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EDITOR'S NOTE

Michael Le Huynh[*]

The *MJLH*'s choice to move to two issues per year reflects the rapid developments in the field of health law. It was a natural response to the increasing demand of authors to have their novel research disseminated as quickly as possible, online and in print. As such, the *MJLH* team is pleased to present its inaugural second issue. Our ability to print biannually and maintain an efficient publishing cycle is thanks to the continuing support of the McGill Faculty of Law, its students, student organizations, and alumni.

This issue begins with a piece whose theme resonates perfectly with the objectives of the *MJLH*. It addresses the complex interplay between law and health. Specifically, it focuses on the nexus of intellectual property and public health, as well as the unique perspective necessary for achieving policy coherence with such inter-sectoral issues. Tania Bubela, E. Richard Gold, and Jean-Frédéric Morin provide three example policy areas at the border of intellectual property and health, and then describe the attempts of various governments to craft coherent policies at the domestic and international levels. The authors analyze the successes and failures, and conclude by proposing guidelines for achieving actual policy coherence.

L'article qui suit traite de la prohibition de la gestation pour autrui au Québec, un sujet toujours controversé. Marie-France Bureau et Édith Guilhermont apportent une critique comparative qui examine les fondements de la prohibition au Québec et en France. Étayée d'une analyse du discours bioéthique dominant et des études scientifiques portant sur les personnes impliquées dans la gestation pour autrui, leur critique conclut que les motivations pour interdire cette pratique en occident relèvent du désir de maintenir une certaine représentation de la maternité.

The third article challenges the civil immunity provisions for physicians employed by the government. Andrew Martin conducts a formidable legislative and case law review to reveal these lacunae in professional responsibility. He argues that Ontario's statutory good-faith immunity provisions, widely applied for most public actors but rarely disputed by legislators, are inappropriate in the context of providing medical services. Instead, he proposes the repeal of these immunity provisions. His alternative legal framework subjects all physicians to tort liability, yet leaves room for consideration of the unique demands of government physicians fulfilling broader policy functions.

I would like to thank my executive board and the entire Volume 4 *MJLH* team for their efforts throughout this academic year. Furthermore, I must commend the incoming Volume 5 team, in particular David Parry, Michael Shortt, and Chad Bass-Meldrum, for their support and willingness to make the *MJLH* a biannual publication. Their exceptional diligence and leadership over the last six months not only provided for the timely release of this second issue but also secured the success of subsequent issues. Their continued dedication undoubtedly lays the groundwork for the Journal's future growth and standing in the health law community.

À votre santé!

[*] Editor-in-Chief, McGill Journal of Law and Health, Vol. 4.

WICKED ISSUES FOR CANADA AT THE INTERSECTION OF INTELLECTUAL PROPERTY AND PUBLIC HEALTH: MECHANISMS FOR POLICY COHERENCE

Tania Bubela, E. Richard Gold, and Jean-Frédéric Morin[*]

This article focuses on the intersection of health and one of the main drivers of the global economy, intellectual property ("IP"). It is widely recognized that IP is an inter-sectoral issue with linkages to many other important public policy areas, such as health, agriculture, the environment, and education. In inter-sectoral issues such as IP, there is discussion on the need for governments around the world to achieve policy coherence not only across their various departments, but also between their domestic and international positions in important fora.

To appreciate better the complexity of achieving policy coherence, this article first gives a multi-disciplinary view of policy coherence and then provides the Canadian context for the debate. Next, it describes three examples at the border of public health and intellectual property in Canada and internationally: (1) health innovation and access to medicines in developing countries; (2) traditional knowledge (medicinal); and (3) pandemic influenza preparedness. Finally, the article discuses international experiences with a variety of mechanisms for achieving policy coherence in IP and health, including the practice of advisory groups, multi-stakeholder dialogue, inter-departmental coordination mechanisms, broad delegations for international meetings, and white papers. From this review, a few observations can be made. First, effective coordination requires two main factors: leadership and a permanent institution that can build trust. While inter-ministerial coordination is a widely used process for policy coherence, it is not always successful. Indeed, the lack of leadership in inter-ministerial coordination has strongly constrained policy coherence.

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Despite the importance of the task of developing policy coherence, achieving it has often been elusive. Many governments around the world have spoken of policy coherence, but few have developed mechanisms to implement it. Of these, fewer still have actually attained coherence, and empirical evidence of the actual impacts of coherence is lacking. One thing appears clear: a government department wishing to create policy coherence should avoid doing it alone. Trying to achieve coherence in the absence of a government-wide and politically supported mechanism is likely to do more harm than good as the department falls prey to those departments fixated on only furthering their own policy agendas. A department—or unit within a department—wishing to engage in policy coherence must therefore raise the importance of attaining coherence at the highest levels of government: the Cabinet. A clear statement of policy by the Cabinet, coupled with strong institutional mechanisms for the administration are likely the best way to ensure the development of policy coherence. While numerous mechanisms may assist in these processes, they can only do so with effective leadership and an environment of trust.

INTRODUCTION

It is widely recognized that Intellectual Property ("IP") is an inter-sectoral issue with linkages to many other important public policy areas, such as health, agriculture, the environment, and education.[1] Like other countries, Canada is increasingly engaged in the particular subset of international discussions that link IP with public health.[2] The intersection points between these two issues may occur at many levels, including local health delivery, health financing, innovation[3] policy, science policy, health research funding and administration, access to health care innovation for marginalized communities and developing countries, research and development in neglected and emerging infectious diseases, traditional medicine, foreign investment, foreign trade, and development assistance.

This intersection of public health and IP may be thought of as a "wicked issue": "a problem that is complex, difficult to define, with no immediate solution, and one where every wicked problem can be considered to be a symptom of another problem."[4] Accordingly, there is discussion on the need for governments to coordinate policies not only across their various departments but between their domestic and international positions in important fora. Such coordination may be termed policy coherence, whole-of-government coordination or joined-up government, depending on the country. This article discusses the particular challenges governments face in developing mechanisms through which to respond to health, economic, and social concerns in a coherent and coordinated manner.

The starting premise is that economic policies (including IP policies) should not impede health equity, for example by privileging access to healthcare for wealthier segments of the population. At the same time, we acknowledge that economic development (including the development of innovative or new drugs and other therapies in the pharmaceutical sector) is a major determinant of the overall health status of countries. At the international level, the right to health has been acknowledged as a human right in various instruments,[5] while at the national level,

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1 Laurence R. Helfer, "Regime Shifting: The TRIPs Agreement and New Dynamics of International Intellectual Property Lawmaking" (2004) 29 Yale J. Int'l L. 1 at 8; Ahmed Abdel Latif, "Developing Country Coordination in International Intellectual Property Standard-Setting" (2005) Trade-Related Agenda, Development and Equity (T.R.A.D.E.) Working Papers 24.

2 To understand the complex nature of the relationship between public health and IP, it is first necessary to define "public health". The Public Health Agency of Canada, in its *Sustainable Development Strategy 2007-2010: Toward Sustainable Development in Public Health*, recognized the 1948 World Health Organization ("WHO") statement that "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" ((Canada: PHAC, 2006) Catalogue No. HP5-17/2006, online: PHAC <http://www.phac-aspc.gc.ca/publicat/sds-sdd/pdf/sds-sdd_e.pdf> at 3 [*Sustainable Development Strategy*]). In this context, "Public health focuses on preventing diseases not just curing them. It pays attention to the economic inequalities, social problems, and environmental issues that cause many diseases and so addresses the root causes of disease. It does this by establishing policies, services, and education programs that can prevent many diseases from occurring in the first place" (UNESCO, "Educating for a Sustainable Future: A Transdisciplinary Vision for Concerted Action" (Background paper delivered at the International Conference on Environment and Society: Education and Public Awareness for Sustainability, Thessaloniki, Greece, 8 to 12 December 1997), online: UNESCO <http://www.unesco.org/education/tlsf/TLSF/theme_a/mod01/uncom01t05s01.htm> at para. 89, citing *Sustainable Development Strategy*, *ibid.* at 3).

3 Here, we rely on Schumpeter's conceptualization of innovation that requires ideas to be successfully applied in practice. This distinguishes innovation from an invention, which is simply an idea made manifest (Joseph Schumpeter, *The Theory of Economic Development* (Boston: Harvard University Press, 1934)).

4 Mark Petticrew *et al.*, "Better Evidence About Wicked Issues in Tackling Health Inequities" (2009) 31:3 Journal of Public Health 453 at 454.

5 For example, *Universal Declaration of Human Rights* (GA Res. 217A (III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71); *International Covenant on Economic, Social and Cultural Rights* (993 U.N.T.S. 3, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entered into force 3 January 1976, in accordance with art. 27 [*International Covenant*]). Several regional human rights instruments also recognize the right to health. See e.g. art.

recent Canadian Supreme Court jurisprudence has recognized, at least to some extent, *Charter* rights to timely access to healthcare.[6] A second starting premise, discussed in this article, is that while IP is justified on the basis that rewarding inventors with property rights stimulates innovation from which society may benefit, it is highly debatable whether increased patent protection for health related products and processes has, in fact, stimulated innovation by the pharmaceutical industry in Canada.[7]

The issue of policy coherence and coordination for health and IP is further complicated by two factors. First, at a national level, it is likely that policies aimed at accomplishing policy coherence between IP and public health would have incidental impacts on other policy arenas. Second, given the proliferation of international fora in which these issues are discussed,[8] when national objectives are promoted in international fora, they may be presented by different government departments and agencies with not only differing objectives and priorities, but also differing degrees of power and autonomy.[9] Such a scenario, as discussed in this article, suggests that national coherence in IP and public health policies is desirable, but challenging. These spillover effects with potential unintended negative consequences coupled with intensely competing interests make the IP-health intersection a wicked issue.

This article starts with a multidisciplinary review of the concept of policy coherence and a description of the key Canadian agencies responsible for IP, public health, or both. It then describes three examples at the border of public health and IP to illustrate the complexity of achieving policy coherence: (1) health innovation and access to medicines in developing countries; (2) access to genetic resources and traditional medicinal knowledge; and (3) pandemic influenza preparedness. Each of these examples illustrates how boundary issues cross departmental jurisdiction and require a coordinated approach.

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11 of the *European Social Charter* (18 October 1961, 529 U.N.T.S. 89, Eur. T.S. 35 (entered into force 26 February 1965)); art. 16 of the *African Charter on Human and Peoples' Rights* (27 June 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 1520 U.N.T.S. 217; 21 I.L.M. 58 (entered into force 21 October 1986)); and art. 10 of the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (*"Protocol of San Salvador"*, 17 November 1988, O.A.S.T.S. 1988 No. 69, 28 I.L.M. 156 (entered into force 16 November 1999)). Furthermore, the right to health is echoed in the *Constitution of the World Health Organization*, which states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being … " ((Off. Rec. Wld Hlth Org., 2, 100) adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States, and entered into force 7 April 1948, online: WHO <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>).

6 See e.g. *Chaoulli v. Quebec (A.G.)*, 2005 SCC 35, [2005] 1 S.C.R. 791 (three of four judges in the majority recognized that a denial of ability to seek private health insurance to access timely care (hip replacement) was a violation of s. 7 of the *Canadian Charter of Rights and Freedoms* (Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), c. 11)). For a general discussion of *Charter* cases on access to health care see Nola M. Ries, "Charter Challenges" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, eds., *Canadian Health Law & Policy*, 3d ed. (Markham, Ont.: LexisNexis Canada, 2007) at 539.

7 Mélanie Bourassa Forcier & Jean-Frédéric Morin, "Canadian Pharmaceutical Patent Policy: International Constraints and Domestic Priorities" in Ysolde Gendreau, ed., *An Emerging Intellectual Property Paradigm: Perspectives from Canada* (Cheltenham: Edward Elgar Publishing Limited, 2008) at 81; Matthew Herder & E. Richard Gold, *Intellectual Property Issues in Biotechnology: Health and Industry* (Report delivered at the 3rd Mtg. of the OECD, Steering Group for the International Future Project, The Bioeconomy to 2030: Designing a Policy Agenda, Paris 7-8 February 2008) at 5, online: OECD <http://www.oecd.org/dataoecd/16/9/40181372.pdf>).

8 See Appendix 1 at the end of this paper for details.

9 Latif, *supra* note 1.

The article then discusses mechanisms for achieving policy coherence through an examination of how other countries have managed policy coherence at the intersection of IP and public health. Specifically, the article outlines institutional mechanisms for greater coherence used in the U.S., the U.K., Switzerland, the Netherlands, Australia, Japan, Brazil, and India. This examination sets the stage for a discussion of mechanisms to achieve policy coherence in Canada. The article concludes with a discussion of the costs and benefits of attempting policy coherence on IP and health for Canada nationally and for the Canadian position in international fora. It discusses the appropriateness of a variety of mechanisms for achieving policy coherence based on international experiences.

I
A MULTI-DISCIPLINARY VIEW OF POLICY COHERENCE

Political scientists tend to favour a substantive definition of policy coherence as an outcome, (i.e., the degree of complementarity and consistency between logically-related policies generated by a political unit).[10] Using this substantive definition, both coherence and incoherence could be the result of political dynamics. Increased coherence could be the result of internal power politics where one organization (a ministry for example) gains control and legitimacy over its peers.[11] Incoherence could also be an intended strategy to extract political gains with diverse and fragmented audiences.[12] Accordingly, two factors are positively correlated with policy coherence in the literature: first, the control of a lead organization within government and second, a united constituency with a shared policy perspective. This paper comes back to this point in the conclusion arguing that based on the countries surveyed, coherence was best accomplished in intersectoral issues with the adoption of a national approach, with clear and consensual policy objectives, organized and supported at the highest levels of government.

The reality, however, is that central decision-makers typically have limited control and agencies involved have multiples audiences and various interests. In this context, institutional and political constraints on policy-making may lead to "policies by the way", a term coined by Dery in 1998 which refers to policies made incidentally in the making of other policies.[13] In this sense, a policy promoted by an agency may be either a "substitute" or a "complement" for another policy that is not under the jurisdiction of this agency.[14] A Canadian example of a substitute policy would relate to Federal and Provincial constitutional division of powers. Canadian provinces do not have constitutional jurisdiction over patent law but can nevertheless incentivize investments in research and development ("R&D") through provincial research policies, periods of exclusive purchasing by provincial health systems, or selective coverage of pharmaceuticals and medical treatments. An example of a complementary policy is the creation of the Patented Medicine Prices Review Board ("PMPRB") in 1987, the mandate of which is to compensate for the effect of new limitations in IP law on compulsory licenses for medicines to ensure that Canadian prices

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10 R.A.W. Rhodes, "'Shackling the Leader?' Coherence, Capacity and the Hollow Crown" in Patrick Weller *et al.*, eds., *The Hollow Crown: Countervailing Trends in Core Executives* (New York: St. Martin's Press, 1997) 198 at 222, n. 1.

11 Alice Moseley, "Joined-Up Government: Rational Administration or Bureaucratic Politics?" (Paper delivered at the Public Administration Committee Annual Conference at the University of Glamorgan, 7-9 September 2009).

12 Moseley, *ibid.*; Robin Pistorius, "Forum Shopping: Issue Linkages in the Genetic Resources Issue" in Robert V. Bartlett, Priya A. Kurian & Madhu Malik, eds., *International Organisations and Environmental Policy* (Westport: Greenwood Press, 1995) at 209.

13 David Dery, "Policy by the Way: When Policy is Incidental to Making Other Policies" (1998) 18:2 Journal of Public Policy 163.

14 *Ibid.*

for medicines are reasonable compared to those in other developed countries.[15] Such substitutes and complements are more frequent than direct policies and produce much of the inconsistency. In Canada, this issue is particularly complex because of Canada's federal structure and the split jurisdiction over healthcare and health research and innovation. This complexity causes spill-over effects for Canada's positions on IP and public health internationally.

A further consideration, especially in light of Federal-Provincial relations and the relations between levels of government and Canada's First Nations, Inuit, and Métis, is that decentralization in policy-making may also lead to policy incoherence. Indeed, it is widely acknowledged that the rise of the "new public management" since the 1980s, which favoured decentralization to local authorities, empowerment of lower echelon employees, and creation of semiautonomous organizations, led to a decline in policy coherence.[16] With increased fragmentation, motivated by enhanced effectiveness, governments lost control and expertise over complex and traversal issues. As the Organization for Economic Cooperation and Development ("OECD") observed, "constitutional, legal and political obstacles to policy coordination exist partly in order to maintain clear distribution of responsibilities and specialization of tasks among sectors and across levels of government."[17] The Canadian example discussed below of decentralization of power and policy-making relates to discussions over Canada's policy on the Implementation of the Access and Benefit Sharing provisions of the UN *Convention on Biological Diversity* ("*CBD*").[18]

A second body of literature favours a procedural definition of policy coherence, namely, the degree to which institutions operate in a coherent and well-coordinated process of deliberation and decision-making. From this perspective, coherence in the process is always desirable, even when leading to incoherence in the outcome. For example, Jordan and Halpin argue that some level of incoherence in the outcome is necessary to avoid the hegemony of one issue-area of policy-making over all others, but that a rational "bargaining among informed and relevant participants" is an essential process of decision-making.[19] One Canadian experience—largely a failure—with an emphasis on procedural coherence is the example of Canada's Access to Medicines Regime, also discussed below.

Notably, the pursuit of greater procedural coherence in a transparent and inclusive process may come at the expense of effectiveness. This compromise is acknowledged by the OECD: "[E]xcessive efforts to enhance coherence can result in a high degree of central control and a consequential loss of flexibility in the policy-making system."[20] The paradox, however, is that

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15 *Patent Act*, R.S.C. 1980, c. P-4, ss. 88-89, 91; *Patented Medicines Regulations*, S.O.R./94-688, ss. 5-6. With respect to most medicines that represent either a change in dosage or a small improvement, the PMPRB compares the price of medicines sold on the Canadian market to existing Canadian medicines (*Patent Act*, *ibid*., s. 85). For breakthrough medicines, the PMPRB will compare the Canadian price to the median price in seven reference countries: France, Germany, Italy, Sweden, Switzerland, the U.K. and the U.S. (*Patented Medicines Regulations*, *ibid*., Schedule, s. 4(1)(f)(iii)). Should the PMPRB find a price to be excessive, the company has the choice of either agreeing to cut its price and pay excess revenues to the federal government or, alternatively, having a public hearing held by the PMPRB. If the hearing supports the conclusion of an excessive price, the PMPRB will impose a penalty of up to twice the amount of excess revenues earned by the drug in question (*Patent Act*, *ibid*., s. 83).

16 Chrisopher D. Foster & Francis J. Plowden, *The State Under Stress: Can the Hollow State be Good Government?* (Buckingham: Open University Press, 1996); Rhodes, *supra* note 10.

17 OECD, "Improving Policy Coherence and Integration for Sustainable Development: A Checklist" *OECD Observer* 1 at 3, (October 2002) [OECD, "Improving Policy Coherence"].

18 *Convention on Biological Diversity*, 5 June 1992, 1760 U.N.T.S. 79, online: UN <http://www.cbd.int/doc/legal/cbd-en.pdf> [*CBD*].

19 Grant Jordan & Darren Halpin, "The Political Costs of Policy Coherence: Constructing a Rural Policy for Scotland" (2006) 26:1 Journal of Public Policy 21 at 21, 39.

20 OECD, *Building Policy Coherence: Tools and Tensions* (Paris: OECD, 1996) at 8 [OECD, *Building Policy Coherence*].

effectiveness requires policy coherence in *outcome*. As stated by the OECD in the context of IP and public health,

> [t]he issue of policy coherence is important in improving the availability of medicines since a number of policy areas need to be brought together in a coherent manner—including health, trade, science and technology, development co-operation and finance—in such a way as to create an environment that will spur both investments in, and efficiency of, research and product development.[21]

Accordingly, there is no consensus and limited practical examples on how to increase coherence in the *outcome* without unduly focusing on increasing coherence in the *process*, since a focus on the latter, while more immediately rewarding, may have detrimental or unintended effects on the former.

II
THE CANADIAN CONTEXT—ROLES OF INDUSTRY CANADA & HEALTH CANADA

This part sets the Canadian context, outlining the structural and economic issues at the IP-public health intersection. In Canada, patents are administered by the Canadian Intellectual Property Office and the *Patent Act*[22] is under the purview of Industry Canada. The *Patent Act* governs patent protection for inventions that are new, useful, and non-obvious.[23] A patent is a limited monopoly that is granted for twenty years in exchange for the public disclosure of the invention.[24] The conventional wisdom is that by providing a legal (but not necessarily economic) monopoly, patents create an incentive or profit motive for the transformation of invention (the creation of ideas) into innovation (products and services that are made available on the market).[25] Patents constitute, however, only a small portion of the incentives that exist to promote invention and innovation; other incentives include tax credits, grants, good management, and simply being the first to market innovative products and services, which often leads to better established distribution channels, increased brand loyalty and decreased production costs associated with "learning by doing".[26]

Surprisingly, it is difficult from an economic and innovation perspective to determine Canada's national interests for public health and IP rights. There is little consistent or coherent data available on Canada's R&D environment, manufacturing capacity, domestic markets, and trade and investment flows for pharmaceuticals, biotechnology, and medical devices—all necessary information for calibrating IP protection with respect to the level of innovation.[27]

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[21] OECD, *Coherence for Health: Innovation for New Medicines for Infectious Diseases* (Paris: OECD, 2009) at 56 [OECD, *Coherence for Health*].

[22] *Patent Act*, *supra* note 15.

[23] *Ibid.* s. 2: "'invention' means any new and useful art, process, machine, manufacture or composition of matter, or any new and useful improvement in any art, process, machine, manufacture or composition of matter".

[24] Lionel Bentley & Brad Sherman, *Intellectual Property Law*, 2d ed. (Oxford: Oxford University Press, 2004) at 323.

[25] Edmund W. Kitch, "The Nature and Function of the Patent System" (1977) 20:2 J.L. & Econ. 265.

[26] See e.g. Frederic M. Scherer, "The Economics of Human Gene Patents" (2002) 77:12 Academic Medicine 1348 at 1350.

[27] The reason for this is due to the fact that official statistics in Canada are based on the North American Industrial Classification System ("NAICS") that categorizes each company according to its core activity, making it difficult to extract product or field specific data. For example, the NAICS does not have a category for biotechnology. Medical devices are not just confined to Medical Equipment and supplies manufacturing (NAICS 33911) but overlap with other categories such as Electromedical and Electrotherapeutic Apparatus Manufacturing (NAICS 334510), Irradiation Apparatus Manufacturing (NAICS 334517) and Other Electronic and Precision Equipment Repair and Maintenance (NAICS 811219). In the case of pharmaceuticals, NAICS

Nevertheless, our analysis[28] accords with the conclusion of Kaland and Shrier, who found that "[a]fter initially raising R&D spending to a previously determined level, the Canadian pharmaceutical industry has steadily lowered its expenditure. Further, based on available data, longer patent protection and increased R&D spending do not appear to have increased research productivity."[29]

In contrast to the importation into Canada of most brand name pharmaceutical products, the Canadian Generic Pharmaceutical Association claims that almost all generics are manufactured domestically.[30] It further contends that most of Canada's pharmaceutical manufacturing capacity is generic.[31] Canada's generic drug industry generates 40% of its sales volume from exports, most of which goes to the U.S., but spends less than half the amount on R&D as brand name firms.[32]

Aside from stimulating innovation, another argument in favour of patent protection for biomedical innovation is tied to the regulatory approval process for such products. Regulation—testing and monitoring the safety and efficacy of new drugs and medical devices—has a significant impact on health innovation in Canada and constitutes a non-patent barrier to entry into the Canadian market that complements the patent regime. One of the largest costs in drug development involves clinical trials. Regulation over safety and efficacy of products takes place not only prior to obtaining approval to sell the product in Canada but also through post-sale monitoring. There are three implications to regulatory activity. First, the cost of complying with regulatory requirements—including clinical trials—is used to justify existing patent rights. With high and increasing costs of clinical trials, companies need secure and exclusive market access in order to recoup their investments in R&D. Second, the cost of meeting regulatory requirements presents a significant barrier to market access in addition to that presented by patents. Only firms with substantial financial resources that can carry the costs of investment for a long period of time can afford to enter the market. Data protection rules maintain this barrier by preventing Health Canada from sharing clinical data with later entrants for a period of eight years (eight and a half years for paediatric medicines).[33] Third, linkages between market approval and patents lead to attempts by policy-makers to balance the interests of innovator companies in recouping their investments against the interests of the general public and generic companies in particular. We argue that the balancing of interests, in addition, needs to take into account the concerns of

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does not list pharmaceutical companies as a category but, instead, pharmaceutical and medicine manufacturing (NAICS 32541). In this category, only companies with pharmaceutical manufacturing as their core activity are listed. A pharmaceutical company more focused on R&D, as with many contract research organizations or human health biotech companies, is often listed in a different category, such as Research and Development in the Physical, Engineering and Life Sciences (NAICS 541710), Other Specialized Design Services (NAICS 541490), Other Scientific and Technical Consulting Services (NAICS 541690), or Medical and Diagnostic Laboratories (NAICS 621510). Each of these categories includes not only pharmaceutical firms but other types of firms, which makes it very difficult to provide accurate information specific to pharmaceuticals.

28 The Innovation Partnership (co-author: T. Bubela), *Intellectual Property and Health, A Report to Health Canada: Bioethics, Innovation and Policy Integration Division* (2010), online: The Innovation Partnership <www.theinnovationpartnership.org>.

29 Norman Kaland & Ian Shrier, "Research Output of the Canadian Pharmaceutical Industry: Where Has All the R&D Gone?" (2006) 1:4 Healthcare Policy 21 at 30.

30 The two biggest players in the Canadian generic sector are Apotex (Canadian-owned) and Novopharm (Israeli-owned). They account for approximately 6% and 2% of the Canadian drugs market, respectively. See The Canadian Generic Pharmaceutical Association, "Resources" (2010), online: CGPA <http://www.canadiangenerics.ca/en/resources/economic_benefits.asp>.

31 *Ibid.*

32 Estimates are that generic manufacturers spent $450 million on R&D, as compared to $1,210 million for name brand firms: Canadian Generic Pharmaceutical Association, *The Role of the Generic Pharmaceutical Industry in Canada's Economy* (Toronto: Canadian Generic Pharmaceutical Association, August 2010), online: CGPA <http://www.canadiangenerics.ca/en/advocacy/docs/The_Role_of_the_Generic_Pharmaceutical_Industry_in_Canada%27s_Economy.pdf>.

33 *Regulations Respecting Food and Drugs*, C.R.C., c. 870, s. C.08.004.1.

the Canadian public about the sustainability and quality of the publicly funded healthcare system. The ever escalating costs of healthcare in Canada,[34] in part driven by the cost of pharmaceuticals and technological innovation, enhances the argument that IP policies should be informed by health policy concerns more than the reverse.

III
EXPERIENCES WITH POLICY COHERENCE IN IP AND PUBLIC HEALTH: THREE EXAMPLES

To appreciate better the complex environment in which public health and IP issues arise at the international level, this Part outlines three recent examples with direct relevance for Canada. Each of these examples illustrates how resolution of the issues required the participation of Health Canada and at least one other federal department. We then compare the Canadian experience to that of other countries attempting to achieve policy coherence at the intersection of public health and IP. While not all of these examples have been successful, they point to the different instruments available to governments to increase coherence without losing momentum in developing policy.

A. Innovation and Access to Medicines

On September 26, 2003, Canada became the first country to announce its intention to amend its *Patent Act* to authorize the export of generic drugs manufactured under compulsory licenses.[35] Briefly, the history of this amendment originates with the passage of *Trade-Related Aspects of Intellectual Property Rights* ("*TRIPS*")[36]—the most comprehensive multilateral agreement on IP that sets minimum standards of protection for copyright, trademarks, and patents, among other forms of IP rights. Most problematically, it required all WTO Members (the majority of the world's countries including both developing and developed countries) to grant patents over pharmaceutical products, whether starting in 1995, 2005, or 2016. Up to that time countries such as India only granted process patents over pharmaceuticals and not product patents. However, there is also ongoing debate about the wording and application of *TRIPS* and what are known as *TRIPS* flexibilities.[37] These include flexibilities as to substantive standards of protection and the availability of compulsory licensing.[38]

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34 Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2010* (Ottawa: CIHI, 2010), online: CIHI <https://secure.cihi.ca/estore/productSeries.htm?pc=PCC52>.

35 Heather Scoffield & Steven Chase, "Ottawa Heeds Call on AIDS" *The Globe and Mail* (26 September 2003) A1. See also James Orbinski, "Access to Medicines and Global Health: Will Canada Lead or Flounder?" (2004) 170:2 Canadian Medical Association Journal 224 at 224.

36 1869 U.N.T.S. 299, 33 I.L.M. 1197 (Annex 1C of the Marrakesh Agreement establishing the World Trade Organization, signed in Marrakesh, Morocco on 15 April 1994), online: WTO <http://www.wto.org/english/tratop_e/trips_e/t_agm0_e.htm> [*TRIPS Agreement*].

37 The World Intellectual Property Organization states: "These [TRIPS flexibilities] aim to permit developing and least-developed countries to use TRIPS-compatible norms in a manner that enables them to pursue their own public policies, either in specific fields like access to pharmaceutical products or protection of their biodiversity, or more generally, in establishing macroeconomic, institutional conditions that support economic development." The flexibilities fall within four broad categories: flexibilities as to the method of implementing *TRIPS* obligations, flexibilities as to substantive standards of protection, flexibilities as to mechanisms of enforcement, and flexibilities as to areas not covered by the *TRIPS* agreement (World Intellectual Property Organization, "Advice on Flexibilities under the TRIPS Agreement", online: WIPO <http://www.wipo.int/ip-development/en/legislative_assistance/advice_trips.html>).

