

Current Bioethics Trends in Canada

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Canadian bioethicists have long enjoyed access to bioethics programs in the United States and have collaborated with U.S. organizations working in this field. Nevertheless, special features of Canada's multicultural society and public health services are increasingly seen as raising distinctive issues requiring special attention. The purpose of this article is to provide an overview of current Canadian bioethics trends in various areas—including those of training, research on human subjects, human reproduction, termination of life, biotechnology, organ transplants, and AIDS. Comparison of this work with other articles in this issue will show that while some of the trends involved have paralleled similar ones in the United States, some trends (such as that regarding confidentiality and the reporting of HIV infection) have been quite different.

TRAINING IN BIOETHICS

Bioethics courses are now common in the philosophy programs of Canadian universities and are also found in related programs of religious studies. The Westminster Institute for Ethics and Human Values, associated with the University of Western Ontario, devoted its 1989 annual symposium to the subject of medical ethics education for the undergraduate medical student. This gathering found that bioethics training for students of medicine and related health professions was inadequate, although both undergraduate and graduate programs have been expanding.

Apart from the Westminster Institute, work in bioethics is conducted at a number of other centers. Modest bioethics training programs exist at the Universities of Calgary, Manitoba, and Montreal; and additional bioethics training is provided by the Joint Faculties Bioethics Project at the University of Alberta. Canada's oldest established bioethics center

is the Center for Bioethics at the Clinical Research Institute of Montreal, while the most ambitious Canadian venture to date is found at McGill University, where the Center for Medicine, Ethics, and Law is promoting a number of imaginative research projects. Another bioethics teaching and research center began operating at the University of Toronto in the fall of 1989; following the experience of McGill, it is to provide bioethics teaching programs conducted at both undergraduate and graduate (including doctoral) levels and undertake research, particularly on macro-ethical issues.

In November 1988 the Canadian Bioethics Society was created by a merger of the Canadian Society for Medical Bioethics and the Canadian Society of Bioethics. The new society is expected to serve as a dynamic center promoting bioethics research as well as both academic and professional instruction in the subject.

It should also be mentioned that Canadian scholars and students of bioethics have long enjoyed access to programs in the United States and have collaborated with such distinguished organizations as

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the Hastings Center and the Kennedy Institute of Ethics at Georgetown University. However, special features of Canada's multicultural society and public health services are increasingly seen as raising distinctive issues that warrant the special attention of research, publication, and training programs.

RESEARCH INVOLVING HUMAN SUBJECTS

In 1987 Canada's Medical Research Council (MRC) produced a new version of *Guidelines on Research Involving Human Subjects*, which superseded its 1978 version. The guidelines apply to all research that the MRC funds. Because such research goes beyond purely biological and biomedical projects, entering realms of other natural and social sciences, these guidelines take into account comparable guidelines issued by two other bodies, the Social Sciences and Humanities Research Council and the Natural Sciences and Engineering Research Council. (For instance, the latter council has interests in development and testing of prosthetic devices and implants.)

The MRC guidelines are initially applied to individual protocols by institutional (mainly university and hospital) research ethics boards. They are also applied in practice to innumerable projects that the MRC does not fund. This latter circumstance has raised the question of authoritative interpretation and application of the guidelines, because the MRC is unable to express opinions on projects that it is not considering for funding.

To address the application of ethical principles to a full range of research involving human subjects, a new body has therefore been created. This body, the National Council on Bioethics in Human Research, was created as a semi-autonomous agency in 1988 at MRC request, under the sponsorship of Canada's Royal College of Physicians and Surgeons. This

council is charged with interpreting and promoting implementation of all relevant existing guidelines on the ethics of biomedical and health-related research involving human subjects, monitoring how institutions comply with such guidelines, and advising and consulting on ethics matters with bodies funding and undertaking human research. It will also foster educational programs among health and related professionals and the general public on ethical issues and concerns regarding human research. The Council held its first Workshop in April 1989, an event that brought together the heads of Canadian university committees overseeing application of the MRC guidelines and related ethical principles to research involving human subjects that takes place within their institutions and affiliated teaching hospitals.

REGULATION OF REPRODUCTION

There have been relatively few developments in Canada regarding family planning, although some activities occurred in the fall of 1989 when the International Planned Parenthood Federation held its annual conference in Ottawa to celebrate the twentieth anniversary of the date when promotion of contraception in Canada became legal.

In 1986 the Supreme Court of Canada held that a purely contraceptive sterilization could not be authorized for a mentally handicapped adult on the basis of parental consent or judicial approval. At the same time, however, the court confirmed that the procedure is lawful when consented to by a mentally competent person. Spousal veto powers are also made unlawful in those provinces whose human rights laws prohibit discrimination on grounds of marital status, and may be more uniformly unlawful when they affect one's right to liberty and personal security, guaranteed by Section 7 of

the Canadian Charter of Rights and Freedoms.

A number of hospitals had retained doubts about the legality of contraceptive sterilization, due to misinterpretation of the law. The 1986 decision removed these lingering doubts, and in early 1989 the Alberta Institute of Law Research and Reform issued a report (No. 52) entitled *Competence and Human Reproduction* that proposed means by which sterilizations might be undertaken on mentally handicapped adults.

