DOE V. CANADA: LESBIAN WOMEN, ASSISTED CONCEPTION, AND A RELATIONAL APPROACH TO RIGHTS

by

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A thesis submitted in conformity with the requirements for the degree of Master of Laws (LL.M.)
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2009

Abstract

This thesis examines Doe v. Canada, a case brought before the Ontario Court of Appeals with the purpose to declare that the definition of “assisted conception” set forth by the respective regulations discriminated against lesbian women. The regulatory framework of assisted conception is embedded with heteronormativity, heterosexism and an over-medicalization of reproduction. The traditional liberal conception of rights, embedded in the Court’s decision did not allow lesbian women to have access to assisted conception free from barriers that other women, seeking insemination with semen donated by their spouse or sexual partner, do not have to endure. However, If we shift our perspective of rights from a liberal view to a relational approach, we will be able consider such decisions from a perspective that takes into account not only the physical health implications of the use of this technology, but also all other social, psychological and contextual relevant factors.
Acknowledgments

First of all I would like to express my appreciation to Professor Rebecca Cook for her constant support, generosity, insightful comments and patience. Also, I am grateful to Linda Hutjens, for all her invaluable assistance during the academic year, the Reproductive and Sexual Health Law Program would not be the same without you. Furthermore, my gratitude goes to the Canadian Institutes of Health Research (CIHR) for providing a space to develop and debate my ideas. To my colleagues and friends Mercedes Cavallo and Patricia Ferreira with whom I shared endless hours at the library, you guys made it fun! I give many thanks to my dear friends Jennifer Simpson (Jenna) and Saira Zuberi (Sairita) for taking valuable summer time to revise, comment and edit this thesis, but above all, for constantly listening to my desperate remarks and providing me with a loving and supporting environment. Finally, my gratitude goes to my family and friends from back home (Chile) for being a persistent source of love and encouragement.

I dedicate this thesis to Ana Manzur Rabba, my dear departed grandmother (mi abuelita); you provided the greatest model a child may have of an intelligent, beautiful, loving and funny woman. I will try to live my life through your teachings; you are in my heart always.
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Introduction

Recently, the Ontario Court of Appeals ruled in *Doe v. Canada*\(^1\) that the regulatory framework of assisted conception did not discriminate against lesbian women. According to the Court, the scheme requiring a series of steps and hardship only applicable to women who intend to use semen from men other than their spouse or sexual partner, and excluding from any requirement those who do, was based on differential treatment not sustained on prejudice, stereotyping or historical disadvantage. Moreover, using a classical liberal approach to the rights set forth in the *Canadian Charter of Rights and Freedoms*, they came to the conclusion that the differential treatment was completely justified by the original intention that drove the creation of the norms regulating this reproductive technology. The original intention was based on a protectionist health approach to reproductive matters, by which there is a necessity to protect those who are dependent on the State from acquiring infectious diseases. This health protectionist argument overruled any conception of autonomy by which other social factors may have played an important part.

Human reproduction is no longer only the result of sexual intercourse. New reproductive technologies have taken out of the equation the need to exchange reproductive fluids through sexual intercourse, challenging for many years now our notions of conception, parenthood and family,\(^2\) and particularly the need to have a female and a male subject form a union central to the meaning of those concepts. These technologies, especially artificial or

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alternative insemination (AI) have given people who live their sexualities with same sex partners, the chance to procreate and have children without engaging in a sexual relationship with members of the opposite sex. However, AI is not only judged as an alternative means of procreation but also as a medical intervention and as such is put under extensive regulation.

Because this kind of medical intervention relates to women’s reproductive capacity it cannot be treated as any other medical intervention at its core. This means it should not only be concerned with a successful medical outcome of the intervention. Women’s capability to bear children and reproduce is an important part of her self determination and autonomy. Health considerations are not to be given more importance than her autonomy and capacity to decide the number of children and the spacing between them.

I argue in this thesis that a liberal conception of rights disadvantages lesbian women, who by depending on the State to become pregnant through the use of assisted conception, particularly AI, are treated as if they have lost their capacity for autonomy. This relationship of dependency should not mean a denial of women’s capacity and autonomy. Furthermore, I explain that precisely in these circumstances the Courts should be cautious of the social implications of their judicial decisions by taking into consideration the kinds of relationships that they are promoting between the lesbian citizen and society. When the context of a certain group of women makes them a vulnerable group, that is, when they become dependent on the State to achieve their life choices, the State – through whatever structure of power or capacity – has the obligation to act according to a substantive conception of freedom and equality. This conception is based on the context of lesbian women in society today and their highest attainable standard of well being. The examination of these issues must not be based on a “simple rationale,” grounded in a health protectionist approach to reproductive technologies,
but conversely, on a very entrenched and complex reflection of all the circumstances that are at play in alternative family formation. Moreover, a relational approach to rights and autonomy, which implies an integral contextual examination of these issues, has the capacity to propose a new way of interpreting and creating relationships between the state and its citizens according to a conception of autonomy that departs from its liberal tradition and permits lesbian women to configure their families according to their desires.

For the purposes of the above I have divided this thesis into four chapters. Chapter 1 provides an account and how heteronormativity and a heterosexist conception of society are embedded within the liberal tradition, informing not only the way the lesbian citizen has been constructed through time and also judicial decisions based on sexual orientation. Afterwards, I examine the regulatory scheme of assisted conception from its background up to the creation of the *Processing and Distribution of Semen for Assisted Conception Regulations*. Finally, I look at the medicalization and social implications of assisted insemination.

Chapter 2 presents *Susan Doe v. Canada* through the Ontario Court of Appeals’ decision. In this section I give an account of the facts of the claim and the reasoning of the Court, explaining how health considerations are placed, from a protectionist perspective, above all others. Here we see how the court found there was no discrimination against lesbian women but differential treatment justifiable by the purpose of the regulatory framework of assisted conception, which the Court interprets to be the protection of lesbian women’s health, their partners, and future children.

In Chapter 3 I introduce the relational approach to rights, departing from a traditional conception of autonomy as independence and reconceiving it as the finding of “our own
law.” This reconception of autonomy is greatly based on the theoretical framework accorded by a series of authors, particularly Jennifer Nedelsky, from which I extract major parts of the analysis. Most importantly I argue that relationships are a major component of autonomy, not to promote that relationships should inform a proper conception of the self, but in the effects that such relationships could have on the individual. Having such concern will allow the individual to consider those relationships that enhance autonomy from those that undermine it. Moreover, I comment on the role of the State manifested through all its power structures and particularly the judiciary, as a responsible entity who should be aware of their interactions with its citizens and how those interactions promote relationships of equality and freedom or relationships based on oppression and misconceptions. Also, I examine public health institutions through the lens of relational autonomy, putting to the test their policies and questioning their most basic structures and configurations.

Finally, Chapter 4 proposes an analytical approach on Doe from a Relational perspective. For that reason I have divided the Chapter into three major issues. First, I examine the purpose of the regulatory framework of assisted conception: protecting the health of women, their partner and future children; promoting equality and non-discrimination in the use of new reproductive technologies; and finally, promoting autonomy and allowing women to make conscious choices regarding their health, and giving them the opportunity to construct their families beyond an oppressive environment. Second, I raised the question whether the health system is promoting autonomy. Third, and considering the analysis conducted, I proposed a new definition of “assisted conception” for the purposes of applying the regulatory framework.
Chapter 1
Heteronormativity, Assisted Conception and the Medicalization and Regulation of Insemination

1. Heteronormativity

Heteronormativity presupposes that there is a natural order within the structure of human relations. This natural order is socially manifested through the composition of family and gender relations; hence, according to that traditional view, “natural and fundamental differences exist between men and women.”\(^3\) Furthermore, sexual attraction to the opposite sex and thus marriage between a man and a woman, is considered the natural and normal manifestation of a pre-established order that perpetuates the objectification and subordination of women and alternative manifestations of sexuality.\(^4\) Heteronormativity is revealed throughout legal systems and norms that regulate public institutions and services according to that “natural order”. Our conception of constitutional rights, particularly their interpretation, content and application given by the Courts, is embedded within these kinds of sociological conceptions of men, women, family, reproduction and citizenship. Even though some progress has been seen in this area, particularly in the construction of a new citizen and legal subject, the “natural order” of society uncovers the biological considerations that still underlie the justifications for hindering lesbian women’s abilities to construct their lives and families with autonomy.

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\(^4\) *Ibid* at 288.
Cornell explains heteronormativity through patriarchy as a “state-enforced and culturally supported norm of heterosexual monogamy as the only appropriate organization of family life.”⁵ In this framework the father is placed at the head of the hierarchical line, where women are defined by their reproductive capacity and their place in the family. As for alternate family compositions, she argues:

Gays and lesbians, as well, since they have no place in this kinship system, continue to be denied their right to the self-representation of their sexuate being. They cannot assume the status given to the father of a heterosexual marriage as head of his line; they do not even have the kind of protection that binds women to their roles in households. Under a patriarchal system, heterosexual women, gays, lesbians, and transgendered persons are in different ways degraded in that their “sex” or way of having “sex” is used to deny them full standing as persons.⁶

Political, cultural and social institutions as well as our legal systems tend to reinforce and perpetuate the assumption that the only natural and legitimate form of sexual expression is a heterosexual monogamous relationship.⁷ Even more, masculinity and femininity are defined by the prescription that our erotic interests should only be directed to the opposite sex in the same manner as an attraction towards the same sex is generally absent or even invisible through the lens of culture and law.⁸ Homosexuality can become a threat to our social structure because this alternative sexual expression breaks the traditional conception of a binary notion of gender, challenging as well a patriarchal organization of society based

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⁵ Drucilla Cornell, At the Heart of Freedom: Feminism, Sex and Equality (New Jersey: Princeton University Press, 1998) [Cornell] at 22
⁶ Ibid.
⁸ Ibid. at 196.
on dominance and nurturance. Moreover, visible, recognized and legitimized homosexual subjects pose a formidable threat to the classic gender script. They deny the inevitability of heterosexuality. They do not fit. Such persons, particularly if they are comfortable with their sexuality and reasonably content and successful in their work and family life, invite heterosexual people to explore whether their own sexual orientation is innate, “freely chosen,” or simply the socially comfortable course of least resistance.

The heterosexism embedded in social structures and hence in the mainstream belief system that sustains the “natural” order of family and society, sees the homosexual subject as a threat, particularly considering that committed and caring homosexual relationships deny, by definition, the belief that stable relationships must be structured through established hierarchies and reciprocity between a polarity represented by the male/female binary.

Although patriarchy has been disrupted by feminists and activists struggling to be recognized as full persons, we will see in the following pages that patriarchy is not yet a phenomenon of the past. In order to understand the progress and evolution that the lesbian subject has had within Canadian society I consider Brenda Cossman’s account of gays’ and lesbians’ path to becoming full citizens. She suggests that gays and lesbians are in the process of becoming fully recognized subjects, equal members to the polity, namely, by

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9 Ibid. at 196.
10 Ibid. at 210.
11 Ibid. at 218.
13 Cornell supra note 5 at 2, 160 and 162.
having the capacity of calling upon rights and the political and cultural practices that denote membership to a nation state.\textsuperscript{14} Moreover, I will examine the way in which subjects are constituted as members of a polity, the ways they are, or are not, granted rights, responsibilities, and representations within that polity, as well as acknowledgment and inclusion through a multiplicity of legal, political, cultural, and social discourses.\textsuperscript{15}

Cossman asserts that with the modern incorporation of the homosexual subject “citizenship is being sexed, privatized, and self disciplined.”\textsuperscript{16} In the following section on precedential evolution of the homosexual legal subject, the biological configuration of differences between men and women, and their ability to naturally conceive children—as opposed to same sex couples—was a clear trend that connoted citizenship or political membership as a heterosexual privilege where lesbians and gays were either considered deviant or strangers to the social structure.\textsuperscript{17}

2. The biological perspective of the courts

In this section I will give an account of how the Courts have ruled on different cases involving sexual orientation, how those rulings have been tainted by a biological perspective of what is “natural,” and how this perspective has sustained heterosexual privilege within the law.

\textsuperscript{14} Ibid at 5.
\textsuperscript{15} Ibid.
\textsuperscript{17} Ibid.
Until recently, the judicial dominant discourse was based on the heterosexual nuclear family as the natural structure for childbearing and caretaking of dependant members.\(^{18}\) Through the marked emphasis of form over function, the legal setting of a conceptual family was relying on the binary male/female.\(^{19}\) However, with the gradual integration of other legal subjects such as gays and lesbians, and their recognition and fusion into a monogamous conception of family, a new emphasis on function—a place to take care of others in a normalized one on one sexual relationship with dependent child members—took place. In a modern liberal political system with a clear separation between the private and the public spheres of life, lesbian couples, according to Cossman, are now legitimized through their normalization and familiialization and at the same time they constitute a challenge to the male/female composition.\(^{20}\)

In the struggle to attain formal legal equality, lesbians and gay men have used the *Canadian Charter of Rights and Freedoms* (hereinafter the “Charter”) as a mean to challenge heteronormativity.\(^{21}\) Many laws that discriminated on the basis of sexual orientation have been declared unconstitutional, and legislation forced to amendment.\(^{22}\) We will also see how the application and interpretation of constitutional rights is permeable to societies and particularly judges’ views and stereotyped conceptions on societal configuration, proper relations and prominent values.

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\(^{19}\) *Ibid.* at 246.
\(^{21}\) For a comprehensive account of court cases see *Ibid.*
\(^{22}\) *Ibid.* at 224.
Starting with *Andrews v. Ontario (Minister of Health)*, it was held that the term “spouse” does not include a homosexual partner in a long-term relationship. Although the *Health Insurance Act* challenged in that case did not define spouse in terms of establishing who could be considered “dependent” and therefore receive coverage, the judge believed that a number of other legal sources consistently defined spouse as someone of the opposite sex. It was held that homosexual couples can be considered a distinct class treated differently from heterosexual couples, however that distinction is justified through a biological difference between the two. Heterosexual couples can potentially procreate and raise their biological children. In any case, the failure to confer dependent status on members of homosexual couples could still be justified under s. 1 of the *Charter*. In sum, gays and lesbians were arguably not even entitled to formal equality.

*Andrews* was followed by *Layland*, an attempt to judicially review the refusal to issue a marriage licence to a homosexual couple, it was held that under the common law of Canada a valid marriage can take place only between a man and a woman. The Court concluded that although sexual orientation is an analogous ground for discrimination, the main purpose of the institution of marriage is to encourage procreation, which cannot be achieved in a homosexual union. As in *Mossop* the Court continued to rely on biological differences reinforcing the notion that “family status did not include same-sex couples.”

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24 See, R.R.O. 1980, Reg. 452, s. 1(c) under the Health Insurance Act, R.S.O. 1980, c. 197.
however, some progressive judges—in minority opinions—advocated for the recognition of diverse family forms.\textsuperscript{29}

With \textit{Egan},\textsuperscript{30} the Court considered sexual orientation to be a deeply personal characteristic that falls within the ambit of s. 15 protection as an analogous ground to the ones enumerated, and thus the opposite sex definition of spouse violated the Charter, constituting discrimination. Nonetheless discrimination in this case is justifiable under s. 1 of the same because, although homosexual couples can provide support for each other and occasionally bring up children, this is exceptional and it does not affect the fact that Parliament affords a measure of support to married couples and those who live in common law relationships, describing a fundamental social unit to which some measure of support is given for procreation purposes, in sum for mere biological reasons.\textsuperscript{31}

In \textit{Vriend}\textsuperscript{32} the Supreme Court of Canada took an innovative path holding that the \textit{Individual’s Rights Protection Act} (IRPA), because it did not include sexual orientation as a protected ground, infringed s. 15 of the Charter and the infringement was not considered justifiable under s. 1. In this case the Court applied the read-in-remedy, in which the words “sexual orientation” should be read into the prohibited grounds of discrimination in the provisions set forth by the IRPA.