38 Article 31 of the *TRIPS Agreement*, *supra* note 36, lists detailed conditions which must be complied with when a WTO Member chooses to use compulsory licensing. "A compulsory license is a license granted by an administrative or judicial body to a third party to exploit an invention without the authorization of the patent holder" (World Health Organisation, *Utilizing TRIPS Flexibilities for Public Health Protection Through South-South Regional Frameworks* (Geneva: The South Centre, 2004) at 12, online: WHO <http://

In this context, a transnational network of NGOs created the political momentum necessary to address some of the concerns raised by *TRIPS* on the issue of access to medicines for developing countries.[39] From the end of the 1990s, this network of NGOs capitalized on controversial cases of access to patented HIV/AIDS medications in Thailand, Brazil, and South Africa,[40] and later on the anthrax crisis of 2001, to communicate their message to media and WTO negotiators. This message was framed in a simple and highly successful formula equating patents with high prices, and therefore with the narrative of premature death.[41] Demonstrations in the streets of Washington, Paris, and Bangkok cast pharmaceutical companies as greedy multinationals, and then juxtaposed these firms against images of the sick and dying in developing countries.[42]

In response, the WTO reached the *Declaration on the TRIPS Agreement and Public Health* ("*Doha Declaration*") in 2001.[43] The *Doha Declaration* called for international negotiations to address the need of countries without sufficient pharmaceutical manufacturing capacity to import generic medicines produced under compulsory licensing. Among other things, the *Doha Declaration* provided that countries could issue compulsory licenses to import needed medicines. This was necessary as *TRIPS* had provided that these licenses could only "be authorized predominantly for the supply of the domestic market."[44] The *Doha Declaration* formally acknowledged that this situation was unacceptable and required WTO members to negotiate an "expeditious solution".[45] After two years of difficult negotiations, WTO members adopted the *WTO Decision* defining conditions under which a country could manufacture and export pharmaceutical products to another under a compulsory license.[46]

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apps.who.int/medicinedocs/fr/d/Js4968e/6.1.1.html>).

39 Debora J. Halbert, *Resisting Intellectual Property* (New York: Routledge, 2005); Ruth Mayne, "The Global Campaign on Patents and Access to Medicines: An Oxfam Perspective" in Peter Drahos & Ruth Mayne, eds., *Global Intellectual Property Rights: Knowledge, Access and Development* (New York: Palgrave MacMillan, 2002); Susan K. Sell & Aseem Prakash, "Using Ideas Strategically: The Contest Between Business and NGO Networks in Intellectual Property Rights" (2004) 48 International Studies Quarterly 143 at 163; Ellen 't Hoen, "Public Health and International Law: TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way From Seattle to Doha" (2002) 3 Chicago J. Int'l L. 27.

40 The U.S. had attempted to impose trade sanctions under the "Special 301" process that authorized the U.S. Trade Representative ("USTR") to undertake a review of IP laws and practices in other countries and impose sanctions if a country failed to revise their patent laws in accordance with TRIPS and other bilateral trade agreements with the U.S. that address IP protection. By a Statement of Administrative Action given to a WTO panel ruling on a dispute involving the Special 301 powers, the U.S. agreed to forego the unilateral imposition of sanctions (World Trade Organization, *United States – Sections 301-310 of the Trade Act of 1974,* WTO Doc. WT/DS152, online: WTO <http://docsonline.wto.org/>). Prior to that time, middle-income countries such as India, Brazil, and Thailand have been threatened with sanctions (Jillian Clare Cohen-Kohler, Lisa Forman & Nathaniel Lipkus, "Addressing Legal and Political Barriers to Global Pharmaceutical Access: Options for Remedying the Impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Imposition of TRIPS-Plus Standards" (2008) 3 Health Economics, Policy and Law 229 at 240-241). The most egregious example of the use of "Special 301", however, has been against South Africa after the South African government introduced its *South African Medicines and Medical Devices Regulatory Authority Act*, No. 132 of 1998, as rep. by *Medicines and Related Substances Amendment* Act, No. 59 of 2002 that allowed the Minister of Health "to revoke patents on medicines and to allow for broad-based compulsory licensing to manufacture generic versions of HIV/AIDS drugs" (Sell & Prakash, *ibid.* at 161). In addition, in 1998, 39 pharmaceutical companies filed a lawsuit against the government of South Africa over its *Act*. The suit was dropped in April 2001 under extreme international and NGO pressure: CPTech, "Court Case Between 39 Pharmaceutical Firms and The South African Government", online: CPTech <http://www.cptech.org/ip/health/sa/pharma-v-sa.html>.

41 Sell & Prakash, *supra* note 39 at 161.

42 Mark Weisbrot, "A Prescription for Scandal" *The Baltimore Sun* (21 March 2001) A17.

43 WTO Doc. WT/MIN(01)/DEC/2, 4th Sess., online: WTO <http://www.wto.org/english/theWTO_e/minist_e/min01_e/mindecl_trips_e.htm> [*Doha Declaration*].

44 *TRIPS Agreement*, *supra* note 36, art. 31(f).

45 *Doha Declaration*, *supra* note 43 at para. 6.

46 WTO, *Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public*

1. Canadian Response to Innovation and Access to Medicines

This example illustrates the outcome of one Canadian attempt at policy coherence between IP and global health that brought together a number of government departments and was supported at the highest political levels by the Prime Minister, Cabinet, and the legislative process. Soon after the *WTO Decision*, the Canadian government announced that it would amend the *Patent Act* to permit the issuance of compulsory licenses for export of pharmaceutical products. During the implementation process, the government faced pressure from conflicting stakeholders who were well aware that the legislation would serve as a model for other jurisdictions. "Members of the government repeated in their speeches and press releases their goal of striking a 'necessary balance' between the 'competing objectives' of facilitating the flow of drugs to developing countries, complying with international obligations, and maintaining the integrity of the domestic patent regime."[47]

To this end, five departments with different perspectives (Industry Canada, Health Canada, International Trade Canada, the Canadian International Development Agency, and the Department of Foreign Affairs) were fully engaged in the process of drafting the legislation that eventually became Canada's Access to Medicines Regime ("CAMR"). Moreover, the government integrated domestic and foreign non-state actors in the debate. Interestingly, each set of non-state actors was consulted separately rather than together. This led to a clearer picture of the different points of view, but left the work of overcoming differences to the government officials rather than to discussion between the stakeholder communities. Despite the difficult inter-ministerial dialogue and the extensive consultative process, the legislative process was rapid: Bill C-9 received its first reading in the House of Commons February 12, 2004 and received royal assent on May 14, 2004.[48]

Canada was not only the first country to amend its patent legislation to implement the *WTO Decision*, but was also the first and only to use its compulsory licensing provisions. On September 20, 2007, the Commissioner of Patents granted a compulsory license to Apotex to produce and export 260,000 packs of TriAvir, an HIV/AIDS combination therapy, to Rwanda.[49] The negotiations and delays in the process, however, were lengthy, and another compulsory license is unlikely to be requested or issued in the near future.[50] To date, no other WTO member has issued a compulsory license for export, and the WTO has received no further notifications from any exporting or importing country of their intention to do so under the system set up by the *WTO Decision*.

Because of failures in CAMR, Canada may become the first country to amend its implementing legislation.[51] On March 31, 2009, Senator Yoine Goldstein (since retired) introduced a private

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Health (held on 30 August 2003), WTO Doc. WT/L/540 and Corr. 1, online: WTO <http://www.wto.org/english/tratop_E/TRIPS_e/implem_para6_e.htm> [*WTO Decision*].

47 Tania Bubela & Jean-Frederic Morin, "Lost in Translation: The Canadian Access to Medicines Regime from Transnational Activism to Domestic Implementation" (2010) at 6 [unpublished, on file with authors]; Industry Canada, "Government of Canada Reinstates Legislative Proposals to Enable Export of Low-Cost Pharmaceutical Products to Least-Developed and Developing Countries" (12 February 2004), online: Government of Canada <http://www.ic.gc.ca/eic/site/ic1.nsf/eng/02437.html>; Privy Council Office, "Speech from the Throne to Open the Third Session of the 37th Parliament of Canada: Canada's Role in the World" (2 February 2004), online: Government of Canada <http://www.pco-bcp.gc.ca/index.asp?lang=eng&page=information&sub=publications&doc=sft-ddt/2004_1-eng.htm>.

48 Lalita Acharya & Kristen Douglas, "Legislative History of Bill C-9" (3 March 2004), online: Parliament of Canada <http://www2.parl.gc.ca/Sites/LOP/LegislativeSummaries/Bills_ls.asp?Parl=37&Ses=3&ls=C9>.

49 Apotex, Press Release, "Canadian Company Receives Final Tender Approval from Rwanda for Vital AIDS Drug" (7 May 2008), online: Apotex <http://www.apotex.com/global/about/press/20080507.asp>.

50 Indeed, at a University of Toronto/McGill University Workshop held in Ottawa in 2009, Apotex expressed significant concerns over CAMR, citing the length of the negotiations and the complexity of the process.

51 Frederick M. Abbott, "The WTO Medicines Decision: World Pharmaceutical Trade and the Protection

member's bill (S-232) to amend CAMR.[52] Then, on May 25, 2009, a similar bill (C-393) was introduced in the House of Commons by the New Democratic Party Member for Winnipeg North, the Honourable Judy Wasylycia-Leis.[53] Both bills were intended to facilitate the issuing of compulsory licenses by simplifying the conditions and requirements provided in the original CAMR.

S-232 and C-393 are actively supported by a group of Canadian NGOs led by the Canadian HIV/AIDS Legal Network and the Stephen Lewis Foundation.[54] These NGOs (as well as Canadian generic companies) criticize the complexity of the process to obtain a compulsory license and consider it unlikely that another compulsory license will be granted soon. According to Richard Elliott, the Executive Director of the Legal Network, "the current system just doesn't work."[55] Stephen Lewis is even harsher, stating publicly, "We have failed lamentably."[56] The brand name pharmaceutical industry, on the other hand, fully supports CAMR and is not in favour of its amendment. The Canadian government supported this latter position in its 2007 review of CAMR, led by Industry Canada, which concluded that the case for making regulatory changes to CAMR had not been made out.[57]

There is widespread agreement among neutral observers that the NGO community is correct in claiming that CAMR, in its attempt to deliver medicines to those who need them, can only be considered a failure.[58] While the idea of CAMR was laudable, the complex set of rules adopted in its implementation makes it among the most bureaucratically complex pieces of legislation administered by the Canadian Intellectual Property Office. The rules led to a quick consensus, but one that does not function in practice.

This discussion of CAMR illustrates that a consensus building *process* that brought together several government departments and stakeholders does not necessarily result in a coherent *outcome*. As will be discussed further in Part IV, coherence requires far more than adoption of the lowest common denominator.

2. Other Responses to Innovation and Access to Medicines

There are four other potential responses to the issue of policy coherence for innovation and access to medicines for developing countries. First, some level of coherence may arise from clarifying the responsibilities of national ministries. There is often a disagreement over the use of

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of Public Health" (2005) 99 Am. J. Int'l L. 317 at 332.

52 Bill S-232, *An Act to amend the Patent Act (drugs for international humanitarian purposes) and to make a consequential amendment to another Act*, 2d Sess., 40th Parl., 2009.

53 Bill C-393, *An Act to amend the Patent Act (drugs for international humanitarian purposes) and to make a consequential amendment to another Act*, 2d Sess., 40th Parl., 2009.

54 Canadian HIV/AIDS Legal Network, News Release, "Move to Reform 'CAMR' Gains Momentum: New House of Commons Bill echoes Senate proposal, would ensure life-saving medicines reach people in developing countries" (25 May 2009), online: Canadian HIV/AIDS Legal Network <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1500>; Canadian HIV/AIDS Legal Network, Press Release, "Dying for Lack of Medicines in Developing Countries: 43 organizations join in statement on the 5th anniversary of Canada's Access to Medicines Regime (CAMR)" (May 14, 2009), online: Canadian HIV/AIDS Legal Network <http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=1494>.

55 *Ibid.*

56 Isabel Teotonio, "Clement Vows to Get Cheap Drugs Flowing; Health Minister Decries Lack of Aid. But Current Law Prevents Action" *Toronto Star* (14 August 2004) A1.

57 Ministry of Industry, *Report on the Statutory Review of Sections 21.01 to 21.19 of the* Patent Act (Ottawa: Ministry of Industry, 2007), online: CAMR <http://www.camr-rcam.gc.ca/review-reviser/camr_rcam_report_rapport-eng.pdf>.

58 Jean-Frédéric Morin & E. Richard Gold, "Consensus-Seeking, Distrust, and Rhetorical Action" (2010) 16:4 European Journal of International Relations 563, online: SSRN <http://ssrn.com/abstract=1435747> [Morin & Gold, "Consensus-Seeking, Distrust, and Rhetorical Action"].

TRIPS flexibilities and mechanisms that might provide a solution to access problems. For example, health ministries may favour the use of compulsory licensing (through mechanisms similar to CAMR), while trade ministries, under pressure from industry and trade partners, generally oppose compulsory licensing.[59] To protect trade ministries from this pressure coming from their constituency, and to allow them to keep their credibility in front of their partners, a country can give the exclusive authority over compulsory licensing for pharmaceutical products to health ministries. In South Africa, Thailand, Malaysia, and other emerging countries, it is the Ministry of Health that initiates requests for the grant of compulsory licenses. In Brazil, "the grant of patents for pharmaceutical products or processes must receive the prior approval of the Brazilian Sanitary Surveillance Agency (ANVISA)."[60] Canada has not adopted this approach and requests for compulsory licenses are managed by the CAMR office within Industry Canada.[61]

Second, coherence may be accomplished by balancing IP and health interests. As the Supreme Court of Canada has emphasized,[62] IP laws represent a balance between the rights of creators or innovators and those of users in order to create a dynamic, creative, and innovative environment. Thus achieving balance could be a legitimate objective when specific changes at the national level are externally motivated. For example, in the context of the Free Trade Negotiations with the U.S., Canada amended its patent legislation in 1987 to allow patents for pharmaceutical products (as opposed to merely protecting the pharmaceutical processes) and introduced a deferral period of exclusivity (for the innovating brand name company), during which a compulsory license could not be issued.

In Canada, the PMPRB was introduced to compensate for these measures motivated by foreign policies and trade considerations. It is now generally acknowledged that the PMPRB is reasonably effective in keeping the price of Canadian patented drugs low (especially compared to the U.S. but not as effective as the U.K. or New Zealand) and there is no evidence that this action chilled R&D investments in Canada.[63]

Third, policy coherence may be accomplished through addressing and distinguishing between push (incentives for research) and pull (incentives for development and manufacturing) mechanisms for incentivizing innovation and access to medicines. Push mechanisms include R&D tax credits and public-private partnerships. Pull mechanisms include international financing options and patent pools.

An example of a push mechanism is the U.S. paediatric exclusivity rule.[64] Drug companies receive an extra six months of patent protection if they test their product on children. However, this mechanism places "the entire burden of financing vaccine and drug development on patients who need the drug for which the patent has been extended,"[65] and it could even have a detrimental effect on access.

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59 Carolyn Deere, *The Implementation Game: The TRIPS Agreement and the Global Politics of Intellectual Property Reform in Developing Countries* (Oxford: Oxford University Press, 2009) at 212.

60 *Ibid*. at 213.

61 Health Canada plays a regulatory role by ensuring that all products destined for export under CAMR meet the same safety, efficacy, and quality requirements as products sold in Canada. Ministry of Industry, "Canada's Access to Medicines Regime", online: CAMR <http://www.camr-rcam.gc.ca/countr-pays/index_e.html>.

62 *Théberge v. Galerie d'Art du Petit Champlain Inc.*, 2002 SCC 34, [2002] 2 S.C.R. 336 at paras. 30-33.

63 Bourassa Forcier & Morin, *supra* note 7.

64 Steven Hirschfeld *et al.*, "Pediatric Oncology: Regulatory Initiatives" (2000) 5:6 The Oncologist 441; Regulations Requiring Manufacturers to Assess the Safety and Effectiveness of New Drugs and Biological Products in Pediatric Patients, Final Rule" 63:231 Fed. Reg. 66631 (1998) (to be codified at 21 CFR Parts 201, 312, 314, 601).

65 OECD, *Coherence for Health*, *supra* note 21 at 121.

An example of a pull mechanism is the Pneumococcal Vaccine Advance Market Commitment. In 2007, Canada, Italy, Norway, Russia, the U.K., and the Bill & Melinda Gates Foundation announced a $1.5 billion Advanced Market Commitment for pneumococcal vaccines. It subsidizes the purchase of vaccines for use in developing countries.[66] Both push and pull mechanisms are necessary and complementary, but their respective objectives and utility should be kept in mind when designing programs and institutions for their implementation; one should not be used to accomplish the goals of the other.

Finally, policy coherence on the issue of access to medicines may be addressed through collaborative mechanisms. For example, Brazil has a *sui generis* mechanism of examining patent applications related to pharmaceutical products. Since 1999, the Brazilian intellectual property office ("INPI") and ANVISA (Brazil's regulatory authority for pharmaceutical products) share jurisdiction over examining patent applications for pharmaceutical products.[67] The concept was to foster coherence between patent policy and the right of access to medicines. In practice, what was meant to lead to stronger coherence has instead led to conflicts in positions between the two governmental bodies.[68] Nevertheless, the Brazilian experience still points to a mechanism that could be used to reconcile patent policy and health.

B. Traditional Knowledge and Traditional Medicines

Approaches to the recognition of traditional knowledge ("TK") and traditional medicines provide an example of how the decentralization of negotiations and extensive consultation with stakeholders may actually lead to policy incoherence. This section will compare the Canadian and Brazilian experiences in this controversial area of the IP-public health interface. It will conclude with a few examples of international approaches to the issue.

The value of indigenous knowledge is recognized internationally in areas as diverse as conservation and agricultural practices, classification systems, land use practices and sustainable management of natural resources, healthcare practices, and medicinal properties of local species.[69] The value of this knowledge raises concerns about its exploitation by non-indigenous peoples, and about the diverse genetic resources found on indigenous lands. These concerns, in turn, have led to calls for the protection of indigenous or traditional knowledge, and for sharing the benefits derived from its exploitation. A number of international bodies and international treaties recognize the need to protect TK. These include, in the specific context of traditional

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66 On 23 March 2010, GAVI released a press release stating: "The governments of Italy, the United Kingdom, Canada, Russia, and Norway and the Bill & Melinda Gates Foundation welcome the first long-term agreements made by pharmaceutical firms to supply new, affordable vaccines against pneumococcal disease to the world's poorest countries. GlaxoSmithKline (GSK) and Pfizer Inc. are the first companies to agree to supply pneumococcal vaccines through the Advance Market Commitment (AMC). These vaccines may be available as early as this year at a fraction of the price charged in industrialised countries." GAVI Alliance, Press Release, "Update: Donors Welcome the Advance Market Commitment's first long-term supply commitments from leading pharmaceutical companies", online: AMC <http://www.vaccineamc.org/update 2mar23_10.html>.

67 Edson Beas Rodriguez Jr. & Maristela Basso, "Legal Evaluation Reconciling Intellectual Property Rights and Human and Technological Development Demands: Challenges for Brazil on the Post-TRIPS/WTO Scenario" in Francisco Rossi, ed., *Technical, Economic and Legal Evaluation of Antiretroviral Production Capacity in Brazil* (Brazil: Ministry of Health, 2008) at 55.

68 *Ibid.* at 87.

69 *Convention Concerning Indigenous and Tribal Peoples in Independent Countries* (27 June 1989) 72 ILO Official Bull. 59, 28 I.L.M. 1382 (indigenous peoples are those who are regarded as indigenous on account of their descent from the population which inhabited the country, or geographical region to which the country belongs, at the time of conquest or colonization or the establishment of present state boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural, and political institutions).

medicines, the UN *Declaration on the Rights of Indigenous Peoples*[70] and the UN *Convention on Biological Diversity* ("*CBD*").[71]

How protection and benefit sharing are to be accomplished,[72] however, is a highly divisive and controversial topic, dividing resource rich developing countries from those with advanced industrial and research capacity.[73] The protection of traditional medicines is particularly controversial. In 2009, the WHO General Assembly adopted a resolution on traditional medicines urging member states "to further develop traditional medicine based on research and innovation, giving due consideration to the specific actions related to traditional medicine in the implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property."[74]

3. Canadian Protection of TK Suffers from the Lack of Coordination of Stakeholders

Canada has yet to achieve a coherent policy to govern Canadian TK. In particular, Canada has made little progress toward the national implementation of Access and Benefit Sharing ("ABS") provisions. Moreover, it does not specifically recognize property or other rights in TK, despite being a signatory to the *CBD*. In Canada, protection of TK is tied up in broader socio-cultural issues, Canadian constitutional law, and self-determination for Aboriginal peoples. It is perhaps due in part to the nature of the issue then, that Canada has made so little progress in policy-making.

Canada's failure to formulate coherent policies for TK, though, is also attributable to issues at the national and international levels. At home, there are multiple federal departments and stakeholders involved in the negotiations, rendering coordination difficult. At the international stage, these departments and stakeholders often present divergent positions at international meetings. The local and international factors will be dealt with in turn.

The Canadian TK experience illustrates how decentralization in policy-making may lead to policy incoherence. Policy-making has attempted to navigate the complexities of Federal-Provincial relations, and of relations between levels of government and Canada's First Nations, Inuit and Métis, but with little success. The failure to implement ABS provisions in Canada has

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70 UN GAOR, 61st Sess., UN Doc. A/61/L.67 (2007), online: IWGIA <http://www.iwgia.org/graphics/Synkron-Library/Documents/InternationalProcesses/DraftDeclaration/07-09-13ResolutiontextDeclaration.pdf>.

71 *Supra* note 18.

72 The *CBD* provides an international framework for the conservation and sustainable use of biological diversity. While access to genetic resources should be granted, the benefits from the utilization of genetic resources must be shared through, for example, transfer of technologies (including biotechnology), rights over the resources and appropriate funding (*supra* note 18, art. 1). The *CBD* grants these rights to the sovereign nation in which those genetic resources are endemic, not to indigenous communities within its boundaries (*ibid.*, art. 15(1)). However, countries are encouraged to develop policies or national legislation to share, in an equitable way, the results of research and development benefits arising from the commercial and other uses of genetic resources (*ibid.*, art. 15(7)). These benefits may arise between Contracting Parties—supplier and receiver of genetic resource—for example, an indigenous community and a pharmaceutical company. For a full discussion of ABS principles and the potential application of contract law versus a *sui generis* legal regime for the protection of traditional knowledge, see Shakeel Bhatti *et al.*, eds., *Contracting for ABS: The Legal and Scientific Implications of Bioprospecting Contracts* (Switzerland: IUCN, 2009).

73 Sylvia I. Martinez & Susette Biber-Klemm, "Scientists—Take Action for Access to Biodiversity" (2010) 2 Current Opinion in Environmental Sustainability 1 at 27; Kaitlin Mara "Mismatch On Traditional Knowledge Treaty Text, Negotiating Sessions at WIPO" *Intellectual Property Watch* (8 December 2009), online: IP-Watch <http://www.ip-watch.org/weblog/2009/12/08/mismatch-on-traditional-knowledge-treatytextnegotiating-sessions-at-wipo/>.

74 World Health Organization, Executive Board, *Traditional* Medicines, 124th Sess. Agenda Item 4.5, WHO Doc. EB.124.R9 (26 January 2009).

occurred notwithstanding several years of concerted negotiations and consultations around the issue. In September 2004, the Federal/Provincial/Territorial Ministers responsible for Forests, Wildlife, Endangered Species and Fisheries and Aquaculture created a working group to advance policy discussions on ABS. The working group released a consultation document on ABS policies for Canada in 2005.[75] In 2008, a federal, provincial, and territorial task group[76] was established to develop policy to address access to genetic resources and a related ABS framework.[77] This policy will also consider TK and associated TK (TK associated with genetic resources such as medicinal plants) held by aboriginal and local communities.

These measures were accompanied by close consultation with stakeholders. Environment Canada, in collaboration with provinces and territories, organized a number of workshops between December 2004 and November 2006 to inform Canadian stakeholders of the on-going policy process in Canada, and to gather stakeholder views as they relate to ABS. Scientists, lawyers, academics, policy-makers, as well as representatives from industry, aboriginal communities and NGOs, were invited to attend these events. Moreover, in 2009, Environment Canada conducted an engagement process to seek views from aboriginal people and key stakeholders on the development of ABS policy in Canada.[78] The National Aboriginal Health Organization and the Inuit Tapiriit Kanatami were two of the key aboriginal organizations that participated in the process on health issues.

There is reason to doubt whether these discussions will result in coherent policy, given the divergent positions of the Canadian Government and key Aboriginal organizations on TK. In the international arena, these two camps have consistently voiced contrary views. Aboriginal organizations have supported enforceable ABS provisions to protect rights of TK holders in Canada, while the Government of Canada has opposed such measures.[79] The disagreement was evident in the recent negotiations on an ABS Protocol at the *CBD* 10th Convention of the Parties (COP 10) held in Nagoya, Japan in October 2010. As described by *Intellectual Property Watch,*

> a group of Canadian indigenous peoples published a press release about Canada's alleged undermining of the biodiversity negotiations. They said that in an interview with the Aboriginal Peoples Television Network, John Duncan, Canadian minister of Indian affairs and northern development, "claimed the ABS issue was a diversion. What is being discussed in Japan is about intellectual property, so to think that has anything really significant to do with the UN Declaration on the Rights of Indigenous Peoples is inappropriate," he was reported saying.[80]

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75 Federal/Provincial/Territorial Working Group on Access and Benefit Sharing of Genetic Resources, *ABS Policies in Canada: Scoping the Questions and Issues*, online: Environment Canada <http://www.ec.gc.ca/apa-abs/documents/ABS_policies_e.pdf>.

76 The Task Group is being led by Environment Canada, with guidance from the Canadian Council of Resource Ministers. The Task Group identified a series of options on an ABS policy framework for Canada (Environment Canada, "Access and Benefit Sharing", online: Environment Canada <http://www.ec.gc.ca/apa-abs/utilisant-using2/default.cfm?lang=eng>).

77 Environment Canada, "Canadian ABS Portal", online: Environment Canada <http://www.ec.gc.ca/apa-abs/>.

78 As of May 2010, its report was not yet available on the website.

79 Convention on Biological Diversity, Collation of Submissions Provided in Relation to Preambular Text, Definitions and Text for Inclusion in Annex II to the Report of the Eight Meeting of the Working Group on Access and Benefit-Sharing, 9th Mtg. (Cali, Columbia 22 to 28 March 2010) CBD Doc. UNEP/CBD/WG-ABS/9/2 (10 March 2010), online: CBD <http://www.cbd.int/abs/documents.shtml>. Note that the position of the government of Canada (one of two from developed countries) was in stark contradistinction to the two submissions from indigenous and local community organizations, international organizations, research institutions, non-governmental organizations and stakeholders, including the Quebec Native Women Inc.

80 Catherine Saez, "Protocol on ABS Could Further Impoverish Indigenous Peoples, Groups Claim" *Intellectual Property Watch* (26 October 2010), online: IP Watch <http://www.ip-watch.org/weblog/2010/

Canadian indigenous representatives claimed, *inter alia*, that indigenous peoples face the danger in the ABS negotiations that "indigenous peoples' inherent right to genetic resources may be deemed to be contingent upon recognition by national legislation in each state."[81] In light of these disagreements on the international stage, then, it remains to be seen how widely the views of First Nations and Inuit will diverge from those of the Canadian government and other stakeholders in domestic consultation processes. That difference will likely be a key factor in whether the process will result in concrete action on recognizing and respecting TK, and on instituting an ABS regime in Canada.

Given the complex nature of the policy discussions in Canada, the multiple federal departments involved, and the divergent international positions on the issue, it may not be surprising that Canada has yet to achieve a coherent policy over TK. As opposed to CAMR, though, in which arriving at a quick decision was given priority over formulating a coherent position, discussions over TK have been inclusive, long, and without a clear path that will likely lead to a result.

4. Brazilian Responses Fail to Integrate Interests of Scientists and TK Holders

As in Canada, Brazilian policy-making in the area of traditional medicines has involved a complex mix of interests, fora, and government departments, combining to create policy incoherence rather than coherence. Brazil's experience thus provides another example of lengthy negotiations which have failed to result in an ABS regime benefiting indigenous peoples, researchers, and local industry.

Brazil holds unique cultural diversity and the largest biogenetic heritage on Earth. This blending of biodiversity and cultural diversity favours the creation of medicinal know-how based on the knowledge of flora and fauna of local communities who inhabit the various Brazilian biomes. The combination could lead to a competitive advantage for Brazil's R&D sector if appropriate innovation policies are put into place to further ethno-pharmacology while respecting the rights of aboriginal TK holders to a fair and equitable share of any benefits.

In Brazil, the main entity for managing TK is the Council for the Management of Genetic Patrimony (Conselho de gestao do patrimonio GENético ["CGEN"]), a special body attached to the Ministry of Environment. CGEN was created by *Provisory measure n°2.186-16,* adopted on August 23, 2001. CGEN makes decisions on access to Brazilian natural resources and acts as regulatory agency on the use of biodiversity and associated TK. It coordinates policies and monitors and manages Brazil's genetic heritage. CGEN also develops technical binding guidelines for use, access, shipping, permits, and obtaining prior informed consent from communities.

CGEN includes a wide variety of stakeholders concerned with the use of natural genetic resources for commercial or research purposes. These stakeholders include representatives of governmental bodies and public research entities (nine ministries and ten federal public administrations), including the Brazilian Environment and Renewable Resources Institute ("IBAMA"), the Indigenous Affairs Body ("FUNAI"), and the Brazilian Patent and Trademark Office ("BPTO").[82] Since 2003, several non-governmental "permanent guest entities" have been invited to participate in debates. Representatives of the Indigenous and Other Local and Rural Communities, environmental NGOs, academic and industrial sectors, and the General Attorney's Office figure among these guest entities. Although some scholars have argued that the variety of stake-

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10/26/protocol-on-abs-could-further-impoverish-indigenous-peoples-groups-claim/>.

[81] Cited in Saez, *ibid.*

[82] Catherine Aubertin, Valérie Boisvert & Vanessa Nuzzo, "L'accès aux ressources génétiques et le partage des avantages : une question conflictuelle, exemples du Brésil et de la Bolivie" in Catherine Aubertin, Florence Pinton & Valérie Boisvert, eds., *Les marchés de la biodiversité* (Montpellier: Éditions de l'IRD, 2007) 121.

holders ensures policy coherence in the field of ABS,[83] caution should be taken in interpreting the Brazilian experience.