Section 7 of the Charter of Rights and Freedoms also played an instrumental role in a January 1988 Supreme Court decision overturning a Criminal Code provision that had made abortion illegal. The court held the provision to be inoperative because it violated constitutional guarantees.

In effectively legalizing abortion in Canada, the Supreme Court observed that some sort of criminal limit on abortion might be constitutional, providing that it respected a woman's own priorities and aspirations and took effect at an appropriate stage of gestation, indicated as being at some time during the second trimester of pregnancy.

Abortion is legally regulated in Canada under provincial laws on the practice of medicine concerning such matters as unqualified and unethical practices. Abortion is otherwise regulated, as the Supreme Court observed, by personal morality. The Canadian Government took time in considering whether any new criminal abortion law should be proposed, and in the fall of 1989 it proposed new criminal law to prohibit abortion unless a doctor finds that a woman's physical, mental, or psychological health would be endangered by continuation of pregnancy. The proposal sets no gestational limits.

Before this, in February 1989, the Law Reform Commission produced for public

discussion its Working Paper 58, entitled *Crimes Against the Foetus*. This was attacked by supporters of restrictions on abortion for proposing that abortion be quite liberally available up to the twenty-second week of gestation, and available thereafter if the fetus were held to be suffering from a malformation or disability of such severity that medical treatment could be legally withheld upon its birth. Supporters of allowing women to choose abortion attacked the report for proposing that abortion be available only to protect a woman's health, whether physical or psychological, and rendering a woman's reproductive choice subject to medical indications and authorization. In the new legislation proposed by the Government as a compromise among different preferences, few of the Law Reform Commission's recommendations were adopted.

In the outline of its program presented at the opening of the new parliamentary session in March 1989, the Government proposed establishing a Royal Commission on New Reproductive Technologies, which came into being in October 1989. The terms of reference of the commission have been widely drawn. The scope of the inquiry will cover infertility, artificial insemination, ovum and pre-embryo transfer, and *in vitro* fertilization, which is becoming increasingly available in Canada but is publicly funded only at a number of centers in Ontario. The inquiry will also cover surrogate motherhood, which is not necessarily dependent on medical technology. A growing phenomenon at some centers is interest in "full" surrogate motherhood, in which preembryos are created *in vitro* and implanted in a woman other than the ovum donor for surrender on birth to the source of the ovum and her sperm-supplying husband.

The commission was created in part at the urging of feminist activists who feel

that the field of assisted reproduction warrants national attention and a nationwide approach. This view emerged partly in response to 1985 recommendations of the Ontario Law Reform Commission that appeared in its two-volume *Report on Human Artificial Reproduction and Related Matters*. The most controversial recommendation in the report, proposed as an exercise in damage-control but sometimes misconstrued as advocating surrogate motherhood, supported a system of "surrogate adoption" dependent on judicial approval. The Canadian Fertility and Andrology Society and the Society of Obstetricians and Gynecologists of Canada are about to approve a code of ethics addressing artificial reproduction, but the proposed Royal Commission may cause other professional associations to halt or eschew independent initiatives in order to collaborate with the commission and respond to its final report and recommendations scheduled for the end of 1991.

The Science Council of Canada has work in hand on the medical, scientific, ethical, and legal issues raised by prognoses of genetic predispositions and is currently producing a report on this subject. The work involved is relatively comprehensive, and while its implications for human reproduction are potentially of considerable significance, human reproduction issues are only some of those to be addressed.

The issue of nontreatment of seriously handicapped newborns has aroused relatively little special concern in Canada, although ethicists and related professionals, including teachers, remain aware of the issues the topic raises and of regulatory responses in the United States, Europe, and elsewhere.

THE DYING PROCESS

In 1984 the Canadian Medical Association, the Canadian Nurses' Association,

and the Canadian Hospital Association issued a *Joint Statement on Terminal Illness* intended to indicate the circumstances and conditions that made it ethical to write "do not resuscitate" orders. A protocol was thereby approved as a basic national guideline for those involved in care of the terminally ill. The joint statement was facilitated by the Law Reform Commission of Canada's 1983 report (No. 20) entitled *Euthanasia, Aiding Suicide, and Cessation of Treatment* and was reciprocally approved by implication in the commission's 1986 report (No. 28) entitled *Some Aspects of Medical Treatment and Criminal Law*.

The latter report went beyond patients in terminal conditions, however, and observed on page 12 that "... an individual may refuse treatment or have it stopped, even if doing so places his life in jeopardy. This is true, for example, of a Jehovah's Witness who refuses a blood transfusion or a patient suffering from a serious illness who desires to end treatment or to stop intravenous feeding. It is clearly important to ensure that the decision is that of a lucid person who is capable of making it. If this condition is met, the Commission considers that the decision should be carried out even though to an impartial observer it may not appear to be objectively valid." Consistent with the commission's thinking, in the spring of 1990 the Ontario Court of Appeal upheld an award of \$20,000 in damages for battery to a Jehovah's Witness plaintiff who suffered blood loss in a serious traffic accident, even though the trial judge found that the blood transfusion she received while unconscious probably saved her life. (The defendant physician knew that the patient was carrying a signed Jehovah's Witness card refusing consent to blood transfusion.)