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{29} \textit{Ibid.} at 226.
  \item \textsuperscript{31} Cossman (2002) \textit{supra} note 12 at 229 and 230.
  \item \textsuperscript{32} See \textit{Vriend v. Alberta} [1998] 1 S.C.R. 493
\end{itemize}
\end{footnotesize}
Moreover, in *M. v. H*\(^{33}\), there was a challenge of the definition of spouse set forth by the *Family Law Act* (FLA) on the grounds that it discriminated against homosexual couples. The Supreme Court held that the definition was a violation of s. 15 of the *Charter* not saved by s. 1, however suspending the effects of the particular provision challenged (s. 29 of FLA) for a period of six months, ordering the Ontario Legislature to modify it. Here, besides recognizing the legitimacy of gay and lesbian relationships, they asserted their need of legal protection.\(^{34}\)

The ultimate legal precedent that challenged the heteronormativity conception of family’s composition is *Halpern*.\(^{35}\) Here, the Court of Appeals of Ontario declared that the common law definition of marriage, which excluded same sex couples, was an analogous ground of discrimination under s. 15, therefore creating a formal distinction on the basis of sexual orientation. This formal distinction was considered discriminatory and in violation of the dignity of same sex couples, not justifiable under s. 1. Applying the read-in-remedy, it was declared that the ancient common law definition was invalid and should now be read as "the voluntary union for life of two persons to the exclusion of all others".\(^{36}\) Here the Court concluded that the institution of marriage deeply influences relations of equality and dignity, acknowledging the need to include same sex couples.\(^{37}\)

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\(^{34}\) Cossman (2002) *supra* note 12 at 234.


\(^{36}\) *Ibid.* at paras. 155 and 156.

In this context, heterosexuality does not any longer define in its core all forms of membership to the nation state.\textsuperscript{38} Gays and lesbians have acquired rights and responsibilities and have, to some extent, been included within citizenship. This inclusion implies conformation to set standards and at the same time, contribution in the reconstruction of the conceptual content of belonging and legal subjectivity.\textsuperscript{39} Yet, citizenship must be more than a game or tension between belonging and inclusion; it must represent a makeover of the foundations of how citizenship is understood and practiced, repealing the fixed customary heteronormativity “beyond gay/straight dichotomy.”\textsuperscript{40}

Though many advances have been gained by judicial precedents, institutions and their legal regulations, they still contribute to heterosexual’s privileges and benefits.\textsuperscript{41} In this sense the very old biological distinction between couples is not over yet. As we may see in the following chapter, in the name of health and protection of women and the unborn child, lesbian women are not considered full citizens capable of autonomy and agency. The traditional weight between private and public interests, the incapability of understanding a person’s situation according to her social circumstances and relations, and a traditional conception of rights have not allowed lesbian women to be truly seen as capable and empowered legal subjects that through her life altering decisions, may contribute to a democratic outcome and the reinforcement of society’s dynamic core value content.

\textsuperscript{38} Cossman (2007) supra note 12 at 9.
\textsuperscript{39} Ibid. at 9 and 10.
\textsuperscript{40} Ibid. at 2.
\textsuperscript{41} Ryder supra note 3 at 293.
3. The regulatory scheme of “assisted conception”

3.1. Background

The Processing and Distribution of Semen for Assisted Conception Regulations\(^\text{42}\) (hereinafter the “Regulations”) were registered on May 7, 1996, pursuant to subsection 30(1) of the Food and Drugs Act,\(^\text{43}\) under the recommendation of the federal Minister of Health. These regulations were set forth as a response to the concerns expressed by the Royal Commission on New Reproductive Technologies (hereinafter the “Commission”) through their final report Proceed with Care\(^\text{44}\) (hereinafter the “Report”).

The Commission was mandated not only to examine the current political or scientific developments related to reproductive technologies, but also to consider the impact that those technologies would have in society as a whole and on specific identified groups such as women, children and families. Also, they were instructed to inform on all ethical, legal, social, economic, and health implications of these technologies.\(^\text{45}\)

In their Report, the Commission concluded that the government, guardian of the public interest, was called to set boundaries respecting the use of new reproductive technologies,

\(^{42}\) Processing and Distribution of Semen for Assisted Conception Regulations, SOR/96-254 [Regulations].

\(^{43}\) Food and Drug Act, R.S., c. F-27, s. 30(1). This section declares that “[t]he Minister may make an interim order that contains any provision that may be contained in a regulation made under this Act if the Minister believes that immediate action is required to deal with a significant risk, direct or indirect, to health, safety or the environment.”

\(^{44}\) Royal Commission on New Reproductive Technologies, Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies (Canada: Minister of Government Services Canada, 1993) [Royal Commission]. During 1989 the Royal Commission was requested to “report upon current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the public interest, recommending what policies and safeguards should be applied.”

\(^{45}\) Ibid. at 2. More specific tasks delineated for the Commission can be found in The Commission’s Mandate, Order in Council No. P. C. 1989-2150.
establishing a system to manage them within those boundaries.\textsuperscript{46} Regarding semen donation, they recommended the creation of a national sperm collection and distribution system that would ensure the availability of safe sperm.\textsuperscript{47}

The Commission was aware that new reproductive technologies have the capacity to unlink fertilization from sexual intercourse, opening, in their opinion, major ethical dilemmas concerning these modern tools with potential for benefit and harm.\textsuperscript{48} In their own words

They offer new options and potential benefits for the people who can use the technologies to form a family, but scientific and medical interventions in procreation also challenge us as a society to be able to recognize their significance and control their development. Would they further entrench existing inequalities or create new ones? How could they potentially alter definitions of parent, family, and generation? What is their potential effect on the way women are viewed in society?\textsuperscript{49}

The questions asked by the Commission are of great importance; particularly, the one addressing the possible inequalities that access to these technologies can create or deepen among citizens. However, the answer to the question of inequality cannot be addressed from a liberal perspective (where the answer would be to protect the private aspect of a person’s life as opposed to that considered public), that is, relying on the fact that certain aspects of human beings, particularly reproduction are better left to the private sphere of families. For this I am not proposing a non-intervenient State that leaves the individual alone in the regulation and struggles of their “private sphere,” but on the contrary, I am advocating a regulatory framework and application that is respectful of the self, promotes

\textsuperscript{46} Royal Commission \textit{supra} note 44 at xxxii.
\textsuperscript{47} \textit{Ibid.} at xxxiv.
\textsuperscript{48} \textit{Ibid.} at 1.
\textsuperscript{49} \textit{Ibid.}
and enhances autonomy, and fosters relationships and interaction, based on freedom and equality and not oppression.

Issues on new reproductive technologies cannot be categorized simply from a medical perspective, nor can a unique approach respond to the questions that may arise from the use of these technologies. Although a health based approach to the regulation of assisted conception is of great importance, and considerations of the health of all the parties involved should not be taken for granted, human reproduction goes beyond a conceptualization of mere medical procedures. It touches the most personal, intimate and delicate aspect of women, their capacity to make decisions that will affect their future, their intimate relationships and the conformation of their families, and above all, it entails decisions that will affect their bodies. In this perspective the Commission also recognizes the importance of having a comprehensive approach to these concerns:

…the issues raised by the new reproductive technologies defy neat categorization as solely a health problem, solely a legal problem, or solely an ethical problem. The research, development, and use of new reproductive technologies involve national concerns that cut across social, ethical, legal, medical, economic, and other considerations and institutions. This characteristic of new reproductive technologies generates the need for a distinct regulatory and organizational response—one capable of responding to and dealing with the issues in a comprehensive way.50

The normative response given by the Regulations to these questions is intended to deal with the issues presented by the Commission in a way that is not only concerned with a health based rationale. The Regulations of 1996 promoted as an answer to the Commission’s concerns for the need for legal uniformity were originally drafted more than a decade ago,  

50 Ibid. at 16.
and any attempt to understand their implementation to our time needs to take into consideration social changes, technological advancements and fast-paced evolving social values.

In the chapter *Social Values and Attitudes Toward Technology and New Reproductive Technologies*\(^5^1\) the commissioners explained how they took a contextual approach to the understanding of new reproductive technologies in the Canadian social context, that included factors such as sexism, racism, poverty, and other sources of discrimination, making sure that “Canadians’ values and attitudes … inform any policy decisions in this area.”\(^5^2\) Nevertheless, not only is it necessary to represent Canadian contemporary voices in policy-making, but also to try to inform those values through policy. In other words, it becomes an imperative of social change towards a more equitable and free society to set forth regulations that also correspond to an ideal of what we are aiming to accomplish. The *Canadian Charter of Rights and Freedoms* does not necessarily represent the values that actually are exercised by Canadians on a regular basis, but an ideal of what Canadian

\(^5^1\) *Ibid.* at 23 ff.

\(^5^2\) *Ibid.* at 23 and 24. The Commission explains how they “conducted a series of national surveys measuring Canadians’ familiarity with and values in areas related to new reproductive technologies. In total, representative samples involving more than 15 000 Canadians took part in personal interviews, focus groups, phone interviews, and/or answered written questionnaires. As well Canadians from across the country attended public hearings and private sessions, sent written submissions or letters of opinion, and gave [them] their thoughts on [their] toll-free telephone lines. In all, more than 40 000 individuals contributed to the work of the Commission. Their contributions added immeasurably to the depth and the breadth of our understanding of Canadians’ perceptions of technology in general and new reproductive technologies in particular, providing an important guide to, and source of wisdom about, the limits of what is ethically acceptable.

From Canadians’ input, from survey research, and from analytic research projects, the Commission gained a sense of the values and attitudes that will carry Canada into the twenty-first century and that must form a context for all public policy decisions … The issues concerning new reproductive technologies are not uniform, nor is Canadian society: both are diverse.”
society aims to become, and so the underlying values of any regulations should also aim to accomplish those ideals.

For instance, in relation to the acceptance and tolerance of homosexual relationships, the Commission found, through surveys, that 35% of respondents considered them acceptable, 21% manifested no opinion on the matter, 16% considered it unacceptable, and 27% totally unacceptable.\textsuperscript{53} In sum, 64% of the people survey either did not manifest an opinion on homosexual relationships or were contrary to them. If policy or legislation were enacted to represent the findings of this survey and not evolving values based on equality, the interpretation and application that the Courts have given the Charter would have to be set back from what has been accomplished today. Now, it is important to remember that the Report was published in 1993, and probably the surveys were conducted earlier than that, when gay marriage was not legally recognized and the status of homosexual relationships represented a rather evolving legal and social conception. From that point on society has change dramatically and the courts through their judicial role have taken a stand to not only represent Canadian society as it is but also as what it aims to become.

The Commission also recognized that Canadian’s sense of equality, tolerance, pluralism and diversity is changing as well as their attitudes toward technology and society as a whole.\textsuperscript{54} They recognized the need for equitable participation in national life through the awareness of human rights.\textsuperscript{55} This trend towards diversity, the Commission said, “tells us something about what twenty-first-century Canada will be like and has significant

\textsuperscript{53} Ibid. at 29.
\textsuperscript{54} Ibid. at 28
\textsuperscript{55} Ibid. at 29
implications for society’s response to new reproductive technologies.” Although the Commission is setting the standards on how their report and even the regulations should be interpreted, that is, as evolving in time according to progressive thinking and values, the courts have not taken the same stand trying to applied the Commission’s values and understandings. A proper interpretation involves framing the Regulations and the Commission’s Report within the time they were published, discover the original intentions that they promote, and, without feeling bound by that original intent but only guided by it, apply it according to the values that society manifests today and the values that the Charter aims that society will manifest tomorrow.

Moreover, the Commission recognized that ethical inquiries related to the use of some reproductive technologies can only be resolved by referring to a changing common set of social beliefs, values and assumptions.

... ethical questions related to the use of some of the technologies will not be resolved by referring to an unchanging common set of social beliefs, assumptions or values. Nor can we assume that established ways of setting priorities, making decisions, developing policies, and delivering services will be adequate to the task of accommodating Canadians’ diverse aspirations and goals ... As Canada becomes more heterogeneous, it will become increasingly important to make core values transparent and to ensure that consensus on technologies takes into account the diverse nature of the country.

Clearly there is a call for participation and dialogue, otherwise how would the diverse nature of the country be able to express itself, and how would the consensus be obtained?

56 Ibid. at 29
57 Ibid. at 29 and 30.
Here, there is not a call to a particular sector of the nation or a group of experts to give their opinions and come up with that set of core transparent values, but a call to the whole nation represented by its diverse groups and minorities. When a group of experts gets together to discuss a subject, as for instance a group of lawyers discussing a particular case and its implications, most certainly the majority of the examination will be centered in legal issues and the law; the same if only medical doctors were allowed to have a say in the regulations and its applications, it would be obvious that health as a core value would take the lead above others and would be given priority above others. However, regulations are not intended to solve only the problems considered relevant by a small sector of society but also by all who conformed and will be affected by it. Only through a real inclusive dialogue, meaning voices that are actually heard and taken into consideration, will those core transparent values be manifested to represent the cultural differences in the different sectors.

3.2. Processing and Distribution of Semen for Assisted Conception Regulations

The scheme set forth in the Regulations and all its requirements are meant to be applied in respect of semen used or intended to be used in assisted conception.58 “Assisted conception” for the objective of applying the Regulations “means 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.”59 In other words, women who intend to use semen from a spouse or sexual partner undergoing alternative insemination with the help of a physician or

58 Regulations supra note 42 at section 2.
59 Ibid. at section 1.
in a clinical setting do not have to comply with the scheme laid down in the Regulations. However, at first sight, the scheme is mandatory to all other women who intend to use donor insemination with the semen of a man who does not have a relationship of a sexual nature with them, even if the donor is known to the woman.\footnote{Regulations supra note 42 at section 9 (1) (a) (i).}

Semen to be used within the scheme of the Regulations should be processed in the following way: First, the donor must be screened, that is it must be determined that the respective donor does not fall into the category of people excluded from donation in accordance with the \textit{Health Canada Directive} called \textit{Technical Requirements for Therapeutic Donor Insemination} (hereinafter the “Directive”).\footnote{Guidance on Donor Semen Special Access Programme: Donor Semen Eligible for Special Access (Canada: Biologics and Genetic Therapies Directorate, Health Canada, November 2002) [Guidance (2002)] at section 2.} Among the exclusionary criteria relevant for the purpose of this thesis we may find “men age greater than 40 years”\footnote{Health Canada Directive: Technical Requirements for Therapeutic Donor Insemination (Canada: Department of Health, July 2000) [Directive] at section 2.1 (d).} and “men with indications of high risk for the Human Immunodeficiency Virus (HIV), Hepatitis B virus (HBV), Hepatitis C virus (HCV), or Human T-call Lymphotropic Virus (HTLV),”\footnote{Ibid. at section 2.1 (e).} including, among others “men who have had sex with another man, even once, since 1977.”\footnote{Ibid. at section 2.1 (d) (i)}

\footnote{The \textit{Guidance on Donor Semen Special Access Programme} defines “donor who is known to the patient” as “[a] donor whose identity is known to the patient. This includes a designated or directed donor who directs his donations for use in a particular patient (e.g., family member or friend of the patient or couple). It does not include the patient’s spouse or sexual partner, or an anonymous donor whose identity is revealed to the patient by the semen establishment.” In the same manner it defines “anonymous donor” as “[a] donor whose identity is unknown to the recipient. This includes donors whose identity is revealed to the patient by the semen establishment.”\textit{Guidance on Donor Semen Special Access Programme: Donor Semen Eligible for Special Access} (Canada: Biologics and Genetic Therapies Directorate, Health Canada, November 2002) [Guidance (2002)] at section 2.}
Second, a series of tests specified in the Directive must be performed such as preliminary semen evaluation that includes a cryopreservation test, physical examination of the donor, collection of his medical history, and a series of serological and microbiological tests performed to determine if the semen sample is contaminated with any of the infectious diseases mentioned above.

Third, the Directive directly prohibits the use of fresh semen; all donated semen must be frozen and quarantined for a minimum of 180 days. After that period of time the donor must be revaluated on the basis of the exclusion criteria and the minimum serological testing must be repeated on a new specimen obtained from the donor. At all times, records must be kept in respect of each donor regarding the steps described above and the finding of each test.