First, the CGEN's enabling statute and regulations demonstrate a lack of coordination between Brazil's IP and TK legal frameworks. As a result, there has been little integration amongst research areas on medicinal plants and TK holders. This lack of integration reflects a failure to consider the needs of Brazil's innovative science sector and has hampered technical and scientific progress in Brazil. It has also negatively impacted local and regional economic development, because benefits have not flowed back to TK holders to foster biological and cultural conservation.[84]

Nowhere are these problems of integration more visible than in the CGEN's long delays in granting permits. As of 2009, CGEN had issued only thirty-six permits to access aboriginal TK since its creation in 2001.[85] Only two of these permits related to projects of technological development that might potentially bring monetary benefits to TK holders. Moreover, in early 2009, CGEN had twenty-eight applications for access to TK under consideration. Some of these applications had been filed over four years previously. This delay in granting permits is incompatible with the requirements of Brazil's scientific and innovation sectors; however, Bills before the Brazilian government to address the interests of Brazil's biotechnology sector have been stalled since 2003. In late 2009, the Bills had still not been brought before Congress, due to a lack of consensus among different stakeholder groups, especially the Brazilian innovation sector and NGOs representing indigenous and local communities.[86]

In addition to the lack of integration between IP and TK frameworks, allegations of biopiracy provide a second reason for caution in assessing Brazil's approach to TK. Indigenous communities continue to be concerned that private companies are misappropriating health-related TK. Although documented occurrences of biopiracy are rare, some anecdotal cases are well known among indigenous communities and feed their suspicion.[87] A number of IP-related measures and initiatives could be developed to address these concerns. India's TK database is one possible model. The database is available internationally to patent examiners to assess the patent criterion of novelty. Other possibilities include the disclosure of origin of generic resources in patent applications, or an internationally adopted definition of novelty that takes into account inventions disclosed orally in any country. These measures, discussed later, could be crafted in a way that would reassure TK holders without significantly impacting the patent application process.

5. Discussion of TK at the International Level Yields some Promise

TK has been discussed both nationally and internationally for over a decade.[88] Yet negotiations over TK in international fora have yielded similarly limited results for a coherent policy

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[83] *Ibid.*

[84] Edson Beas Rodriguez Jr. in a forthcoming book chapter on Brazil—unpublished manuscript on file with author.

[85] Maria Celeste Emerick, Acesso aos Recursos Genéticos e aos Conhecimentos Tradicionais Associados: Legislação Vigente e Consulta Pública þsobre APL (São Paulo: FEBRAPLAME, September 1st, 2008).

[86] Beas Rodriguez Jr., *supra* note 84.

[87] The most often cited examples are Turmeric, Neem, Basmati Rice, Kava, Ayahuasca, Quinoa, and Hoodia according to the Traditional Knowledge Digital Library, "Bio-piracy of Traditional Knowledge", online: TKDL <http://www.tkdl.res.in/tkdl/langdefault/common/BioPiracy.asp?GL=#Oth> [TKDL]. For discussion of the agreement between the Brazilian Association for the Sustainable Use of Amazonian Biodiversity ((Bioamazônia) and the Swiss pharmaceutical company Novartis Pharma AG (Novartis)) that prompted the government of Brazil to establish a legal framework for ABS see Aubertin, Boisvert & Nuzzo, *supra* note 82.

[88] Kaitlin Mara, "Fate of Traditional Knowledge A Key Decision at WIPO Assemblies" *Intellectual Property Watch* (22 September 2009), online: IP Watch <http://www.ipwatch.org/weblog/2009/09/22/

approach to TK. One recent development, though, is the work of the WIPO Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore. In response to individual countries' mixed experiences with protection for traditional medicines,[89] the committee has considered a health-related exception for the use of TK "in government hospitals, especially by [TK] holders attached to such hospitals, or use for other public health purposes."[90] That committee is also currently working on a document entitled *The Protection of Traditional Knowledge: Revised Objectives and Principles*.

A second promising initiative is the compromise ABS protocol treaty against biopiracy, which was recently adopted at the UN *CBD* Conference of the Parties ("COP 10") in Nagoya.[91] The instrument is aimed at preventing misappropriation of genetic resources and ensuring that benefits accrued from the use of those genetic resources are shared equitably with the provider country. It will come into force once ratified by 50 countries, but some countries, such as the U.S., are not parties to the *CBD*. The issue of biopiracy is also under discussion at the WIPO Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge, Folklore, which has been mandated by the 2009 WIPO General Assembly "to create an 'international legal instrument' on the protection of [TK]."[92]

The examples of Canada and Brazil demonstrate that TK policy-making involves a complex mix of interests, fora, and government departments. Despite the length of TK discussions that have taken place in multiple settings, these discussions have resulted in policy incoherence rather than coherence. Unfortunately, none of the mechanisms adopted—such as Brazil's multi-stakeholder agency, CGEN—, nor the negotiations at any international fora, have yet resulted in an ABS regime that benefits indigenous peoples, researchers, and local industry.

C. Pandemic Influenza Preparedness

1. Canadian Preparedness

The Canadian example of influenza preparedness illustrates how privileging IP rules and industrial interests over public health may lead to the unintended consequence of tying the hands of policy-makers and politicians responding to public health crises. In the event of a pandemic or a national health emergency in Canada, the provisions of the *Patent Act* relating to compulsory licenses are available.[93] Under normal circumstances, the Commissioner of Patents will only consider an application for a compulsory license after the federal or provincial government has attempted to obtain authorization from the patentee under reasonable commercial terms. However, the government is exempted from this obligation in cases of "national

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fate-of-traditional-knowledge-a-key-decision-at-wipo-assemblies/>.

89 See e.g. South Africa, Traditional Health Practitioners Act, No. 35 of 2004 and Philippines, *Traditional and Alternative Medicinal Act (TAMA) of 1997*, Republic Act No. 8423.

90 World Intellectual Property Organization, Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore, *The Protection of Traditional Knowledge: Revised Objectives and Principles,* 9th Sess., (Geneva, 24 to 26 April 2006) WIPO Doc. WIPO/GRTKF/IC/9/5 Annex, (9 January 2006) at 33 art. 8 (Exceptions and Limitations).

91 Catherine Saez, "Compromise UN Protocol Treaty Against Biopiracy Adopted in Japan" *Intellectual Property Watch* (29 October 2010), online: IP Watch <http://www.ipwatch.org/weblog/2010/10/29/compromise-un-protocol-treaty-against-biopiracy-adopted-in-japan/>.

92 Kaitlin Mara, "WIPO Traditional Knowledge Committee Opens with Hope for Text-Based Talks" *Intellectual Property Watch* (3 May 2010), online: IP Watch <http://www.ipwatch.org/weblog/2010/05/03/wipo-traditional-knowledge-committee-opens-with-hope-for-text-based-talks/>.

93 *Patent Act*, *supra* note 15. Sections 19 and 19.1 give the Commissioner of Patents the power to grant compulsory licenses under certain circumstances.

emergency or extreme urgency or where the use for which the authorization is sought is a public non-commercial use."[94] Nevertheless, no Canadian government has exercised these rights.

These compulsory licensing provisions of the *Patent Act* in respect of medicines involve two government departments and one agency. Health Canada is likely to be the department requesting the compulsory license; Industry Canada is responsible for the *Patent Act* itself; and the Canadian Intellectual Property Office is responsible for granting and administering compulsory licenses. Nevertheless, there is no sustained discussion between these departments over whether the compulsory licensing provisions function as intended.

Following the September 11 terrorist attacks, Health Canada, fearing an attack on Canadian soil, placed an order for ciprofloxacin ("CIPRO"), a drug used to treat anthrax poisoning, with Apotex Inc., a generic drug company.[95] Apotex agreed to sell Health Canada a generic version of CIPRO for less than the price usually demanded by Bayer Inc., the owner of the CIPRO-related patents. Health Canada claimed that it had the authority to ignore the patents because Bayer appeared unable to meet its supply demands. The federal government ultimately negotiated a settlement with Bayer Inc., in order to avoid a domestic lawsuit or an international trade dispute before the WTO Dispute Settlement Body.[96]

Similarly, during the avian flu outbreaks of 2005, Canada considered obtaining compulsory licenses to patented drugs used to treat the virus. Ultimately, Roche Phamaceuticals, the patent holder over TAMIFLU, agreed to allow the production of a generic version of the product in Canada. However, had a pandemic occurred, a severe shortage would have nevertheless arisen; Roche management estimated that it would take generic manufactures three years to prepare for production.[97]

2. Other Country Preparedness

In the case of a global pandemic and associated drug or vaccine shortage, it is generally assumed that countries with manufacturing capacities will be better positioned than those without. During an outbreak, countries with production facilities would declare a national emergency and limit or ban the export of drugs and vaccines to other countries. Accordingly, those without sufficient manufacturing capacity would not be able to take advantage of the flexibilities granted by the *Doha Declaration* and the *WTO Decision* of August 30th, 2003, including the issuance of compulsory licenses for the importation of drugs and vaccines from countries with adequate manufacturing capabilities.

To avoid such a scenario where the lack of manufacturing capacity could pose significant problems, Brazil enacted *law n° 9279 of 14 May 1996*. It authorizes the grant of a compulsory license if the patent holder does not manufacture the product in Brazil.[98] This law prepared Brazil for facing a global pandemic by providing a strong incentive for foreign direct investment in drug manufacturing in Brazil. Although it is frequently criticized by the U.S. government on the ground that it discriminates between imported and locally manufactured products, the U.S. has never requested a WTO panel to settle the dispute (beyond the request for consultation with Brazil filed in 2001).

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94 *Ibid.* s. 19.1(2). Note that this section does not exempt the government from its obligation to fairly compensate the patentee.

95 M.D. Penner & A. Abouali, "The Impact of Intellectual Property Rights on Health Care" (2008) 28:3-4 Health L. Can. 89 at 91.

96 *Ibid.*

97 *Ibid.*

98 Art. 68 (regulates rights and obligations relating to industrial property).

Arguably, however, even countries with adequate manufacturing capability such as, the U.S., Canada, the E.U., Japan, Australia, and other countries that have opted-out of the *WTO Decision*'s compulsory licensing mechanism as importing countries, could also suffer in the case of a global pandemic. For example, during the 2005 bird flu crisis, the U.S. had supplies of TAMIFLU available for less than 1% of its population. It did not have the capacity to switch all of its domestic manufacturing capacity to produce the medicine quickly enough if the crisis had worsened. Without the mechanism for compulsory licensing, the U.S. could not have imported the medicine from another country without the patent holder's consent, making it legally impermissible for the country to address its health crisis. Canada or another country that has opted-out of the *WTO Decision* could face a similar problem during a pandemic or other emergency situation. Therefore, the problem of countries with insufficient manufacturing capacity, a problem which the *WTO Decision* was aimed at addressing, is not necessarily limited to developing countries but also to developed countries that privilege IP over health interests. This possibility illustrates that a failure to understand the domestic health implications of trade policy could severely hamper a country's ability to effectively deal with a health crisis.

A more immediate connection exists between research using genetic resources, IP and pandemics. As described in The Economist:

> [In 2006], the Indonesians stopped giving the WHO samples of the H5 virus which is responsible for avian flu, a disease that has forced a mass slaughter of poultry in many countries and could, if it mutates, cause a deadly epidemic among humans. Indonesia won some sympathy for its complaint that it was giving away precious intellectual property, while it might well be unable to afford the vaccines which are then developed. Indonesian officials put it bluntly: why should they hand over precious virus strains when the resultant vaccine may never benefit their people? There was little the WHO could do in response.[99]

The international policy response was appropriate in the circumstances and privileged health over IP rights. At the WHA, in May 2007, developed countries agreed in principle that developing regions must have access to life-saving vaccines in the event of a pandemic.[100] As a result, Indonesia once again shared its virus samples, but negotiations continue on how to ensure this access through an inter-governmental working group.[101] In 2009 the WHA adopted the resolution on *Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits*.[102] Among other things, it requested the Director-General to facilitate a transparent process to finalize the remaining elements, including the Standard Material Transfer Agreement ("SMTA") and its annex. A consultation on the SMTA, IP rights more generally, and benefit sharing was attended by seventy-four member states, a regional integration organization and two other international organizations. It resulted in broad support for a system for sharing virus samples and benefits that would be more sustainable, predictable, and structured than the current ad hoc arrangement for sharing of vaccines and other benefits. There was agreement on the need for an SMTA, some general agreement on an expanded list of potential benefits, disagreement on whether benefit sharing should be mandatory or voluntary, and a wide divergence of opinion on IP rights.[103] Negotiations are ongoing.

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99 "How Dr Chan Intends to Defend the Planet from Pandemics" (16 June 2007) 383 *The Economist* 67 at 67.

100 World Health Assembly, *Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits*, WHA Res. 60.28, 60th Sess., (23 May 2007).

101 WHO, *Public Health, Innovation and Intellectual Property Rights: Report of the Commission on Intellectual Property, Innovation and Public Health* (Geneva: WHO Press, 2006), online: WHO <http://www.who.int/intellectualproperty/report/en/> [*Report of the Commission on Intellectual Property, Innovation and Public Health*].

102 World Health Assembly, Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access to Vaccines and Other Benefits, WHA Res 62.10, 62d Sess., WHA (22 May 2009).

103 World Health Assembly, *Pandemic Influenza Preparedness: Sharing of Influenza Viruses and Access*

While pandemic preparedness would seem to give rise to a need for coherence only at the level of the delivery of medical care, it actually embodies a complex mix of industrial, trade, and health policy. It also raises the contentious issue of access to genetic resources and benefit sharing with developing countries. For the most part, both industrial and trade policy have been designed around "normal" circumstances, that is, the absence of a critical, short-term health need. These policies are not necessarily appropriate for the case of an extraordinary event, such as a pandemic, during which resources need to be quickly reallocated and access becomes paramount. It is exactly because trade and industrial policy do not consider extraordinary situations such as pandemics that it is of vital importance for public health authorities to be involved in establishing broader policy.

IV
INSTITUTIONAL MECHANISMS FOR GREATER POLICY COHERENCE USED INTERNATIONALLY

As the discussion of the three examples of innovation and access to medicines, traditional medicines, and pandemic influenza preparedness illustrate, both national and international policy at the border of public health and IP are "wicked issues".[104] Because of their complex nature, these issues often engender policy responses that are quick but inefficient (as in the case of CAMR), slow and ineffective (as have been debates over TK), or undertaken in good faith but with a failure to anticipate the unexpected (pandemic influenza).

Given the prevalence of "wicked issues" at the public health-IP boundary, it is critical that countries such as Canada develop mechanisms to develop a coherent policy that avoid negative spillovers, are inclusive, and yet do not drown in unending debate. This section surveys mechanisms that Canada and other countries have employed to deal with these issues with the goal of assessing their feasibility, costs, and benefits.

A. Advisory Committees and Expert Groups

The practice of advisory groups is extensively developed in countries like the U.S. to address issue coherence. However, their composition, mandate, and interests may lead to widely divergent policy recommendations on similar issues. For example, in the U.S., the Secretary's Advisory Committee on Genetics, Health and Society ("SACGHS") recently released a report recommending additional exceptions to patent rights in order to increase patient access to genetic tests.[105] In contrast, the reports of the Industry Trade Advisory Committee on Intellectual Property Rights consistently recommend restricting exceptions to patent rights provided in free trade agreements.

Probably the most significant difference between these committees is in their membership: few pharmaceutical companies are represented on SACGHS, and few health advocates are represented on industry or trade focused committees. This imbalance in membership has led to criticisms and court challenges.

One solution that has been explored, particularly with respect to environmental issues, has been to appoint both representatives of NGOs and industry to the same committee. Most of the time, however, these groups fail to reach a consensus and submit two reports instead of one. This

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to Vaccines and Other Benefits, Report by the Secretariat on the Outcome of the Process to Finalize Remaining Elements Under the Pandemic Influenza Preparedness Framework for the Sharing of Influenza Viruses and Access to Vaccines and Other Benefits, 63d Sess., WHA A63/4, WHA (15 April 2010).

104 Petticrew *et al.*, *supra* note 4 at 454.

105 U.S. Department of Health and Human Services, *Gene Patents and Licensing Practices and Their Impact on Patient Access to Genetic Tests*, Report of the Secretary's Advisory Committee on Genetics, Health, and Society (2010), online: SACGHS <http://oba.od.nih.gov/SACGHS/sacghs_documents.html>.

pattern of oppositional positions between NGOs and industry occurs at both the international and national levels. It is, for example, interfering with UNITAID's ability to implement a patent pool over HIV/AIDS medicines,[106] and has lead to a deadlock in Canada over addressing the defects in CAMR.

Other countries have more workable models. Australia has an independent body, appointed by the government: the Advisory Council on Intellectual Property that advises the Federal Minister for Innovation, Industry, Science and Research on Intellectual Property Matters and the Strategic Administration of IP Australia. The Council's membership reflects a cross section of stakeholders of the IP system, and includes industry representation (SMEs and large firms) as well as representatives from the legal and academic communities. It is currently reviewing the test for patentable subject matter in Australia, in part based on the Australian Law Reform Commission's ("ALRC") report and recommendation on gene patenting and human health.[107] In the past, it has considered patents and experimental use exemptions, and the patentability of plants and animals.

In 2001, the U.K. Secretary of State for International Development established the Commission on Intellectual Property Rights ("CIPR") to develop a report on IP rights and development issues, including health. That commission was unusual in that it comprised members from a diversity of countries, backgrounds, and perspectives and incorporated voices from both developed and developing countries in the fields of science, law, ethics, economics, as well as industry, government and academia. Although appointed by the British Government, the CIPR was given freedom to set its own agenda, devise its own programme of work, and reach independent conclusions and recommendations. CIPR was granted the capacity and financial support to improve its understanding of the issues through commissioning studies, organizing workshops and conferences, and visiting officials and affected groups throughout the world.[108] The CIPR issued its report in September 2002.[109]

The Canadian experience has been more similar to that of the U.S. For example, the Sectoral Advisory Groups on International Trade included mostly representatives from industry. This has lead to criticism, and Blouin, Foster and Labonté recommended the inclusion of "more public health representatives in the Sectoral Advisory Groups on International Trade (SAGITs) which advise the government on trade policymaking."[110]

One solution may be for government to cease to select members of advisory committees on the basis that they represent a group of stakeholders. It is a mistake to consider that "industry" or "NGOs" are cohesive and monolithic groups.[111] Even among more specific groups such as "innovative industry" or "development NGOs", major disagreements exist. Therefore, more productive debates may emerge by focusing on selecting the right individuals rather than select-

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106 E. Richard Gold & Jean-Frédéric Morin, "The Missing Ingredient in Medicine Patent Pools" (2009) 374:9698 The Lancet 1329.

107 Austl., Commonwealth, Australian Law Reform Commission, *Genes and Ingenuity: Gene Patenting and Human Health* (Australian Government: ALRC 99, 2004), online: ALRC <http://www.alrc.gov.au/publications/report-99>.

108 It visited Brazil, China, India, Kenya and South Africa and consulted with NGOs based in the U.K., Europe and the U.S. as well as the pharmaceutical industry in the U.K. It was supported by a Secretariat supplied by the U.K. Department for International Development ("DFID") and the U.K. Patent Office.

109 U.K., Commission on Intellectual Property Rights, *Integrating Intellectual Property Rights and Development Policy* (London: Commission on Intellectual Property Rights, 2002), online: CIPR <http://www.iprcommission.org/papers/text/final_report/reportwebfinal.htm> [Commission on Intellectual Property Rights].

110 Chantal Blouin, John Foster & Ronald Labontée, *Canada's Foreign Policy and Health: Toward Policy Coherence* (Ottawa: North-South Institute, 2002) at 82.

111 Jean-Frédéric Morin, "The Two-Level Game of Transnational Network" (forthcoming in 2010) International Interactions.

ing the right representatives. The idea here is to have fewer appointed lobbyists (either NGO or industry) and more appointees with practical experience in business, health care, and research.

However, Canada's experience with an advisory committee in areas of biomedical innovation and health—the now disbanded Canadian Biotechnology Advisory Committee—illustrates the dangers of such an approach. While the members may have been experts and may have represented a variety of interests without including lobbyists, the committee had little impact on policy development. Since the committee was considered little more than a group of experts, its recommendations were largely ignored by governments.[112]

B. Multi-Stakeholder Consultations

It is widely assumed that open exchanges among informed parties based on argumentative interaction will improve the coherence of a policy, its social acceptance and its normative acceptability. This is especially the case when ethical issues are at stake. In these circumstances, governments increasingly rely on multi-stakeholder dialogue to ensure that sufficient debate occurs to confront values, perceptions and views. The OECD has recognized the value of a breadth of viewpoints: "Innovative decision-making mechanisms that associate the private and public sectors as well as NGOs are in demand, and, increasingly, business is playing a positive role."[113]

This model has potential if stakeholders share some norms, world-views, interest and trust each other.[114] This may have been the case in India—the fact that "India … stands out for its strategic and tailored approach to *TRIPS* implementation" might be the result of its extensive consultation process:

> Starting in 1996-1997, the Commerce Ministry initiated one of the most comprehensive consultation processes among developing countries on *TRIPS*, involving industry and trade organizations, NGOs, research and academic institutions, political parties, and parliament.[115]

Similarly, Brazil instituted CGEN, discussed above, to include a wide variety of representatives, gathering all the stakeholders concerned by the use of natural genetic resources for commercial or research purposes. However, given the procedural complications and delays in obtaining aboriginal TK permits, CGEN exemplifies process trumping outcome.

There are, however, other risks and pre-conditions for deliberative approaches that are not well understood and require further research. One is the risk of groupthink.[116] Conversely, when stakeholders have radically different views and interests and do not trust each other, there should likely be no attempt to reach consensus among them. In addition, the Canadian experience with the enactment of CAMR, discussed above, also illustrates that process might prevail over outcome.[117] Every document published by the government on the original Bill before Parliament underlined "the concerted and sustained efforts of all relevant actors."[118] But Morin and Gold's interview-based study concluded that most bureaucrats recognized the regime would

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[112] The Canadian Biotechnology Advisory Committee prepared reports on the patenting of higher life forms and made recommendations regarding research exemptions and plant breeders' exemptions. It is no longer active.

[113] OECD, "Improving Policy Coherence", *supra* note 17 at 3.

[114] Morin & Gold,"Consensus-Seeking, Distrust, and Rhetorical Action", *supra* note 58.

[115] Deere, *supra* note 59 at 213.

[116] Janis Irving, *Victims of Groupthink* (Boston: Houghton Mifflin, 1972); Janis Irving, *Groupthink: Psychological Studies of Policy Decisions and Fiascos*, 2d ed. (Boston: Houghton Mifflin, 1982).

[117] Morin & Gold,"Consensus-Seeking, Distrust, and Rhetorical Action", *supra* note 58.

[118] Government of Canada, *Report on the Statutory Review of Section 21.01 to 21.19 of the* Patent Act (Ottawa: Industry Canada, 2007), online: CAMR <http://www.camr-rcam.gc.ca/review-reviser/camr_rcam_report_rapport_e.html> at 5.

most likely fail to reach its objective. For example, one Canadian government official, when asked whether he was surprised that the CAMR mechanism was not used, answered: "not particularly: it was a bit of a false issue right from the beginning."[119]

C. Intra-Governmental Coordination Mechanisms

These mechanisms involve an institutional "catalyst" (a group, an office, a committee, etc.) in charge of intra-governmental coordination. To be effective, the institutional entity must be located within the government machinery and at the centre rather than at the margin of decision-making. It should have a mandate to favour coherence, such as reviewing laws and regulations, managing conflicting knowledge, expanding the number of scenarios and options, exploring "dissident opinions", conducting joint impact assessments, etc. Here, it is important to distinguish coordination from control. The goal is not higher control in the hand of one unit to achieve consistency in policy outcome: "[i]t is coordination among the parts rather than of the parts by some controlling body or person."[120]

Intra-governmental coordination mechanisms are important to IP given the disparate interests among different agencies and their stakeholders. In most countries, several agencies are responsible for different dimensions of IP. Copyright and patent are often dealt with by different agencies or departments as are domestic enforcement and international trade-related issues. What follows is a discussion of some country experiences with intra-governmental coordination mechanisms.

Switzerland presents an interesting example. An empirical study showed that Switzerland has one of the highest levels of policy coherence internationally when comparing communications on genetic resources and IP sent to the WTO, WIPO, and the CBD.[121] There are two reasons for this finding. First, Switzerland may be the only country where one agency (the Swiss Federal Institute of Intellectual Property) is responsible both for domestic and international issues. This centralization facilitates coordination on IP-specific issues and enables coordination on cross-sectoral issues like IP and environment, IP and health, or IP and organized crime. Second, Switzerland has created an inter-departmental expert group.

> [This] group – which includes people from the ministries responsible for economics and trade, health research, development, human rights, foreign affairs, drug approvals and intellectual property – covers a broad range of issues and has managed to expand the debate on IP and health in particular.[122]

Similarly, the Netherlands has integrated development considerations (including health) into its economic and trade policies in what it terms "policy coherence for development".[123] This policy, which was endorsed by the Dutch Cabinet, "implies that governments must always examine how decisions in other areas relate to goals and efforts in development cooperation" and that "policy areas should reinforce one another."[124] The Ministry of Foreign Affairs increased its

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[119] Morin & Gold, "Consensus-Seeking, Distrust, and Rhetorical Action", *supra* note 58 at 14.

[120] Martin Painter, Steering the Modern State: Changes in Central Coordination in Three Australian State Governments (Sydney: Sydney University Press, 1987) at 8.

[121] Amandine Bled & Jean-Frédéric Morin, "Policy (In)coherence on Genetic Resources: Strategic Behavior, Bureaucratic Politics, or Socialization By-Product?" (Paper delivered at the REPI Workshop on Issue-Linkages and Regime-Complexes, Brussels, 21 May 2010).

[122] Tove Iren S. Gerhardsen, "Swiss Initiative Seeks To Dispel 'Black-And-White' View Of Patents" *Intellectual Property Watch* (19 December 2006), online: IP Watch <http://www.ip-watch.org/weblog/2006/12/19/swiss-initiative-seeks-to-dispel-black-and-white-view-of-patents/>.

[123] World Intellectual Property Organization, Assemblies of the Member States of WIPO, *General Report*, 40th Series of Mtgs., WIPO Doc. A/40/7 (5 October 2004) at para. 71.

[124] The Foreign Ministry of the Netherlands, cited in Hirohisa Kohama, "Introduction: Aid, Trade, and

capacity to deal with coherence issues by establishing a Policy Coherence Unit in 2002. The task of the Unit is to ensure that the development dimension and the interests of developing countries are taken into account in the formulation of the Netherlands's positions in areas, such as trade, both at the European and international level, particularly through awareness raising and coordination with all relevant government departments and administrations. The Unit has played a role in coordinating the positions of the Netherlands's government departments and agencies during the negotiations on paragraph 6 of the *Doha Declaration* on *TRIPS and Public Health*, both at the national level and at the E.U. level. It is noteworthy that the Netherlands ranked first in the 2004 Commitment to Development Index."[125]

In the U.K., a decade ago, the Labour Government instituted a policy of "joined-up-government". The principle here is to improve coordination in local public services and in central government and numerous initiatives and funding streams.[126] In the area of health, an independent inquiry was set up to address health inequalities under a "whole-of-government" approach. It considered both personal risk factors and the social determinants of health.[127] The inquiry conducted public consultations to identify programmes that were successfully addressing both the causes and effects of health inequalities. However, the experience with "joined-up-government" in the U.K. should also be treated with some caution because there is little empirical evidence on the effectiveness of these policies.[128]

In the context of global health, the U.K. government released a Strategy in 2008 called Health is Global.[129] The Interministerial Group for Global Health is responsible for reviewing progress on the implementation of the Strategy, which follows on from the 2007 report discussed in the section on "White Papers" below.[130] The Interministerial Group for Global Health is supported by a cross-government steering group of senior officials. The impetus for the strategy and the Interministerial Group for Global Health is the recognition that in a globalized, interdependent world, health has become a global issue.[131] In particular, the Strategy recognizes that global health is "determined by factors which themselves show scant respect for national boundaries—such as international trade, climate change, pollution, conflict, environmental degradation and poverty."[132] Thus, the U.K. must partner with other countries, agencies and international organizations (e.g., the E.U. and UN) to improve global health. IP arises in the context of access to medicines in the strategy. The strategy promotes a "robust system of intellectual property rights, used innovatively and flexibly to promote access to medicines."[133] This includes

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FDI for Economic Development in East Asia" in Hirohisa Kohama ed., *Asian Development Experience Vol 1: External Factors for Asian Development* (ASEAN Foundation: 2004) at 2.

125 Latif, *supra* note at 1.

126 Moseley, *supra* note 11 at 7.

127 D. Nutbeam & A.M. Boxall, "What Influences the Transfer of Research into Health Policy and Practice? Observations from England and Australia" (2008) 122 Public Health 747 at 748-49.

128 Jeannette Moore & Justin Keen, "Accounting for Joined-Up Government: The Case of Intermediate Care" (2007) 27 Public Money & Management 61.

129 U.K., Department of Health, *Health is Global: A UK Government Strategy 2008-13* (London: Department of Health, 2008), online: Dept. of Health <http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088753.pdf> [*Health is Global*].

130 U.K., Department of Health, *Health is Global: Proposals for a UK Government-Wide Strategy – A Report from the UK's Chief Medical Adviser Sir Liam Donaldson* (London: Department of Health, 2007), online: Dept. of Health <http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_072696.pdf> [*Donaldson Report*].

131 The Strategy recognizes that a healthy population, as a cornerstone of a national economy and social development, is fundamental to global security and stability. Global health threats undermine the economic and political interests of all countries, and improving global health is a core component of meeting the United Nations Millennium Development Goals.

132 *Health is Global*, *supra* note 129 at 7.

