up and tight” until the child is 18 years old. Nevertheless, access to the online communities of the DSR has placed them in contact with other donor sib families, and based on their experience Paula could confidently assert that this method of tracking “is changing everything.”

LGBTQ parents are seeking reproductive support at clinics across Canada and confronting a legal regime that is poorly attuned to their needs. In many ways, queer people may be uniquely adapted to handle these challenges. As families already based on inherently non-reproductive sexuality, there is no expectation that a child will biological affiliation with both or all parents. Queer people have also prided ourselves upon the ability to create “families of choice” and develop new communities when our biological networks of family failed.⁶⁶ Indeed these new affiliations may prove sources of great community and alliance...at the very least,

⁶⁶ Weston, *supra* note 28.

they could make for some epic family reunions. What is clear, however, is that an intergenerational effect is brewing with an impact that remains uncertain, and LGBTQ families stand at the fore as new family modes and lateral kinships are being produced through AHR. The queer experience may thereby provide a useful prism for all manner of families seeking reproductive assistance through donor gametes, gay and straight alike.⁶⁷

Postscript

As I was readying this chapter for publication in the *Canadian Journal of Women and the Law*, I checked in with Paula and Nicole to share the final draft and see how they were progressing with the Facebook group. Paula sent an update on their daughter Johanna that speaks precisely to the new forms of family being created, and she has generously allowed me to reproduce the letter here in its entirety. I am delighted to give her the last word on these lateral kinships and the potential they hold for new forms of family and queer community.

Hi Stu,

I'd be more than happy to catch you up on our little Sibs community. I am always happy to talk about this stuff - I think if we are going to be redefining family like we are, we need to talk more about it so others aren't so freaked out about donor siblings. Johanna being connected to her donor sibs surprisingly gets many people labeling what we are experiencing as weird and crazy. Even some of the most politicized folks who claim to be totally non-judgmental have had a hard time not finding it strange and having a hard time wrapping their heads around our families.

Our group has grown immensely over the past couple years. At last count there are 37 children born into our sibs group that we know of and we are getting bigger and bigger with second children being born. We have nine families in Ontario, there are two families in Israel and the remainder in the US. So far we have met five families and get together with them two to three times a year. We have grown a little closer to two of these families who we often see out amongst the queer community and we have just started to attend one other's kids birthday parties. We are getting together with the five families in a couple weeks at one of the sib families homes. We may

⁶⁷ Please note that while this chapter has only been able to explore the lesbian experience of anonymous third-party donor sperm, there are also urgent problems with how ova are sourced, how known donors are treated, as well as how surrogacy arrangements are structured under the *AHRA*. These issues will be discussed through reference to empirical data in Chapters Nine and Ten.

also book a camping trip this summer. Some of the families in the US have also met one another and have been talking about doing a bigger vacation like a Disney cruise or beach vacation.

I really like the folks we have connected with so far up here in Toronto. Johanna seems to enjoy her time spent with her donor sibs. This may change and we will be there to support however she decides to move forward with these relationships in the future. I don't know, but I imagine it just may be her 'normal' experience. Both Nicole and I come from non-traditional family structures and for us it's just been how it is.

You see many different levels of participation from folks on our Facebook group. Some people will always be posting photos and comments to the group, others comment from time to time, some people just lurk and don't say anything and we have had a couple people appear and soon disappear without us finding much out about them. I imagine it can be a little overwhelming for folks who are first learning about the donor sibling registry and this new Sibs culture we are all now a part of. When Nicole and I first signed up we only had a handful of families and now it's quite hard for even me to keep up with what kid goes with which family. As of now we are still only a group of single women and queer women. Not sure where the hetero couples are? We know they're out there!

Take good care,

Paula