Fourth, since the year 2000 Health Canada established the Donor Semen Special Access Programme (hereinafter DSSAP). This program provides access in “exceptional circumstances” to semen that is not processed in accordance with the requirements of the Regulations. The DSSAP was originally intended for cryopreserved semen donation that was detained because it was not processed in accordance with the requirements in place, or because they did not meet the updated regulatory requirements. If a physician wished to obtain access to this kind of semen he/she may apply in writing to the Minister of Health.

\[65 \text{Regulations supra note 42 at section 9 (1) (a) (ii).} \]
\[66 \text{See, Directive supra note 62 at sections 3.5.2, 3.2.3 and 3.2.4.} \]
\[67 \text{Ibid. at section 4.} \]
\[68 \text{See, Regulations supra note 42 at section 12.} \]
\[69 \text{Therapeutic Products Programme Guidance: Donor Semen Special Access Programme (Canada: Therapeutic Products Programme, Health Canada, December 2000) [Guidance (2000)]} \]
\[70 \text{Guidance (2002) supra note 60 at section 3.} \]
\[71 \text{Ibid.} \]
for a special access authorization that allows the processor, distributor or importer of the semen to distribute or import the semen for the purpose of assisted conception. However the DSSAP could not be used to process semen from a donor considered excluded by the Directive and “a special access authorization [would] not be granted if it [was] determined that the processor intentionally omitted an exclusion criteria or a test for any of the infectious agents specified in the Directive.”

Nevertheless in 2002 Health Canada produced a new document known as Guidance on Donor Semen Special Access Programme: Donor Semen Eligible for Special Access (hereinafter the Guidance). Health Canada became aware of the wishes of individuals to build their families using semen from known donors who fall into the excluded category in accordance with the Directive. Conducting an analysis of that situation in “context of the requirements and objectives of the special access regulation” they decided to interpret the Regulations and the Directive in such a way that an authorization to use semen from excluded donors could be issued under those circumstances because in their own words “none of the regulatory requirements prohibit the issuance of a special access authorization if the donor falls within the group set out in the Directive under the heading ‘Exclusions.’” They replaced s. 4 of the DSSAP Guidance entirely with a new version that in part reads

"Thus, although the current Semen Regulations and the Directive make no distinction between anonymous and known donors, a"
rationale for not applying the exclusion criteria that may be considered acceptable for known donors, could be considered unacceptable for anonymous donors. This distinction is based on the specific needs of individuals who wish to build their families using semen donated by friends and family members, and consequently, can justify the use of such donations under “exceptional circumstances.”[77][Emphasis added]

Health Canada taking upon a contextual approach understood that the exclusion criteria were affecting primarily alternative families, particularly, lesbian women who wished to use gay friends as donors for their conception and of course others who wished to use a donor older than 40 years of age. The importance of this change is actually the recognition that through time certain rules that are initially intended to protect those undergoing medical procedures can be interpreted and amended taking into consideration certain social factors that can override health concerns. All of this is possible because through time and putting the scheme at play, it can be seen where the faults are. Also, because comprehension of the configuration of alternative families comes in time in an evolutionary manner, as they become more visible and socially integrated, institutions become aware of the necessities of these new families and their special needs and how to adapt the regulatory framework to these changes. Moreover they become aware of the discrimination that a well intended scheme may provoke on certain groups.

The differentiation made between known donors and unknown donors is relevant to the discussion of the case I will present in the next chapter, where the distinction there will not be made only upon the knowledge of the donor itself, but on the nature of that knowledge. The sexual nature of the relationship between a woman undergoing assisted conception and

77 Ibid. at section 5.
a man providing the semen will be crucial to the determination that the Ontario Court of Appeals gives to the application of the scheme. The Court has not acknowledge the distinction from the needs and context of the persons involved, but has taken an approach that has tended to perpetuate the status quo of the original intentions of the purpose of the regulatory scheme in a rather archaic way, rather than taking a more modern interpretation that understand norms as changing according to the dynamic evolution of social values. More than being preoccupied with the original purpose of a regulation, a court must be preoccupied as to how its implementation and interpretation may cause harm more than benefit the users.

4. The medicalization and social implications of assisted insemination

The Regulations understand “assisted conception” in the same way as the literature understands “donor insemination,” “artificial insemination,” or “therapeutic donor insemination.” Donor insemination can be defined according to Haimes and Daniels as “the process through which a (usually anonymous) fertile man provides semen (most often with the assistance of medical personnel) to a fertile woman in order to help her try to conceive a child.”

This definition does not describe the characteristics of the woman or couple seeking the use of this method, but merely a description of the process.

Conversely, Robert Miller describes artificial insemination as a method that is applied “when a woman can conceive but the man either cannot deliver semen or cannot produce

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effective semen… In the former situation, the husband’s semen may be injected, while in the latter situation donor semen is used.” Here, we may see how the method is circumscribed and implied to be used in a monogamous heterosexual relationship, even the use of the term “husband” connotes that marriage between a man and a woman is a component of the couple involved. This heterosexist medical description of the procedure is what informs the minds and opinions of most people when thinking of insemination, in other words, a legally instituted family of a man and a woman, where the male partner has a fertility problem and needs medical assistant to overcome such affliction.

With the boom of reproductive technologies and their gradual advertisement and regulation many people have had the wrong idea that assisted reproduction was developed very recently; however, the first recorded case of medical assistance to the act of procreation goes back more than a hundred years ago when a doctor in Philadelphia used the sperm donated by a medical student to inseminate a woman whose partner was sterile. Nevertheless, after all the years that have passed since that time, we still maintain a suspicious outlook on the use of these technologies and their moral implications. This can be explained because beyond the wonders of technical advancement, we will never get the same reaction towards, for instance, the cure to a terminal illness than to the intervention of science to what is consider the “natural process of reproduction.” This kind of progress affects, beyond any health consideration the ability to form families and live according to our own desires.

79 Robert D. Miller, Problems in Health Care Law (Sudbury: Jones and Bartlett Publishers, 2006) at 746.
The use of this technology goes beyond a scientific, medical or even legal perspective. It is more than just a question of diagnosis, treatment and how or when to use the method, who should be admitted as a donor, how to process the semen, or how to mediate the different relationships between recipients, donors and physicians. Instead, the fundamental question should be to look at the social perspective of making and becoming parents, having children and forming families. In sum, these issues are more “about social relationships and social processes that incorporate, but also go beyond, the medical perspective.”

These perceived new technologies and capabilities bring with them public concern and discourses in the medical and legal field. These discourses, nevertheless, tend to represent mostly dominant power groups within society that are embedded in a heterosexist conception of family that needs to be questioned and disrupted if we are to construct a diverse society with no “others” of “others.”

In reproductive matters, women are mostly affected by the legal and social tendency to put health concerns as a major justification either to restrict or to increment agency in reproductive choices. In this particular subject, “[t]he options made available to, or withheld from, women are determined centrally by the medical profession with reference to legal issues and social values.” Yet there is an urgent need to make a valuable consideration of the relationship between procreative freedom and agency, and mostly to reconstruct our comprehension of autonomy in order to understand these matters in a way

81 Haimes & Daniels supra note 78 at 2.
82 Peterson supra note 80 at 280.
83 Ibid.
that promotes non-oppressive relationships between the medical profession, patients and society.

We cannot deny the fact that reproductive technologies open new opportunities not only for those who suffer from physical impediments to childbearing, but also for those who can be consider socially infertile.\textsuperscript{84} When donor insemination is used by lesbian couples or single women, we are not addressing a physical condition of one of the parties that prevents insemination, but rather we are looking at the lack altogether of a partner able to provide semen; in this case, we are referring to a social condition and not a medical one. Although medical considerations are important to the procedure itself, the procedure is not conducted to correct a medical condition, but to allow access to have a child and ultimately to conform the kind of family that a person has chosen.

The dissociation of fertility and family from sexual intercourse is the new social context in which these technologies are being developed.\textsuperscript{85} These techniques help avoid the obstacles of conceiving through sexual intercourse with the use of alternative means to produce a pregnancy. If we consider medical treatment as a solution to symptoms rather than the causes of a disease or affliction then, assisted conception can be seen to treat infertility by dealing with its major symptom: the lack of a child.\textsuperscript{86} However, as stated by Simone Bateman Novaes, its therapeutic attributes have more to do with a social disability, the

\textsuperscript{84} Ken Daniels, “The Semen Providers” in Ken Daniels and Erica Haimes eds. Donor Insemination: International Social Science Perspectives (United Kingdom: Cambridge University Press, 1998) at 77.
\textsuperscript{86} Ibid. at 105.
“stigma of childlessness,” than a medical disability of physical impediment. All the same 
“[a]ssisted conception thus presents itself essentially as a medical managed solution to a 
painful personal and social problem.”

This dual aspect of assisted reproduction—a medical procedure that addresses and solves a 
social problem more than a physical impediment—has recently confronted physicians with 
moral questions regarding their patients. Now, not only heterosexual couples with infertility 
problems seek the use of these technologies, but also healthy women with no male partner. 
In general, the system has leaned on medical discretion to accept, refuse, or deny access to 
treatment, dependent on the personal opinions of the practitioner in charge of the case. 
Physicians may feel that

they cannot legitimately provide instrumental assistance with 
conception if the sole reason is to short-circuit the circumstances 
which require sexual intercourse: the woman to be inseminated 
must have an infertile male partner within a socially recognized 
reproductive relationship. These physicians have thus tended for the 
most part to restrict their provision of reproductive services to 
patients for whom such treatment is ‘medically indicated,’ that is, to 
cases in which a physiological obstacle or cause prevents 
conception under the usual circumstances. These restrictive 
attitudes are often reflected in legislation.

Technical and legal control over reproductive processes create a new conception of 
reproduction now defined as therapeutic, where the decisions are transferred to 
physicians. In fact, the medical profession is progressively informing reproductive 
choices on whom, when, with whom and in what circumstances these technologies can be

87 Ibid. at 106.
88 Ibid. at 106.
89 Ibid. at 116 and 117.
90 Ibid. at 122.
We have become accustomed to this interference over the past hundred years, probably out of fear of what these technologies may bring into society and how they will affect the health of their users. But even if we consider some of these interferences proper, we may not lose sight that these technologies are there for the benefit of all, and that they touch a part of human beings that constitute their most delicate intimate relationships, their abilities to have families when and how they choose to. These essential aspects of humanity must remain a personal choice and part of our capacity for autonomy, that although influenced by society cannot be overridden by the medical profession.

Ibid. at 122.
Chapter 2

*Doe v. Canada*: Placing Physical Health Above all Other Considerations

1. The facts and the claim

In 2007 Ontario’s Court of Appeals—Justices Jim MacPherson, Marc Rosenberg and Paul Rouleau—upheld the decision of Superior Court Justice Michael Dambrot dismissing the application of Susan Doe. She was asking the court to declare that the definition of "assisted conception" contained in s. 1 of the Regulations infringes ss. 7 and 15 rights to liberty and security of the person and to equality of the *Canadian Charter of Rights and Freedoms*\(^2\). The definition states that

> "assisted conception" means 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.\(^3\)

At the moment of the claim in front of the first level court, Susan Doe was a 39 years old lesbian woman in a long term relationship with “J”. They had a child with the intervenor “D” acting as a semen donor. The lesbian couple wanted to have a second child biologically related to their first. D only agreed to provide up to 6 semen samples to Susan. In view of these circumstances and in order for the insemination to be more effective, Susan decided to conceive through assisted conception, as she considered it to be the surest way to conceive considering the limited amount of samples offered by D. Being a gay man over 40 years old

\(^2\) *Doe (2007)* *supra* note 1.

\(^3\) *Ibid* at para. 2.
he was excluded from semen donation, however, would be allowed to participate through the DSSAP. Susan did not apply for special access authorization because D did not want his semen to be stored at a semen bank, as is required. He felt discomfort in having his samples stored and quarantined fearing for the possibility that someone else would use his semen. Susan was unable to conceive using self insemination.94

Susan claimed that the definition of “assisted conception” set forth in section 1 of the Regulations violates s. 7 and s. 15 of the Charter, hence challenging its constitutional validity. In sum she alleges that because lesbian women will never have a spouse or sexual partner capable to produce semen they are always subject to the Regulations when intending to be impregnated by medical or clinical assistance.95 She sought for the court to make a declaration that asserted that the definition was in violation of the Charter and that an exception for the designated donor of a women’s choice be read into the definition in a way to exempt from the scheme any woman that seeks to be impregnated in a clinical setting with the semen of a known donor, independent of whether the nature of the relationship between the woman and the donor is of a sexual nature.96

95 Ibid. at para. 8.
96 Ibid. at para. 9.
2. The reasoning of the court

The Ontario Court of Appeal considered that the application judge in “particularly comprehensive reasons” dismissed the appellant’s claim.\textsuperscript{97} The definition of “assisted conception” in the Regulations did not violate Susan Doe’s Charter s. 7 and 15 rights.\textsuperscript{98}

The Court set the issues of the appeal as follows:

   (1) Does the definition of “assisted conception” in the Regulations violate s. 15 of the Charter?

   (2) Does the definition of “assisted conception” in the Regulations violate section 7 of the Charter?

   (3) Do the exclusion criteria for men over 40 years of age and men who have had sex with another man, even once, since 1977 violate s. 15 of the Charter?

   (4) If the answer to any of the questions (1) to (3) is “Yes”, is the provision saved by s. 1 of the Charter?

   (5) If either the “assisted conception” definition of the exclusion criteria violates the Charter, what is the appropriate remedy?\textsuperscript{99}

2.1. Does the definition of “assisted conception” in the Regulations violate s. 15 of the Charter?

In this part of the analysis the Court of Appeal took several steps:

a. Through \textit{Egan} and \textit{M v. H}\textsuperscript{100} the Court of Appeal recognised sexual orientation as a prohibited ground of discrimination in section 15 of the Charter.\textsuperscript{101}

\textsuperscript{97} Doe (2007) \textit{supra} note 1 at para. 14.
\textsuperscript{98} \textit{Ibid.}
\textsuperscript{99} \textit{Ibid} at para. 16.
\textsuperscript{100} See \textit{Egan supra} note 30 and \textit{M. v. H.}, \textit{supra} note 33.
- In *Egan* the court established that the opposite sex definition of spouse violated section 15 of the Charter, constituting discrimination, nonetheless justifiable under section 1 of the same, for biological reasons.\(^{102}\)

The appellate court deliberately chose to cite *Egan* to articulate that sexual orientation is a prohibited ground of discrimination under s. 15. As we may remember from what was said above, *Egan* declared that opposite sex definition of “spouse” constituted discrimination and infringed s. 15, although was justifiable in that particular case under s. 1 of the *Charter*. In this formal equality framework, the obvious conclusion becomes a ludicrous interpretation of the Regulations, because although we may consider them to embrace a definition of spouse or sexual partner irrespectively of sexual orientation, lesbian women are not practically able to use semen from their partner who by definition of what lesbianism implies will be another woman.\(^{103}\)

- In *M v H*, besides recognizing the legitimacy of gay and lesbian relationships, they asserted their need of legal protection.\(^{104}\)

Cossman acknowledges that *M. v. H.* “brought a new lesbian and gay legal subject on stage,”\(^{105}\) constituted through a formal equality discourse and diverted from the traditional exclusion based on biological differences. This new legal subject displaced the heteronormativity of legal subjectivity in the familial context.\(^{106}\) Nevertheless, the problem

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105 Ibid. at 245.
106 Ibid.
Cossman sees in this legal recognition is that no traditional structures have been reconceptualised, moreover, this new legal subjectivity has been conformed and normalized by the old definition of family relations:

The lesbian and gay legal subject was a familial subject, a subject recognized in and through dominant familial discourses. While the heteronormativity of the family may have been challenged, its role in an increasingly privatized world has not, and lesbian and gay subjects have been absorbed into this family.107

b. The Court recognises Law v. Canada108 as the leading case re the interpretation of section 15109

The 3 step inquiry set forth by Law is as follows

First, does the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant's already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics? If so, there is a differential treatment for the purposes of s. 15(1). Second, was the claimant subject to differential treatment on the basis of one or more of the enumerated and analogous grounds? And third, does the differential treatment discriminate in a substantive sense, bringing into play the purpose of s 15(1) of the Charter in remedying such ills as prejudice, stereotyping, and historical disadvantage?110

107 Ibid. at 238.
Although the Court cited up to this part, actually in Law it continued to say that “The second and third inquiries are concerned with whether the differential treatment constitutes discrimination in the substantive sense intended by s.15(1)”\textsuperscript{111}

c. Before addressing the Law analysis, according to the Court of Appeal, the application judge addressed preliminary issues\textsuperscript{112}:

[T]he purpose of the Regulations, the reason for the exclusion of women proposing to use semen from donors who are their spouses and sexual partners from the definition of “assisted conception”, and the identification of the relevant comparator group for purposes of the s. 15 analysis.\textsuperscript{113}

(i) The purpose of the Regulations

Here the Court cites the application judge’s description of the purpose of the Regulation as “to protect the health of women undergoing assisted conception, to reduce the risk to women and their partners of acquiring transmissible infectious diseases and to reduce the risk to their unborn children of acquiring transmissible infectious diseases and suffering birth defects”\textsuperscript{114}

In sum the purpose of the regulation is to protect the health of the women undergoing assisted conception, her partner and the unborn child.