133 *Ibid.* at 10.

supporting the right of developing countries to use flexibilities built into *TRIPS* such as the use of compulsory licensing to improve access to medicines and innovative models such as patent pools for antiretrovirals. However, the strategy immediately cautions that "this should not be at the expense of damaging incentives to invest in research and development. Central to achieving this is agreeing to appropriate differential pricing policies for countries at different stages of development."[134] In the context of policy coherence, the strategy calls for greater coherence and consistency between international and domestic policies that affect global health.[135] It specifically lays out departmental responsibilities.[136]

Similar to the U.K., Australia has a broad policy framework and a number of initiatives to ensure policy coherence between areas of government, which come from the highest levels of government, the Department of the Prime Minister and Cabinet.[137] Senior executives within the Australian government are also expected to adhere to the Australian Public Service Senior Executive Leadership Capability Framework, which emphasizes relationship building, cooperation, and cross-government priorities.[138]

Relating to IP and public health, specifically, the Australian Department of Health and Aging established the Intellectual Property and Trade Policy Section as part of its Regulatory Policy & Governance Division. The Section provides and implements advice on both domestic and international IP issues. Furthermore, it liaises with other departments and agencies on relevant issues, regardless of whether the Department of Health and Aging is the lead department, in formulating policy or Australia's negotiating position in an international context. Other departments include those with industry and trade portfolios, as well as IP Australia. The goal is to outline issues from a health perspective to assist in overall policy formulation, including coordinating the development of IP and global health related positions at the WHO.

Japan is more similar to Canada in that it has privileged IP policy over health policy and has made little attempt to achieve coherence between the two. In terms of IP policy and Japan's

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134 *Ibid.* at 28.

135 *Ibid.* at 30-31 recommends that the government will work with a variety of partners domestically, as well as the WHO and EU, both of which are crucial players in global health research. The government plans to increase its investment in public-private product development partnerships for a range of neglected diseases and encourages health systems research. In addition, the U.K. strategy indicates the government's willingness to "work effectively with non-governmental partners, especially when developing and implementing government policy; foster greater coherence and consistency of policy and action with non-governmental partners; and work more transparently with non-governmental partners".

136 The summary of departmental responsibilities is laid out in *Health is Global, supra* note 129 at Annex 5. Each of the five principles under the strategy: "better global health security"; "stronger, fairer and safer systems to deliver health"; "more effective international health organizations"; "stronger, freer and fairer trade for better health"; and "strengthening the way we develop and use evidence to improve policy and practice" lists a number of areas of action and ways of working. Each of these specific areas is designated a lead department and then lists supporting departments. Interestingly, the Intellectual Property Office is the lead department for an action item under the principle "stronger, freer and fairer trade for better health." The action item is to "promote innovative ways to use the intellectual property system to encourage innovation and access to medicines, for example investigating patent pools for antiretrovirals." The supporting departments are Department for Business, Enterprise and Regulatory Reform, DFID, and the Department of Health.

137 The Department of the Prime Minister and Cabinet also provides guidelines and procedures to other Australian Government agencies on administration, the two most relevant being: the *Legislation Handbook* ((Commonwealth of Australia: Australian Government, 2000), online: DPMC <http://www.dpmc.gov.au/guidelines/docs/legislation_handbook.pdf>); and the *Cabinet Handbook* 6th ed. ((Commonwealth of Australia: Australian Government, 2009), online: DPMC <http://www.dpmc.gov.au/guidelines/docs/cabinet_handbook.pdf>).

138 Austl., Commonwealth, Australian Public Service Commission, *Senior Executive Leadership Capability (SELC) Framework*, online: Australian Public Service Commission <http://www.apsc.gov.au/selc/framework.pdf>.

broader national interests, however, it has achieved remarkable coherence following the announcement by then Prime Minister Koizumi in 2002 that Japan would be an "IP-based nation".[139] The Japanese government quickly followed on this statement by introducing and passing the *Intellectual Property Basic Act*, the objective of which was, according to article 1, "realizing a dynamic economy and society that is based on the creation of added values through the creation of new intellectual property and effective exploitation of such intellectual property."[140] This Act created the Intellectual Property Strategy Headquarters within the Cabinet Office,[141] and encouraged universities[142] and businesses[143] to promote the dissemination of ideas and to develop strategies around the protection and licensing of IP.

The Diet (Japanese Parliament) and the Japanese Patent Office both took steps to implement the government policy, through legislative support or, in the case of the patent office, a labour-intensive effort to map the patents held by Japanese and foreign patent holders in Japan, the U.S., Europe, and China in a variety of strategic areas including biotechnology and nanotechnology.[144] This mapping was undertaken in the interests of advancing Japanese knowledge-based sectors and research by identifying areas of high patenting activity (an indication of innovative activity) and potential competitors or markets. Officials were therefore conscious of the overarching government policy and were attempting as best they could to find ways to advance that policy. While this policy had little to say about global access to medicines, and thus is not a direct comparator for policy coherence in the IP-health nexus, it does illustrate how policy coherence can be constructed with high-level political support.

In India, policy coherence on IP and health requires not only coordination across federal or national governments, but also with the state/provincial or regional governments. In 2002, India put in place comprehensive legislation on biodiversity and IP rights at the local, national, and federal levels, to ensure policy coherence on the topic of traditional medicines. The *Biological Diversity Act* adopted in 2002 established several bodies to manage uses for biodiversity at the federal, national and local levels—the National Biodiversity Authority, the State Biodiversity Authority, and the Biodiversity Management Committee—as well as two funds to manage Access and Benefit Sharing in India (National and Local Biodiversity Funds).[145]

The last version of India's *Patent Act* (2005) recognized the patentability of plants and medicines but included several special clauses related to biodiversity management, such as disclosure of origin and of TK.[146] This last point has now been facilitated by the recent creation in India of a network of TK holders and databases at district, state, and national levels, such as the Traditional Knowledge Digital Library[147] and the Community Biodiversity Registers.[148] All these

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139 Hisamitsu Arai, "Intellectual Property Revolution: Japan's Experience in Formulating a National IP Strategy" in *Intellectual Property Revolution* (Tokyo: Kadokawa Publishing Corporation, 2006), online: WIPO <http://www.wipo.int/export/sites/www/academy/en/research/research/pdf/national_ip_strategy.pdf>.

140 Act 122 of 2002.

141 *Ibid*. at art. 24.

142 *Ibid*. at art. 7.

143 *Ibid*. at art. 8.

144 In October 2007, two of the authors of this article met with representatives from both the legislature office of the Diet (Japanese Parliament) and the Japanese Patent Office.

145 Philippe Cullet & Jawahar Raja, "Intellectual Property Rights and Biodiversity Management: The Case of India" (2004) 4:1 Global Environmental Politics 97 at 103.

146 *Patents (Amendment) Act 2005*, No. 15 of 2005.

147 TKDL, *supra* note 87.

148 R.V. Anuradha, Bansuri Taneja & Ashish Kothari, "Experiences with Biodiversity Policy-Making and Community Registers in India" in Krystyna Swiderska ed., *Participation in Access and Benefit-Sharing Policy* (London: International Institute for Environment and Development (IIED), 2001) Case Study No. 3, online: CBD <http://www.cbd.int/doc/case-studies/abs/cs-abs-reg-in-en.pdf>.

instruments aim to implement a coherent policy regarding the use of biological material in traditional medicines but do not, in themselves, constitute a legislative framework to protect TK.[149]

More recently, the Department of Industrial Policy and Promotion ("DIPP"), the nodal agency for IP issues in India has set up a discussion forum on IP rights issues to facilitate a wider consultation on all IP issues, particularly those under discussion at WIPO.[150] However, legislation (under consideration but not yet passed) specifically aimed at protecting TK within a *sui generis* system is unlikely to be implemented by the DIPP, but rather by the Ministry of Environment.[151] Shamnad Basheer, an Indian IP expert, questions the DIPP's jurisdiction over issues under discussion at WIPO because these and other issues of international IP affairs were shifted by the Prime Ministers' Office from the Ministry of Human Resource Development ("HRD") to the Ministry of Commerce, except for copyright which remained with HRD. Indeed most WIPO meetings on copyright issues are attended by Mr. G. Raghavender, the current registrar of copyrights.[152] From this, Basheer calls for coherent IP policy formulation in India, commencing with clarification of the jurisdictional bounds of the various ministries.[153] Further, Basheer concludes that there is increasing incoherence between India's "domestic" and "international" positions on IP. In this context, pharmaceutical IP policy is likely to be particularly problematic, with the involvement of an increasing number of ministries.[154] The Ministry of Commerce can legitimately claim the greatest interest, given that it is in charge of patents overall. However, the Ministry of Health and Family Welfare could theoretically intervene and devise solutions, in so far as public health issues intersect with patents. That said, it has not been very active yet on the issue of pharmaceutical patents.

Basheer concludes by noting that the increasing number of government agencies involved at the intersection of IP and health, if combined with little coordination is a sure recipe for confusion.[155] The confusion is likely to increase unless jurisdictional issues are made clear. More

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149 Cullet & Raja, *supra* note 145.

150 The website invites comments from individuals, organizations, stakeholders, and other interested parties, online: DIPP <www.dipp.nic.in>.

151 Shamnad Basheer, "Indian IP Policy Formulation: From Confusion to Coherence" (2010), online: Spicy IP Blog <http://spicyipindia.blogspot.com/2010/03/indian-ip-policy-formulation-from.html>. Text on India is adapated from Basheer (2010) with permission. Mr. Bhaskar's task is to coordinate all IP issues that fall within the jurisdiction of the DIPP, including patents, trademarks Geographic Indications, and Industrial Design. However, it does not include copyright that falls under the exclusive domain of the HRD, new plant varieties that fall under the jurisdiction of the Ministry of Agriculture, and circuit topography that falls under the jurisdiction of the Ministry of Information Technology.

152 *Ibid.*

153 *Ibid.*

154 *Ibid.*

155 For example, "the Ministry of Chemicals and Fertilizers is starting to play a larger role in pharmaceutical patent matters. Indeed, in 2008, the Department of Pharmaceuticals was set up to exclusively focus on pharmaceutical issues. And this department has already [begun] flexing its 'patent' muscle ... A recent notice announcing a [Federation of Indian Chambers of Commerce & Industry] patent round-table suggests that key personnel from [the Department of Pharmaceuticals] will hold forth on section 3(d) [of the *Patents Act*, 1970], a section that is yet to be conclusively interpreted by a court of law." (Basheer, *supra* note 151); According to the Federation of Indian Chambers of Commerce & Industry, "[s]ection 3(d) was introduced in 2005. The section provides that mere discovery of a new form of a known substance which does not result in enhancement of the known efficacy of that substance or mere discovery of new property or new use for a known substance or of the mere use of a known process, etc., are not patentable" (Federation of Indian Chambers of Commerce & Industry, "Roundtable on Section 3d of the Patents Act, 1970" (New Delhi: Mar 29, 2010), online: Federation of Indian Chambers of Commerce & Industry <http://www.ficci.com/events-page.asp?evid=20336>); According to Basheer, *supra* note 151: "Apart from the above, the Ministry of Chemicals has a little more 'IP' say through its agency, the National Pharmaceutical Pricing Authority (NPPA), tasked with regulating pharmaceutical prices. With the creation of the [Department] of Pharmaceuticals, NPPA functions have now been moved to the [Department of Pharmaceuticals].".

importantly, it will be necessary to find effective ways of helping the agencies involved to coordinate better with each other, so as to make for coherent IP policy formulation, both domestically and internationally.

In Canada, the task of ensuring coherence on international matters traditionally fell to the Department of Foreign Affairs and International Trade ("DFAIT"). The Department of Foreign Affairs and International Trade Act provides that one of the duties of DFAIT is to "coordinate Canada's international economic relations."[156] However, with increasing internationalization of what was formerly understood as domestic issues, other departments developed extensive international activities. As a result, permanent and institutionalized inter-governmental coordination offices are sometimes useful. Canada has various Ministerial Coordinating Committees, including some on related issues, such as biotechnology and sustainable development. During the drafting of what eventually became CAMR, five departments with different perspectives (industry, health, trade, international development, and foreign affairs) were fully engaged in the process of drafting the legislation. Each official interviewed in the study by Morin and Gold confirmed that he or she was committed to reaching an inter-departmental consensus.[157] However, this experience has not lead to a permanent inter-governmental committee on IP and health.

In general then, effective coordination requires two main factors: leadership and a permanent institution that can build trust. On the first point, inter-ministerial coordination is a widely used process for policy coherence, in particular for multidisciplinary issues such as traditional medicines—that involve trade, IP rights, relations with indigenous peoples and local communities, and environmental issues. However, this process is not always successful. Indeed, the lack of leadership in inter-ministerial coordination has been found strongly to constrain policy coherence. For example, in France, decisions relating to ABS are discussed by the General Secretariat to European Affairs (Secrétariat général des affaires européennes, "SGAE"). Coordination meetings include the main actors involved in regulating ABS, namely the ministries of research, environment, agriculture, and trade. But the lack of institutional leadership has impeded any clear decision on the topic.

Inter-ministerial coordination is a process that is also used at the European level of policy-making. In this case, the coordination meetings involve all the interested member states that are in turn often represented by different ministries. Despite the wide variety of the representatives gathered, these meetings are often successful thanks to the strong leadership of the European Commission—in particular, the Directorate General for the Environment is the leader on ABS issues.[158]

However, there are exceptions to the requirement for leadership. One case of successful coordination without strong leadership has been pandemic influenza preparedness across the E.U. But a recent study concluded that this may be explained by special circumstances:

> The EU's powers in the field of pandemic influenza preparedness are limited to coordination, surveillance, monitoring and the issuing of recommendations. So far this soft method of inter-governmental cooperation has worked remarkably well. Although differences of influenza preparedness persist between member states, public fear and the media-frenzy about bird flu have enhanced the willingness of member states to cooperate.[159]

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156 *Department of Foreign Affairs and International Trade Act*, R.S.C. 1985, c. E-22, s. 10.

157 Morin & Gold, "Consensus-Seeking, Distrust, and Rhetorical Action", *supra* note 58.

158 Amandine Bled, *L'influence des firmes sur les négociations internationales, le cas de la Convention sur la diversité biologique* (D. en Science Politique, Université Montesquieu – Bordeaux, 2009) [unpublished manuscript].

159 Oliver Wiechoczek, *The EU's Contribution to Global Governance: The Case of Global Infectious Diseases* (Bruges: College of Europe, 2006) at 44.

The second factor for successful inter-ministerial coordination is a permanent institution that can build trust.[160] This is because coordination mechanisms do more than coordinate action. They help to improve the mutual understanding among bureaucrats from different departments by building trust. According to Felix Addord, the deputy director general and head of legal and international affairs of the Swiss Federal Institute of Intellectual Property, the goal of the Swiss Inter-Departmental Expert Group was "to build trust between the different players in the Swiss Federal Administration and to get all national experts around one table."[161]

Furthermore, Christiansen has shown that collective identity, shared allegiance, increased knowledge, and informal relations increase coherence between institutions.[162] This is especially important for issue-areas such as IP, which rely more on beliefs (on all sides) than solid empirical evidence; while the international IP system might appear rational, it is neither supported nor contested by clear empirical evidence.[163] Notwithstanding the availability of rich literature on the economics of patents, methodological constraints—especially the inability to control all the factors that drive innovation—prevent anyone from clearly establishing the optimal depth and breadth of patent protection.

D. Broader Delegations at Inter-governmental Meetings

At the 2009 WHO General Assembly, some countries (developed and developing) sent IP experts. The U.S. delegation included people from the U.S. Trade Representative ("USTR"), including an advisor for IP and an IP attaché from the Permanent Mission in Geneva. Kenya had a Patent Examiner from the Kenya Intellectual Property Institute. The U.K. sent an advisor from the Intellectual Property Office. Switzerland sent people from the Swiss Federal Institute of Intellectual Property.

Brazil is one of the few countries that systematically send people from its Health Ministry to IP related meetings, including the *TRIPS* Council, the WIPO Standing Committee on the Law of Patent, and the WIPO General Assembly. As observed in a recent study, "Brazilian diplomats serve key roles in health and other ministries to assure policy coherence across the government."[164]

Likewise, Switzerland has strong follow-up on international negotiations. For example, so that it can participate with greater precision and coherence in the different decision-making processes linked to the issue of traditional medicines, the Swiss government often sends the same representatives to different international negotiation processes. Indeed, an analysis of the Swiss delegation to WIPO and *CBD* revealed that Swiss representatives often have very intense follow-up sessions after international negotiations.[165] Moreover, several delegates specialized in both negotiation processes. Switzerland has also made efforts to send the same representatives

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160 A report from the International Expert Group on Biotechnology, Innovation and Intellectual Property, *Toward a New Era for Intellectual Property: From Confrontation to Negotiation*, (Montreal: International Expert Group on Biotechnology, Innovation and Intellectual Property, 2008), online: The Innovation <http://www.theinnovationpartnership.org/en/ieg/report/> [International Expert Group on Biotechnology, Innovation and Intellectual Property]; Morin & Gold, "Consensus-Seeking, Distrust, and Rhetorical Action" *supra* note 58.

161 Gerhardsen, *supra* note 122, quoting Felix Addor, the deputy director general and head of legal and international affairs of the Swiss Federal Institute of Intellectual Property.

162 Thomas Christiansen, "Intra-Institutional Politics and Inter-Institutional Relations in the EU: Towards Coherent Governance" (2001) 8:5 Journal of European Public Policy 747.

163 International Expert Group on Biotechnology, Innovation and Intellectual Property, *supra* note 160.

164 Ilona Kickbusch *et al.*, "Global Health Diplomacy: Training Across Disciplines" (2007) 85:12 Bulletin of the World Health Organization 971 at 971.

165 Amandine Bled & Jean-Frederic Morin, "Strategic Behaviour, Socialization By-Product, or Bureaucratic Politics? The Case of Genetic Resources" (unpublished manuscript on file with authors).

to negotiation processes regarding IP and health, for example, the open-ended Working Group at WIPO and the Intergovernmental Meeting of the WHO on sharing of influenza viruses and access to vaccines and other benefits.[166]

Another interesting case is that of the European Commission. According to the list of delegates sent to inter-governmental meeting, there was a specialized unit (Directorate General) taking the lead for each forum. However, such a division of labour is not put in place to the detriment of European policy coherence. To the contrary, there is evidence showing that the compartmentalization of the Commission's administrations is accompanied by strong inter-Directorate General coordination. One author already underlined this "apparent paradox: while intra-institutional politics are becoming increasingly fragmented, the relative coherence of inter-institutional relations in the EU is improving."[167] One explanation is that the institutional identification of European bureaucrats belongs to the Commission as whole. Specific Directorate Generals must hold together to resist the pressure and competition coming from the Council and the Parliament.[168] In a Europe that is still in construction, the bureaucratic politics is to be found among European institutions rather than within the Commission.

By way of contrast, at the 2009 WHO General Assembly, the Canadian delegation included mostly delegates from Health Canada, but also two delegates from CIDA (Population and Public Health, and Multilateral Institutions Division) and two from DFAIT (Health and Population Division). The delegation did not include a representative from Industry Canada or from DFAIT's Intellectual Property, Information and Technology Trade Policy Division. It is also very uncommon to have Health Canada representation at WIPO meetings such as the WIPO Standing Committee on the Law of Patent and the WIPO General Assembly, or at the Intergovernmental Working Group on TK, Genetic resources and Folklore. This may represent a missed opportunity for multi-sectoral policy development for Canada in IP and health at the international level.

E. White Papers

To ensure policy coherence, other countries have opted for the inclusion of health priorities in their national and international agenda. National efforts to develop health diplomacy are based on an "emerging recognition of the need for policy coherence, strategic direction and a common value base in global health."[169] Here, the assumption is that coherence could be creased, not by new mechanisms or processes, but with a clearer collective vision spelled out in a single document. The emergence of the sustainable development paradigm, for example, changed the way economic and environmental issues are addressed. Following this paradigm shift, it became natural to conduct environmental impact assessments as part of trade agreements (while few think about conducting health impact assessments).

For example, in the U.K., in March 2007, the Department of Health published a report entitled *Health is Global: Proposals for a UK Government-Wide Strategy* that provided the rationale for a U.K. global health strategy.[170] The *Donaldson Report* recognized that, in today's globalized world it is not possible to consider a nation's health interests in isolation. This is true

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166 *Ibid.*

167 Christiansen, *supra* note 162 at 747.

168 Magdalena Frennhoff Larsén, "Trade Negotiations Between the EU and South Africa: A Three-Level Game" (2007) 45:4 Journal of Common Market Studies 857.

169 Ilona Kickbusch, Gaudenz Silberschmidt & Paulo Buss, "Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health" (2007) 85:3 Bulletin of the World Health Organization 230 at 231, cited in Katherine Bond, "Commentary: Health Security or Health Diplomacy? Moving Beyond Semantic Analysis to Strengthen Health Systems and Global Cooperation" (2008) 23:6 Health Policy and Planning 369 at 377.

170 *Donaldson Report*, *supra* note 130.

not only for infectious diseases that do not recognize national boundaries, but also for chronic diseases that are becoming a global rather than a developed country problem. In addition, globalization has led to new international governance structures that make decisions directly affecting the ability of national governments to respond to health challenges. The report makes the case for

> concerted action on global health and for developing a global health strategy, one that will benefit the health of the UK population and those in the rest of the world. The report provides a framework for developing a strategy, and provides the basis for a public debate on what current global health priorities are, what the UK should focus on, and what the global health strategy should look like.[171]

A government-wide steering group was established to develop the strategy (as discussed above).

However, the report only dealt with IP issues briefly. In describing *TRIPS*, it concluded that "TRIPS strikes a good balance between the need to provide a return on the investment in research and development of new drugs and the need to secure access to medicines for poor people."[172] It expressed the U.K.'s commitment to promoting investment in pharmaceutical R&D. At the same time, however, the report recognized that "TRIPS should not prevent members from taking measures to protect public health and that, accordingly, it should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all."[173] The U.K. was a strong supporter of the compulsory licensing provisions in *TRIPS*.

An earlier report commissioned by the U.K. Secretary of State for International Development dealt more directly with IP rights, but in the context of development policy.[174] That report considered how national IP laws could be designed to benefit developing countries in the context of international agreements such as *TRIPS*. Chapter Two of the report examined the issue of IP rights and health. The primary issues canvassed and discussed in detail were access to medicines in developing countries and generating the resources necessary to develop pharmaceuticals and vaccines for diseases that primarily impact developing countries. It concluded with the recommendation that "[p]ublic funding for research on health problems in developing countries should be increased. This additional funding should seek to exploit and develop existing capacities in developing countries for this kind of research, and promote new capacity, both in the public and private sectors."[175] Public funding is necessary because IP rights are not providing the incentives to the private sector to research in this area because there is no profitable market apparent.

On the issue of access to medicines, the report concluded that:

> Countries need to adopt a range of policies to improve access to medicines. Additional resources to improve services, delivery mechanisms and infrastructure are critical. Other macroeconomic policies need to be in harmony with health policy objectives. But so also does the IP regime. Countries need to ensure that their IP protection regimes do not run counter to their public health policies and that they are consistent with and supportive of such policies.[176]

In support of access to medicines, the report recommended that "[d]eveloping countries should establish workable laws and procedures to give effect to compulsory licensing, and

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171 *Ibid.* at 7.
172 *Ibid.* at 46.
173 *Ibid.* at 46.
174 Commission on Intellectual Property Rights, *supra* note 109.
175 *Ibid.* at 39.
176 *Ibid.* at 46.

provide appropriate provisions for government use."[177] Indeed, this last recommendation supports the enactment of laws that can take advantage of regimes such as CAMR.

In Switzerland, health has been included as a general policy objective in all governmental sectors to ensure better policy coherence.

> Switzerland has prioritized health in foreign policy by emphasizing policy coherence through mapping global health across all government sectors. Through the Departments of Interior (Public Health) and Foreign Affairs, an agreement on the objectives of international health policy was submitted to the Swiss Federal Council to assure coordinated development assistance, trade policies, and national health policies that serve global health.[178]

What would such a paradigm shift entail in the context of health in Canada? Blouin, Foster, and Labonté suggest a number of paradigm shifts to increase coherence on global health issues, such as a formal recognition of the right to health and a formal recognition of health as a global public good.[179] According to these authors, this approach would imply the

> application of human rights commitments in a variety of subsidiary and related elements of health policy. It implies the development of a more effective monitoring and reporting agency within Canadian government structures, whether an enhanced role for the Canadian Human Rights Commission or some other body or process. It implies the human rights assessment of policies, whether domestic or international, which impinge on, potentially enhance or undermine Canada's human rights obligations. We believe that such an approach would bring coherence and anchor to Canadian health policy and its future development.[180]

CONCLUSION

Whether termed policy coherence, whole-of-government coordination, or joined-up-government, a central concern of governments around the world has been to coordinate policies not only across their various departments but between their domestic and international positions in important fora such as WHO, WTO, WIPO, OECD, *CBD*, and others. However, the pursuit of greater procedural coherence may come at the expense of effectiveness, specifically the loss of flexibility in the policy-making system as acknowledged by the OECD.[181] The paradox is that effectiveness requires policy coherence in outcome.[182] Nevertheless, there is no consensus and limited practical examples on how to increase coherence in the outcome without unduly focusing on increasing coherence in the process, since a focus on the latter, while more immediately rewarding, may have detrimental or unintended effects on the former.

The task of achieving policy coherence at the intersection of a "wicked issue" such as public health and IP has been especially important given that policy-making in this area affects so many domestic and international policies ranging from local health delivery, to health financing, innovation policy, science policy, health research funding and administration, marginalized communities, traditional medicine, links between health and socio-economic conditions, foreign investment, foreign trade, aid and humanitarian assistance, and so on.

Despite the importance of the task of developing policy coherence, achieving it has often been elusive. As this paper illustrates, many governments around the world have spoken of policy coherence, but few have developed mechanisms to implement it. Of these, fewer still have actually attained coherence and empirical evidence of the actual impacts of coherence is lacking.

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177 *Ibid.* at 53.
178 Ilona Kickbusch *et al.*, *supra* note 164 at 971.
179 Blouin, Foster & Labonté, *supra* note 110 at 28.
180 *Ibid.* at 28.
181 OECD, *Building Policy Coherence: Tools and Tensions*, *supra* note 20 at 8.
182 OECD, *Coherence for Health*, *supra* note 21 at 4.

Some of the countries most held up as examples of having developed such coherence have not, in the end, been able to deliver. Of the countries surveyed, only Switzerland could be said to have a truly coherent policy on issues of IP and health.

Switzerland achieved its success through a coordinating body, the inter-departmental expert group on IP. Likely because it is a small country—Switzerland has a population under 8 million—and its history of international engagement, and of broad, public consultations, this coordinating committee has actually succeeded in providing a forum through which different IP positions are debated and a decision attained and implemented. As previously discussed, the success of Switzerland's experience was likely due to the level of trust that it was able to achieve between departments and others involved with IP issues.

While not related specifically to health, the Japanese experience is instructive. Japan attained policy coherence around IP through a decision of the Prime Minister and Cabinet to make Japan "an IP nation". The Prime Minister then formed the Intellectual Property Strategy Headquarters within the Cabinet office to oversee the creation and implementation of the country's IP strategy. As a result, legislation was introduced and passed and a diverse set of departments and agencies, including the patent office, consulted with their stakeholders in order to build tools and develop policies to assist private and public actors to make Japan an IP nation. Nevertheless, attaining coherence in respect of IP alone is less complicated than achieving coherence with respect to health and IP together. The question remains, therefore, of whether the Japanese experience can be extended to intersecting issues of IP and public health.

The U.K. has attempted policy coherence in implementing its global health strategy through a high level Interministerial Group for Global Health. The impact of that approach and the overall strategy will be assessed in 2013, but the overall strategy calls for greater coherence and consistency between international and domestic policies that affect global health, including IP. The focus of the strategy, therefore, is assessing government policies, including IP, with respect to global health. The focus is therefore on global health and not the public health and IP nexus.

In Australia, the Department of the Prime Minister and Cabinet provides guidelines and procedures to government agencies. Senior executives within the Australian government are also expected to shape strategic thinking by operating "on the basis of a 'whole of government' framework and tak[ing] the broader context into account" and ensuring "portfolio effort contributes to cross-government priorities", envisaging "what might be and how future possibilities balance with the 'here and now'."[183] Specifically relating to IP and public health, Australia established the Intellectual Property and Trade Policy Section as part of the Regulatory Policy & Governance Division of the Department of Health and Ageing, and tasked it with liaising with other government departments. The IP and Trade Policy Section provides and implements advice on both domestic and international IP issues and liaises with other departments and consults with other Ministries on relevant issues, regardless of whether the Department of Health and Aging is the lead department in formulating policy or Australia's negotiating position in an international context.

In India, however, while there are some attempts to coordinate all IP issues that fall within the jurisdiction of the Department of Industrial Policy and Promotion, the nodal agency for IP issues, Basheer notes that the increasing number of government agencies involved at the intersection of IP and health, if combined with little coordination, is a sure recipe for confusion overall rather than coherence.[184]

What, then, is to be learned from these examples? First, policy coherence is much easier said than done. Second, when it has been done, it has generally not achieved nearly the success that

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183 Australian Public Service Commission, *supra* note 138 at 3.

184 Basheer, *supra* note 151.

was expected. Third, in many cases it is too soon to judge success or failure due to lack of empirical evidence—it is one thing to outline the number of processes and mechanisms, and another to determine their effectiveness in meeting their objectives. Finally, where it has succeeded, it has done so either because of the particular characteristics of the country—small and engaged in politics and debate as in Switzerland—, due to the adoption of a national policy organized through the highest offices in the land—as in the case of Japan and the U.K.—, or as a result of a strong internal champion and conditions of trust, as in the EU and in Switzerland.

While not dealing directly with the health-IP nexus, we can point to the relative success of Canada's Science and Technology Strategy[185] in providing coherence between different government departments over science and technology. While some may criticize the policy itself for what it says or does not say, the fact is that most government departments do more than pay lip service to it: they try to justify their actions and policies in terms of it. While the strategy ostensibly is the responsibility of only one department, Industry Canada, its frequent mention by ministers and in Throne Speeches indicates that it was adopted and is supported at the very highest political levels in Canada.