Associations of health professionals have been active in developing guidelines applicable to terminal care. In Feb-

ruary 1987, for instance, the Canadian Medical Association issued a position statement on resuscitation of the terminally ill, and later in the year issued the report of its Committee on the Health Care of the Elderly. This latter report identified many strengths and weaknesses of the health care system in the geriatric field and recognized many critical areas, both medical and nonmedical, that affect the independence of elderly persons regarding terminal care decisions and other matters.

No Canadian jurisdiction has enacted legislation on natural death that legitimates "living wills"; but judicial decisions, including Supreme Court decisions, have given such statements considerable legal significance. Indeed, following the aforementioned Ontario Court of Appeal decision on the claim of the Jehovah's Witness plaintiff, such refusals of treatment may now be said to have the force of common law. Several jurisdictions have enacted or amended laws on powers of attorney so as to permit such powers to apply when the principal who executed the power is no longer mentally competent. In these ways, advance medical care directives may be legally effective.

Death is increasingly defined in Canada to include whole brain death. This is legislated only in Manitoba, but following the Law Reform Commission of Canada's 1981 report (No. 15) entitled *Criteria for the Determination of Death* and its 1984 working paper (No. 33) entitled "Homicide," it is now widely accepted that death may be legally certified on the basis of this neurologic criterion.

BIOTECHNOLOGY

Since the Canadian Minister of State for Science and Technology issued the 1981 task force report entitled *Biotechnology: A Development Plan for Canada*, a

number of agencies have published relevant papers. The most active agency has been the Science Council of Canada, which has produced papers including *Biotechnology in Canada: Promises and Concerns* (with the Institute for Research on Public Policy, 1981); *Biotechnology in the Pulp and Paper Industry* (1984); *Regulatory Policies of Biotechnology in Canada* (1984); and *Seeds of Renewal: Biotechnology and Canada's Resource Industries* (Report 38, 1985). Institutions in both the public and private sectors are responding to the industrial, commercial, agricultural, veterinary, medical, and other challenges and opportunities presented by biotechnology. Industrial and research activities tend to be based in the major population centers of Ontario and Quebec, but the potential for uniform regulation arises through federal law.

Accordingly, the Law Reform Commission of Canada has recently proposed commencing a study of regulatory law that would promote biotechnologic developments and also control applications of biotechnology where the public interest so requires. The project may stand by itself or be part of wider programs—such as one in administrative law that published the study paper *Pollution Control in Canada: The Regulatory Approach in the 1980s* in 1988, or the protection of life program that published the study paper *Pesticides in Canada: An Examination of Federal Law and Policy* in 1987.

ORGAN TRANSPLANTS

Most provincial legislation in Canada relating to organ transplants is based on the Uniform Human Tissue Gift Act approved by the Uniform Law Conference of Canada in 1971. However, in 1987 the Uniform Law Conference of Canada, composed of those who chair the different provincial and territorial Law Reform Commissions, approved a new

Uniform Human Tissue Act that was presented at the initiative of the Alberta Commissioners.

The new uniform draft act is currently under consideration for adoption in some Canadian jurisdictions. It retains the "opting in" basis of current legislation, except regarding the pituitary gland, which in some jurisdictions is subject to an "opting out" or "presumed consent" law. The uniform draft act generally reflects the conservative approach taken to amendment of prevailing legislation by the Alberta Commissioners, although it does include common law (legally unmarried) spouses among those able to consent to *post mortem* donations.

The Report of the Alberta Commissioners found no Canadian agreement on formalization of a national transplantation registry, although the Federal Government favored a national registry. The commissioners similarly considered that issues of donor and recipient selection should be addressed at the provincial rather than the federal level. Permission for commerce in transplantable human tissues was not proposed for consideration.

AIDS

The Canadian Federal Center for AIDS has proposed standards for anonymous unlinked seroprevalence studies. Such

studies, currently being undertaken in Quebec, have been proposed in British Columbia and Ontario but are being obstructed there by laws that require, or are interpreted to require, that applicants for AIDS tests give their names, addresses, and perhaps health insurance plan numbers.

AIDS is a reportable disease in all Canadian jurisdictions, but it is unclear in some jurisdictions whether the AIDS-related complex (ARC) and HIV-positivity are reportable. Medical officers of health often seem reluctant to accommodate anonymous testing, although the climate of other informed opinion is turning strongly in favor of testing anonymity or strict confidentiality. At both federal and provincial levels, officers of governmental human rights protection agencies acknowledge that AIDS, ARC, and HIV-positivity are conditions of disability, and that to discriminate on the basis of them is unlawful. In January 1989 the Canadian Medical Association issued general guidelines on physicians' ethical responsibilities regarding management of HIV-positive patients and those at high risk of being positive, and also on the rights to compensation that arise in the case of occupational exposure to HIV. Recommendations for health professionals have also been issued by organizations such as the Canadian Dental Association and the Canadian Hospital Association.