(ii) The reasons for the exclusion of women proposing to use semen from donors who are their spouses and sexual partners from the definition of “assisted conception”

\textsuperscript{111} Ibid.
\textsuperscript{112} Doe (2007) supra note 1 at para. 19.
\textsuperscript{113} Ibid.
\textsuperscript{114} Ibid at para. 20
Here the Court identified that the application judge used what they called the “simple rationale.” In other words the reasons for excluding women who propose to use semen from a male partner is justified by the assumption that “there is no point in imposing the Semen Regulations on a woman seeking assisted conception with the semen of a spouse or sexual partner, because she has already been exposed to any risk that exists.”

(iii) Identification of the relevant comparator group for purposes of the s. 15 analysis

As told by the Court, the application judge determined the appropriate comparator group to be women seeking insemination with the semen of their spouse or sexual partner. These women are the ones excluded from complying with the strict requirements set forth by the regulatory scheme.

d. The Law analysis

(i) First, does the impugned law (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or (b) fail to take into account the claimant’s already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics? If so, there is a differential treatment for the purposes of s. 15(1).

\[\text{115 Ibid at para. 21.}\]
\[\text{116 Ibid at para. 22.}\]
The Court explained that the application judge determined that the Regulations did, in its effect, impose a differential treatment between lesbian women and women exempted from the scheme (the comparator group) on the reasons that lesbian women “do not ordinarily have spouses or sexual partners who can donate semen”\textsuperscript{117}

(ii) Second, was the claimant subject to differential treatment on the basis of one or more of the enumerated and analogous grounds?

In this part, according to the Appeals Court, is where the application judge found the Appellant’s arguments to falter.\textsuperscript{118} The judge considered that although the exclusion created by the definition “is available more often to heterosexual women than to lesbians, sexual orientation is not the basis for differential treatment.”\textsuperscript{119} Differential treatment, on his opinion rested on his “simple rationale,” that is, that is that a woman seeking to be inseminated by semen from their spouse or sexual partner “has already been exposed to any risk that exists”\textsuperscript{120}

(iii) And third, does the differential treatment discriminate in a substantive sense, bringing into play the purpose of s 15(1) of the Charter in remedying such ills as prejudice, stereotyping, and historical disadvantage?

Cited by the Court of Appeal, the application judge reasoned this part of the analysis by recognising a few important facts: Lesbian women “have experienced disadvantage,

\textsuperscript{117} Ibid at para. 24.
\textsuperscript{118} Ibid at para. 25.
\textsuperscript{119} Ibid.
\textsuperscript{120} Ibid.
stereotyping, prejudice and vulnerability;”¹²¹ they are viewed by some “as less worthy of recognition or value as human beings or members of Canadian society”¹²² and some may even believe them to be “less worthy of being mothers than heterosexual women” and would even go as far as denying them the right to have children.¹²³

However, when it comes to the legislation—without defining what is meant by legislation—the judge considered that it does not deny the “right to have children,” or the right to be clinically inseminated, but simply that a “health based exclusion” from the assisted conception regulatory scheme is not available to them, for the simple reason that they do not “ordinarily” have spouses or sexual partners capable of donating semen.¹²⁴

Then the judge asks himself a question that he answers negatively

Does this simple fact, having regard to the contextual considerations I have listed, discriminate, by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration?¹²⁵

The judge’s negative response to this question is based on the assumption that the legislation only excludes from the regulatory scheme a portion of heterosexual women and not all of them. In other words, he considers that “[l]esbians and other heterosexual women with

¹²² Ibid.
¹²³ Ibid.
¹²⁴ Ibid.
¹²⁵ Ibid.
known donors are treated identically.\textsuperscript{126} For this the scheme is not passing on the message that lesbian women are less worthy of recognition or value as human beings or citizens than other women, nor that they are less worthy of becoming mothers, nor that they should be or are denied the right to have children. In sum, the application judge considers the exclusion from the scheme a rational narrow exclusion based on health.\textsuperscript{127}

The Appeal Court tell us that the Appellant expressly accepted the intentions of the Regulations to be the protection of health of women and their unborn children, however, the appellant contends that the context in which the Regulations are intended to operate is when the semen comes from an anonymous donor. The appellant interpreted the exclusion of some women from the regulatory scheme as recognition that women “are entitled to knowingly and voluntarily accept the risks to themselves and to their unborn children associated with conceiving a child with the donor of their choice,”\textsuperscript{128} and for that this voluntariness principle embedded in the Regulations should be applied also to all women, heterosexual or lesbian, using a known donor.

In dealing with this interpretation, the application judge, according to the Court of Appeals, considered the background leading to the Regulations, including the Report prepared by the Royal Commission on New Reproductive Technologies (Proceed with Care), among other antecedents. Based on this examination he reasoned that simple logic led him to the conclusion that the justification for the exemption of the comparator group from the Regulations “cannot be the recognition that women are entitled to knowingly and voluntarily

\textsuperscript{126} Ibid.
\textsuperscript{127} Ibid.
\textsuperscript{128} Ibid at para. 28.
accept the risks to themselves and to their unborn children associated with conceiving a child with the donor of their choice.”

The Court of Appeal completely agreed with the application judge by asserting that the rationale for the exclusion is not the one declared by the appellants. The scheme is not “primarily concerned with personal autonomy or self-actualization, but rather with health.”

Although the Court does not justify why the provision should mainly be concerned with health, it seems that they see it as the only logical conclusion since the procedure is medically prescribed, in the way forwarded by the respondent:

It makes perfect sense to exclude from the scheme women seeking assisted conception with the semen of their spouses or sexual partners, because there is no point in imposing the Semen Regulations on such women having regard to the fact that they have already been exposed to any risk that exists, and will likely continue to be exposed. It also makes perfect sense not to exclude any other donors, but rather to insist on the same safeguards for all of them, whether they are known to the woman or not.

Although it is true that assisted conception in a clinic setting can be characterized as a medical procedure, because it deals with reproductive choices that concern family life and in this case concerns women, the extreme medicalization of the procedure stripped of any consideration of women’s autonomy or agency does not comply with a holistic approach to the values that the Charter tries to shape in the Canadian society.

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129 Ibid at para. 29
130 Ibid.
131 Ibid.
Ultimately the Court declared itself to completely agree with this reasoning, categorizing it as “impeccable.”132 Because they affirmed the application judge’s description of the purpose of the Regulations, they considered the appellant’s other section 15 arguments to fall away. Also the Court found the judge’s analysis on the second and third steps of the Law analysis to be correct.133

Because sexual orientation was not thought to be the main reason for differential treatment in this case—in the eyes of the Court—they explained it through health considerations and protectionism. The use of “wom[e]n ... using semen from a donor who is not her spouse or sexual partner” as the comparator group, that is, women who have a male sexual partner or spouse, reinforces the long lasting tendency to make Charter decisions upon formal equality as opposed to substantive equality. Health considerations were called namely to reduce the risk of women, their partners and unborn children from acquiring transmissible infectious diseases or birth defects. If the same considerations were not applied to the comparator group, it was simply for the reason that there was no point in imposing them, if through sexual intercourse the women and the unborn child were already exposed to the health risks that exist.134 In sum, the Court agreed with the application judge in considering that although there was a distinction or differential treatment, it was not based on sexual orientation, nor did it involved prejudice, stereotyping or historical disadvantage.135

132 Ibid.
133 Ibid at para. 30.
134 Ibid at paras. 17-21.
135 Ibid at para. 30.
Ultimately the rationale used by the Court is that a woman willing to expose herself and her unborn child to infectious diseases through sexual intercourse, is more entitled to make that choice within this scheme, than a woman consciously making the same decision through the use of technology. The problem framed on health considerations underlines woman’s capacity to make conscious decisions respecting her body and future configuration of family. The option to use one’s sexual partner or spouse as a donor in order to conceive, means that when sexual intercourse is unable to conclude in pregnancy—when “natural conception” is not able to produce an offspring—the respective woman is not subject to review of her decision to have a child with that specific partner. As opposed to a woman who has chosen a known donor—probably a friend—and is not able to conclude in pregnancy because no sexual intercourse did nor will take place. In both cases, the only differential element not shared, is the involvement of a man having sexual intercourse with a specific woman, or willing to bear children with public assistance when that conception was intended to be “natural” but was unable, due to some infertility impediment.

The traditional liberal view of rights as limitations to the State’s interference in private life is clearly prospected in this case. In the part concerning the analysis of s. 7 of the Charter, the court plainly stated that the “liberty interest ... is engaged when state compulsions or prohibitions affect fundamental life choices.” Next they recognized that the right to liberty includes the right to conceive with the person chosen by the woman. Nonetheless they did not consider this to be the right at stake in this particular case. The Court framed the discussion taking two competing interests: the right to conceive using a donor’s semen

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136 Ibid at para. 29.
137 Ibid. at para. 32.
through assisted conception without the burden of waiting periods and screening for infectious diseases\textsuperscript{138} and “a compelling interest in minimizing the risk of disease transmission via donated semen to women and to their future children.”\textsuperscript{139} According to the Court the first competing interest falls out of the category of protection of s. 7 and by no examining the second interest—the state’s interest—by default, it appears to have more weight.\textsuperscript{140}

2.2. Does the definition of “assisted conception” in the Regulations violate section 7 of the Charter?

a. The right to liberty

(i) First, the Court assessed the content of section 7 of the Charter and asserts that the right to liberty includes the right to conceive a child with the person of a woman’s choice.

Section 7 guarantees the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. Here the Court explains that the liberty interest set forth in section 7 “is engaged when the state compulsions or prohibitions affect fundamental life choices.”\textsuperscript{141} \textit{[Emphasis added]} The Court bases its opinion on \textit{R v. Morgentaler, Blencoe v. British Columbia} and \textit{R. v. Malmo-Levine}, without examining these rulings or citing their reasoning, but concluding that there is

\textsuperscript{138} \textit{Ibid} at para. 33.
\textsuperscript{139} \textit{Ibid} at para. 36.
\textsuperscript{140} \textit{Ibid} at para. 33.
\textsuperscript{141} \textit{Ibid} at para. 32.
no doubt that the right to liberty contains “the right to conceive a child with the person of a
women’s choice.”

The explanation that section 7 of the charter is engaged when the state compulsions or
prohibitions affect fundamental life choices, phrases the discussion in the competing interests
of the right to privacy, the intrusion of the State and the capacity of making life changing
choices. This examination that concludes in competing interests and that frames the
discussion on how the State affects the particular right, and that probably will lead us to find
a justification for that intrusion, is classical liberal interpretation of rights as walls that
protect us from the State. Therefore, the State needs to justify under strong democratic
principles the intrusion it is willing to make into the private sphere of personal decision
making. Within a relational approach to rights, examined more thoroughly in the next
chapter, the Court could have considered the interdependence of people to the health care
system in this case, not as a loss of autonomy and a need for intrusion, but questioning in
which manner the regulatory scheme of assisted conception and its application foster
relationships of equality and freedom between its members themselves and with the state as
opposed to oppressive relationships that are justifiable by the State’s compulsory interests.

(ii) Second, the Court takes the appellants statement in which the definition of
“assisted conception” in the Regulations violates the rights set forth on section 7
and explains how the application judge rejected the argument.

\[\text{\footnotesize \cite{Ibid.}}\]
The application judge in agreement with the Attorney General recognizes that “the freedom to conceive a child with the person of one’s choice” can be characterized as a fundamental life choice protected by the liberty branch of the respective section. However, the applicant’s claim is considered to be much broader. The judge interpreted the appellant’s interest in constitutionally protecting an “asserted right to attempt to conceive using a semen donor’s semen [sic] through assisted conception without that semen being screened or tested for infectious diseases … not of the nature of the liberty interest accepted by the Supreme Court as falling within the protection of s. 7.” The Court of Appeal agreed with the application judge in this part as well.

Here we may ask, is the true interest of the appellant to assert a right to use a known donor without screening the semen? Second, can we assert that even so, this right is broader than the freedom to conceive with the person of one’s choice? On the contrary, the freedom to conceive with the person of one’s choice is drafted broadly, as opposed to the right to use semen with no screening, which is very restrictive and can be considered falling within the liberty protected by the section, therefore, further consideration and analysis should have been taken by the court on this part before coming to their conclusion.

b. The right to security of the person

On regard to the right to security of the person the appellant made three submissions that the Court disagreed with in the following terms:

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143 Ibid at para. 33.
144 Ibid at paras. 34 and 35.
(i) The Regulations interfere with her psychological integrity by prohibiting her to use the donor of her choice hence engaging her right to security of the person.

The Court considered that this submission navigates the same ground claimed in the liberty branch seen above, thus must be rejected for the same reasons expressed in that portion.

(ii) If she wishes to use the donor of her choice she would have to obtain a permit from the Minister of Health allowing her to use the excluded donor.

The Regulations exclude from semen donation any man over 40 and men who had have sex with other men even once since 1977. The appellant in this case wanted to use a man who was over 40 and gay. If the Donor Semen Special Access Program does apply to her than in order to use the donor of her choice she has to obtain a permit from the Minister of Health, causing her psychological harm. The Court considered the submission to be “far removed from any reasonable notion of psychological harm.” The rationale used by the court is as follows: because the purpose of the regulations is to preserve the health of the women and their unborn children, the regulations promote psychological comfort and not injury.

(iii) The Donor Semen Special Access Program also interferes with her physical security imposing delays in treatment and hence increasing the risk of failure of the treatment or other complications during pregnancy

145 Directive supra note 62 at section 2.1.
146 Doe (2007) supra note 1 at para. 34.
147 Ibid at para. 35.
148 Ibid.
For the Court, although there is a six month delay for women who apply for assisted conception, this time is justified by the need to screen the semen, promoting physical health for both the woman and her unborn child as well as psychological well-being and not harm.\textsuperscript{149}

c. It’s not necessary to consider the principles of fundamental justice

Since the Court dismissed all the arguments presented by the appellants respecting the infringement of section 7 of the Charter, they saw no need to engage in the examination of whether the principles of fundamental justice may justify that infringement. Once more they asserted the opinion of the application judge in this part, declaring that

\begin{quote}
The Regulations are neither overbroad nor arbitrary; the donor screening regime is carefully tailored to the valid and important purpose of the Regulations, namely, a “compelling interest in minimizing the risk of disease transmission via donated semen to women and to their future children.”\textsuperscript{150}
\end{quote}

I will not consider extensively the three other issues for falling out of the scope of this thesis; however I will make a short comment on them. On the third issue “(3) Do the exclusion criteria for men over 40 years of age and men who have had sex with another man, even once, since 1977 violate s. 15 of the Charter?”, \textsuperscript{151} the application judge and the Appeals Court rejected the appellants and intervenor’s arguments. The reasons given were that by having the “special access authorization” a physician may apply to the Minister of Health to permit him to use semen that has not been processed in accordance with the Regulations.\textsuperscript{152}

\begin{footnotes}
\item\textsuperscript{149} Ibid.
\item\textsuperscript{150} Ibid at para. 36.
\item\textsuperscript{151} Ibid at para. 16.
\item\textsuperscript{152} Ibid at para. 40.
\end{footnotes}
The “over 40” exclusion is not consistent with a substantive equality argument—according to the Court—it was not based on sexual orientation but on age considerations and it applied irrespectively to all males, heterosexual or homosexual. Moreover, it corresponded to a biological opinion that men over that age are “subject to an increased risk of spontaneous genetic mutations,” and therefore the exclusion is necessary to protect the unborn child.\textsuperscript{153}

The exclusion of "men who have had sex with another man, even once, since 1977," does create—under the eyes of the Court—a distinction between gay and heterosexual donors, but such distinction is not discriminatory, nor does it promote the view that gay men are less worthy of being parents. The exclusion was considered to be factually based on health data considerations that asserted that gay men have higher risk of being HIV positive or having Hepatitis\textsuperscript{154}.