Given these lessons, it seems that reaching full coherence requires both substantive and procedural coherence, or as Table 1 puts it, both a political commitment and the institutional capacity for greater coherence. Being politically committed to coherence means that a government has renounced "strategic ambiguity" or "strategic inconsistency". But a number of studies suggest that most governments still rely on these strategies to extract simultaneous gains from diverse and fragmented audiences, especially in international IP debates.[186]

However, as stakeholders motivated primarily by health issues become increasingly involved in IP fora, and IP experts learn to see the world from a health perspective, inconsistencies become more perceptible and reputational costs associated with these strategies rise. In this sense, multi-stakeholder consultations contribute to learning processes which may create pressure on the governments that set up these consultation processes to address problems of incoherence. As a result, an increasing number of governments, as this study has shown, are committed to policy coherence and have conceptualized their objectives. White papers and reports from expert groups are especially useful to identify the issues to be considered, conflicts to avoid, and synergies to seek. In some cases, the highest authorities in the country even gave an explicit impetus to pursue these objectives.

Table 1: Two conditions for policy coherence

		Political commitment (substantive coherence)	
		No	**Yes**
Institutional Capacity (procedural coherence)	**No**	Full incoherency	Functional coherency
	Yes	Strategic incoherency	Full coherency

[185] Industry Canada, *Mobilizing Science and Technology to Canada's Advantage – 2007*, online: Industry Canada <http://www.ic.gc.ca/eic/site/ic1.nsf/vwapj/S&Tstrategy.pdf/$file/S&Tstrategy.pdf>.

[186] Raustiala Kal & David Victor, "The Regime Complex for Plant Genetic Resources" (2004) 32:2 International Organization 301; Helfer, *supra* note 1.

Political commitment, however, is not enough to reach full coherence, even when it comes from the highest authorities. IP and health policies rely heavily on bureaucratic administrations since they are quite technical issue-areas and are rarely controversial for the broader public beyond specific groups of informed stakeholders. Given the exceedingly technical issues, one could not necessarily expect the head of government or the cabinet alone to conceive and implement a strategy for greater coherence. Therefore, in addition to political commitment, full coherence requires the institutional capacity for bureaucrats to build trust, share experiences, and identify potential collaborations.

This study has discussed two mechanisms for countries like Canada to enhance this institutional capacity, namely intra-governmental coordination and broad delegation at inter-governmental meetings. Without similar mechanisms, the various agencies interested in IP and health have no choice other than to operate within policy silos, i.e. artificial boundaries between issue-areas to minimize conflicts between different authorities. We call this situation, where a government has the political commitment but not the institutional capacity, "functional coherence". It is arguably more desirable that strategic incoherence remains but a second-best. Therefore, a clear statement of policy by the Cabinet coupled with strong institutional mechanisms for the administration are likely the best way to ensure the development of policy coherence for seemingly intransigent "wicked issues" such those found at intersection of IP and public health.

APPENDIX 1: FORA THAT ADDRESS THE INTERSECTION OF IP AND PUBLIC HEALTH

The need to deal with issues relating to IP and public health on an international level was first recognized in 1994 with the incorporation of minimum levels of IP protection in the World Trade Organization ("WTO") *Agreement on Trade-Related Aspects of Intellectual Property Rights* ("*TRIPS*"),[187] followed by the WTO Ministerial Conference, *Declaration on the TRIPS Agreement and Public Health* ("*Doha Declaration*"),[188] and a decision of the WTO General Council that introduced a formal amendment to *TRIPS* to allow greater flexibility to developing countries on the issue of IP and health.[189]

The WHO began work on IP and public health at about the same time as WTO members were debating the *Doha Declaration* and while the UN established the United Nations Millennium Development Goals and Project.[190] The WHO focused its attention on the interrelated issues of IP, health, and innovation, forming the Commission on Intellectual Property Rights, Innovation and Public Health in May 2003, at the Fifty-sixth World Health Assembly, by virtue of resolution WHA56.27, and released a report in 2006.[191] On May 27, 2006, the Fifty-ninth World Health Assembly adopted Agenda 11.1 entitled "Public Health, Innovation, Essential Health Research and Intellectual Property Rights: Towards a Global Strategy and Plan of Action" and established an inter-governmental working group ("IGWG") charged with drawing up the global action plan.[192] The IGWG spent the next year or so elaborating a document entitled "Elements of a Global Strategy and Plan of Action" which it released on December 14, 2007.[193] In May 2008, the Sixty-first World Health Assembly adopted Resolution WHA61.21: Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property ("GSPOA").[194] Currently, the WHO's focus is on implementing the GSPOA and other regional organizations such as the Pan American Health Organization.

Other international fora dealing with aspects of IP and public health include the Organization for Economic Cooperation and Development ("OECD"), which recognizes, on behalf of OECD countries, the need for greater coherence across sectors that affect developing countries, especially health, recognizing that aid alone cannot address the needs of the developing world. In this arena, the OECD has developed an initiative named Policy Coherence for Development.[195] The World Intellectual Property Organization ("WIPO"), fuelled by the rise of concerns about the

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[187] 1869 U.N.T.S. 299, 33 I.L.M. 1197 (Annex 1C of the Marrakesh Agreement establishing the World Trade Organization, signed in Marrakesh, Morocco on 15 April 1994), online: WTO <http://www.wto.org/english/tratop_e/trips_e/t_agm0_e.htm>.

[188] WTO Doc. WT/MIN(01)/DEC/2, 4th Sess., online: WTO <http://www.wto.org/english/theWTO_e/minist_e/min01_e/mindecl_trips_e.htm>.

[189] WTO, *Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health* (held on 30 August 2003), WTO Doc. WT/L/540 and Corr. 1, online: WTO <http://www.wto.org/english/tratop_E/TRIPS_e/implem_para6_e.htm>.

[190] UN Department of Economic & Social Affairs, "We Can End Poverty 2015 Millennium Development Goals" (2008), online: UN <http://www.un.org/millenniumgoals/>.

[191] *Report of the Commission on Intellectual Property, Innovation and Public Health*, *supra* note 101.

[192] WHO, "Public Health, Innovation and Intellectual Property", online: WHO <http://www.who.int/phi/en/>.

[193] Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, *Elements of a Global Strategy and Plan of Action*, Doc. A/PHI/IGWG/1/4, 8 December 2006, online: WHO <http://apps.who.int/gb/phi/pdf/igwg1/phi_igwg1_5-en.pdf>.

[194] World Health Assembly, *Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property*, Resolution WHA61.21, 24 May 2008, online: WHO <http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R21-en.pdf>.

[195] OECD, "Policy Coherence for Development", online: OECD <http://www.oecd.org/about/0,3347,en_2649_18532957_1_1_1_1_1,00.html>.

impact of increased IP protection in developing countries on health, has also adopted its own Development Agenda—launched by a group of developing countries that brought the issue to the fore at the 40th session of the WIPO Assemblies (September 20 to October 5, 2004).[196] In particular, the Agenda raises issues related to the welfare costs of increasing IP protection, the difficulty for developed and least developed countries to benefit from higher levels of protection, and the differences in economies and health status between developing countries and those countries proposing minimum standards of IP. WIPO also hosts negotiations on TK in its Intergovernmental Committee on Intellectual Property and Genetic Resources, Traditional Knowledge and Folklore.

Finally, the UN *Convention on Biological Diversity* ("*CBD*") provides an international framework for the conservation and sustainable use of biological diversity.[197] It is relevant in the context of IP and health because it contains provisions on access to genetic resources, the allocation of benefits from the utilization of genetic resources which must be shared through, for example, transfer of technologies (including biotechnology), and rights over the resources and appropriate funding.[198] There are also bilateral trade agreements that address IP and health, as well as current negotiations under the proposed Anti-Counterfeiting Trade Agreement that address counterfeit medicines.

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196 World Intellectual Property Organization, "Development Agenda for WIPO", online: WIPO <http://www.wipo.int/ip-development/en/agenda/>.

197 *Convention on Biological Diversity*, 5 June 1992, 1760 U.N.T.S. 79, online: UN <http://www.cbd.int/doc/legal/cbd-en.pdf > [*CBD*].

198 *Ibid.,* art. 1.

MATERNITÉ, GESTATION ET LIBERTÉ : RÉFLEXIONS SUR LA PROHIBITION DE LA GESTATION POUR AUTRUI EN DROIT QUÉBÉCOIS

Marie-France Bureau et Édith Guilhermont [*]

Le Québec et la France prohibent les contrats de gestation pour autrui. Malgré la nullité des contrats prévue par la loi, des couples choisissent néanmoins cette avenue et certains d'entre eux ont saisi les tribunaux afin d'établir un lien de filiation entre eux et l'enfant porté par une tierce partie. La question de la maternité pour autrui est toujours controversée et a donné lieu à une jurisprudence contradictoire à ce jour.

La présente étude examine les fondements de la prohibition au Québec et en France et envisage ses conséquences juridiques sur la filiation des enfants nés de cette pratique. Les auteures répertorient les solutions retenues dans divers droits occidentaux afin d'éclairer de quelle façon les législateurs peuvent répondre aux défis posés par cette technique de procréation assistée.

Grâce à une analyse du discours bioéthique dominant et à la lumière des études scientifiques portant sur les personnes impliquées dans la gestation pour autrui, les auteures concluent que les motivations du législateur pour interdire cette pratique sont d'abord d'ordre idéologique. Les craintes exprimées depuis une vingtaine d'années, de même que les arguments avancés contre la gestation pour autrui, ne semblent pas validés par les études empiriques sur la pratique en occident et relèvent davantage du désir de maintenir une certaine représentation de la maternité.

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INTRODUCTION

La maternité a toujours été considérée par les juristes québécois comme une évidence. La mère est tout naturellement la femme qui accouche de l'enfant. Pour appuyer cette affirmation, on se plaît à répéter l'adage romain *mater semper certa est*. Contrairement à la paternité, qui peut faire l'objet de controverses et de présomptions, la maternité serait toujours certaine, en raison de la réalité du ventre et de l'accouchement. Ces mêmes *a priori* caractérisent le discours juridique en France.

Et pourtant, il est indéniable que les arrangements procréatifs impliquant plus de deux protagonistes (et même deux mères) ont toujours existé en Occident, comme dans le reste du monde. L'anthropologue Maurice Godelier rappelait d'ailleurs dans *Métamorphoses de la parenté* qu'il faut davantage que la rencontre de deux géniteurs pour faire de la parenté[1]. Cependant, bien que les dons d'enfants et les diverses techniques d'adoption aient été utilisés de façon courante pour pallier la stérilité[2], la pratique consistant à porter un enfant pour autrui n'a fait l'objet d'études en Occident qu'à compter de la fin du XX[e] siècle.

Au Québec et en France, la gestation pour autrui est devenue plus fréquente depuis les années 1980[3], en partie grâce au développement des techniques de fécondation *in vitro*. Ce que nous appelons la gestation pour autrui est également souvent appelée «maternité pour autrui», «maternité de substitution» ou «recours à une mère porteuse». Nous estimons ces dernières expressions peu satisfaisantes dans la mesure où elles sont essentiellement révélatrices des présupposés de ceux qui les emploient. Elles supposent en particulier l'abandon maternel d'enfants au profit des parents d'intention et sont, à ce titre, réductrices.

En effet, la gestation pour autrui peut prendre deux formes. Dans un cas, elle est dite maternité pour autrui *gestationnelle,* lorsqu'elle implique une fécondation *in vitro* avec les gamètes du couple demandeur. Dans l'autre cas, la femme est impliquée génétiquement, dans la mesure où ce sont ses propres ovocytes qui sont fécondés par le sperme d'un des parents demandeurs ou par un donneur, selon les circonstances. C'est la maternité de substitution dite *traditionnelle*. Plusieurs auteurs marquent la distinction entre les deux types de gestation pour autrui en insistant sur le fait que dans le premier cas, la gestatrice *n'est pas la mère* génétique de l'enfant et qu'il s'agit en l'occurrence d'une pratique plus acceptable[4]. Selon cette logique où le géniteur est assimilé au parent, le fait de fournir ses propres ovocytes transforme la gestatrice en véritable mère et rend moins acceptable la remise de l'enfant aux demandeurs.

Dans la suite de cette étude, nous préfèrerons utiliser l'expression gestation pour autrui dans tous les cas puisque notre position théorique demeure la même, que des liens génétiques entre la gestatrice et l'enfant existent ou non. Nous avons par ailleurs choisi de référer à la femme qui porte un enfant pour autrui comme une gestatrice et non pas comme une mère porteuse. Il ne s'agit évidemment pas de diminuer le rôle exercé par ces femmes, mais plutôt de respecter la façon dont elles conçoivent elles-mêmes leur rôle qui, bien que fondamental et unique, n'est en aucun cas celui de parent lorsqu'elles entrent dans un tel arrangement.

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1 Maurice Gaudelier, *Métamorphoses de la parenté*, Paris, Fayard, 2004.

2 Geneviève Delaisi de Parseval et Chantal Collard, «La gestation pour autrui : Un bricolage des représentations de la paternité et de la maternité euro-américaines» (2007) 183 L'Homme 29 à la p. 31.

3 Il demeure néanmoins difficile de quantifier la pratique dans la mesure où les contrats de gestation pour autrui sont interdits au Québec et en France.

4 Delaisi de Parseval et Collard, *supra* note 2. Voir également *Adoption – 09184*, [2009] R.D.F. 835 (C.Q.).

C'est en 1991 que le législateur québécois adoptait un régime afin d'encadrer non seulement l'insémination artificielle (comme il l'avait fait en 1981), mais aussi l'ensemble de ce que l'on désignait par l'expression procréations médicalement assistées («PMA»). Le *Code civil du Québec*[5] (ci-après «*Code*») établissait d'abord à l'article 538.2 qu'un apport génétique ne peut à lui seul servir à fonder un lien de filiation entre l'auteur du don et l'enfant (ce qui évite la multiplicité potentielle des pères ou mères). Suivant en cela les recommandations du Barreau[6], et dans une quasi-synchronie avec un arrêt de principe en droit français[7], la mère était donc celle qui donnait naissance à l'enfant qu'elle avait porté et le père était celui qui le reconnaissait ou à l'égard duquel la présomption de paternité jouait, si le couple était marié.

Au moment où le législateur adoptait cette disposition, les auteurs étaient en général en accord avec cette orientation. Marie Pratte et Michèle Rivet affirmaient que ces conventions étaient contraires aux principes généraux du droit civil et les jugeaient inacceptables dans le contexte social[8]. Le discours dominant au moment de l'adoption de ces règles était à l'effet que la gestation pour autrui faisait entorse au principe de l'indisponibilité des personnes et risquait de créer des litiges sans fin sur la filiation des enfants[9]. Comme la plupart des juristes québécois, Marie Pratte rappelait que «conformément au droit civil classique, la mère de l'enfant sera celle qui l'a mis au monde»[10]. Cette position de la doctrine et du législateur québécois est très largement en accord avec la position qui prévaut aujourd'hui en droit français.

À une époque où les techniques d'assistance à la procréation ont considérablement progressé et compte tenu du fait que de nombreuses personnes ont recours à des tiers pour mener à bien leur projet parental, les certitudes en matière de filiation s'en trouvent ébranlées. Cependant, plutôt que de repenser les notions de maternité et de filiation au regard de cette réalité, le législateur québécois, à l'instar de ceux d'autres pays comme la France, continue d'interdire la pratique de la gestation pour autrui, sanctionne de nullité les conventions qui ont pour objet de l'organiser et persiste à relier automatiquement la maternité au ventre. Dans ce contexte, les couples qui recourent néanmoins à la gestation pour autrui, de même que les enfants issus de cette pratique, se retrouvent dans une situation délicate. En raison du choix procréatif de leurs parents, des enfants se voient alors dépourvus de filiation maternelle et inversement, des femmes se voient empêchées d'établir une filiation à l'égard de leur enfant, faute de l'avoir porté.

Cette situation, illustrée par plusieurs décisions qui ont été rendues au cours des dernières années, soulève des débats quant à l'intérêt des enfants et des femmes impliqués dans ces contrats de gestation pour autrui. En effet, puisque la pratique existe et qu'elle implique des personnes vulnérables, la pertinence de l'interdiction de principe posée par le droit civil dans les années 90 mérite d'être examinée.

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5 *Code civil du Québec*, L.Q. 1991, c. 64.

6 Comité du Barreau du Québec sur les nouvelles technologies de reproduction, Rapport, «Les enjeux éthiques et juridiques des nouvelles technologies de reproduction» (avril 1988), aux pp. 47-48.

7 Voir la partie I.A.1, ci-dessous. Cass. Ass. Plén., 31 mai 1991, *Bull.civ*. A.P, n° 4, en ligne : Legifrance <http://www.legifrance.gouv.fr>.

8 Marie Pratte, «Le nouveau Code civil du Québec : Quelques retouches en matière de filiation» dans Ernest Caparros, dir., *Mélanges Germain Brière*, Montréal, Wilson & Lafleur, 1993, 283 à la p. 300 ; Michèle Rivet, «La vérité et le statut juridique de la personne en droit québécois» (1987) 18 R.G.D. 843 à la p. 850.

9 Michèle Giroux, «L'encadrement de la maternité de substitution au Québec et l'intérêt de l'enfant» (1997) 28 (4) R.G.D. 535 à la p. 538.

10 Pratte, *supra* note 8 à la p. 300.

Récemment les juristes français, mais aussi plus largement les parlementaires et la société civile, ont renouvelé la réflexion sur la maternité de substitution à l'occasion de la discussion qui devait précéder la révision des lois bioéthiques en France. À l'issue de ces réflexions et consultations, il apparaissait très clairement que le droit français se prononçait pour le maintien de la prohibition de la maternité de substitution. Les juristes québécois n'ont pas eu l'occasion de participer à un tel débat dans la province. Toutefois, à l'automne 2009, la *Commission de l'éthique, de la science et de la technologie* s'est prononcée sur la gestation pour autrui dans son avis relatif à l'éthique et à la procréation[11]. Les membres de la commission rejoignent très largement la position des diverses instances et autorités françaises qui ont eu l'occasion de donner leur avis. Il en résulte, à l'heure actuelle, qu'au Québec comme en France, la prohibition des conventions de gestation pour autrui est toujours considérée comme étant la solution la plus appropriée.

Soulignons que vingt ans après la mise en place de cette prohibition, on aurait pu s'attendre à un changement de ton dans le discours juridique. En effet, la pratique de la gestation pour autrui est aujourd'hui beaucoup plus répandue et socialement plus intelligible. Ce type de contrat a en outre été légalisé et encadré par de nombreux États, ce qui a eu pour effet de permettre à des chercheurs de plusieurs domaines des sciences sociales d'étudier les familles qui avaient recours à ce mode d'entrée en parenté et d'enquêter sur les femmes qui décident de porter un enfant pour autrui. Or, malgré ces développements importants dans la recherche qui ont permis une meilleure connaissance du phénomène et, malgré la transformation des pratiques en matière de procréation, les législateurs français et québécois ont favorisé le *statu quo*.

Le maintien de la position actuelle n'est pas de nature à faire cesser les discussions autour de la gestation pour autrui. Cette étude propose de nourrir le débat en interrogeant, grâce au droit comparé, la pertinence de maintenir la prohibition de la gestation pour autrui en droit québécois. En effet, la prohibition nous semble poser davantage de problèmes qu'elle ne parvient à en résoudre. Elle mérite, selon nous, d'être mise en question. L'analyse des études empiriques sur la question et la variété des approches normatives empruntées dans divers pays occidentaux démontrent que le problème posé par cette pratique ne concerne pas tant les personnes impliquées dans ces arrangements que la remise en question de principes tenus pour certains. En ce sens, l'analyse du discours juridique sur la gestation pour autrui, de même que les arguments mis de l'avant par les experts pour l'interdire, nous éclairent davantage sur les représentations culturelles de la maternité et une certaine conception du droit, que sur les enjeux réels soulevés par ce mode d'entrée en parenté.

Dans cette perspective, la première partie de notre propos envisagera le principe et le fondement de la prohibition avant d'envisager ses conséquences juridiques sur la filiation des enfants nés de la gestation pour autrui.

Dans la seconde partie de l'étude, nous exposerons les différentes solutions qui ont été retenues ou proposées pour relever les défis posés par la gestation pour autrui aux droits occidentaux. Nous poursuivrons cette seconde section en questionnant les arguments classiques invoqués à l'encontre d'une libéralisation de la pratique de la gestation pour autrui.

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[11] Commission de l'éthique, de la science et de la technologie, *Éthique et procréation assistée: des orientations pour le don de gamètes et d'embryons, la gestation pour autrui et le diagnostic préimplantatoire* (Avis), Québec, 2009.

I
LA PROHIBITION DE LA GESTATION POUR AUTRUI EN QUESTION

A. Principe et fondement de la prohibition

1. L'affirmation du principe

En droit québécois, la prohibition de la gestation pour autrui a été inscrite dans le *Code* au chapitre relatif à la filiation des enfants nés d'une procréation médicalement assistée, où l'article 541 interdit «[t]oute convention par laquelle une femme s'engage à procréer ou à porter un enfant pour le compte d'autrui», la rendant «nulle de nullité absolue». Comme le précisent les commentaires du ministre, l'interdiction vaut même pour les conventions qui ne seraient pas conclues à titre onéreux. L'objectif poursuivi par ce texte semble moins résider dans l'interdiction de recourir à une mère porteuse que dans l'impossibilité d'établir la filiation d'un enfant né du recours à une telle pratique : «Il a paru contraire à l'ordre public de permettre que la filiation de l'enfant soit déterminée par une convention. Celle-ci étant réputée n'avoir jamais existé, la filiation sera établie suivant les modes de preuve prévus précédemment» [12].

En cela, le droit québécois se distingue du droit français qui avait d'abord commencé par interdire l'adoption d'un enfant né d'une mère porteuse par sa mère d'intention avant d'affirmer, dans le chapitre du *Code civil* français intitulé «Du respect du corps humain», la nullité des conventions de maternité de substitution. Ainsi, en 1991 la Cour de cassation réunie en assemblée plénière avait rendu un arrêt [13] par lequel elle affirmait, tout d'abord, que la convention par laquelle une femme s'engage, fût-ce à titre gratuit, à concevoir et à porter un enfant pour l'abandonner à sa naissance, contrevient aux principes d'ordre public de l'indisponibilité du corps humain et de l'état des personnes. Puis, constatant que l'adoption requise n'était en réalité que l'ultime phase d'un processus d'ensemble destiné à permettre à un couple l'accueil à son foyer d'un enfant conçu en exécution d'un contrat tendant à son abandon à la naissance par sa mère, elle conclut qu'il s'agissait là d'un détournement de l'institution de l'adoption. Par la suite, le législateur français s'est doté en 1994 d'une *Loi de bioéthique* dans laquelle il saisit l'occasion d'affirmer que la maternité de substitution est prohibée. Cette affirmation s'est matérialisée dans le *Code civil* français par l'insertion d'un article 16-7 au terme duquel «[t]oute convention portant sur la procréation ou la gestation pour le compte d'autrui est nulle» [14].

Tandis que la prohibition des conventions de gestation pour autrui trouve son prolongement dans le *Code pénal* français [15], l'article 60 de la *Loi fédérale sur la procréation assistée* ne sanctionne pénalement que le fait de rétribuer ou de se faire rétribuer pour être mère porteuse, puisqu'elle n'interdit pas quant à elle les conventions.

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[12] Québec, Ministère de la Justice, *Commentaires du ministre de la Justice*, Montréal, Publications DAFCO, 1993 à la p. 201 (sous l'art. 541 C.c.Q.).

[13] Cass. Ass. plén., *supra* note 7.

[14] Deux autres textes complètent cette disposition. Ainsi, l'art. 16-5 prévoit que «[l]es conventions ayant pour effet de conférer une valeur patrimoniale au corps humain, à ses éléments ou à ses produits sont nulles» et l'art. 16-9 précise que les dispositions précédentes «sont d'ordre public».

[15] L'article 227-12 al. 3 incrimine «le fait de s'entremettre entre une personne ou un couple désireux d'accueillir un enfant et une femme acceptant de porter en elle cet enfant en vue de le leur remettre à la naissance». Le *Code pénal* français interdit également tout rattachement de l'enfant à la mère d'intention puisque l'art. 227-13 fait de «la substitution volontaire, la simulation ou dissimulation ayant entraîné une atteinte à l'état civil d'un enfant», et de leur tentative un délit passible d'une peine d'emprisonnement. Le recours à ces textes n'est pas pure hypothèse d'école, puisqu'un procureur a récemment fondé un réquisitoire introductif sur ces textes dans l'affaire *Mennesson*. Sur réquisitions du parquet, le tribunal de Créteil a toutefois rendu une ordonnance de non-lieu. Voir Valérie Depadt-Sebag, «Non-lieu dans une affaire de maternité pour autrui», note sous TGI Créteil, ord., 30 septembre 2004, D. 2005.476.

Le droit québécois, tout comme le droit français ou d'autres législations, n'admet pas la validité des conventions de mères porteuses, quand bien même il s'agirait de lutter contre l'impossibilité médicale d'une femme de porter un enfant. En pratique, on observe toutefois que le contentieux lié à la gestation pour autrui est loin d'être abondant. À notre connaissance, il se résume à deux décisions récentes de la Cour du Québec en apparence contradictoires, rendues dans le cadre d'une demande d'adoption, par la mère d'intention de l'enfant né du recours à une gestatrice[16].

La première de ces décisions, rendue par le juge Dubois au début de l'année 2009, a suscité les commentaires de nombreux experts, mais davantage dans la presse québécoise qui s'était rapidement fait l'écho du jugement[17], que dans les revues juridiques[18].

En matière d'adoption : X.[19] — Dans cette affaire de requête en adoption par la conjointe du père biologique de l'enfant, l'acte de naissance n'indiquait que la filiation paternelle, le champ réservé à la mère étant demeuré vide. En réalité, l'enfant était né d'une mère porteuse avec laquelle le couple avait conclu une entente verbale en vertu de laquelle elle s'engageait à porter leur enfant et à le leur remettre à sa naissance. Dans le constat de naissance, l'accoucheur avait indiqué «le nom de sa mère biologique nommément identifiée»[20]. En revanche, les champs réservés à l'identification de la mère dans la déclaration de naissance ne portaient quant à eux aucune indication. Peu de temps après la naissance de l'enfant, le père avait consenti à son adoption par sa conjointe[21], et cette dernière avait saisi la cour pour obtenir une ordonnance de placement en vue de l'adoption[22].

L'avocate de la requérante faisait valoir que le Tribunal n'avait pas à sanctionner la nullité absolue du contrat de maternité de substitution prévue à l'article 541 du *Code* (sur laquelle d'ailleurs il ne lui était pas demandé de se prononcer), mais devait ici constater que les conditions d'adoption étaient bien réunies, conformément aux exigences des articles 543 et suivants du *Code*, pour s'assurer notamment que les consentements requis avaient été valablement donnés en vue d'une adoption[23] .

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[16] *En matière d'adoption : X*, [2009] R.D.F. 199 (C.Q.), *Adoption – 09184*, *supra* note 4. Par ailleurs, même dans les pays où la pratique est admise, les conventions de gestation pour autrui ne suscitent guère de contentieux. Des auteurs estiment à moins de 1% le nombre de cas de gestation pour autrui se terminant devant les tribunaux aux É.-U. et en Grande Bretagne. Dans 99% des cas, les gestatrices remettent volontairement l'enfant aux parents d'intention. Hormis la célèbre affaire américaine *In re : Baby M*, 109 N.J. 396 (1988) et une décision de 2009 de la Cour supérieure du New Jersey (*A.G.R. v. D.R.H. & S.H.*, N.J. Super. Ct., 23 décembre 2009), nous n'avons recensé aucune décision impliquant une gestatrice qui aurait refusé de remettre aux parents commanditaires l'enfant issu de la gestation pour autrui. Il n'existe par ailleurs, à notre connaissance, aucun cas recensé de demandeurs qui auraient refusé d'établir leur filiation avec l'enfant né d'une gestatrice. Voir Elly Teman, *Birthing a Mother, The Surrogate Body and the Pregnant Self,* Berkeley, University of California Press, 2010 à la p. 3 [Teman, «Birthing»].

[17] Judith Lachapelle, «Recours aux mères porteuses, Il faut changer la loi, selon un expert» *La Presse [de Montréal]* (19 mars 2009) A8 ; Christian Rioux, «La mère porteuse, à quel prix?» *Le Devoir [de Montréal]* (23 mars 2009) A1 ; Ginette Durand-Brault (Forum), «Recul pour les droits des enfants» *La Presse [de Montréal]* (18 mars 2009) A21.

[18] Jane Grant, «Commentaire sur la décision *Dans la situation de : X, sub nom. Adoption - 091* – L'intérêt de l'enfant, mais pas à tout prix» *Repères*, Avril 2009; Renée Joyal «Parents, enfants, conjoints: À la recherche d'un sens» (2009) 50 C. de D. 361.

[19] *Supra* note 16.

[20] *Ibid.* au para. 29.

[21] En vertu de principe du consentement spécial à l'adoption en faveur du conjoint prévu à l'art. 555 C.c.Q.

[22] Articles 566 et 573 C.c.Q.

[23] *En matière d'adoption : X, supra* note 16 aux paras. 37 et 38.

Interprétant l'article 543 alinéa 1, selon lequel «[l]'adoption ne peut avoir lieu que dans l'intérêt de l'enfant et aux conditions prévues par la loi», le juge Dubois précisa que «les conditions prévues par la loi» visées par ce texte vont bien au-delà du respect formel et procédural du consentement à l'adoption effectué par le père. Ainsi expliqua-t-il qu'il «n'est […] pas possible de dissocier la question de la validité de ce consentement des étapes précédentes concoctées dans la réalisation du projet parental de ce couple […]»[24]. C'est la raison pour laquelle le juge Dubois en vint à conclure, tout comme les juges français avant lui, que ce consentement n'était que «la suite logique et prévue de ce même projet parental soigneusement planifié bref, *une manière détournée de donner effet à cette entente contractuelle* "en faisant produire des conséquences juridiques à ce qui est prohibé par la loi"»[25]. Pour rejeter la requête en adoption de la mère d'intention, le juge expliqua se refuser à «faire preuve d'aveuglement volontaire et [à] confirmer que la fin justifie les moyens».

En juin 2009, la Cour du Québec était à nouveau saisie d'une requête en adoption en lien avec une gestation pour autrui. Si les faits de cette espèce étaient assez semblables à ceux de la précédente, le raisonnement du juge Tremblay prenait le contrepied du raisonnement qu'avait eu le juge Dubois.

Adoption - 09184[26] — Dans cette affaire, où la requérante se trouvait dans l'impossibilité de mener une grossesse sans risquer sa vie, c'est sa propre tante qui avait offert de porter l'enfant conçu grâce à une fécondation *in vitro* des ovules de la requérante et du sperme de son conjoint. La gestatrice était identifiée comme mère dans la déclaration de naissance des deux jumeaux aux côtés du père biologique, mais personne en revanche n'avait réclamé un certificat de naissance. À l'occasion de cette demande en adoption intra familiale, la mère d'intention demandait au tribunal à être substituée à la mère porteuse en ce qui avait trait à la filiation maternelle de l'enfant. Après avoir longuement constaté que les enfants étaient nés d'une convention de mère porteuse entre la requérante et sa tante, et après avoir constaté que tous les consentements à l'adoption étaient réunis, le juge Tremblay s'est attaché à l'intérêt de l'enfant. Pour décider qu'il était en l'espèce dans son intérêt d'être adopté par la requérante et que cette dernière devait se voir attribuer le plein exercice de l'autorité parentale, le juge relevait que «cet enfant reçoit une réponse complète à ses besoins moraux, intellectuels, affectifs et physiques auprès de madame A et de monsieur B […]»[27]. Ce n'est donc que dans un second temps que le juge avait évoqué la validité de la convention de mère porteuse au regard de l'article 541 du *Code*. Or, s'il reconnaissait que ce texte était tout à fait applicable à l'espèce et que l'entente verbale était sans doute nulle, c'est pour expliquer que les parents d'intention n'auraient pu contraindre la mère porteuse à mener à terme cette grossesse ou à consentir à l'adoption en vertu de la convention verbale conclue entre eux. En effet, cette convention étant nulle, elle n'aurait pu produire aucun de ses effets. Or, le juge avait pris soin de relever qu'en l'espèce, ce n'était pas de ce genre de question qu'il avait à décider. Il devait plutôt «décider du statut d'un enfant qui existe et qui a droit au respect intégral de ses droits»[28].

C'est ainsi que, contrairement au juge Dubois dans l'affaire précédente, le juge Tremblay avait fini par «rendre une décision du point de vue de l'enfant et non du point de vue des personnes qui [avaient] fait […] une entente de procréation assistée»[29] et à ordonner le placement de l'enfant en vue de son adoption auprès de sa mère d'intention. Toutefois, la position du droit québécois à l'égard du sort qu'il convient de réserver aux enfants nés d'une convention de maternité pour autrui n'est probablement pas remise en cause par cette seconde

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24 *Ibid.* au para. 57.
25 *Ibid.* au para. 59.
26 *Supra* note 4.
27 *Ibid.* au para. 15.
28 *Ibid.* au para. 22.
29 *Ibid.*

décision. Le juge explique en effet sa solution divergente de celle du juge Dubois en invoquant l'absence de lien génétique entre la gestatrice et l'enfant. Avec égard pour cette position, la licéité de l'adoption d'un enfant issu de la gestation pour autrui ne devrait pas dépendre de la provenance des gamètes[30].

Désormais bien établie au Québec comme en France, la prohibition de la gestation pour autrui mérite d'être envisagée dans son fondement.

2. Le fondement de la prohibition

La prohibition de la gestation pour le compte d'autrui trouve dans l'adage *mater semper certa est* son fondement le plus général et apparemment le plus sûr. Aussi, les auteurs n'hésitent-ils pas à l'invoquer, notamment pour justifier l'impossibilité d'établir un lien de filiation avec la mère d'intention[31]. Cet adage, selon lequel «la mère est toujours certaine» traduit une règle de preuve du droit romain. À cet égard, «[l]e Digeste oppose la preuve de la maternité à la preuve de la paternité ; la première est susceptible de démonstration directe car elle découle d'un fait visible, l'accouchement, qui permet de découvrir la mère : *mater semper certa est*»[32].

C'est d'ailleurs le sens de cette fameuse maxime que le juge Dubois rappelait dernièrement : «Pendant des siècles, l'accouchement était un fait si naturel, facile à constater, que la maternité allait de soi. Plus maintenant, comme plusieurs auteurs s'évertuent à nous le rappeler»[33], pour expliquer ensuite qu'au Québec «il n'y a pas de présomption de maternité au sens où la femme qui accouche n'est pas réputée être légalement la mère de l'enfant»[34]. Les juges français continuent eux aussi à se fonder sur cette maxime même si elle n'a jamais correspondu à la réalité[35].

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30 La provenance du matériel génétique et les liens biologiques n'ont jamais été suffisants pour créer la parenté. Il suffit de penser à la force des liens du mariage dans la tradition civiliste et notamment à la présomption de paternité pour s'en convaincre. Par ailleurs, la possession d'état, qui a toujours été un mode de preuve fort en matière de filiation, confirme la place relative accordée à la biologie dans l'établissement des liens de parenté. On peut a fortiori penser qu'aujourd'hui, en raison de la prolifération des techniques d'assistance à la procréation et de la complexification des arrangements familiaux, l'intention d'agir comme parent et la réalité des liens vécus sont au moins aussi importants qu'un lien génétique. Qui plus est, ce dernier peut même être complètement éliminé au profit de l'intention dans le cas du don de gamètes, par exemple. Voir l'art. 538.2 al. 1 C.c.Q.

31 «La reconnaissance et, donc, l'organisation par la loi de la maternité de substitution suppose de remettre en cause le principe selon lequel la mère est la femme qui accouche, lequel correspond pourtant à l'écrasante majorité des cas, y compris le cas des enfants issus de procréations médicalement assistées» selon Aude Mirkovic, «À propos de la maternité pour autrui» (2008) 6 Droit de la famille étude 15 au para. 27 [Mirkovic, «Maternité»]. Voir également François Terré, «Mater semper certa est - Un débat incertain ou prématuré ?» J.C.P. 2009.62 à la p. 56 [Terré, «Mater»] ; Adeline Gouttenoire, «Enfant issu d'une convention de mère porteuse : ordre public : 1 - intérêt de l'enfant : 0», (2009) 346 Lexbase Hebdo, Édition privée générale (consulté sur Le Doctrinal Plus) [Gouttenoire, «Enfant»] ; Monique Brandac, Geneviève Delaisi de Parseval et Valérie Depadt-Sebag, «Repenser la prohibition de la gestation pour autrui ?» D. 2008.434 à la p. 439.

32 Laurent Boyer et Henri Roland, *Adages du droit français*, 3e éd., Paris, Litec, 1992. Voir aussi Albert Mayrand, *Dictionnaire de maximes et locutions latines utilisées en droit*, 4e éd., Cowansville, Yvon Blais, 2007.

33 *En matière d'adoption : X*, *supra* note 16 au para. 46.

34 *Ibid.* au para. 44.

35 «[…] Considérant que la loi française ne donne pas une définition de la mère tout comme elle ne dit pas que le mariage est l'union d'un homme et d'une femme tant ces notions sont inscrites dans les mentalités depuis des siècles ; que l'adage latin "mater semper certa est" qui signifie que la mère est celle qui a accouché de l'enfant trouve application en France même si ce principe est atténué par la possibilité d'accoucher anonymement et par l'obligation qu'a le plus souvent la mère naturelle de reconnaître son enfant ; qu'il est donc patent qu'en droit français la mère est celle qui porte l'enfant et lui donne la vie en le mettant au monde ; […]»,Cour d'appel de Rennes, 4 juillet 2002, D. 2002.Jur.2902 (note Frédérique Granet). Il n'est peut-être pas inopportun d'observer que la Cour, qui confirmait alors l'annulation de la reconnaissance maternelle d'enfants nés d'une mère porteuse, était composée exclusivement de trois femmes magistrats. À l'inverse de

Malgré les critiques que l'on peut lui adresser, et sa perte de sens, la règle selon laquelle la mère est celle qui accouche est donc toujours en vigueur au Québec, aussi bien qu'en France, comme on a d'ailleurs pu le rappeler récemment de part et d'autre. Dans son récent avis sur la question, la *Commission de l'éthique, de la science et de la technologie*, explique que : «[e]n droit québécois, c'est l'accouchement qui, par la voie du constat de naissance, détermine la maternité ; il n'est aucunement possible de la contester au motif que l'ovule ou l'embryon ne provient pas de la femme qui a mené la grossesse à terme»[36]. En France, le législateur a réaffirmé[37], dans le *Code civil*, que la mère d'un enfant ne peut être que celle qui en a accouché et pas celle qui a transmis sa génétique en fournissant ses gamètes[38].

Au-delà de ce fondement très général, qui se dresse comme l'ultime obstacle à la levée de l'interdit, de nombreux arguments s'opposent à la reconnaissance de la gestation pour autrui. Ils sont d'ordre juridique bien sûr, mais aussi d'ordres philosophique, religieux, sociologique, psychologique et enfin éthique[39]. Parmi les multiples justifications invoquées pour interdire la gestation pour autrui, deux raisons principales se dégagent nettement : le souci de protéger les mères porteuses et celui de protéger les enfants nés des conventions conclues par elles en vue de leur remise aux parents commanditaires. Ainsi, la *Commission de l'éthique, de la science et de la technologie* considère «que la gestation pour autrui comporte des risques d'exploitation des femmes qui sont inacceptables sur le plan éthique et qu'une telle pratique entraînerait une forme de réification de l'enfant», ce qu'elle affirme réprouver[40].

Pour s'en tenir aux seuls arguments d'ordre juridique et en commençant par la mère gestatrice, on craint tout d'abord une marchandisation de son corps. Le corps humain étant par principe juridiquement indisponible, la gestation pour autrui porte atteinte à cette indisponibilité dans la mesure où le procédé s'apparente à une «location d'utérus». Au-delà de cette indisponibilité, c'est en réalité à la dignité de ces femmes que le procédé porte atteinte et, plus généralement, à la dignité humaine[41].

À l'encontre de la gestation pour autrui on invoque aussi, naturellement, l'intérêt de l'enfant, lequel est expressément protégé par le droit québécois et le droit international. En effet, cet intérêt paraît totalement absent d'un processus qui aboutit à réifier celui qui n'est que l'objet de désir d'un couple prêt à l'échanger contre de l'argent[42]. Ici, l'enfant n'est pas traité «comme un être humain véritable, mais bien plus comme une chose, un objet, une marchandise»[43]. De plus, on estime que l'intérêt de l'enfant n'est pas assuré parce que le recours à une gestatrice a pour effet de remettre en cause la structure traditionnelle de la famille, de disloquer maternité et famille,

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cette position jurisprudentielle, des auteures soutiennent que la réorganisation de la maternité autour du ventre et de l'accouchement est un phénomène récent en droit français et québécois. Voir Iacub, *infra* note 124 aux pp. 156 et s. Voir également Bureau, *Filiation*, *infra* note 154, aux pp. 67 et s.

36 Avis, *supra* note 11 à la p. 75.

37 Avec la *Loi n° 2009-61 du 16 janvier 2009, JO, 18 janvier 2009, 1062 ratifiant l'ordonnance n°2005-759 du 4 juillet 2005 portant réforme de la filiation et modifiant ou abrogeant diverses dispositions relatives à la filiation*, *en ligne* : Legifrance <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000020104273&dateTexte=>.

38 En effet, l'art. 325 du *Code civil* français prévoit que : «[à] défaut de titre et de possession d'état, la recherche de maternité est admise. L'action est réservée à l'enfant qui est tenu de prouver qu'il est celui dont la mère prétendue a accouché» ; tandis que l'art. 332 al. 1 dispose que «[l]a maternité peut être contestée en rapportant la preuve que la mère n'a pas accouché de l'enfant».

39 Terré, «Mater», *supra* note 31.

40 Avis, *supra* note 11 à la p. 85.

41 Pour de plus amples détails, voir la partie II.B.1 ci-dessous.

42 Giroux, *supra* note 9 à la p. 538.

43 Jean-Louis Baudouin et Catherine Labrusse-Riou, *Produire l'homme, de quel droit*?, Paris, Presses Universitaires de France, 1987 à la p. 112.

de dépersonnaliser la maternité et, finalement, de préfabriquer une famille éclatée[44]. Enfin, l'intérêt de l'enfant est mis en péril par le recours à un procédé qui rendra le statut de l'enfant des plus incertains[45] et qui risque de le placer «au cœur de litiges dès sa naissance»[46].

En réalité, la valeur des arguments avancés pour justifier la prohibition ou son maintien, est depuis longtemps contestée[47]. Aujourd'hui, nombre d'entre eux, formulés il y a plus d'une vingtaine d'années, ont perdu de leur pertinence, notamment au regard des techniques de procréation médicalement assistée. Mais bien qu'il existe de sérieuses raisons de critiquer ces arguments[48], *de lege lata* le recours à la gestation pour autrui et les conventions qui ont pour objet de l'organiser sont condamnés. On ignore combien de temps cette solution va pouvoir perdurer. Si le Québec, à travers la *Commission de l'éthique, de la science et de la technologie*, vient de se prononcer à nouveau contre la levée de l'interdiction de la gestation pour autrui, il n'est pas certain que les positions des uns et des autres n'évolueront pas dans les mois et années à venir. L'exemple français est à cet égard très parlant. Alors qu'au-delà de la jurisprudence et de la majorité de la doctrine juridique, toutes les instances consultées ces dernières années se sont prononcées contre la légalisation de la gestation pour autrui, seul un rapport d'information très documenté émanant d'un groupe de sénateurs proposait de l'autoriser pour mieux l'encadrer[49]. À l'été 2009, et comme en réponse à cet appel des sénateurs, le Conseil d'État puis les états généraux de la bioéthique[50] ont clairement opté pour le maintien de la prohibition. Toutefois, un sondage d'opinion a ensuite montré qu'en octobre 2009, 65 % des Français étaient favorables à la légalisation. En janvier 2010, le Sénat a alors déposé deux propositions de loi tendant à autoriser et encadrer la gestation pour autrui[51]. Ces propositions font suite au rapport d'information de juin 2008.

Cette possible évolution serait justifiée par les effets que produit la prohibition. Les faits ont montré que, bien qu'interdite par la loi, la pratique de la gestation pour autrui continue d'exister et des enfants naissent de mères porteuses. Or, à l'heure actuelle, le sort de la filiation des enfants nés de conventions de mères porteuses s'avère très problématique en raison, précisément, du principe de prohibition.

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44 Giroux, *supra* note 9.

45 Pour les différents scénarios envisageables, voir Avis, *supra* note 11 à la p. 75.

46 Giroux, *supra* note 9.

47 Voir par ex. François Terré, *L'Enfant de l'esclave. Génétique et droit*, Paris, Flammarion, 1987, aux pp. 179 et s. [Terré, *Enfant*], qui plaidait en faveur de la légalisation encadrée de la maternité de substitution avant que la Cour de cassation ne rende son arrêt fondateur en la matière pour interdire ce procédé. Voir aussi, la même année, Baudouin et Labrusse-Riou, *supra* note 43.

48 Pour un exposé détaillé des arguments et l'appréciation de leur valeur actuelle, voir la partie II.B.1 ci-dessous.

49 France, Sénat, *Commission des Affaires sociales et Commission des Lois constitutionnelles, de législation, du suffrage universel, du Règlement et d'administration générale*, Rapport n° 421 (2008) [*Rapport du Sénat*].

50 États généraux de la bioéthique, Rapport final (1er juillet 2009), en ligne : États généraux de la bioéthique <http://www.etatsgenerauxdelabioethique.fr/uploads/rapport_final.pdf> qui fait état de l'intérêt tout particulier des citoyens (ayant donné leur avis sur le site créé à cet effet) pour la question des procréations médicalement assistées et spécialement la question des mères porteuses (p. 55). Mais il montre aussi que l'opinion exprimée par les citoyens, notamment dans la ville de Rennes, va à l'encontre des sondages d'opinion, quant à eux favorables à la légalisation de la maternité de substitution (p. 68).

51 Il s'agit de deux propositions identiques, mais émanant de deux groupes de sénateurs, l'un de gauche, l'autre de droite. Voir *Propositions de loi n° 233 et n° 234 tendant à autoriser et encadrer la gestation pour autrui*, en ligne : Sénat <http://www.senat.fr/leg/ppl09-233.pdf> et <http://www.senat.fr/leg/ppl09-234.pdf>. Ces textes proposent de modifier le Code de la santé publique afin d'inscrire la gestation pour autrui dans le cadre de l'assistance médicale à la procréation. Ils visent, comme leur titre l'indique, à encadrer la pratique en fixant les conditions restrictives dans lesquelles un couple pourrait recourir à cette pratique de procréation.

B. La filiation des enfants nés de conventions de gestation pour autrui

La question de la reconnaissance des enfants nés d'une gestation pour autrui est sans doute à l'origine de l'évolution de plusieurs législations vers l'admission et l'encadrement de la pratique[52]. Elle apparaît en effet, aujourd'hui, comme l'un des enjeux majeurs du débat que soulève la gestation pour autrui[53]. Avant d'envisager dans quelle mesure la prohibition actuelle peut porter atteinte à l'intérêt des enfants nés par ce procédé, il convient de situer sa cause dans l'impossibilité, ou la difficulté, dans laquelle se trouve les parents de faire reconnaître la filiation maternelle de leur enfant lorsqu'ils ont eu recours à la gestation pour autrui.

1. L'impossibilité d'établir la filiation maternelle des enfants nés de convention de gestation pour autrui

L'impossibilité d'établir la filiation maternelle d'un enfant issu d'une convention de mère porteuse résulte de l'article 541 du *Code* et de l'intention avouée du législateur d'éviter que la filiation d'un enfant puisse dépendre de la volonté de ses parents[54]. La preuve de la filiation est régie par l'article 523 qui dispose :

> La filiation tant paternelle que maternelle se prouve par l'acte de naissance, quelles que soient les circonstances de la naissance de l'enfant.
>
> À défaut de ce titre, la possession constante d'état suffit.

Or, sauf à imaginer le cas de fraude, l'acte de naissance d'un enfant né d'une convention de gestation pour autrui fera apparaître la gestatrice comme la mère. En pratique, outre la possession d'état, la seule manière d'établir un lien filial entre la mère d'intention et l'enfant né d'une gestation pour autrui semble de recourir à la technique de l'adoption. À cet égard, la position du droit québécois est loin d'être bien établie, alors que l'impossibilité d'établir un lien de filiation est avérée en droit français dans chacun des cas de figure envisagés et soumis aux juges par les couples ayant eu recours à la gestation pour autrui.

L'adoption — Avant que ne soient rendues les décisions des juges Dubois et Tremblay au cours de l'année 2009, la jurisprudence québécoise n'avait pas eu l'occasion de se prononcer sur la question de l'adoption des enfants nés d'une convention de gestation pour autrui. La doctrine semblait quant à elle assez incertaine sur la question. En 2005, Carmen Lavallée estimait que, saisis d'une telle question, «les tribunaux québécois tenteraient sans doute de limiter les conséquences négatives pour l'enfant qui découlent du comportement de ses parents, surtout si la mère biologique l'a abandonné et que la conjointe du père désire le prendre en charge comme son propre enfant»[55]. L'analyse de Benoît Moore penchait davantage du côté du détournement de l'adoption[56]. La voie de l'adoption par consentement général lui semblait exclue car allant à l'encontre de l'article 543 du *Code* selon lequel l'adoption ne peut avoir lieu «dans le but de

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52 Cette question est d'ailleurs au cœur des propositions de loi du Sénat français, déposées en janvier 2010 : «Il revient au législateur de se préoccuper de toute urgence du sort de ces enfants», peut-on lire dans l'exposé des motifs de ce texte qui, tout en rappelant le problème d'établissement de la filiation maternelle, entend maintenir l'art. 16-7 du Code civil qui affirme la nullité de toute convention portant sur la procréation ou la gestation pour le compte d'autrui. *Proposition de loi n° 233*, *ibid.* à la p. 4.

53 Voir notamment, Guillaume Kessler, «La consolidation de situations illicites dans l'intérêt de l'enfant» (2005) 7 Droit de la famille, étude 16.

54 Voir la partie I.A.1, ci-dessus.

55 Carmen Lavallée, *L'enfant, ses familles et les institutions de l'adoption – Regards sur le droit français et le droit québécois*, Montréal, Wilson & Lafleur, 2005 à la p. 413.

56 Benoit Moore, «Les enfants du nouveau siècle - Libres propos sur la réforme de la filiation», dans Barreau du Québec, Service de la Formation permanente, *Développements récents en droit familial (2002)*, Cowansville, Yvon Blais, 2002 75 aux pp. 95-96 [Moore, «Enfants»]. Le raisonnement de l'auteur porte plus spécifiquement sur l'hypothèse du recours à une mère porteuse par un couple d'hommes, mais les arguments tirés du sens des dispositions du *Code civil* semblent avoir une portée générale.

confirmer une filiation déjà établie par le sang (ce qui serait le cas pour le père) et exige du D.P.J. qu'il participe à une opération que la loi dénonce expressément à l'article 541 C.c.Q»[57]. Quant à l'adoption avec consentement spécial, elle ne serait envisageable que dans l'hypothèse où l'accouchement aurait eu lieu clandestinement. Malgré le libellé de l'article 555 du *Code*, la mère porteuse ne pourrait consentir à l'adoption en faveur de la conjointe du père biologique car, expliquait le professeur Moore, «ce serait permettre indirectement une opération qui est expressément déclarée contre l'ordre public aux termes de l'article 541 C.c.Q». Pourtant, comme le faisait observer Michelle Giroux, le législateur québécois avait refusé de suivre le comité du Barreau lorsqu'il préconisait d'interdire expressément l'adoption d'un enfant issu d'une convention de maternité de substitution. Selon cette auteure, si les conditions de l'adoption étaient réunies et que l'intérêt de l'enfant était en ce sens, les tribunaux n'[auraient] d'autre possibilité que de permettre l'adoption par consentement spécial»[58].

Aujourd'hui, les décisions des juges Dubois et Tremblay dessinent l'état du droit positif en la matière. L'impossibilité d'établir la filiation s'étendrait-elle à d'autres hypothèses que l'adoption ? À notre connaissance, il n'existe pas de décision ayant eu à se prononcer sur d'autres cas de figure. Il n'est cependant pas sans intérêt de signaler les échecs répétés auxquels les couples français se sont heurtés. Aucune des possibilités envisagées pour faire établir un lien de filiation maternelle n'a été admise par les juges français qui refusent, au nom de l'ordre public, de donner un quelconque effet aux conventions de mères porteuses, fût-ce dans l'intérêt concret et avéré de l'enfant.

La transcription d'actes étrangers — Les couples français ayant eu recours à la gestation pour autrui savent depuis 1991 qu'il est vain ou très risqué d'emprunter le chemin de l'adoption de l'enfant du conjoint, la jurisprudence étant bien établie en la matière. Il s'agirait, aux yeux de la Cour de cassation, d'un détournement de l'adoption. Certains couples ont alors opté pour la voie du «tourisme procréatif». À cet égard, la Californie apparaît comme une destination privilégiée. Cet État autorise la gestation pour autrui en reconnaissant la validité des conventions de mère porteuse et permet aux parents d'intention d'être déclarés père et mère de l'enfant, par un jugement qui servira ensuite aux autorités américaines à dresser un acte de naissance[59]. L'affaire *Mennesson*, du nom de ce couple devenu célèbre pour avoir été emporté dans une longue épopée judiciaire, illustre à elle seule les déconvenues des couples qui ont tenté la gestation pour autrui à l'étranger. Le couple avait eu recours à une mère porteuse avec don d'ovocytes. Des jumelles étaient nées et leur acte de naissance, établi en Californie, faisait apparaître le couple d'intention comme leurs parents. Ces derniers ont ensuite sollicité la transcription des actes de naissance sur les registres d'état civil français, ce qu'ils ont obtenu après leur retour en France. Toutefois, quelques mois plus tard, le procureur de la République de leur lieu de résidence demandait l'annulation de cette transcription en se fondant sur les articles 16-7 et 16-9 du *Code civil* ainsi que sur l'article 423 du *Code de procédure civile* l'autorisant à «agir pour la défense de l'ordre public à l'occasion des faits qui portent atteinte à celui-ci»[60]. Devant le Tribunal de grande instance, le procureur invoquait donc la nullité d'ordre public de la convention de mère porteuse et faisait valoir la fausseté des énonciations qui figuraient sur la transcription des actes de naissance américains, puisqu'à défaut d'avoir pu prouver qu'elle avait accouché des jumelles, l'épouse ne pouvait être leur mère légitime. Aussi bien en première instance qu'en appel, le ministère public fut jugé irrecevable en sa demande. Saisie d'un pourvoi contre la décision de la Cour d'appel, la Cour de cassation devait se prononcer sur la seule question de la recevabilité de l'action du ministère public au regard du respect de l'ordre public et non sur la gestation pour autrui en elle-même. La Cour a censuré la Cour d'appel en décidant

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57 *Ibid.* à la p. 96.
58 Giroux, *supra* note 9 à la p. 544.
59 Voir *infra* note 104.
60 Article 423 N.C. proc. Civ.

qu'aux termes de l'article 423 du *Nouveau Code de procédure civile*, le ministère public peut agir pour la défense de l'ordre public à l'occasion de faits portant atteinte à celui-ci et à l'article 16-7 du *Code civil* selon lequel toute convention portant sur la procréation ou la gestation pour le compte d'autrui est nulle[61]. L'arrêt des juges d'appel ayant été cassé, l'affaire a été renvoyée pour être à nouveau jugée. Par une décision rendue le 18 mars 2010, la Cour d'appel de Paris s'est définitivement ralliée à la solution adoptée par la Cour de cassation et a prononcé l'annulation de transcription des actes de naissance dressés en Californie, en raison de l'atteinte portée à l'ordre public international[62]. Un an plus tôt, cette même cour s'était déjà ralliée à la solution de la Cour de cassation en décidant, dans un cas tout à fait semblable à l'affaire *Mennesson*, d'accueillir la demande de rectification des actes d'état civil dont le ministère public l'avait saisie. La Cour d'appel de Paris relevait en effet que les jugements prononcés aux États-Unis qui avaient eu pour effet de valider une convention portant sur la procréation et la gestation pour le compte d'autrui étaient contraires à la conception française de l'ordre public international et qu'en conséquence, la transcription de l'acte de naissance de l'enfant effectuée sur les registres français de l'état civil, au vu de l'acte de naissance américain, lequel comporte l'indication du nom de la femme du père en qualité de mère, devait être rectifiée[63].

La possession d'état — En 2001, un couple français ayant eu recours à une mère porteuse américaine vivant au Minnesota, s'était vu reconnaître père et mère de l'enfant, né de cette convention, dans l'acte de naissance établi conformément au droit de cet État. S'étant vu refuser la transcription de l'acte de naissance américain sur les registres consulaires français, le couple avait saisi un tribunal français afin qu'il dresse un certificat de notoriété attestant de la possession d'état de l'enfant à l'égard de ses parents[64]. Puis, il avait demandé la transcription du certificat de notoriété. Le ministère public s'était alors opposé à cette transcription et avait requis l'annulation du certificat de notoriété. Le tribunal de Lille refusa la transcription et la Cour d'appel de Douai[65] confirma sa décision par un arrêt du 14 septembre 2009[66]. En effet, après avoir rappelé que «la possession d'état doit, pour pouvoir constituer une présomption légale, permettant d'établir la filiation, être également exempte de vice», les juges conclurent alors :

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61 Cass. Civ. 1re, 17 décembre 2008, *Bull. civ*. n° 289.

62 C.A. Paris, 18 mars 2010, JurisData : 2010-002814, n° 09/11017. Voir, à propos de cette décision, Adeline Gouttenoire, «Filiation d'enfants nés d'une mère porteuse : parents aux États-Unis mais pas en France … », (2010) 389 Lexbase Hebdo, Édition privée générale (consulté sur Le Doctrinal Plus) [Gouttenoire, «Filiation»], qui rappelle à nouveau les problèmes pratiques que cette solution risque d'engendrer pour les enfants et qui note : «Comme le reconnaît, peut-être même, avec un certain cynisme, la Cour d'appel de Paris, l'annulation de la transcription ne remet pas en cause le lien de filiation reconnu par le droit californien ! Ce qui revient à constater très clairement l'existence d'une "situation boiteuse", que le droit international privé a, en principe, pour fonction même d'éviter, c'est-à-dire la situation d'une personne qui bénéficie d'un statut juridique dans un pays lequel n'est pas reconnu dans un autre. Or, une telle situation est particulièrement problématique, surtout lorsque le défaut de reconnaissance provient du pays de résidence de la personne». Également, on peut consulter V. Égéa, «Gestation pour autrui : Épilogue» D. 2010.1683.

63 C.A. Paris, 26 février 2009, (2009) JCP Jur 17, (annotation Aude Mirkovic), JurisData :2009-000867, n° 07/18559 et la note sous cet arrêt : Jacques Massip, «La reconnaissance en France des décisions étrangères relatives à la gestation pour autrui» (2009) 139 Les Petites Affiches 18.

64 Les faits devaient être jugés conformément aux textes du *Code civil* français tels qu'ils se trouvaient avant l'entrée en vigueur de la réforme de 2005. À cet égard, le *Code* prévoyait qu'à défaut de pouvoir être prouvée par les actes de naissance inscrits aux registres de l'état civil, la filiation des enfants légitimes se prouve par la possession d'état (art. 319 et 320 anciens, désormais). Dans cette perspective, l'art. 311-13 al. 1 disposait que «les parents ou l'enfant peuvent demander au juge des tutelles que leur soit délivré, dans les conditions prévues aux art. 71 et 72 du présent code, un acte de notoriété faisant foi de la possession d'état jusqu'à preuve contraire.» Ces règles ont été reprises dans les nouveaux textes. Voir notamment, les articles 310-13 et 335 du *Code civil* français.

65 C.A. Douai, 14 septembre 2009, D. 2009.2845.

66 Voir Aude Mirkovic, «La gestation pour autrui entache de vice la possession d'état» D. 2009.2845 [Mirkovic, «Gestation»].