On the fourth and fifth issue, that is “… (4) If the answer to any of the questions (1) to (3) is ‘Yes’, is the provision saved by s. 1 of the Charter? (5) If either the ‘assisted conception’ definition of the exclusion criteria violates the Charter, what is the appropriate remedy?”\textsuperscript{155} the Court saw no need in addressing them because if no discrimination is found but only a distinction then nothing needs to be saved by section 1 and of course no remedy is needed.

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\textsuperscript{153} Ibid.
\textsuperscript{154} For more extensive arguments see Ibid at paras. 37-44.
\textsuperscript{155} Ibid at para. 16.
Chapter 3
Relational Approach to Rights and Autonomy

Within a liberal conception of rights, autonomy and citizenship, lesbian women can be disadvantaged. The condition as women and as individuals who do not conform to dominant notions of “natural sexuality” makes them vulnerable to sexist and heterosexist oppressions and the denial of sexual privileges that others enjoy.\(^\text{156}\) Western legal systems have historically been constructed upon the binaries male/female, husband/wife, and heterosexual/homosexual,\(^\text{157}\) following a traditional Christian view of family and sexual reproduction, with its corresponding legal recognitions and regulations. Moreover, the heterosexual paradigm embedded in our legal structures, has been and continues to be seen as a natural phenomenon and not as a political or social cultural construction. This embeddedness results in “heterosexual privileges” fostered by the State through its legal regulations and public institutions.\(^\text{158}\)

Women who love women are excluded from a gender comparison scheme.\(^\text{159}\) Their comparator, against which they are invariably measured when a formal equality claim arises, is not men, but either straight women or heterosexual couples. Formal equality with its inherent exclusions becomes a limited tool that will only consider the traits and benefits that comparators have or are entitled to in their own context. However, the differences between a lesbian woman and a heterosexual one, and moreover, the differences between heterosexual

\(^{156}\) Ryde supra note 3 at 289 and 293.

\(^{157}\) Ibid at 288.

\(^{158}\) Ibid at 290.

\(^{159}\) Cornell supra note 5 at 3.
couples and same sex couples exceeds by far any attempt to even the odds by conforming lesbians to heterosexual lifestyles or arranging equality without considering a relational approach. A person’s rights and well-being are constituted by her relationships, and it is only in that context, that her capacities will be enhanced and her rights can be protected and conceptualized to promote that well-being.\textsuperscript{160}

Freedom from any comparison can be grasped as a demand for a space to reconceive our differences beyond oppressive notions and relationships: to recreate a concept of rights that recognizes the necessary freedom to provide that place where we are able to imagine sexual difference\textsuperscript{161} in a contextual setting and without forgetting our social nature.\textsuperscript{162} The lesbian subject has a claim to be legally and politically recognized not only as a visible reality, but also as a source of legitimate meaning and representation,\textsuperscript{163} which implies participation in the reconstruction of basic human values, institutions and relationships. It is only in such a way, that we may see a true political and social membership that is inclusive and appreciative of the range of beautiful creative differences and similarities that human beings share with each other.

1. Reconceiving autonomy through a relational approach

Autonomy is one of the core values of today’s conception of democracy. However, its conceptualization is charged with political meaning in accordance with a conception of

\textsuperscript{160} Jennifer Nedeslky. \textit{Reconceiving Autonomy, Chapter 2, Relational Self, Relational Law} [Forthcoming Oxford] [Nedelsky (Chapter 2)]

\textsuperscript{161} Cornell \textit{supra} note 5 at 6.

\textsuperscript{162} Nedelsky (Chapter 2) \textit{supra} note 160.

\textsuperscript{163} Cornell \textit{supra} note 5 at 8.
government, and more particularly, according to what kinds of limitations must be set between the State and its citizens. Within the Anglo-American liberal tradition, autonomy is perceived as a sign of independence from state institutions and interference. A critical approach to the liberal conception of autonomy departs from its inherent masculinist nature, challenging its masculine character ideals of individuality and rational thinking. These ideals are based upon assumptions of the self and agency that are considered to be problematic from a feminist perspective because they are linked to a political tradition mostly hostile to women’s interests and freedoms.\textsuperscript{164} By giving normative primacy to independence, self-sufficiency, and separation from others, relations of dependency and interconnection become devalued, thus undermining women’s experience.\textsuperscript{165}

Some examples of this conception of autonomy may be found for instance in bioethics, where autonomy has been equated to informed consent; in rational choice theory with voluntary, rational choice; in liberal political theory with individual rights. Libertarians construe autonomy in negative terms, as a right to be free from undue interference in the exercise of choice and preference. These conceptions are linked by the idea of self-determination or self-government, a component considered a vital characteristic of any free moral agent.\textsuperscript{166} Although these conceptions may recognize to some degree the social nature of human beings, none of them considers this nature to directly influence the value of


\textsuperscript{165} \textit{Ibid.} at 8 and 9.

\textsuperscript{166} \textit{Ibid.} at 5.
autonomy, or even to impact upon its meaning or shape its identity. According to Lorraine Code within the perception of a liberal tradition an

[a]utonomous man is—and should be—self sufficient, independent, and self-reliant, a self-realizing individual who directs his efforts towards maximizing his personal gains. His independence is under constant threat from other (equally self-serving) individuals: hence he devises rules to protect himself from intrusion... In short, there has been a gradual alignment of autonomy with individualism.}\[167][emphasis in the original]\n
In this scenario, to be autonomous means to be independent from any other person, to be conceived of as an individual outside a social context and to be protected against the State’s intrusions and those of other entities.\[168\] The main purpose of this vision is to draw boundaries, establishing a “wall of rights”, the underlying logic being that the “most perfectly autonomous man is thus the must perfectly isolated” from the threats of others.\[169\] Nonetheless, a more realistic or nuanced approach would be to recognize that the State and community may be both sources of autonomy and threats to it.\[170\]

According to Mackenzie and Stoljar, although theorists recognize that the abstraction is a fantasy impossible to ever attain, they still continue to rely on this theory, leading to numerous problematic views.

First it supports valuing substantive independence over all other values, in particular over those arising from relations of interdependence, such as trust, loyalty, friendship, caring, and responsibility. Second, it promotes a very stripped-down conception of agents as atomistic bearers of rights, a conception in which the

168 Nedelsky (Chapter 2) *supra* note 160.
diversity and complexity of agents are pared away and agents are reduced to an interchangeable sameness. Third, it suggests that values, social practices, relationships, and communities that are based on cooperation and interdependence threaten, or at least compromise, autonomy.\textsuperscript{171}

The fictional conception that implies we are constituted merely by the choices that we make becomes void when confronted with a network of emotions, beliefs, dispositions, impulses, and drives that are not entirely voluntary. Not everything that we consider to be of importance has come to be so as a matter of choice; not everything that we desire can be explained by a simple rational process of considering the pros and cons between two options. Sometimes we just find ourselves caring for some things with no logical or rational explanation or with no logical or rational conscious decision to back up the desire. For instance, Mackenzie expresses how our identities are shaped in fairly determinate ways by our various characteristics, by the relations between these characteristics and our social context, and by what matters to us. To say that what matters to us is not a simple matter of choice is to say that to a certain degree, we just find certain things mattering to us. This may be because we are disposed in certain ways by the manner in which different aspects of our identities, for example, our temperament and talents, reinforce one another; what matters to us may be connected with commitments to others, for example, parents, that are not entirely of our choosing; or, what matters may be the result of significant events in our particular histories or of decisions we made in the past that are now no longer a matter of choice. Thus, we cannot simply choose to abandon our cares or to give up what matters to us. Or rather, we cannot do so without forfeit or loss, certainly what matters to a person may change, perhaps because of a decision she has made or because of an event or action that has intervened to disrupt the reflective equilibrium she had established among different aspects of herself. But something that has mattered usually cannot simply cease to matter. It can only do so, or

\textsuperscript{171} Mackenzie & Stoljar \textit{supra} note 164 at 6.
come to matter in a different way, as a result of a process of readjustment of the elements of the self.\textsuperscript{172}

Moreover, Mackenzie does not proposed a deterministic view of the self, although not everything may appear to be under our voluntary control, this should not be taken as an invitation to be passive with respect to ourselves. We negotiate actively the relationships between our points of view, self-conceptions and values.\textsuperscript{173}

Jennifer Nedelsky also asserts that the liberal construal of autonomy as independence can only be made possible within a fictitious conception of the self.\textsuperscript{174} Human beings’ nature has proven to be dependent on relationships; hence real autonomy is only possible if we develop relationships which foster and enable autonomy, instead of concerning ourselves so drastically with assembling a complex protectionist mechanism to guard us against the State, public institutions or other relevant relationships.\textsuperscript{175} Moreover, human capabilities are developed in the context of relationships, thus, it is “only in the context of those relationships that one can understand how to foster capacities, define and protect one’s rights, or promote one’s well being.”\textsuperscript{176} Thus, there is a necessity to turn away from a single perception of the self into a multiple perception that includes, as a central core ingredient, the social dimension of humanness. Here, interdependence is central to political and social life, particularly by

\textsuperscript{173} \textit{Ibid.} at 135.
\textsuperscript{174} Nedelsky (Chapter 2) \textit{supra} note 160.
\textsuperscript{175} \textit{Ibid.}
\textsuperscript{176} \textit{Ibid.}
asking how to ensure individual autonomy within collective power and not by examining a clash of rights and interests.\textsuperscript{177}

Governments should be concerned with freeing their members from oppressive relationships. These relationships promote underlying stereotypes and discrimination that set up imposed definitions of how persons may be or should behave or what entitlements they have. However, that protection cannot override a social context.\textsuperscript{178}

Some perspectives on Relational Autonomy are centred in a certainty that there is not a single understanding of the conception of autonomy, but rather a wide range of related perspectives that share the premise that persons are socially embedded and that autonomy and agency is formed and delineated by the context of those relationships. The objective of these approaches is to focus on the implications of the inter-subjective and social dimensions of the self in order to give content to a new understanding of autonomy.\textsuperscript{179}

Within the different notions of a relational approach there are common concerns. First, relational approaches are concerned with understanding autonomy in a richer conception of agency, where agents are not only rational but also emotional, embodied, desiring, creative and feeling creatures, and where features such as memory, imagination and emotions should be considered and valued,\textsuperscript{180} and most importantly, contemplating how relationships, be they social, political or otherwise have the capacity to trump or enhance autonomy.\textsuperscript{181} Second, relational approaches are concerned with examining the way oppressive relationships impede

\textsuperscript{177} Nedelsky (Chapter 6) \textit{supra} note 37.
\textsuperscript{178} Nedelsky (Chapter 2) \textit{supra} note 160.
\textsuperscript{179} Mackenzie & Stoljar \textit{supra} note 164 at 4.
\textsuperscript{180} \textit{Ibid.} at 21.
\textsuperscript{181} \textit{Ibid.} at 22.
autonomous agency within agents’ processes of forming their desires, beliefs, emotional attitude, development of competencies and capacities necessary for autonomy and, their ability to act on autonomous desires or make choices. Here, autonomy can be restricted not only by overt restrictions on freedom, “but also by social norms, institutions, practices, and relationships that effectively limit the range of significant options available to them.”

A relational approach of the self serves the purpose of distinguishing between those structures of relationship that foster autonomy and those that undermine it. Lesbian couples attempting to have children with the help of the State become subject to bureaucratic requirements, forming relationships of power and dependencies. The State, according to a relational approach, should be concerned with the kind of relations it is promoting within a contextual examination. As explained by Nedelsky

The purpose of focusing on the centrality of relationships is not to valorize relationships as such, nor to assume that existing relationships deserve preservation. On the contrary, it is exactly to distinguish between those structures of relationship that foster autonomy and those that undermine it. (Of course, a relational analysis could also be applied to other values, such as dignity, equality, or security.) It is only when such attention to relationship replaces the mere stipulation of autonomy as a human characteristic that the concept of autonomy can guide the transformation of destructive relationships into those that foster autonomy for all.

Now, if autonomy is not a synonym of independence from any other, we must then find a better conception that takes into account both the individual and social natures of human beings. Nedelsky proposes to reconceive autonomy as being “governed by one’s own

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183 Nedelsky (Chapter 2) *supra* note 160.
law”. A person must be able to develop and sustain a capacity to find his or her own law and to have an insight into “what structures of power, patterns of relationship, and personal practices foster that capacity”. To become autonomous, to find one’s own law, is not a solitary quest; it suggests that the journey “[is] shaped by the society in which one lives and the relationships that are a part of one’s life.”

The capacity to become autonomous is an ongoing process that implies the task of understanding our relationships and distinguishing and enhancing those that foster autonomy. One’s own law is embedded in the individual but not necessarily made by the individual; he develops it in connection with others by a process of recognition and affirmation. This law is constructed of values, limits, order and commands that come from within each person and are not imposed from without, a combination between law and freedom. According to Nedelsky, the social dimension of autonomy has two components.

[F]irst is the claim that the capacity to find one’s own law can develop only in the context of relations that nurture this capacity. The second is that the “content” of one’s own law is comprehensible only with reference to shared social norms, values, and concepts. Our conception of the content is, for example, mediated through language, itself a social phenomenon. To be autonomous is to find one’s own law and live in accordance with it. This is a life long process whose individual dimensions are embedded in a social context.

Nedelsky sees self-consciousness as an element of autonomy. To live in accordance to one’s own law is to have a consciousness of how that is happening. Although some unconscious decisions to resist external impositions and oppressions are compatible with

185 Ibid.
186 Ibid.
187 Ibid.
188 Ibid.
189 Ibid.
autonomy, conscious decisions are a better aid to expel fear or unwanted values from the way we live our lives.\textsuperscript{190} Those fears may come from within, however we cannot forget that we are not self-made persons but are always influenced and shaped by our relationships.

Marilyn Friedman conceives of autonomy in a very similar way as Nedelsky. She claims that it involves choosing and living in accordance with standards and values that are one’s own,\textsuperscript{191} in other words, living in accordance with certain rules that one considers to be morally binding.\textsuperscript{192} This sense of “ownness” involves two dimensions:

(1) An autonomy-conferring reflection. The act of reflecting, in an autonomy-conferring manner, about the choices that are taken and the values that guide us. This reflection is not necessarily purely rational and cognitive but also emotional.\textsuperscript{193}

(2) An autonomy-impeding interference. This refers to an exercise to free the reflection itself from any variety of interference that opposes or impedes achieving autonomy. This does not mean that this reflection won’t be influenced by our social context; instead it will be free from any form of imposition and coercion.\textsuperscript{194}

Friedman also believes that autonomy can be freed from its historically exclusive association with male traits. But in order to do so, it requires a “systematic rethinking”, that is to find a

\begin{flushright}
\textsuperscript{190} Ibid.
\textsuperscript{192} Ibid.
\textsuperscript{193} Ibid.
\textsuperscript{194} Ibid.
\end{flushright}
new paradigm of autonomy that features female protagonists. If autonomy is freed from its liberal male construction, then it no longer requires an individual to be considered or consider him/herself as a social atom defined solely by a capacity to choose, or to exercise freedom. Because our reflective capacities and our identities are informed and constructed upon communal traditions and norms, the fiction of voiding ourselves from that influence ultimately would void our capacity to reflect.