«Cette possession d'état repose [...] sur un contrat portant sur la gestation, contrat atteint, en application des articles 16-7 et 16-9 du *Code civil*, d'une nullité absolue qui s'impose aux parties comme aux tiers. Dans ces conditions, une telle possession d'état est viciée et ne peut avoir d'effet en ce qui concerne la filiation quel que soit le demandeur»[67]. En cela les juges d'appel français ont estimé que la possession d'état d'un enfant né d'une convention de mère porteuse ne satisfaisait pas aux conditions de l'article 311-12 du *Code civil* selon lequel la possession doit être continue, paisible, publique et non équivoque. Ajoutons brièvement qu'au Québec, selon nos informations, aucun recours en ce sens n'a été tenté.

La reconnaissance par la mère — Cette voie avait été empruntée par un couple de concubins français qui avait eu recours à une Californienne pour porter l'enfant conçu avec leurs gamètes. La mère d'intention avait été inscrite sur les registres de naissance californiens aux côtés de son concubin, le père biologique. Très rapidement, chacun des parents avait procédé en France à la reconnaissance des deux jumelles nées de la gestation pour autrui. Le parquet avait réclamé l'annulation de la transcription des actes de naissance, avec mention des reconnaissances, à laquelle le consulat général de France à San Francisco avait procédé en 1997. Pour accueillir la demande du parquet, et après avoir rappelé qu'en droit français la mère est celle qui accouche, les juges de la Cour de Rennes[68] avaient expliqué, en 2002, que les parents d'intention avaient violé les principes de l'indisponibilité du corps humain et de l'état des personnes en cherchant à détourner les règles de la filiation maternelle.

2. L'intérêt de l'enfant

L'intérêt de l'enfant né du recours à la maternité de substitution est mis à mal de plusieurs manières par le droit positif actuel. Tout d'abord, et de manière générale, l'état actuel du droit a pour effet, qu'on le veuille ou non, de sanctionner l'enfant pour des choix effectués par ses parents. Et cela, malgré le principe prévu à l'article 522 du *Code* selon lequel les enfants ne devraient pas être discriminés en raison des circonstances entourant leur conception. Ensuite, et de façon plus spéciale, il est sans doute dans l'intérêt de tout enfant de se voir reconnaître un lien de filiation complet. Or, il est indéniable que l'impossibilité d'établir un lien de filiation maternelle porte atteinte à l'intérêt de l'enfant.

En distinguant l'intérêt *a priori* et l'intérêt *a posteriori* de l'enfant, Michelle Giroux parvenait à expliquer à la fois l'interdiction des conventions de mère porteuse et la nécessité de prononcer l'adoption d'un enfant né d'une telle convention. En effet, si l'intérêt de l'enfant, envisagé abstraitement, est sans aucun doute au fondement de l'article 541 posant la nullité des conventions de mère porteuse, l'intérêt de l'enfant, envisagé cette fois concrètement, est que le juge prononce l'adoption sollicitée par la mère d'intention et consentie par son conjoint[69]. Ce n'est cependant pas cette conception de l'intérêt de l'enfant qui a guidé le juge Dubois dans sa décision de 2009. Après avoir reproché à la mère d'intention d'avoir cherché à acculer le tribunal à décider dans le seul intérêt de l'enfant, sans considérer le détournement de l'adoption que cela impliquait[70], le juge a fait sienne l'idée que l'intérêt concret de l'enfant n'est pas une norme de droit autonome en soi mais plutôt une règle d'interprétation qui suppose la légalité du processus[71]. Enfin, ayant constaté que le droit québécois admet fort bien, par ailleurs, qu'un enfant puisse demeurer sa vie durant avec un état civil incomplet, le juge Dubois conclut ainsi son jugement : «[c]ette enfant n'a pas droit à une filiation maternelle à tout prix»[72]. Si l'on peut comprendre l'embarras du juge

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67 C.A. Douai, *supra* note 65.
68 Granet, *supra* note 35.
69 Giroux, *supra* note 9 aux pp. 544 et 546.
70 *En matière d'adoption : X*, *supra* note 16 aux paras. 61 à 67.
71 *Ibid.* au para. 69, où le juge s'appuie sur le raisonnement de Carmen Lavallée *supra* note 55.
72 *Ibid.* au para. 77.

et la nécessité dans laquelle il s'est trouvé de faire primer l'ordre public sur l'intérêt concret de l'enfant, il n'en reste pas moins que cette solution est préjudiciable à l'enfant[73].

En pratique, les conséquences sont lourdes pour ces enfants nés «hors norme»[74] qui, privés de tout lien de filiation maternelle, sont privés de tous les effets qui s'y attachent. Ceux que le droit tient finalement pour des étrangers vis-à-vis de leur mère, sont placés dans une situation juridiquement semblable à celle qui caractérisait autrefois les enfants adultérins. Ils sont tout simplement stigmatisés[75]. Autrement dit, les enfants nés du recours à une gestation pour autrui ne peuvent tout d'abord se voir transmettre le nom de leur mère[76]. Ensuite, quoique la mère exerce la garde, la surveillance et l'éducation, elle n'est pas juridiquement titulaire de l'autorité parentale. En cas de décès du père ou de séparation du couple[77], la relation entre la mère et l'enfant risque d'être gravement mise en péril de même que les relations avec le reste de la famille maternelle. En outre, à défaut de dispositions testamentaires le gratifiant, l'enfant ne peut succéder à sa mère puisqu'il ne saurait être considéré comme un descendant au sens de l'article 666 du *Code*. Ce ne sont là que les conséquences les plus graves découlant de l'impossibilité d'établir un lien de filiation entre la mère d'intention et l'enfant né du recours à la gestation pour autrui. On pourrait cependant poursuivre la liste et l'intérêt de l'enfant n'en apparaîtrait que davantage contrarié.

Quoi qu'il en soit de la réalité des atteintes portées à l'intérêt de ces enfants, celles-ci n'ont jusqu'à présent pas suffi pour infléchir la ligne jurisprudentielle des tribunaux. Ainsi, pour prononcer la nullité de la transcription de l'acte de naissance effectuée sur les registres français de l'état civil d'un enfant né d'une mère porteuse en conformité avec le droit californien, la Cour d'appel de Paris[78] a estimé que l'intérêt supérieur de l'enfant ne permet pas d'anéantir les autres principes directeurs du droit français. Pourtant, on pourrait fort bien considérer, à l'inverse, que

> lorsque lesdits principes directeurs aboutissent à une violation manifeste de l'intérêt supérieur de l'enfant dans une situation spécifique, ils doivent être écartés. L'intérêt supérieur de l'enfant jouerait alors comme un mécanisme correcteur, appliqué de manière concrète et particulière[79].

La position actuelle des droits québécois et français, qui excluent respectivement l'adoption par consentement spécial et l'adoption plénière, risque cependant de ne pas résister bien longtemps à la logique des droits fondamentaux. En France, on prévoit déjà depuis quelque temps que le vent de la Cour Européenne des Droits de l'Homme ne devrait pas tarder à souffler ; et dans une direction qui serait favorable aux enfants issus de conventions de mère porteuse. De solides arguments peuvent en effet être tirés de l'interprétation des textes protecteurs des droits des personnes et des enfants en particulier.

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73 Commentant cette décision, Jane Grant observait d'ailleurs que : «[l]e juge Dubois ne pouvait pas en venir à une conclusion différente sans contourner les lois et les conditions de l'adoption. La notion de l'intérêt de l'enfant ne peut être appliquée à toutes les sauces et ainsi permettre aux parties de passer au-dessus des lois. Cependant, il est vrai également que nous aurions tendance à faire droit à la demande d'ordonnance de placement en se disant qu'il est dans l'intérêt de l'enfant qu'il puisse avoir une filiation maternelle et paternelle et que les circonstances de sa naissance ne peuvent lui être préjudiciables» ; Jane Grant, *supra* note 18.

74 Hélène Gaumont-Prat, «La révision des lois de bioéthique face à l'évolution des modes de procréation : la maternité pour autrui» (2008) 45 Revue Lamy Droit Civil 39 à la p. 41.

75 *Ibid.* à la p. 42.

76 Le premier alinéa de l'art. 53 du *Code* dispose en effet que «[l]'enfant dont seule la filiation paternelle ou maternelle est établie porte le nom de famille de son père ou de sa mère, selon le cas, et un ou plusieurs prénoms choisis par son père ou sa mère.»

77 Articles 513 et 521 du C.c.Q. Voir aussi pour la France, Kessler, *supra* note *53* aux paras. 7 et 16.

78 C.A. Paris, *supra* note 62 à la p. 18.

79 Gouttenoire, *supra* note 31.

L'article 3.1 de la *Convention internationale des droits de l'enfant* ne prévoit-il pas, en effet, que «[d]ans toutes les décisions qui concernent les enfants, qu'elles soient le fait des institutions publiques ou privées de protection sociale, des tribunaux, des autorités administratives ou des organes législatifs, l'intérêt supérieur de l'enfant doit être une considération primordiale» ? Comme on l'a très justement fait remarquer, ce texte pourrait être interprété «comme imposant la primauté de l'intérêt supérieur de l'enfant dans toutes les décisions qui le concernent, y compris lorsque l'ordre public est en jeu»[80]. Il est vrai que l'argument porte davantage en droit français où le juge est lié par ce texte[81] qu'en droit québécois où la *Convention* ne joue que comme élément d'interprétation pour le juge qui cherche à donner un sens à un texte québécois mettant en jeu le droit des enfants[82]. Il ne devrait cependant pouvoir être ignoré. Le juge Dubois avait, quant à lui, pris soin de préciser dans sa décision que le droit international n'était en l'espèce d'aucun secours à la requérante. Le juge avait bien évoqué la *Convention sur les droits de l'enfant*, mais c'était pour s'appuyer sur le seul article 7 et conclure que le droit de l'enfant de connaître ses parents, en l'espèce respecté, n'était pas absolu[83].

En outre, l'article 2.2 pourrait être invoqué pour éviter que les enfants nés de mère porteuse soient injustement discriminés, puisque selon ce texte :

> [l]es États parties prennent toutes les mesures appropriées pour que l'enfant soit effectivement protégé contre toutes formes de discrimination ou de sanction motivées par la situation juridique, les activités, les opinions déclarées ou les convictions de ses parents, de ses représentants légaux ou des membres de sa famille.

Outre-Atlantique, on s'attend d'ailleurs à ce que la Cour Européenne des Droits de l'Homme soit amenée prochainement à se prononcer sur la compatibilité de l'interdiction d'établir la filiation maternelle avec le droit au respect de la vie familiale[84].

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80 *Ibid.*

81 L'article 3-1 de la *Convention internationale des droits de l'enfant* est d'application directe en droit français depuis que le Conseil d'État, puis la Cour de cassation, l'ont admis respectivement en 1997 et en 2005. Un justiciable peut donc obliger le juge français à fonder sa décision sur l'art. 3-1 et, le cas échéant, à écarter la règle de droit français qui contrarierait l'intérêt supérieur de l'enfant. Sur ces questions, voir Adeline Gouttenoire *et al.*, «La Convention internationale des droits de l'enfant vingt ans après - Commentaire article par article» (2009) 11 Droit de la famille dossier 13.

82 Le Canada a ratifié la Convention en 1991 et le Québec a adopté un décret en décembre 1991, aux termes duquel il se déclare lié par le texte international, comme le lui permet la *Loi sur le Ministère des Relations internationales*, L.R.Q. c. M-25.1.1.

83 *En matière d'adoption : X*, *supra* note 16 aux paras. 73 et 74.

84 Un auteur écrit, à propos de l'arrêt de la C.A. de Paris du 26 février 2009, que : «[e]u égard aux droits fondamentaux (Convention européenne des droits de l'homme aussi bien que Convention internationale des droits de l'enfant) et à la sensibilité croissante de la Cour EDH pour les questions d'adoption, la position paraît intenable : il paraît de plus en plus certain que, pas plus que l'enfant adultérin n'avait à payer le prix de l'infidélité d'un de ses auteurs, l'enfant né d'une gestation pour autrui ne doit avoir à payer le prix de la mondialisation et de l'exacerbation du désir d'enfant : si l'on veut trouver des moyens de pression pour éviter l'exploitation des femmes, il faudra sans doute les chercher ailleurs que dans des restrictions apportées aux droits de l'enfant [...]», Pierre Murat, «Gestation pour autrui : les palinodies de la cour d'appel de Paris» (2009) 6 Droit de la famille 75. Adeline Gouttenoire, *supra* note 31, explique pour sa part que :

> La Cour européenne pourrait procéder, comme elle le fait depuis plusieurs années, à une interprétation de l'article 8 de la Convention de sauvegarde des droits de l'homme à la lumière de la Convention internationale des droits de l'enfant et particulièrement de son article 3-1. Dans l'arrêt *Wagner et J.M.W.L. c. Luxembourg* du 28 juin 2007, elle a ainsi considéré, au nom de l'intérêt supérieur de l'enfant que le refus du Luxembourg d'accorder l'exequatur à un jugement d'adoption péruvien rendu au bénéfice d'une femme célibataire, au motif que le droit luxembourgeois limitait le recours à l'adoption aux seuls couples mariés, constituait une atteinte disproportionnée au droit à la vie familiale de l'enfant et de sa mère. Elle pourrait, de même, considérer que l'atteinte au droit à la vie familiale subie par les enfants nés de mères porteuses n'est pas proportionnée au but légitime poursuivi, en s'appuyant notamment sur l'idée, déjà développée dans l'arrêt "Mazureck", à propos de

Quoi qu'il en soit, l'état actuel du droit au Québec, mais aussi celui d'autres pays comme la France, place les couples désirant recourir à la gestation pour autrui face à une alternative insatisfaisante : affronter la loi, avec les incertitudes, voire les échecs, que cela implique d'assumer ; ou la contourner frauduleusement. S'il est si difficile de connaître dans quelle mesure les couples infertiles ont recours à la pratique de la gestation pour autrui, c'est probablement en partie parce qu'ils demeurent dans l'ombre et qu'il existe, ce faisant, un chiffre noir de la gestation pour autrui un peu comme il existe un chiffre noir de la criminalité. Ainsi, le contentieux judiciaire en la matière est, plus qu'ailleurs, un piètre reflet de la réalité sur laquelle il s'agit ici de raisonner.

Les parties à la convention de gestation pour autrui peuvent tout d'abord contourner la loi avec l'aide complaisante de l'accoucheur, médecin ou sage-femme, qui acceptera éventuellement d'inscrire la mère d'intention dans le constat de naissance à la place de celle qui a accouché[85] et ils rempliront la déclaration de naissance de manière à faire apparaître la mère d'intention comme la mère de l'enfant. Pour peu que cette dernière ait fourni ses ovules, elle n'aura aucun scrupule à inscrire son nom dans la rubrique réservée à la "mère biologique»[86] et rien ne devrait permettre d'alerter le Directeur de l'état civil qui inscrira directement les parents d'intention sur les registres d'état civil. Le contournement de la loi pourra également résulter de l'attitude du juge, qui, sans chercher à la violer, pourra décider, dans son application, ne pas tenir compte de la convention de gestation pour autrui. C'est exactement ce que le juge Dubois s'était explicitement refusé à faire et que le juge Tremblay avait pour sa part admis de faire en ne se prononçant que sur la demande d'adoption qui lui était soumise et en s'assurant que les conditions d'une telle adoption était bien remplies, en particulier du point de vue de l'intérêt de l'enfant[87]. Autrefois, c'est le même raisonnement qui avait d'ailleurs été avancé par la Cour d'appel de Paris[88], mais cette décision était demeurée une exception.

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l'enfant adultérin, que ce n'est pas à l'enfant de subir les conséquences des choix parentaux.

85 Après tout, en faisant obligation à l'accoucheur de dresser le constat de naissance, l'art. 111 du C.c.Q. exige qu'il ne désigne que «le nom et le domicile de la mère», et ne vise pas celle qui a accouché.

86 Le formulaire de déclaration de naissance, qui doit être adressé au Directeur de l'état civil en vertu de l'art. 113 C.c.Q., ne comporte aucune référence à la femme qui accouche, pas plus que l'art. 115 C.c.Q. d'ailleurs. En effet, en vertu de ce texte, la déclaration doit seulement énoncer «le nom et le domicile des père et mère». Il précise même que si les parents sont de même sexe, «ils sont désignés comme les mères ou les pères de l'enfant». L'intention d'être officiellement désigné comme parent semble ici l'emporter.

87 Voir *Droit de la famille – O9184, supra* note 4. Il n'est pas déraisonnable de penser que la même attitude a été adoptée par la Cour du Québec, mais implicitement cette fois, dans sa décision *A.H. (Re)*, [2005] R.D.F. 475 (C.Q.). En effet, saisi d'une demande d'adoption de deux enfants consentie par la mère au profit du requérant (le conjoint du père biologique), le tribunal accepta de prononcer le placement des enfants sans jamais évoquer la question de la maternité de substitution. Il s'est contenté de raisonner sur la possibilité d'avoir deux pères sur un acte de naissance, possibilité qui fut d'ailleurs confirmée.

88 […] Mais attendu qu'en l'espèce la cour, qui n'est pas saisie de la validité ni même de l'existence d'une telle convention, n'a à statuer que sur la requête aux fins d'adoption ; Attendu qu'aux termes de l'art. 353 c. civ., la cour doit rechercher «si les conditions de la loi sont remplies et si l'adoption est conforme à l'intérêt de l'enfant» ; Attendu que cette dernière exigence est rappelée par l'art. 3-1 de la *Convention relative aux droits de l'enfant* signée à New York le 26 janv. 1990 et publiée par décret n° 90-917 du 8 oct. 1990 qui énonce : «Dans toutes les décisions qui concernent les enfants, qu'elles soient le fait des institutions publiques ou privées de protection sociale, des tribunaux, des autorités administratives ou des organes législatifs, l'intérêt supérieur de l'enfant doit être une considération primordiale» ; Attendu que les conditions exigées par les art. 343 s. c. civ. sont remplies ; […]
(Virginie Larribau-Terneyre, «La nullité d'une convention de mère porteuse n'interdit pas de prononcer l'adoption plénière de l'enfant» D. 1991.381).

Mais au-delà de ces accommodements, quelles solutions juridiques peut-on envisager pour répondre non seulement au problème des couples désireux de recourir à la gestation pour autrui mais aussi, et surtout, à la question de la filiation des enfants nés de cette pratique ? Plusieurs pistes de réponses sont théoriquement envisageables et certaines sont effectivement mises en pratique. C'est à leur exposé que nous nous attacherons dans la suite de cette étude.

II
LES RÉPONSES AUX PROBLÈMES POSÉS PAR LA PROHIBITION DE LA GESTATION POUR AUTRUI

L'évolution récente de plusieurs législations étrangères, qu'elles soient de tradition civiliste ou de common law, offre aux juristes québécois un laboratoire d'hypothèses et d'expériences précieuses pour alimenter leurs réflexions et chercher des solutions aux problèmes que soulève la gestation pour autrui. Ces solutions, essentiellement de droit positif mais parfois aussi de droit prospectif, dépendent finalement toutes de la conception que les divers systèmes juridiques se font de la maternité. Or, au-delà des solutions de droit actuellement disponibles, il nous semble aujourd'hui opportun de reconsidérer la maternité, en particulier à l'une des savoirs acquis ces dernières années dans les diverses disciplines qui ont porté un regard sur la maternité pour autrui et qui ont dissipé de nombreuses inquiétudes au sujet de cette pratique.

A. Les solutions offertes par le droit comparé

L'établissement du lien de filiation avec l'enfant né du recours à cette pratique étant le vecteur des positions arrêtées par les législateurs, il s'agit de présenter les diverses manières de traiter la gestation pour autrui à travers le prisme de ce problème, en distinguant la manière dont la filiation peut être établie lorsque la pratique est juridiquement prohibée et la manière dont elle l'est lorsque la pratique est admise par le droit.

1. L'établissement de la filiation lorsque la pratique est prohibée

Dans les systèmes juridiques qui prohibent explicitement le recours à la gestation pour autrui, l'établissement d'un lien de filiation, et plus largement la reconnaissance des liens que la mère d'intention entretient avec son enfant, sont très difficiles, comme en témoignent d'ailleurs l'exemple de la France et, dans une moindre mesure, celui du Québec où la situation demeure incertaine[89]. La prohibition de la gestation pour autrui elle-même semble se confondre avec ce refus d'établir un lien juridique avec la mère d'intention[90]. C'est par exemple le cas de l'Allemagne où la loi sur la médiation en matière d'adoption interdit à la fois le recours à la gestation pour autrui et la possibilité d'adopter l'enfant qui en serait issu[91]. La loi espagnole suit la même logique en prévoyant d'une part, que tout contrat de gestation pour autrui est nul et, d'autre part, que «la filiation des enfants nés à l'issue d'une maternité de substitution sera déterminée par l'accouchement»[92]. Le droit italien, qui interdit très strictement la pratique, exclut la possibilité d'adopter et précise que tout enfant né d'un don de gamètes est juridiquement celui de la femme qui l'a porté et de son conjoint[93].

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89 Voir la partie I.B.1, ci-dessus et Benoit Moore, «Des nouvelles de la Belle Province» D. 2010.880.

90 On observe que cette prohibition est souvent énoncée dans le cadre juridique réservé à l'assistance médicale à la procréation et qu'elle va souvent de pair avec l'interdiction du don d'ovules. Pour l'exemple de l'Allemagne ou de l'Italie, voir France, Sénat, Les documents de travail du Sénat, *La gestation pour autrui*, LC 182, janvier 2008, en ligne : Sénat <http://www.senat.fr/lc/lc182/lc182.pdf> [Sénat, *La gestation pour autrui*].

91 *Loi du 27 novembre 1989* (*Adoptionsvermittlungsgesetz*), BGBI I 2014.

92 *Loi n° 14 du 26 mai 2006 sur les techniques de reproduction médicalement assistée* (*Ley 14/2006, de 26 de mayo, sobre técnicas de reproducción humana asistida*), BOE 126 27/05/2006 9292, p. 19947-56.

93 *Loi n° 40 du 19 février 2004* sur la procréation médicalement assistée (*Norme in materia di procrea-*

Face à une telle impossibilité, mais sans remettre en cause la prohibition de la pratique, des solutions ponctuelles ont pu être proposées pour reconnaître juridiquement le lien existant, de fait, entre la mère d'intention et l'enfant issu de la gestation pour autrui. Une partie de la doctrine française se montre ainsi favorable à la possibilité de prononcer une adoption simple[94] mais cette voie est généralement jugée insatisfaisante[95] et n'est pas admise par les juges ; de leur côté, plusieurs auteurs québécois plaident en faveur de l'adoption par consentement spécial[96] et c'est cette solution que préconise l'avis rendu par la Commission de l'éthique, de la science et de la technologie[97]. Afin de répondre à l'intérêt de l'enfant qui a noué des liens affectifs avec une personne, en l'occurrence la mère d'intention, on a également suggéré la création d'un statut de «quasi-parent» qui pourrait bénéficier à cette dernière[98]. Le Conseil d'État français a pour sa part proposé que, une fois la filiation paternelle admise, la mère d'intention pourrait bénéficier d'un jugement de délégation et de partage de l'autorité parentale consentis par le père[99].

Quoi qu'il en soit, ces «demi-mesures» en faveur de l'enfant issu d'une gestation pour autrui, peuvent toutes se voir reprocher un inconvénient majeur, souvent dénoncé : celui de ne pas respecter la cohérence du système juridique. Il est en effet très difficile de faire coexister au sein du même ordre normatif un principe de prohibition de la gestation pour autrui et l'organisation d'un régime juridique qui viendrait en pallier les effets au point de rendre caduque la prohibition.

2. L'établissement de la filiation lorsque la pratique est admise

L'étude des droits étrangers[100] montre que, s'il s'agit toujours de faciliter ou d'organiser l'établissement de la filiation des enfants ainsi conçus, le sort réservé aux conventions de gestation pour autrui et les conditions auxquelles un couple peut recourir à cette pratique varient d'une législation à l'autre. Dans certains systèmes, la pratique est plus ou moins strictement encadrée par la loi et les conventions de mère porteuse sont nulles[101], tandis que dans d'autres ces conventions sont admises pourvu qu'elles soient conclues à titre gratuit[102]. D'autres droits encore

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zione medicalmente assistita), Gazzetta Ufficiale n. 45 del 24 febbraio 2004.

94 Voir, par exemple, Pierre Murat, *supra* note 84 : «Si l'on veut conserver la prohibition des maternités pour autrui, on voit mal comment on évitera, à titre de tempérament, le recours à l'adoption pour donner un statut aux enfants nés d'une gestation pour autrui, sauf à faire implicitement mais certainement de la privation de filiation la sanction de la gestation pour autrui. Dès lors, il faut sans doute penser ne plus faire du recours à la gestation pour autrui un empêchement à l'adoption, au moins à l'adoption simple [...]». Voir également, Mirkovic, «Maternité», *supra* note 31 au para. 20.

95 Voir Alain Sériaux, «Maternités pour le compte d'autrui : la mainlevée de l'interdit?», D. 2009.1215 à la p. 1218. ; *Rapport du Sénat*, *supra* note 49 à la p. 70.

96 Notamment, Giroux, *supra* note 9 à la p. 544.

97 Avis, *supra* 11 note à la p. 76.

98 L'intervention du juge serait requise pour organiser les relations entre l'enfant et la mère et consisterait essentiellement à conférer à la mère d'intention certaines prérogatives qui resteraient cependant limitées. Voir à cet effet Kessler, *supra* note 53 aux paras. 17 et s.

99 Conseil d'État, *La révision des lois de bioéthique*, Les études du Conseil d'État, Paris, La Documentation française, 2009 à la p. 52, en ligne : Le Conseil d'État <http://www.conseiletat.fr/cde/media/document/etude-bioethique_ok.pdf>. Dans le même sens et pour d'autres solutions ponctuelles envisagées en droit français, voir Mirkovic, «Maternité», *supra* note 31 au para. 20.

100 Pour un aperçu de plusieurs législations européennes, on pourra consulter Les documents de travail du Sénat, *supra* note 90.

101 Ainsi, les récentes propositions de lois françaises tendant à la légalisation de la pratique de la gestation pour autrui réaffirment ce principe. Voir par exemple, *Proposition de loi n° 233*, *supra* note 51, exposé des motifs, à la p. 7 où la volonté d'instaurer un régime légal, plutôt que contractuel, est clairement affirmée.

102 C'est ce qu'affirme la *Loi sur la procréation assistée*, L.C. 2004, c. 2, art. 6. Le R.-U. fournit également une illustration de ce choix avec sa loi relative à la maternité de substitution, voir *Surrogacy Arrangements Act* (R.-U.), 1985, c.49 et le texte subséquent qui l'a modifié: *Human Fertilisation and Embryology Act* (R.-U.), 1990, c. 37. La loi grecque suppose une telle convention avant qu'une requête judiciaire soit introduite.

admettent que ces conventions soient conclues à titre onéreux et en organisent les modalités[103]. Mais le recours à la gestation pour autrui n'est pas toujours consacré par la loi, c'est parfois la pratique judiciaire qui, dans le silence du législateur, a dessiné les contours de l'admission[104].

S'agissant de la reconnaissance de la filiation des enfants nés de cette pratique, on observe que les droits étrangers l'organisent selon différents modèles, caractérisés par la plus ou moins grande facilité offerte aux couples pour faire établir ce lien. Ces solutions supposent toutes que la mère porteuse consente à ne pas être reconnue comme la mère légale de l'enfant qu'elle a porté et exigent souvent que l'un des parents au moins soit le parent génétique de l'enfant.

L'adoption — La possibilité de recourir à l'adoption de l'enfant est la voie la moins facile. Si cette solution est favorable aux enfants et aux parents, il est évident qu'elle repose quand même toujours sur l'idée que la mère est celle qui accouche. En Belgique, en l'absence de dispositions légales particulières, l'adoption peut être consentie par la mère de l'enfant à partir de deux mois après la naissance. La loi danoise sur l'adoption ne favorise pas l'adoption par la mère d'intention, mais la rend cependant possible, pourvu que le père soit déclaré comme tel sur l'acte de naissance, que la mère porteuse lui transfère l'autorité parentale et qu'elle n'ait pas reçu de l'argent pour consentir à cette adoption. Le droit néerlandais permet, quant à lui, aux parents de recourir à la procédure d'adoption de droit commun. L'adoption est aussi parfois envisagée comme un pis-aller, lorsque les couples commanditaires ne remplissent pas toutes les conditions énoncées par la loi autorisant la gestation pour autrui et régissant l'établissement de la filiation[105].

L'inscription des parents à l'état civil sur intervention du juge — Cette solution, qui vise à faciliter la reconnaissance de la filiation des parents d'intention, est moins longue et plus sûre que celle de l'adoption. La jurisprudence ontarienne, dans le silence de la loi et en considération de la *Loi sur la procréation assistée*[106], semble admettre la validité des conventions de gestation pour autrui conclues à titre gratuit et autorise les parents d'intention à faire modifier l'acte de naissance de l'enfant pour y inscrire leur nom[107]. En Colombie-Britannique, la solution est sem-

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Voir Frédérique Granet-Lambrechts, «Maternités de substitution, filiation et état civil. Panorama européen» (2007) Droit de la famille n° 12 étude 34 au para. 21.

[103] Par exemple dans l'État de l'Illinois : *Gestational Surrogacy Act* 2005, sect. 25. C'est également le cas d'Israël où les contrats de gestation pour autrui sont permis, de même que la rémunération des gestatrices et les agences intermédiaires commerciales*, Surrogate Motherhood Agreements (Approval of Agreement and Status of Newborn) Law 5756-1996, 1996, S.H. 1577, 176 (Une traduction anglaise non officielle disponible chez Aryeh Greenfield Publications, P.O. Box 7422, Haifa, Israel 31070).* Voir également Teman, *Birthing*, *supra* note 16 à la p. 12.