All the same we are not hopeless individuals immersed only by the shared goals, language, struggles, values, and other factors that shape our communities or our relationships. Linda Barclay expresses the importance of considering “which particular attachments to nourish, which particular shared values should be part of our common good.” [Emphasis in the original]

One component of finding our “own law,” that is, to become autonomous, is the ability to self-define. Catriona Mackenzie makes three interrelated suggestions concerning the process of self-definition. First, self-definition requires an integral and internal account of self, involving a process of negotiation between three elements of the person: her point of view; her self-conception; and her values, ideals, commitments, and cares. In this negotiation, Mackenzie posits that we achieve “a kind of reflective equilibrium among these different elements of the self,” integrating the self in a stable way, with no serious or persistent

195 Ibid.
196 Ibid. at 41
197 Ibid. at 41
199 Mackenzie, supra note 172 at 133.
conflict among these elements. Second, self-definition requires a process uniting reflections guided by the person’s values, ideals, commitments, and cares, where a person recognizes certain elements of herself as external, while appropriating others. Third, self-definition features the capacity to imagine as a central role in the formation of a person’s self-conception and within the process of integrating the different elements of the self.200

Understanding the role played by imaginative representation in self-definition and understanding the relationships among our individual imaginative projects, social recognition, and the cultural imaginary are crucial parts of understanding how socialization can impede autonomy at the first level—at the level of the processes of formation of our beliefs, desires, patterns of emotional interaction, and self-conceptions. What it can help explain is why, in oppressive social contexts, the capacities of agents for autonomous action can be impaired by their own inabilities to imagine themselves otherwise.201

The path of finding our own law can be combined with Cornell’s “imaginary domain.” Although Cornell can be more clearly linked to a classical conception of autonomy as independence, I am interested in rescuing that private moral and legal space of the finding.202

To be exact, the imaginary domain is a space of freedom to “create ourselves as sexed beings, as feeling and reasoning persons” free from a hierarchical definition of the self.203

Both Nedelsky and Cornell agree on freeing the self from external impositions and oppression. However, Cornell is still centered on the protection of individual rights as a main tool to achieve such freedom and the relational approach I promote, without abandoning rights, conceives a transformation of institutions and relationships from oppressiveness into autonomy protective.

200 Ibid.
201 Ibid. at 144.
202 Cornell supra note 5 at 15.
203 Ibid. at ix.
The “imaginary domain” is an invitation to participate in the richness of life with the freedom to evaluate and represent who we are and be free from imposed sexual choices.\textsuperscript{204} Cornell centres her analysis on social equality, which she interprets as emancipation from state-imposed sexual choices and institutions that reinforce those impositions.\textsuperscript{205} She states that when every person has a “right” to the imaginary domain, then the State cannot force a person to play a role, either by law, or manipulation of social institutions. People are to freely express themselves in intimate lives that are their own. She constructs this freedom from the perspective of sexual freedom, a sexual freedom that is not meant to replace equality but rather to redefine it so it can serve freedom.\textsuperscript{206}

The conception put forward by Cornell is embedded in a corporeal recognition of the self as a “sexuate being.”\textsuperscript{207} Enriched by the “imaginary domain,” it considers sexuality a key ingredient of self-definition, putting aside the fear of exploring diverse sexual representations.\textsuperscript{208} She does not see sexual orientation as a choice. Sexual imago is inseparable from the bodily ego and therefore, to deny a person the capacity to live out her sexuate being as represented in her persona would be “to undermine her most basic self of self.”\textsuperscript{209} Lesbian women, because they are called and identified as lesbians, that is, by their sexual orientation, must include in their equal intrinsic value a capability of generating their own evaluation of life changing decisions, and those evaluations should not only be taken by

\textsuperscript{204} Ibid. at ix, x, xi.
\textsuperscript{205} Ibid. at xi.
\textsuperscript{206} Ibid. at xii.
\textsuperscript{207} Ibid. at 8.
\textsuperscript{208} Ibid.
\textsuperscript{209} Ibid. at 37.
the courts as elements of consideration but as important aspects of a person conceived to be politically free.  

A capability of generating and evaluating life plans, such as conceiving a child using sperm from a particular donor, will be made possible within an institutionalized fostered “imaginary domain.” The development of equal intrinsic value does not necessarily invite the comparison of one lifestyle with another. As a political decision, institutions that are reconceived to foster this new concept of autonomy, should aim to provoke within members of society a well-being defined by their own contexts and understandings, giving prominence to a particular set of values in which the newly recognized and legitimized lesbian subject is invited to participate by contributing to the definition, conceptualization and interpretation of those values.

Cornell sees the imaginary domain as a moral space where we can imagine who we might be if we made ourselves our own end and claimed ourselves as our own person. She claims for protection of the imaginary domain through moral and legal rights. The imaginary domain gives the individual a “right to claim who she is through her own representation of her sexuate being”, on the path to becoming a morally and legally recognized source of self representation and re-symbolizing the meaning of sexual difference in a way that is consistent with the priority that liberalism gives to liberty. This inviolable “sanctuary” must be defined by the person herself; it is not looking to make the law the main tool to

210 Ibid. at 19.
211 Ibid. at 8.
212 Ibid. at 10.
213 Ibid.
214 Ibid. at 19.
conceptualized sexual difference, because it would make the state and not the person this source of meaning.\textsuperscript{215}

2. The protection of rights through a relational perspective

Judicial settlement of conflict between individuals and bureaucracies has been characterized by a liberal view by the threat that the collective may impose on the individual. In this scenario, the courts have found themselves in a particularly troubled position, between accepting state’s intrusion into previously private spheres—for example, when welfare is thought to merit such intrusions—and protection of individual rights.\textsuperscript{216} These can all be more adequately addressed within a framework of the relational self, as opposed to the creation of a wall of rights that may try but not succeed in enhancing autonomy in the context of dependence.

Democracy today, as defined and practice by our present western governments, can’t by itself protect, promote and enhance autonomy. According to Nedelsky, “democratic majorities can decide to trample the rights of individuals and minorities.”\textsuperscript{217} However, we can understand and instruct institutions on the nature of autonomy, guide the public and private practices to foster autonomy and provide the appropriate remedies for the judicial body to review autonomy violations, so that “citizen/members can hold their democratic institutions accountable.”\textsuperscript{218} It is within the sphere of the State’s dependant citizens that autonomy must be enhanced the most, for the foreseen vulnerability they face and the

\textsuperscript{215} Ibid. at 23.
\textsuperscript{216} Nedelsky (Chapter 2) supra note 160.
\textsuperscript{217} Ibid.
\textsuperscript{218} Ibid.
dangers of easily eroding the value of autonomy. The relational approach to autonomy invites institutions to be engaged in dynamic ongoing dialogues with members/citizens. This dynamic dialogue is to be centered on whether the actions and decision-making processes utilized by public institutions are consistent with this conception of autonomy. By “[e]xamining institutional practices (and the law that shapes them) can, in turn, shed light on what fosters autonomy, and thus on the practical and theoretical contours of this value.”

Democratic participation is not exhausted by the possibility to elect representatives, or make presentations before a court, but by having “mechanisms to encourage and facilitate the posing of questions about institutional compatibility with autonomy.” It is the state’s responsibility to create and guide public institutions with the objective of protecting this conception of autonomy. But this responsibility may entail not only a negative obligation of “permitting to be”, but also a positive and affirmative action of offering a moral and a legal space—the imaginary domain—to find our own law, and redefine our own self. The imaginary domain is not a reclusive sphere of isolation. On the contrary it is dependent on relationships and institutions not only in means of protection but also submitting content. To give content to the finding of one’s own law requires an active obligation of the state to continuously allow its citizens to question public institutions.

There is an optimal relation between the individual and the collective based upon the value of freedom. A person that is dependant on the State in some way or another may be maliciously affected by a liberal view of autonomy as independence and rights as limitations.

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219 Ibid.
220 Ibid.
221 Ibid.
A transformation may occur from being considered to be a citizen to acquiring the status of a helpless subject under the power of the collective.\textsuperscript{222} In the example I have been analysing, the Court may have felt that because a citizen is dependent on the State’s public health system to become pregnant, than that person should be subjugated by the State’s over-regulations and requirements. The Court took a stand that clearly posits the member/citizen as an individual who has, for the mere fact of being dependant on a public institution, lost her sense of competence, control and integrity. On the contrary, they should have ensured the autonomy of Susan Doe, taking into account her interdependence to the collective power and her sense of helplessness.

Autonomy must “serve as a standard for democratic outcomes.”\textsuperscript{223} As said before, the constitutional protection of autonomy is not only an effort to protect the individual within a space into which the State may not intrude, but to structure relationships between the collective and the individual in a way that autonomy is fostered and enhance. The mechanism of holding a government accountable to dynamic basic values set out by all members of a nation, can be made possible through dialogue. For the most part, that dialogue has taken place within judicial review in which democratic outcomes are measured.\textsuperscript{224} A new conception of autonomy within a relational approach shapes institutions to be structured in a way that understands, listens and is moulded according to social changes by respecting and promoting modern human relations according to core values that are shaped by the very same people it is serving.

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\textsuperscript{222} \textit{Ibid.}
\textsuperscript{223} Nedelsky (Chapter 6) \textit{supra} note 37.
\textsuperscript{224} \textit{Ibid.}
The Canadian Charter has been and will be a useful tool for recognizing that social and legal subjects are entitled to protection and promotion. Nedelsky’s conception of constitutional rights will serve perfectly to reinforce lesbian women’s autonomy within a relational approach. Only through this approach can we really see how citizenship is fully attained and how equality can be reconstructed as the foremost attainable well-being of the human subject. Constitutional rights must serve multiple purposes. They are not only intended to structure relationships of equality between citizens and the state, but also to be concerned with the relations they structure among citizens themselves.\textsuperscript{225} Nedelsky sees how the Charter is somehow suited to provoke a dialogue between different social actors.\textsuperscript{226} Section 33 of the Charter, known as the “override” provision, has the ability, if used appropriately, to create a public debate between the legislature and the courts; the same as section 1, which enables a dialogue within the courts themselves and others, by considering the constitutionality of a particular law that can reasonably limit some rights if those limitations are “demonstrably justified in a free and democratic society.” Of course the content of the limitations and the definition of a free democratic society will be influenced by mainstream political theories, which so far have given prominence to an individualistic conception of rights. Nonetheless, the relational approached proposed can restore this tendency by interpreting rights by the way they construct relationships of freedom and equality between both citizens and the State, and citizens in relation to one another.\textsuperscript{227}

\textsuperscript{225} Ibid. \\
\textsuperscript{226} Ibid. \\
\textsuperscript{227} Ibid.
Cornell’s Kantian liberal analysis, on the contrary, is only preoccupied with finding a concept of rights that allows us “to be recognized as the source of our own evaluations and representations of our sexual difference”\textsuperscript{228} and ultimately to protect citizens from improper intrusions of the state. Rights must enable citizens to claim before the law and institutions they are consider free and equal. Those rights should not be overruled in the name of a “greater good,”\textsuperscript{229} but be used in a way that prioritizes the freedom of all and propends to an equal evaluation of our sexual difference. However, her individual conception of rights is mitigated by her recognition that a right to represent one’s sexuate being is also a demand to foster a space where sexual, as well as kin relationships can be nurture.\textsuperscript{230} She recognizes that a person cannot separate herself from the history and culture that makes her who she is. But at the same time, the answer to her anxiety of freedom is individuation, breaking free from relationships to become our own persona.\textsuperscript{231} Nonetheless, this fictitious and unattainable theoretical view of reality works more as a source of frustration than incentive. Considering our relationships instead of excluding them, and transforming those that promote oppression to foster autonomy seems to be a more consistent answer.

Interpretation and application of constitutional rights must be coherent with its contested and shifting meaning. Within this framework we may see rights as a collective decision of implementing certain fundamental values, which construct relationships of power, responsibility, trust and obligations.\textsuperscript{232} Altogether it is important to focus on the types of

\textsuperscript{228} Cornell \textit{supra} note 5 at 11.
\textsuperscript{229} \textit{Ibid.} at 11.
\textsuperscript{230} \textit{Ibid.} at 62
\textsuperscript{231} \textit{Ibid.} at 63.
\textsuperscript{232} Nedelsky (Chapter 6) \textit{supra} note 37.
relationships we intend to foster, the values at stake and how institutions can contribute to that fostering.\textsuperscript{233} We cannot elude the fact that different cultures and political systems may interpret, conceptualize and apply values in a different manner, giving priority to one over others in ways different from the western liberal approach.\textsuperscript{234}

Contemporary constitutional democracies consider equality as a fundamental base of constitutional rights.\textsuperscript{235} However we must be careful to understand what kind of equality we are promoting. Formal equality is centered on the idea of equivalence; it sees all persons and judges all persons as the same and when a comparator is used, it is only to apply the comparator’s standards and requirements. Substantive equality, on the other hand, is not necessarily set as a comparison between two subjects; it may very well be a comparison between a subject’s situation and a better attainable quality of life and well-being, which takes into consideration the contextual circumstances of the subject itself.

A liberal tradition and judicial interpretation of rights was made possible because of formal equality. Substantive equality, on the other hand, would imply an effort on the part of the courts to consider all relevant elements and factors. A focus on relationships has the ability to turn the court’s attention to context within the belief that there are basic and dynamic human values in need to be articulated and conceptualized.\textsuperscript{236}

Although we do not necessarily have to abandon the old traditional conception of rights as a protection from democratic abuse, we can jointly worry about the problem of giving them

\textsuperscript{233} Ibid.
\textsuperscript{234} Ibid.
\textsuperscript{235} Ibid.
\textsuperscript{236} Ibid.
content.\textsuperscript{237} It is only through socially updated content and taking into account newly configured relationships that we may foster a system that gives full citizenship to lesbian women.

3. Public health institutions and relational autonomy

All people affected by policy or decision making process may be active participants rather than recipients of those decisions.\textsuperscript{238} Institutions should be aware of how those who interact and depend on them experience those interactions, for example how other lesbian women and gay men interact with health care and how they feel about their interactions. Does it allow them to enhance autonomy or is it a disappointment because burdens that do not allow them to create the families they seek are imposed? How do we allow lesbians and gays be part of the policy making process? Institutions should be concerned with the subjective experiences they create in the lives that are influenced by them, in other words, what kinds of feelings they are generating.

Institutions should be required to recognized diversity, openness to difference and an understanding of others.\textsuperscript{239} Institutions should be careful to promote relationships that respect and foster autonomy, inviting the people that would be influenced by their policies to be part of their creation. However, such participation should not exhaust the necessary protection that autonomy may entail from democratic decision making. Democratic accountability is a necessary component if we are to protect minorities from democratic majorities.

\textsuperscript{237} Ibid.
\textsuperscript{238} Nedelsky (Chapter 2) supra note 160.
\textsuperscript{239} Nedelsky (Chapter 2) supra note 160.
In matters of bioethics, autonomy has been equated with informed consent, where, prior to any invasive treatment, the physician has a duty to inform the patient about his condition, possible treatment and potential impacts and/or complications. With informed consent, the paternalistic approach that the medical profession took over their patients in the past seemed to be overturned by respect for patient’s autonomy. Nevertheless, the sense of autonomy created through informed consent only provides a narrow account of autonomy, circumscribing it as only an election process between the alternatives offered by the physician in charge, and not actually promoting an ability to construct different alternatives to a health concern with the help of the physician. In sum, this view is not preoccupied with the decision-making process of the patient, but only with the actions of the physician, if he or she has taken all appropriate measures to fully inform their patients. As stated by Susan Dodds

Over the past three decades, the effect has been to change the image of the doctor-patient relationship from the presumed beneficent paternalism of the doctor, acting on the best (medical) interests of the compliant patient, to a contract between patient-consumer and doctor-service provider. In this approach the physician has the role of expert adviser, providing information to the consumer, who then makes her or his health-care decisions free from paternalistic medical interference.

When in medicine autonomy is viewed only in terms of informed consent, the examination of boundaries and respect becomes very narrow and constrained by the assumption that all patients are fully autonomous/independent, and confronted with a patient who does not fall

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241 Ibid.
into the ideal category of an autonomous agent, they are treated as dependants in need of paternalistic protection losing altogether all capacity to make choices concerning their health. Women in particular seem to be negatively impacted by this conception of autonomy equated only to informed consent due to the association of irrationality and emotionality as culturally considered feminine traits. In this sense, Dodds assures, women’s health care options are structured in a way that limits their autonomy.\footnote{Ibid. at 217.}

The kinds of relationships formed between physicians and patients can be essential to the determination of whether patients will actively be involved in the decision making process or, more passively, be the recipient of a fixed set of options from which to choose. From a relational approach, it is not only important to consider the health care choices but also, as Dodds explains “the ways in which health-care practices can contribute to the development and shaping of people’s capacity for autonomy.”\footnote{Ibid. at 214}

Particularly, regarding public health institutions it is important to consider which values are to be given prominence, and what kind of relationships their legal framework is structuring among lesbian citizens and the collective. By giving priority to a protectionist trait based on health considerations, public health institutions are neither promoting relations of equality nor enhancing autonomy. On the contrary, by undermining the agency of lesbian women, they reinforce relations of dependency combined with helplessness and a sense of loss of citizenship. They are not allowed, as are others, to live in accordance with their own law

\footnote{Ibid. at 217.}
\footnote{Ibid. at 214}
considering their social context and circumstances. Above all they are promoting relationships of inequality and a sense of less worth.

“Homophobia” or “heterosexism” shapes the health institutions and legislation regulating assisted conception. According to Sylvia A. Law, homophobia suggests an opposition or fear to homosexuality “and an individual pathological hatred of them.” 244 However heterosexism is a broader phenomenon that does not circumscribe its action to the person as an individual, but can be “structured into basic familial, economic and political relationships.” 245 That is how heterosexism can shape “the lives, choices, believes and attitudes of millions of people who experience neither feared nor hatred of gay and lesbian people.” 246 In this sense the definition of assisted conception set forth in the Regulations shows that in a heterosexual relationship, where the sperm used comes from the male partner, the health risks are to be tolerated or even outweighed by the autonomous decision of the couple to set aside any testing or screening of the semen and moreover by the autonomous decision to continue the health risks that they are already undertaking through sexual intercourse. The Regulations are embedded by a heterosexist conception of family where the “actions and relationships that are tolerated or even celebrated when they involved a man and a woman are condemned when they involve two people of the same sex.” 247

244 Sylvia A. Law supra note 7 at 195.
245 Ibid. at 195.
246 Ibid. at 196.
247 Ibid. at 196.
Our public health institutions are entrenched with legal liberalism and based on a series of statements believed to be true. These statements, according to Didi Herman are as follow:\textsuperscript{248}:

1. society is pluralistic;

2. there are majorities and minorities;

3. true democracy protects minorities from the tyranny of majorities;

4. true minorities share characteristics that differentiate them from the majority norm, and

5. the majority must exhibit qualities of tolerance, understanding and compassion entangled with the will to extend legal protections to those identified as minorities.

Nevertheless, we can question this model from the perspective of its social worth, where Herman thinks (and I agree), seems to be inappropriate, particularly considering that sexuality is socially constructed and that there is not necessarily a link between “reproductive capacities, gender categories, and sexual desire, then representing lesbians and gay men as an immutable minority may restrict rather than broaden social understandings of sexuality.”\textsuperscript{249} Lesbians and gays are represented as a homogenous group, a small group of people who have no control over their sexual orientation, which is what defines them as a minority.\textsuperscript{250}

\textsuperscript{248} Didi Herman, \textit{Rights of Passage: Struggles for Lesbian and Gay Legal Equality} (Toronto: University of Toronto Press, 1994) [Herman] at 38.
\textsuperscript{249} \textit{Ibid.} at 43.
\textsuperscript{250} \textit{Ibid.} at 50.
The heterosexist view, does not grant legitimacy to homosexuality based on the disruption or denial of gender roles and sexual hierarchies, thus there is no real criticism to our structures and institutions or the relationships that they promote, but rather the legitimacy granted is based on homosexuality as a fixed minority group, finally constituting the “other” group, different from the “normal” or major group, who deserves to be protected.251 Constitutional rights are promoted, interpret and applied within the same framework it intends to challenge, that is within the dominant social relations,252 where there is a sense of “naturalness” represented by the majority without questioning the superiority of heterosexuality.253

Lesbian women are more likely to depend on the state to get pregnant and to use a gay donor as the father of their future children,. In theory, a lesbian woman or a lesbian couple have a number of options to choose from to become a biological parent. One option is to co-parent with the child’s biological father, who according to Fred A. Bernstein is often a gay man;254 another option is to obtain semen from a known donor and procure insemination at home or in a clinical setting; or use an anonymous donor.255 In this sense the policies set forth by Health Canada should take into consideration the fact that lesbian women are more likely to use a known donor than heterosexual single women or couples.256 Usually the males they seek to provide semen are from within the gay community. This practice can be traced as

251 Ibid. at 44.
252 Ibid.
253 Ibid. at 51.
255 Ibid. at 23.
early as the 1980s where gay and lesbian parenting groups and newsletters began making arrangements to provide such matches.\(^{257}\)

There are special circumstances in which a lesbian couple can bear children. Technology and the inclusion of a third party, known or unknown, will always be necessary for conception—at least until parthenogenesis becomes a new trait in the biological evolution of the female body. Furthermore, gay men will engage in fraternal relationships with lesbian women more often than heterosexual men. For these reasons the State overburdens their relationships and the ability of the women to choose the father of their children, fostering relationships of oppression between public health institutions and lesbians and gay men.

The only difference between a heterosexual woman and her spouse or partner and a lesbian women and her gay friend is that in the latter, sexual intercourse is not likely to occur. Women’s ability to decide to bear children with a certain male and to expose her and the nasciturus to infectious diseases is only justifiable by sexual intercourse. Heterosexual privilege is once more manifested through a biological ability and probably justified through sex drive. However, health institutions have regulated access to assisted conception and the courts have interpreted those regulations in such a way, that it impedes family relations from easily flourishing in the homosexual community.

Claire L. Wendland \textit{et al.}, conducted a research on donor insemination where they compared lesbian couples, heterosexual couples and single women.\(^{258}\) This research was conducted

\(^{257}\) Bernstein supra note 254 at 17.

about the same time when the Commission’s *Report and the Regulations on Assisted Conception* were published. Some of their findings are relevant for the understanding how these women with different sexual orientation or different family compositions approach this issue.

For instance regarding the fear of acquiring infectious diseases, all three groups considered it to be the least important of all concerns along with the acceptance of the child by their respective partners.\(^\text{259}\) Regarding the selection of a donor 51\% of women, no matter their sexual orientation or family status, undergoing donor insemination considered conception using a known sperm donor. However, 85\% of lesbian patients were more likely to consider using a known donor and to try this alternative. Moreover, all of their respective “lesbian partners considered using known donor sperm whereas less than a third of husbands considered this option,” constituting the only alternative among assisted conception viewed differently by husbands and lesbian partners.\(^\text{260}\)

In sum the study showed that:

lesbian and single women to be similar to married women demographically, in TDI [therapeutic donor insemination] outcome, and in many concerns and questions that face anyone having donor insemination. When considering alternatives to TDI, married women were more likely to consider adoption, single women more likely to consider sexual intercourse with a man unaware of their plan for pregnancy, and lesbians most likely to consider using a known semen donor or having intercourse with a man aware of their desire to have a child … Lesbians were more likely to report stress in their relationships as a result of TDI…\(^\text{261}\)

\(^{259}\) *Ibid.* at 767.

\(^{260}\) *Ibid.* at 767.

\(^{261}\) *Ibid.* at 770.
Taking care of health considerations in a therapeutic context of assisted conception is not exhausted by assessing or taking care of the risks of infectious diseases. There are other technical requirements that have to be considered. For instance the efficacy of frozen semen versus fresh semen for the effects of conceiving and the consequences of a late term pregnancy, that according to Judith N. Lasker, is more expensive and has a lower success rate, usually requiring additional cycles of insemination before pregnancy.\textsuperscript{262} Another consideration would be the age of the woman attempting to conceive and how prolonged waiting periods may affect her health by increasing risks associated with childbirth.

There is a claim to be made before public health institutions that we must be evaluated as “free and equal persons” whose rights cannot be “easily overridden in the name of some greater good” and that an “equivalent evaluation of our sexual difference” be made.\textsuperscript{263} This demand must be met at a “crucial moment in the evolution of a theory of justice [distributive] before we move on to a broader egalitarian theory.”\textsuperscript{264}

If lesbian women are dependent on the State and particularly on Health Canada’s regulatory framework in order to bear children and construct family in accordance with their “own law”, than this public institution should have a flexibility that takes into account the particular circumstances of lesbian women, and their ability to construct personal relations that allows them to bear children. Sexual intercourse should not be a defining element to entrusting a women with the decision of who is the father of her children. Although a suspicious category arises when heterosexual men become the only element of difference to apply the

\begin{itemize}
\item \textsuperscript{262} Lasker, supra note 256 at 12.
\item \textsuperscript{263} Cornell supra note 5 at 11.
\item \textsuperscript{264} Ibid. at 14 and 15.
\end{itemize}
Regulations. A heterosexual male within a stable relationship with a woman as a “spouse” or partner, in contrast with a gay male that participates in a an already stable lesbian couple, allows the woman to have easy access to a medical procedure without being overly regulated or protected against her own choices. It looks like the protection of a woman and an unborn child are entrusted to a heterosexual man in an undefined stable relationship—the Regulations do not explain what can be understood as a sexual partner, it may mean a casual encounter, or a possible one—and when that man is excluded from the scheme, the State takes responsibility for protecting the woman and her future child.

In sum a regulatory framework that promotes autonomy would allow lesbian women to prosper as individuals and relate to others as equal members of society. To have substantive equality based on the differences that make lesbian life and families a contribution to the richness of the broader community, without making such differences disappear but rather “structur[ing] relations of equality among people with many different concrete inequalities.”

265 Nedelsky (Chapter 6) supra note 37.
Chapter 4
An Analytical Approach for the Court on Doe from a Relational Perspective

In this chapter I intend to apply some principles of the relational approach discussed in Chapter 3 to the case as examined in Chapter 2. I do not pretend to be able to single-handedly propose the ideal or perfect solution in the treatment that the law should give to diversity, and particularly, to how it should regulate assisted conception, nor is my intention to create a set of rules applicable to judges when considering such issues. My intentions are more modestly to propose some questions that the judges could have considered in the case in question, and some important principles that they should have applied in this rapidly growing and complex area of juridical interpretation and application of the law.

As explained in the previous chapter, a new notion of autonomy that departs from the traditional liberal conception of independence may more effectively support efforts towards attaining greater equality. This new conception, re-read as “finding one’s own law,” can only be possible in a moral and legal space that allows us to envision a concept of the self informed by our social context. Since human capabilities develop in the context of human relationships, it is necessary for a person to develop the capacity to allow her to understand what structures of power, pattern of relationships, and her own personal practices either foster the capacity to be autonomous or undermine it. Health-care practices form relationships of dependence between the user and the provider, which can help develop and shape people’s capacities for autonomy. In this context, institutions, legal norms and social practices can restrict autonomy by limiting the range of options available. Thus, it is
important for the courts to understand the relationships that are being created between social subjects and institutions, whether those relationships are created upon this re-conception of autonomy by promoting freedom and substantive equality, or whether oppression is reinforced as the main component of socially constructed values.

In new reproductive technologies, particularly assisted conception in the way defined by the Regulations, a traditional view of the decision-making process in medicine is not properly suited to address all issues that may need to be considered. Beyond the medical or therapeutic perspective, there are social values that play a key role, particularly bearing in mind that we are considering women’s reproductive choices. In matters of family constitution or decisions related to when and how to have children through the use of these technologies, “the interest of the medical professionals may not sufficiently reflect either the specific desires of patients or the broader societal interest in shaping medical values and health care policy.”

We aim to have a perspective where technologies serve those social needs and values and where the judiciary examines and puts to the test all explicit or implicit assumptions that are currently at play in the use of these methods. Those assumptions are tainted by a heterosexist and heteronormative view of family and society that, although it may not be manifested expressly or explicitly as homophobia, permeates different structures of relationships that are embedded in our institutions and thus conceive of alternative forms of society and family as “the other” of what is normal or natural.

267 Ibid. at 1528.
One aspect that is very critical in the examination of any legal claim, particularly when based on important constitutional rights such as equality, liberty or security of the person, is the social context of the person herself and how a decision may or may not affect that social context. Because we are looking at equality not simply from a formal perspective, but also as the highest attainable standard of well-being of the person herself without necessarily having to conform to standards that do not always apply, understanding the consequences of a court decision in all the relevant areas of the life of a person who might be affected by that decision, and not framed only in one issue (physical health, as important at it may be), is what I propose through the relational approach applied in specific cases.

A relational analysis of Doe would place context as a key component, revealing discrepancies about underlying social values.\(^{268}\) It would consider which values are to be given prominence and what kind of relationships the Regulations are structuring among lesbian citizens and the collective. It would consider if public health institutions should be held accountable to constitutional rights, evaluating their consistency with those values and their interpretation.\(^{269}\)

Autonomy and equality in opposition to the State’s interest in health protection appear to be the competing values at stake in Doe. Autonomy was not considered by the Court to be a central part of the discussion, since, as mentioned in Chapter 2 of this paper, all liberty considerations were believed to fall out of the scope of s. 7. Equality was evaluated from a simplistic framework, mainly relying on the examinations and conclusions made by the

\(^{268}\) Nedelsky (Chapter 6) supra note 37.

\(^{269}\) Ibid.
application judge. The only contextual analysis conducted was relevant to the comparator group and the fact that they did not need to comply with the Regulations requirement because they were already at risk of contracting infectious diseases or conceiving a nasciturus with a potential birth defect.

1. The purpose of the Regulations

We have seen in Chapter 2 that under the opinion of the Court the purpose of the Regulations are to protect the health of women undergoing assisted conception, as well as of the health of their respective partners and future children, particularly by reducing the risk of acquiring transmissible infectious diseases.\(^{270}\) For the Court it made perfect sense only that the Regulations exclude women seeking assisted conception with the semen of their partners and not exclude any other donors, but impose the same “safeguards” for all of them, whether the donor is known or unknown to the woman.\(^{271}\) The reason for not applying the same criteria to those women using semen from their current sexual partners or spouses was that through sexual intercourse, those women were already potentially vulnerable to infectious diseases. However, there was no consideration given to the health of the future child in this situation. If precaution is the reason for protection, there is no assurance that the male spouse or sexual partner of the woman might not have acquired an infectious disease just before insemination, thus infecting the woman and probably the nasciturus. In both cases, Doe and a woman procuring insemination from a partner are intending to use a known donor, and in both cases there is uncertainty about the possibility of acquiring an infectious disease.

\(^{270}\) Doe (2007) supra note 1 at para. 20.

\(^{271}\) Ibid at para. 29.
Moreover, it is my understanding through what we have studied in Chapter 1 in the section entitled “The Regulatory Scheme of Assisted Conception” that the purposes of the Regulations are: (1) to protect the health of women, their partners and future children; (2) to promote equality and non-discrimination in the use of reproductive technologies; and (3) to promote autonomy and allow women make conscious choices regarding their health, and allow them to have the opportunity to construct their families beyond the oppressive environment in which we live.

1.1. Protecting the health of women, their partners and future children

The view of health promoted by the Court on Doe is centred on reducing the risk of acquiring a disease. This narrow conceptualization of the meaning of health does not comply with its internationally accepted definition. The World Health Organization (WHO) has defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

Health, thus, is not just the absence of illness but an integral form of wellbeing that holistically considers the physical, mental and social aspects of a particular person. The WHO definition does not establish which of these aspects should be given prominence; on the contrary it seems to imply that all three factors, the physical, mental and social, are to be considered in an egalitarian manner when assessing whether the protection or promotion of health is fully being achieved. Therefore if the purpose of the Regulations is effectively to

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protect health, that protection should consider social and psychological wellbeing, and not simply physical health.

The *International Covenant on Economic, Social and Cultural Rights*<sup>273</sup> (ICESCR), ratified by Canada on May 19, 1976, is a binding legal document that imposes negative and positive obligations on all State parties. Article 12.1 of the ICESCR declares:

> The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.<sup>274</sup>

Here, again we see a component of health that goes beyond the mere absence of infirmities to include also mental health. The right to health is considered a fundamental human right “indispensable for the exercise of other human rights,”<sup>275</sup> and the enjoyment of the highest attainable standard of health must be conducive to living life with dignity. In this sense, the formulation of health policies as well as any other social policy ought to comply with this integral conception of health.<sup>276</sup> The right to health is dependant on the realization of other rights, including, for example, human dignity, life, equality and non-discrimination, the prohibition against torture, privacy, access to information, etc; all of which address integral components of the right to health.<sup>277</sup> Inherently the right to health confers all people the freedom to control their health and their bodies.<sup>278</sup>

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<sup>274</sup> *Ibid.* at article 12.1.


<sup>276</sup> *Ibid.*

<sup>277</sup> *Ibid.* at para. 3.

In *General Comment 14*\textsuperscript{279}, the Committee on Economic, Social, and Cultural Rights (hereinafter the Committee) asserts that the ICESCR imposes immediate obligations “such as the guarantee that the right will be exercised without discrimination of any kind,” as well as the obligation to take deliberate, concrete and targeted steps towards the full realization of Article 12.\textsuperscript{280} Hence, the State should “move as expeditiously and effectively as possible.”\textsuperscript{281}

For the Committee, the right to health imposes three types or levels of obligations on State parties: respect, protect and fulfil.\textsuperscript{282} The “obligation to respect” requires the State to “refrain from interfering directly or indirectly with the enjoyment of the right to health,”\textsuperscript{283} particularly

refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; *abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs.*\textsuperscript{284}

[Emphasis added]

The “obligation to protect” requires the State party to take legislative or other measures that prevent third parties from interfering with the enjoyment of the right to health,\textsuperscript{285} and to ensure that

harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning ... and to take measures to protect all vulnerable or marginalized groups of society, in

\textsuperscript{279} Ibid.
\textsuperscript{280} Ibid. at para. 30.
\textsuperscript{281} Ibid. at para. 31.
\textsuperscript{282} Ibid. at para. 33.
\textsuperscript{283} Ibid.
\textsuperscript{284} Ibid. at para. 34.
\textsuperscript{285} Ibid. at para. 33.
particular women, children, adolescents and older persons, in the light of gender-based expressions of violence ...\(^{286}\)

The “obligation to fulfill” on the other hand requires the State “adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.”\(^{287}\) Fulfilling means to facilitate, provide and promote by taking positive measures to enable and assist individuals and communities in the enjoyment of the right to health; to provide a specific right when individuals or a group of individuals are unable to ensure the fulfillment of their own rights by the means at their disposal; and to undertake actions to promote, create, maintain and restore the health of such individuals or groups.\(^{288}\)

Finally the fulfillment of the right to the highest attainable standard of health can be inferred from Article 2.2 of the ICESCR where the State parties commit themselves to guarantee that the rights enunciated in the Covenant “will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”\(^{289}\)

In sum, when considering the right to health of lesbian women in the context of the Regulations and access to assisted conception without undue burdens, the absence of infirmities or the prevention of infectious diseases by itself is an incomplete interpretation of that purpose. Lesbian women’s health, and their partners’ and future children’s health are all entangled with social, psychological and physical aspects of wellbeing. It is not enough to

\(^{286}\) Ibid. at para. 35.

\(^{287}\) Ibid, at para. 33.

\(^{288}\) Ibid, at para. 37.

\(^{289}\) ICESCR supra note 273 at Article 2.2.
say, as did the Court, that because the purpose of the Regulations is to preserve health, then automatically as a logical conclusion it promotes comfort and not injury.\textsuperscript{290} The Regulations are to be interpreted and applied to promote an integral conception of health, and in that sense, the Court should consider if the imposition of delays in treatment and the subsequent possibility of increasing the risk of failure of the treatment or other complications of a late term pregnancy, may entail a lack of health and not its promotion.

1.2. Promoting equality and non-discrimination in the use of reproductive technologies

As seen in \textit{Doe} considering only a comparator group and contextualizing the claim only within this comparator’s reasons for privilege—women’s capability of choosing to use donors who are their sexual partners without enduring any burden, because they are already at risk of infectious diseases—failed to consider the contexts of lesbian women, who will never be unburdened in this way.

The Court failed to address how the Regulations would allow lesbian women to prosper as individuals and relate to others as equal members of society. Yet substantive equality must be based on the differences that make lesbian life and families a contribution to the richness of the broader community, without making such differences disappear but rather “structur[ing] relations of equality among people with many different concrete inequalities.”\textsuperscript{291} Susan Doe was not granted the opportunity to engage in a serious dialogue with the Court, since her context was almost completely undermined by health concerns.

\textsuperscript{290} \textit{Doe} (2007) \textit{supra} note 1 at para. 35.
\textsuperscript{291} Nedelsky (Chapter 6) \textit{supra} note 37.
As noted in Chapter 1, the Regulations were drafted in answer to the questions and issues raised by the Commission in their Report. The ethical dilemmas that became apparent with the ability to unlink fertilization from sexual intercourse questioned these reproductive technologies’ capacities to even further entrench existing inequalities or even create new ones.  

Considering these inequalities the Regulations should be interpreted to assess the potential differences that lesbians in their contexts may confront. For this, and taking into account that in effect lesbian women will be impacted by the process most of the time as they will be unlikely to use a donor considered to be their sexual partner or spouse, they should also be exempted from its regulatory scheme when using a known chosen donor.

Health Canada explained how, through a contextual approach and looking at the objectives of the Regulations they had interpreted the scheme in such a way as to make a distinction between known and unknown donor without making sexual intercourse a third category of distinction. The known/unknown donor distinction that replaced the sexual partner-spouse/not sexual partner-spouse donor distinction was justifiable on the “needs of individuals” to form families using semen from friends or family members.

Also, the Commission was aware of the possible inequalities that access to these technologies might have on different individuals and couples, and they also understood how these inequalities cannot only be addressed from one single perspective, but through a regulatory framework that was aware of the social, ethical, legal, medical and economic implications of

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292 Royal Commission supra note 44 at 1.
293 Guidance (2002) supra note 60 at section 5.
its implementation, and that dealt with these categories in a comprehensive manner. The Regulations in this sense have to represent evolving and progressive thinking and values, without circumscribing its content to an original intention that represents outdated values, and must also ensure that they take into account sexual diversity.

1.3. Promoting autonomy and allowing women to make conscious choices regarding their health, and giving them the opportunity to construct their families beyond an oppressive environment.

Susan Doe and her partner “J,” according to “their own law” had constructed a plan on how to form their family. “J” gave birth to their first child with “D” as the biological father and subsequently they wanted Susan to conceive a second child also fathered by “D” through assisted insemination. “D” was not only a known donor for them; he was the father of their first child. That plan was truncated when Susan had to face burdens set forth in the Regulations. Therefore, in order for them to complete their life plan Susan would have to comply with the following: donor screening, preliminary semen evaluation, physical examination of the donor, and a series of serological and microbiological tests performed on the semen sample to determine if the sample was contaminated with an infectious disease such as HIV. She could not use fresh semen, which is prohibited, thus the semen would have to be frozen and cryopreserved for a minimum period of 180 days after which the donor would be revaluated.

294 Royal Commission supra note 44 at 16.
295 See chapter 1 at 3.2.
All these requirements—that do not apply to women using semen from a spouse or opposite-sex sexual partner—promote an oppressive environment as a result of the embedded heterosexism of the regulatory scheme of assisted conception. The tolerated risk of physical injury among a well established male/female partnership based on their right to configure a family according to their own desires is not tolerated within a well established lesbian partnership. Women who have male partners who would be the biological fathers of their future children are allowed to make conscious decisions regarding their health and their reproductive capacities whereas women who use known donors, even if those donors have already fathered previous children with those women, are not allowed the same privilege.

The Regulations are not intended or should not be intended to promote a mainstream belief system sustaining a conception that some family structures are more worthy than others, nor should the Regulations promote a “natural” or “biological” order of family or society. On the contrary, the evolving values of Canadian society towards pluralism and recognition of all citizens without discrimination, should inform the way the Regulations are applied, interpreted or amended. Allowing a conception of relational autonomy through the Regulations and promoting an environment where lesbian women relate to others as equal members of society, helping them overcome the barriers that they may confront in conceiving children and not imposing a burden that others do not face is the correct way to understand the spirit of how, when and why such regulations should apply.

2. Is the health system promoting relationships protective of autonomy?

In the Canadian health context of childbearing, lesbian women are most likely to rely on and be dependent upon the State. Public institutions, therefore, bear the responsibility of
enhancing and protecting the autonomy of those lesbian subjects.\textsuperscript{296} Autonomy seen as independence would mean that lesbian’s reliance on the state precludes her capacity to construct and define for herself what the form of her family will be. However, if autonomy is constructed among relationships, even if those relationships imply a dependency on the States assets, the courts would not judge claims within a framework of competing opposing interests, but as a matter of enhancing socially constructed values through the protection of constitutional rights.

Applying the Regulations to a specific group under a criterion that is not sustainable, or at least under a criterion that could be extended to the group exempted from them seems to uncover other considerations informing the courts. These underlying considerations are mostly based on what I have explained as a structural heterosexism that sees the heterosexual monogamous family unit as an untouchable sphere were the State cannot intervene, a ‘sacrosanct’ sphere that is not extended to the families or potential families of lesbian couples. However, I do not intend to argue that there is a space in family in which the State cannot intervene; in other words I am not sustaining my arguments on the right to privacy, but on the right to autonomy, an autonomy in which the State not only plays a part but one where the State has the responsibility of promoting and enhancing that right.

One outcome that the Court should have considered in this decision was how, by ruling that the Regulations do not constitute discrimination against lesbian women, the findings promoted oppression. The relationship of oppression that we see here is established between the lesbian citizen and society. She may feel that by closeting her sexuality and her family,

\textsuperscript{296} Nedelsky (Chapter 2) \textit{supra} note 160.
she may be able to access the same privileges as a heterosexual woman who uses semen from a partner, thereby attaining exemption from the scheme.

The Court does not necessarily see the definition of “assisted conception” as particularly referring to heterosexual women. The gender neutral language—based on a formal equality interpretation—speaks of “spouse” and “partner”, and so, taken upon the analysis embraced by the application judge, they have concluded that a lesbian woman is not intrinsically excluded from the formal interpretation of the definition. But the mere fact that we may conceive of the idea of applying such an interpretation is ludicrous, since as mentioned before, by mere definition of what lesbianism infers, no spouse or partner of a lesbian woman is capable of impregnating her, and the interpretation of the norm becomes void and stripped of any coherent meaning.

I note in Chapter 1 that one of the reasons for permitting donations from a man originally affected by the exclusion criteria (MSM, over 40 years old, etc) was made on a distinction between known and anonymous donors. It was stated that although there was a recognition that the Regulations and the Directive at the time of its creation made no distinction between both categories “a rationale for not applying the exclusion criteria that may be considered acceptable for known donors, could be considered unacceptable for anonymous donors.” 297 However, the Court failed to see that there has been a distinction made by the Guidance between known and unknown donors since 2002, almost six years after the creation of the

scheme, and that this distinction “is based on specific needs of individuals who wish to build their families using semen donated by friends and family members.”

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Here the needs of individuals who wish to build alternative families outweigh any medical consideration upon which the exclusion criteria were built. The radical assumption made by the Court that it made “perfect sense” to impose the same safeguards for all other women who do not use semen from a partner, whether the donor is known or unknown, interprets the Regulations according to the original intent of its drafting, but does not take into account evolving social values. Nor do the Court make a comprehensive account of how even Health Canada has interpreted and applied a new criterion to the application of the regulatory scheme by incorporating individual needs and an understanding of alternative family formation that cannot be judged or normalized to our conception of a heterosexual monogamous family.

3. A new definition of “assisted conception” for the Regulations

Taking into account that the purpose of the Regulations are not only to protect women, their partners and future children from risk of physical injury or illness, but to promote an integral conception of health, equality and non-discrimination, and to allow a conception of autonomy respectful of women’s reproductive and family choices; bearing in mind a contextual approach centred in lesbian women’s relationships and families for the interpretation and application of the Regulations, with the purpose of promoting relationships of freedom and not oppression; in view of the changes that Health Canada made to the Donor

298 Ibid.
Semen Special Access Programme making a differentiation between known and unknown donors; and considering that women who use semen from a spouse or sexual partner are granted the privilege of making conscious decisions to expose themselves to the risk of infectious diseases through sexual intercourse, and that such privilege should be extended to lesbian women through the use of technology, the definition of “assisted conception” in the context of the Regulations should be read as

a reproductive technique performed on a woman for the purpose of conception, using semen from an unknown or anonymous donor.

In such a definition, all women who intend to use semen from unknown donors would have to comply with all the requisites set forth in the regulatory scheme of assisted conception. However, those women, regardless of sexual orientation, who use known donors, either a sexual partner/spouse, or friends or family members, would be exempted from complying with the scheme. Nonetheless, if women who would be exempted chose to comply with the Regulations out of concern for acquiring potential infections, they would also be free to do so.
Conclusion

Although health is an important factor to be considered by any courtroom concern with a decision regarding any medical procedure, a narrow conception of health, as well as an overemphasis of its importance, will have the effect of losing perspective of other relevant factors that could, inclusively, become more relevant to the specific judicial discussion. Social factors, such as the context in which a particular circumstance exists, as well as the kinds of oppressions or freedoms that are being promoted, can be more valuable to a certain group of individuals than strictly or narrowly defined medical or health factors, in particular when health is only being defined as the absence of illness or infirmity.

We are impacted by a radically medicalized society, where our lives are measured by the amount or lack of diseases we are affected by, on a daily basis. In recent years, the medical profession has become—particularly with current complexity and rate of advancement of scientific developments—, something of a proxy or replacements for spiritual belief. From them we expect to find all the answers of life and death, and in them we place our absolute trust. Particularly in places where the health system is public, the State has become, in this new view of society, a gatekeeper of citizens’ health, even if it be against their own will.

Medicalizing reproductive choices can have the advantage of offering a discussion on delicate matters, stripped of irrational beliefs and placed in evidenced-based scientific arguments. However, we must not forget that reproduction is primarily a social, intimate and emotional event. Even though a physician (or indirectly, the State) may be involved in a reproductive choice, or in facilitating the having or not having of children, that interference
or relationship between the health system/State and the user/citizen must not be translated into a loss or expropriation of autonomy just because the woman involved is in a position of vulnerability or dependency.

Moreover, it is precisely in situations of vulnerability and dependency where the State has the duty to address relevant barriers and take critical steps toward the protection and enhancement of autonomy. The task of finding “our own law” and of having a recognized moral and legal space that allows us to discover what the components of that law are, and what kind of relationships we wish to nourish and encourage, should be facilitated and supported by our governments.

Women, and within this broader category, lesbian women, seem more vulnerable to a protectionist and paternalistic tendency. Choosing to have children without heterosexual intercourse is not only a decision that avoids sexual contact with the opposite sex, or the incommodities of exchanging bodily fluids or of requiring an opposite-sex partner; it is also a decision that many times seeks to avoid bringing a third parent into the picture when there already two involved, although one of them is unable to provide semen, or it may be a decision seeking to involve a third party in the family equation but without granting him the same rights as the biological father of a child who is a product of sexual intercourse.

Diversity implies not the acceptance of difference or the tolerance of somewhat reproachable behaviors, but rather the view that within our society there is a range of possibilities from which to choose and none of those possibilities can be considered superior, more “normal” or be granted the capacity to influence society above all others. If patriarchy and heterosexism are ever to be disrupted and cast out of our laws and institutions, we have the task of at least
starting the process by interrogating the ways in which they inform us today and how, at least until we can recreate or legislate according to new freely expressed values, we can interpret our laws and guide our institutions to facilitate autonomy.
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