[104] La Californie en est une belle illustration où c'est la Cour suprême de cet État qui a reconnu pleinement la maternité d'intention au détriment de la maternité par accouchement. Voir *Johnson v. Calvert Cal.*, 5 Cal.4th 84, 851 P.2d 776 (1993) ; *Elisa B. v. Superior Court*, 117 P.3d 660 (Cal. 2005) *; K.M. v. E.G.,* 117 P.3d 673 (Cal. 2005) *; Kristine H. v. Lisa R.,* 117 P.3d 690 (Cal. 2005) *; In re Marriage of Buzzanca,* 72 Cal. Rptr. 2d 280 (Cal. Ct. App. 1998) *; In re Marriage of Moschetta,* 30 Cal. Rptr. 2d 893 (Cal. Ct. App. 1994) ; ainsi que la législation sur la famille: *California Family Code*, § 7600 et seq. (2009). C'est aussi le cas de la Belgique où la pratique est tolérée, mais n'a pas encore fait l'objet d'un encadrement législatif malgré les propositions de loi déposées à cet effet. Voir Nicole Gallus, *Le droit de la filiation. Rôle de la vérité socioaffective et de la volonté en droit belge*, Bruxelles, Larcier, 2009 aux pp. 392-93.

[105] Voir le cas du droit britannique : *Human Fertilisation and Embryology Act* 1990, *supra* note 102, l'art. 30.

[106] *Ibid.*

[107] *J.R. v. L.H.*, [2002] O.J. No. 3998 (Ont. Sup. Ct.), décision fameuse qui débute par ces mots enthousiastes du juge : «This is a good news case. It involves two families who shared a common goal. The applicants and respondents are not adverse. Indeed, they have collaborated in their gestational carriage agreement and this application is simply the legal outcome of a wonderful arrangement». Voir aussi, en dernier lieu *M.D. v. L.L.*, [2008] O.J. No. 907 (Ont. Sup. Ct.), décision de la Cour supérieure ontarienne dans laquelle, au para. 40 le juge déclare : «the applicants should be declared the parents of E.D. Certainly, it

blable[108]. L'intervention judiciaire pour permettre la modification de l'état civil peut également être prévue par la loi comme c'est le cas en Alberta ou en Nouvelle-Écosse[109].

La reconnaissance du lien de filiation avant même la naissance — Cette solution, la plus libérale, se pose résolument comme une exception à l'adage *mater semper certa est*. Elle est la solution la plus libérale, la plus sûre et la plus simple pour les couples commanditaires relativement à l'établissement de la filiation. Le droit jurisprudentiel californien offre une telle possibilité dans la mesure où les parents d'intention, pourvu qu'ils soient les parents génétiques de l'enfant et que la mère porteuse y consente, peuvent obtenir une décision judiciaire leur attribuant la filiation avant la naissance. Ainsi, la déclaration de naissance portera les noms des parents d'intention dès l'origine[110]. La législation grecque[111] se montre tout aussi libérale puisque, dès lors que la mère d'intention a obtenu l'autorisation judiciaire de recourir à la maternité de substitution, l'article 1464 du *Code civil* grec la répute «comme étant la mère légale et prévoit qu'elle est inscrite comme telle dans l'acte de naissance dès l'origine»[112].

B. Une réponse en guise de question : *est mater semper certa* ?

À la lumière des développements en matière de procréation assistée, et compte tenu de la transformation des pratiques de parenté, il convient de repenser les certitudes sur la maternité. Nos sociétés occidentales ont déjà eu à remettre en question ce qui était tenu pour évident ou naturel en terme de parenté face aux phénomènes que sont les dons de gamètes, l'adoption ou l'homoparenté. Les familles elles-mêmes, les médecins, les enseignants et les législateurs sont autant d'acteurs qui ont eu à repenser la façon dont on imbrique filiation et parenté sociale comme découlant naturellement de l'acte hétérosexuel fécond.

Malgré les transformations des quarante dernières années en matière de parenté, il semble que la gestation pour autrui continue de susciter un malaise, une anxiété sociale, en dissociant la gestation de la maternité. Dans la mesure où la filiation et l'amour que l'on porte aux enfants sont supposés découler naturellement de la grossesse et de l'accouchement, la gestation pour autrui fait effectivement basculer des certitudes. Des études récentes nous démontrent pourtant que les mères d'intention sont d'aussi bons parents que celles qui ont porté elles-mêmes leurs enfants[113]. Ces mères se trouvent dans une situation semblable aux mères adoptives. Or, aujourd'hui, plus personne n'oserait affirmer que les mères adoptives sont moins aimantes ou compétentes en raison de l'absence de lien biologique avec leur enfant. Leur maternité fondée sur l'intention n'est en rien moins certaine que celle découlant d'un lien corporel. Ce qui compte donc en la matière, au-delà des capacités reproductives des parents, est que l'enfant se voit assuré d'un lien de filiation avec ceux qui ont décidé de former un projet parental. Cette approche implique de faire reposer la filiation sur l'intention de devenir parents et non pas sur la seule base de liens biologiques. Cette orientation nous apparaît tout à fait cohérente et s'insère logique-

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would be in the child's best interests for such a declaration to be made in this case.».

108 *B.A.N. v. J.H.*, [2008] B.C.J. No. 1169 (B.C. S.C.).

109 En Alberta, l'art. 12(2) du *Family Law Act*, S.A. c. F-4.5 prévoit que : «A genetic donor may apply to the court for an order declaring the genetic donor to be the mother of a child who is born in Alberta to a gestational carrier» et en Nouvelle-Écosse, le *Birth Registration Regulations*, O.I.C. 2007-498 (September 20, 2007), N.S. Reg. 390/2007 précise, après avoir rappelé que celle qui a accouché doit être inscrite comme la mère légale, à l'art. 5(2) que : «On application by the intended parents in a surrogacy arrangement, the court may make a declaratory order with respect to the parentage of the child».

110 Sénat, *La gestation pour autrui*, *supra* note 90 à la p. 38.

111 *Loi n° 3089 du 19 décembre 2002* sur l'assistance médicale à la procréation humaine et *Loi n° 3305-2005 du 27 janvier 2005* sur la mise en œuvre des méthodes de reproduction médicalement assistée.

112 Granet-Lambrechts, *supra* note 102 au para. 21.

113 Voir *infra* note 150.

ment dans l'ordonnancement du droit québécois qui reconnaît l'intention comme fondement du lien parental dans les cas d'adoption et en matière de procréation assistée.

Il reste que, contrairement à l'adoption qui est toujours pensée comme un remède aux enfants abandonnés, la gestation pour autrui implique le choix conscient de recourir à une autre femme pour porter son enfant en contrepartie, la plupart du temps, d'une certaine forme de rémunération. Plusieurs s'objectent à cette pratique et nous avons vu que le Québec et la France sont parmi les juridictions qui interdisent toujours ces contrats. Cette interdiction n'empêchant pas la pratique de prendre de l'ampleur[114], il nous semble important d'évaluer les arguments classiques qui sont opposés à cette pratique et de les confronter aux résultats des recherches actuelles.

Le maintien de la prohibition des contrats de gestation pour autrui se fonde essentiellement sur quatre arguments principaux, soit (1) la non-commercialisation du corps humain et la non-instrumentalisation des personnes, (2) la santé et l'autonomie des femmes, (3) l'intérêt de l'enfant à naître et (4) la protection de l'ordre public et de l'intérêt général. Voyons-les en détails.

1. La non-commercialisation du corps humain et la non-instrumentalisation des personnes

Les experts de la bioéthique affirment que la gestation pour autrui comporte de sérieux risques d'exploitation des femmes, particulièrement des femmes pauvres[115]. Il s'agirait en somme d'une «forme moderne d'esclavage» pour reprendre l'expression utilisée par le professeur Sériaux[116]. La commercialisation des échanges entre mère porteuse et couples demandeurs ferait peser un risque de dérive financière, que le contrat soit à titre gratuit ou non, puisqu'une forme de rémunération au moins indirecte est habituellement versée[117]. L'aspect commercial de ce type de convention ferait en sorte de placer les femmes porteuses à risque de subir des pressions de la part des demandeurs ou des intermédiaires mercantiles[118]. Il y aurait alors atteinte à la dignité des «mères porteuses» qui verraient ainsi leurs corps instrumentalisé, transformé en objet marchand, en objet de location. La *Commission de l'éthique, de la science et de la technologie* va jusqu'à considérer que la remise d'une compensation financière pourrait introduire une discrimination entre les femmes puisqu'il pourrait être plus avantageux de porter un enfant pour autrui que pour soi-même[119]. Au-delà des intérêts de la gestatrice, les experts poursuivent dans l'argument de la non-commercialisation en affirmant que la gestation pour autrui introduit le risque que les enfants deviennent de simples biens de consommation, que l'on puisse en quelque sorte les acheter et les vendre[120]. La pratique mènerait donc à la réification tant de la femme que de

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114 Il n'existe pas de données sur le nombre d'enfants nés de la gestation pour autrui au Canada, mais on estime aujourd'hui que 1500 bébés naissent chaque année de tels arrangements aux É.-U. Teman, *Birthing, supra* note 16 à la p. 1.

115 Avis, *supra* note 11 à la p. 77.

116 Sériaux, *supra* note 95 à la p. 1216 : «Le temps n'est pourtant pas si loin où l'on s'insurgeait contre cette forme moderne d'esclavage qui conduit une femme à abdiquer, même contre rémunération (cette ultime liberté…), ses forces génétiques au profit du couple commanditaire … ».

117 Conseil D'État, *supra* note 99 à la p. 49.

118 Mirkovic, «Maternité», *supra* note 31 au para. 4-6.

119 Avis, *supra* note 11 à la p. 78. Cette affirmation des membres de la commission, qui n'est assortie d'aucune justification, est contredite par les conclusions que les études de terrain ont révélées à ce jour. L'anthropologue Elly Teman, qui a effectué une vaste enquête qualitative s'échelonnant sur près d'une décennie a recueilli des données et interviewé plus d'une vingtaine de gestatrices et près de trente parents d'intention. Dans son ouvrage intitulé *Birthing a Mother*, elle explique, par exemple, que toutes les mères d'intention ayant participé à son enquête ont eu recours à la gestation pour autrui en tout dernier recours, après avoir épuisé toutes les autres possibilités de devenir mère. Les gestatrices, quant à elles, ont eu leurs propres enfants avant d'offrir leurs services à autrui. Teman, *Birthing*, *supra* note 16 à la p. 107.

120 *Ibid.*

l'enfant à naître. Ces arguments n'ont rien de nouveau et ont été brandis au moment de l'adoption des lois interdisant la gestation pour autrui au cours des années 1990. On peut admettre qu'il s'agissait alors de craintes légitimes face à une pratique que l'on connaissait mal et qui remettait en question des principes que l'on pensait volontiers intouchables dans l'ordre civiliste de la procréation au Québec et en France. Il est néanmoins surprenant que la même rhétorique soit reprise sans plus de nuance aujourd'hui compte tenu de l'évolution des pratiques de parenté, des théories contemporaines de la filiation et du nombre impressionnant de données empiriques dont nous disposons sur la pratique dite des mères porteuses[121].

Cette première série d'arguments contre la gestation pour autrui s'appuie en fait sur le principe de l'indisponibilité du corps humain. Cette formule peut être interprétée comme signifiant, en somme, que le corps humain appartient à la catégorie de choses qui sont hors commerce. Il apparaît aujourd'hui que ce principe relève davantage de l'aspiration ou de l'incantation que d'une réalité juridique. Ce qui apparaissait comme une évidence pour plusieurs auteurs civilistes est maintenant remis en question[122]. Affirmer que le corps ne peut faire l'objet de conventions est d'abord clairement contrarié par plusieurs types de contrat dont le contrat de travail ou celui d'assurance-vie pour ne nommer que ceux-là. De plus, il semble exister de si nombreuses exceptions au principe, notamment dans le domaine médical, que l'on peut douter de sa portée.

Le principe d'indisponibilité du corps est d'autant plus difficile à cerner qu'il ne fait l'objet d'aucune disposition juridique expresse, tant en droit positif français qu'en droit québécois. Principe dégagé par la doctrine et repris par les tribunaux depuis les années 1990, la juriste française Stéphanie Hennette-Vauchez explique :

> Poser que le corps humain est indisponible et accepter dans le même temps la licéité de nombre de conventions le prenant pour objet sans qu'il soit possible de donner une définition a priori des conventions acceptables et des conventions illicites, revient à poser le principe contraire : on ne sait plus, entre indisponibilité et exceptions au principe, lequel demeure un principe et ce qui constitue les exceptions[123].

Le principe d'indisponibilité ne vise en réalité qu'à éviter que le corps humain ne fasse l'objet de «commerce marchand», pour reprendre l'expression de Stéphanie Hennette-Vauchez. En ce sens, les conventions qui portent sur le corps, que ce soit sur les organes, sur l'usage de la voix ou sur l'utilisation des embryons surnuméraires, témoignent de l'évolution du droit qui a, par ailleurs, toujours permis de disposer de son corps dans les limites posées par l'ordre public. Marcela Iacub affirme, dans ce contexte, que sous couvert d'un principe général, le droit français a simplement mis l'utérus hors commerce[124].

Comparer la gestation pour autrui à une marchandisation illicite du corps apparaît problématique pour plusieurs raisons. Cela laisse supposer que les femmes qui acceptent de porter un enfant sont des victimes, qu'elles se font payer pour un usage de leur corps et cela introduit l'argument de la chosification de l'enfant.

Dans le contexte actuel des procréations assistées, et compte tenu de l'évolution des usages du corps, il est tout à fait possible d'envisager la gestation pour autrui non pas comme la vente du corps de la femme (l'approchant ainsi de la prostitution) mais comme un don ou comme la fourniture d'un service selon que le contrat est conclu à titre gratuit ou à titre onéreux.

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121 Voir notamment les études citées aux *infra* notes 122 et s.

122 Stéphanie Hennette-Vauchez, *Disposer de soi? Une analyse du discours juridique sur les droits de la personne sur son corps*, Paris, L'Harmattan, 2004 à la p. 70.

123 *Ibid.* à la p. 63.

124 Marcela Iacub, *L'Empire du ventre. Pour une autre histoire de la maternité*, Paris, Fayard, 2004 à la p. 227.

Dans l'hypothèse où une compensation est versée, on peut raisonnablement affirmer qu'il s'agit du paiement d'un service et non pas d'un droit acquis par le couple demandeur sur le corps de la gestatrice. Les demandeurs ne peuvent faire ce qui leur plaît avec le corps de la mère porteuse et les parties doivent s'en tenir aux termes du contrat comme dans n'importe quel autre contrat de service qui implique l'utilisation du corps humain. La rémunération ou une forme de compensation peut certes constituer un incitatif à porter un enfant pour autrui, mais il a été démontré par des études qualitatives que la rémunération en elle-même n'était pas une motivation suffisante pour décider d'entrer dans un tel contrat[125]. De toute façon, on voit mal en quoi le paiement d'une compensation serait problématique, comme des auteures le soulignaient justement, dans la mesure où la plupart des gens n'accepteraient pas de travailler, en dépit de l'amour qu'ils portent à leur métier, s'ils n'étaient pas payés en retour[126].

Finalement, l'argument selon lequel la gestation pour autrui s'apparenterait au trafic ou à la vente d'enfant revient si souvent dans le discours qu'il convient d'y répondre. Tout d'abord, mentionnons que les couples demandeurs ne contractent pas avec une gestatrice dans un but spéculatif, mais bien pour avoir un enfant. La plupart fournissent d'ailleurs leurs propres gamètes. À l'instar des adoptants ou des personnes ayant recours aux banques de sperme ou d'ovules, ils ne cherchent manifestement pas à faire un quelconque commerce. Les sommes investies sont alors nécessaires pour réaliser un projet parental qu'ils ne peuvent mener à bien sans aide extérieure pour des raisons d'ordre médical, comme l'infertilité, ou en raison du sexe des partenaires. Cela n'a donc rien à voir avec le fait de vendre des enfants.

Les auteurs écossais McLachlan et Swales ont écrit un article convaincant sur la question dans un cadre théorique d'analyse économique du droit[127]. Ils suggèrent que les contrats de gestation pour autrui devraient être licites et contraignants. Ils soutiennent également que la rémunération des gestatrices et l'autorisation d'agences intermédiaires pourraient être permises sans que l'on craigne une marchandisation de la femme ou de l'enfant. Ces contrats, expliquent-ils, n'impliquent aucune vente, mais représentent une entente dans l'intérêt mutuel des parties. Ils en arrivent à la conclusion que la rémunération des gestatrices de même que l'exécution de ces contrats est souhaitable. Cela dit, compte tenu des risques et des vulnérabilités créées par cette pratique, ils préconisent un régime juridique encadrant les contrats de gestation pour autrui et prévoyant l'exécution forcée de telles ententes.

Ces auteurs soutiennent, dans la logique classique de cette école, qu'en l'absence d'arguments sérieux justifiant la prohibition des contrats de gestation pour autrui, ceux-ci devraient être licites. D'autres spécialistes de l'analyse économique du droit avaient déjà pris position en faveur des contrats de gestation pour autrui dans les années 80 et 90. Ces prises de position apparaissent antithétiques d'un courant important du féminisme nord-américain dit féminisme différentialiste qui valorise la différence des sexes et la spécificité de la nature féminine ou de ce que l'on a nommé l'éthique de la sollicitude (care feminism)[128].

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[125] Philip J. Parker, «Motivations of Surrogate Mothers: Initial Findings» (1983) 140 Am. Jour. Psychiatry aux pp. 117-18 ; Hal B. Levine, «Gestational Surrogacy: Nature and Culture in Kinship» (2003) 42 Ethnology 173 à la p. 178. Levine explique que dans le contexte de la gestation pour autrui commerciale, les femmes considèrent évidemment la rémunération comme une condition importante, mais non déterminante dans leur motivation. Il précise que plusieurs États américains et agences intermédiaires maintiennent les compensations financières basses pour éviter toute association avec le trafic d'enfants et pour décourager les pratiques mercenaires.

[126] Jennifer Damelio et Kelly Sorensen, «Enhancing Autonomy in Paid Surrogacy», (2008) 22:5 Bioethics 269 à la p. 271.

[127] Hugh V. McLachlan et J. Kim Swales, «Commercial Surrogate Motherhood and the Alleged Commodification of Children: A Defense of Legally Enforceable Contracts» (2009) 72 Law and Contemp. Probs 91.

[128] Voir par ex. l'ouvrage phare de Carol Gilligan, *In a different voice: psychological theory and women's development*, Cambridge, Harvard University Press, 1982.

On peut cependant, au contraire, considérer le potentiel émancipateur de cette vision plus instrumentale de la reproduction. La gestation pour autrui devient alors un moyen pour les femmes de bénéficier d'une liberté économique propre à transformer et à redéfinir les contours du travail reproductif comme le prétendait le professeur canadien Michael Trebilcock dans un article de 1991. À cette époque, cette position pouvait être considérée comme étant théorique compte tenu de la rareté de la pratique et de l'absence de données anthropologiques sur la question au Canada. Vingt ans plus tard cependant, les études semblent donner raison à la théorie du bénéfice mutuel justifiant la légalisation de la gestation pour autrui commerciale.

2. *La santé et l'autonomie des femmes*

En admettant même l'hypothèse de la licéité de tels contrats dans l'ordre juridique québécois ou français, des auteurs continuent de s'opposer à leur admission en raison de la nature particulière du travail à accomplir, que l'on qualifie de forme d'esclavage. Les sacrifices demandés aux femmes candidates et les risques que la gestation pour autrui leur fait courir seraient trop élevés[129].

Ces craintes témoignent d'une anxiété face à la pratique, mais encore une fois ne s'ancrent pas dans la réalité vécue des acteurs impliqués dans ces arrangements procréatifs. En effet, les recherches menées sur la maternité pour autrui démontrent de façon systématique que les femmes choisissant de porter un enfant pour autrui ont la plupart du temps leurs propres enfants, connaissent parfaitement les risques reliés à une grossesse et décident de la poursuivre parce qu'elles aiment être enceintes[130]. En 1983, Parker constatait que certaines d'entre elles «voulaient être enceintes pour le reste de leur vie»[131].

Il est donc raisonnable de penser que les femmes qui se portent candidates dans ce contexte ont une volonté propre et consentent au contrat en sachant ce qu'une grossesse exige. Comme des auteures le soulignent[132], ce travail de tous les instants durant la gestation est particulier, certes, sans être unique. Les exigences d'un travail quasi constant posées par exemple à des acteurs, des mannequins ou à des chirurgiens spécialistes peuvent présenter des similitudes en ce qu'elles restreignent leur liberté corporelle dans une certaine mesure.

Cela étant posé, il est néanmoins primordial que les États mettent en place des structures pour éviter l'exploitation des mères porteuses. Les risques d'exploitation sont sérieux et méritent d'être pris en considération. Des auteures féministes soulignent à juste titre l'importance d'examiner le potentiel d'exploitation des femmes posé par la gestation pour autrui en tenant compte du déséquilibre éventuel entre les couples demandeurs et les gestatrices qui ont généralement des revenus plus faibles que ces derniers[133].

De plus, il convient de souligner que la pratique de la gestation pour autrui demeure une pratique générée, fortement ancrée dans les stéréotypes féminins qui, en ce sens, peut contribuer à maintenir les femmes dans un rôle reproductif subalterne, dans une dynamique de rapports de pouvoirs asymétriques[134]. Cependant, critiquer les institutions et le contexte social dans lequel la pratique se développe et s'inscrit ne signifie aucunement qu'il faille l'interdire ou continuer de

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129 Avis, *supra* note 11 à la p.75. Voir également Renée Joyal, *supra* note 18 aux pp. 9-10.

130 Damelio et Sorensen, *supra* note 126 à la p. 272.

131 Parker, *supra* note 125 à la p. 118.

132 Damelio et Sorensen, *supra* note 126 à la p. 272.

133 *Ibid.* à la p. 269 ; Suze G. Berkhout, «Buns in the Oven: Objectification, Surrogacy, and Women's Autonomy» (2008) 34 Social Theory and Practice 95 à la p. 103.

134 *Ibid.* aux pp. 100-03.

l'ignorer[135]. Au contraire, permettre de tels contrats, et encadrer la pratique paraît être le meilleur moyen pour l'État d'empêcher les abus dans ce domaine.

En effet, bien que révélateurs du malaise que la pratique suscite, les arguments relatifs à l'exploitation des femmes sont purement théoriques et ne s'ancrent aucunement dans la réalité des personnes impliquées dans les arrangements de gestation pour autrui. Plutôt qu'une forme d'esclavage, les données ethnographiques comparées dont nous disposons sur la gestation pour autrui aux É.-U., en Inde et en Israël, montrent plutôt un haut niveau de satisfaction chez les femmes qui ont porté un enfant pour autrui. Elles affirment s'être senties valorisées par l'expérience qui a contribué à les définir et à hausser leur estime d'elles-mêmes[136].

Il convient donc de se méfier du présupposé selon lequel les femmes qui portent un enfant pour autrui le feraient nécessairement pour des raisons douteuses, soit par abnégation ou à l'inverse, dans le cas des contrats commerciaux, en raison d'une extrême pauvreté qui les forcerait à conclure de tels contrats. En réalité, de nombreuses études scientifiques présentent un biais méthodologique, en prenant pour acquis que les gestatrices auraient nécessairement des motivations douteuses puisqu'une femme «normale» ne consentirait pas à un tel arrangement sans y avoir été forcée[137].

Plutôt que de voir la gestation pour autrui comme menant nécessairement à l'exploitation des femmes, de plus en plus d'auteurs, se fondant sur un corpus d'enquêtes et de diverses études longitudinales, soutiennent au contraire que la légalisation des contrats de gestation pour autrui favoriserait l'autonomie des femmes.[138] En donnant la possibilité aux femmes de contrôler leurs capacités reproductives tout en valorisant des tâches féminines historiquement dévaluées et non rémunérées, la gestation pour autrui leur offre de nouvelles avenues d'indépendance ou d'autonomie. Exerçant déjà le rôle de mère pour la plupart, il s'agirait là pour ces gestatrices d'améliorer leurs revenus tout en ayant la possibilité de rester à la maison et de s'occuper de leurs enfants.

Certains argueront que les femmes se voient ainsi, en quelque sorte, forcées de faire ce choix en raison de désavantages liés au genre et à la classe sociale classe qui continuent de les confiner aux tâches maternelles et soignantes sous valorisées. Cet argument ne tient cependant pas compte du fait que la plupart des gestatrices aiment être enceintes et affirment qu'elles ne le font pas que pour des raisons économiques, tel que nous l'avons évoqué. De plus, une vaste enquête américaine affaiblit davantage encore l'argument de l'exploitation des femmes en démontrant que ce ne sont pas les femmes les plus pauvres qui choisissent de porter un enfant pour autrui, mais plutôt des femmes mariées, ayant des enfants et issues de la classe moyenne.[139]

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135 *Ibid.* à la p. 96.

136 Teman, *Birthing*, *supra* note 16 à la p. 293.

137 «Whatever reason is proffered for her choice, the surrogate is constructed as deviant [...]. By finding ways of constructing the surrogate as deviant, the scholarship "proves" that a "normal" and "natural" woman would not make such a choice unless compelled by circumstance.» (Elly Teman, «The Social Construction of Surrogacy Research: An Anthropological Critique of the Psychosocial Scholarship on Surrogate Motherhood» (2008) 67 Social Science & Medicine 1104 à la p. 1108 [Teman, «Social»]).

138 Richard A. Posner, «The Ethics and Economics of Enforcing Contracts of Surrogate Motherhood» (1989) 5 J. Contemp. Health L. & Pol'y. 21 ; Michael J. Trebilcock et Rosemin Keshvani «The Role of Private Ordering in Family Law: A Law and Economics Perspective» (1991) 47 U.T.L.J. 533 ; McLachlan et Swales, *supra* note 127 ; Teman, «Social», *supra* note 137; Teman, *Birthing*, *supra* note 16 et Damelio et Sorensen, *supra* note 126.

139 Une étude américaine de 1988, rajustée en dollars courants de 2005 à partir des données d'un document gouvernemental, démontre que le revenu des gestatrices se situait entre 25,000 et 50,000$ en 2005, voir Damelio et Sorensen, *supra* note 126 à la p. 274.

Pour Elly Teman, qui a effectué une importante étude qualitative sur une période de huit ans auprès d'une vingtaine de gestatrices et de parents demandeurs en Israël, les femmes qui portent des enfants pour autrui trouvent une forme de reconnaissance qu'elles ne trouvent pas ailleurs dans leur société machiste et militariste.[140]

Il apparaît aujourd'hui important de prendre au sérieux ce que les femmes impliquées dans ces arrangements relatent de leur expérience afin de vérifier si les appréhensions formulées il y a vingt ou trente ans représentent les réels problèmes posés par la pratique. Dans cette optique, affirmer que les femmes choisissant de porter un bébé pour autrui ne comprennent pas la portée de leur geste, ou présumer du caractère nécessairement abusif de la pratique, semble condescendant et réducteur. Comme l'affirmait le juge Posner en 1989, cela rappelle par trop l'idée selon laquelle les femmes sont nécessairement sujettes à exploitation en matière commerciale, servant ainsi de justification à des mesures de soi-disant protection, comme l'incapacité juridique de la femme mariée. Ce rappel évocateur force le questionnement. Aussi peut-on se demander aujourd'hui qui est réellement protégé par la prohibition des contrats de gestation pour autrui. Sont-ce véritablement les femmes et les enfants ou s'agit-il de figer la vision que nous entretenons de la féminité et de la maternité ?

3. L'intérêt de l'enfant à naître

Plusieurs arguments sont avancés par les auteurs de doctrine juridique et les experts de la bioéthique selon lesquels la gestation pour autrui serait contraire à l'intérêt *a priori* des enfants. En interdisant la gestation pour autrui, la loi protégerait l'intérêt de l'enfant *in abstracto* et non pas l'intérêt actuel d'enfants particuliers[141]. La pratique serait néfaste puisqu'elle organise un abandon *irréparable* à la naissance[142] et les enfants issus de ces arrangements présenteraient des troubles psychiques en raison du désinvestissement affectif de la mère porteuse[143]. Ces enfants pourraient également développer des troubles de l'identité et ressentir des conflits face à une loyauté contradictoire envers les différents protagonistes impliqués dans sa naissance. Ainsi, la *Commission de l'éthique, de la science et de la technologie* s'appuie sur le témoignage d'un psychiatre, selon lequel les enfants issus d'une gestation pour autrui ne pourraient guérir leur blessure d'abandon (contrairement aux autres enfants abandonnés …), puisque la mère de substitution remet l'enfant aux parents intentionnels en vertu d'un contrat et non par amour[144].

Par ailleurs, la Commission réitère la crainte maintes fois exprimée depuis les années 1990 que le statut de l'enfant est incertain et que la gestation pour autrui le place au cœur de litiges au sujet de la filiation, notamment parce que la mère porteuse pourrait décider de garder le bébé[145]. Le Conseil d'État français considère pour sa part qu'il n'existe pas d'études permettant de mesurer l'impact psychologique de la gestation pour autrui sur les enfants nés de cette technique.

Pourtant, l'ensemble de ces arguments révèle davantage les préconceptions et les croyances populaires reliées à la maternité et à la fusion qui existerait naturellement entre une femme

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140 Teman, *Birthing, supra* note 16 à la p. 293.

141 Mirkovic, «Maternité», *supra* note 31 au para. 24.

142 Avis, *supra* note 11 à la p. 73.

143 C'est ce qu'indique par exemple le *Rapport du Sénat*, *supra* note 49 à la p. 62, en évoquant l'opinion de deux pédopsychiatres. Pourtant, des auteurs estiment à moins de 1% le nombre de cas de gestation pour autrui se terminant devant les tribunaux aux É.-U. et en Grande Bretagne. Dans 99% des cas, les gestatrices remettent volontairement l'enfant aux parents d'intention. Il n'existe par ailleurs, à notre connaissance, aucun cas recensé de demandeurs qui auraient refusé d'établir leur filiation avec l'enfant né d'une gestatrice. Voir Teman, *Birthing*, *supra* note 16 à la p. 3.

144 Avis, *supra* note 11 à la p. 74.

145 *Ibid.* aux pp. 70 et 79 ; Giroux, *supra* note 9 à la p. 545.

normale et le bébé qu'elle porte[146], que des problématiques réelles dont souffriraient les enfants issus de cet arrangement procréatif.

En réalité, il n'existe aucune théorie concluante sur l'influence et la nature des échanges prénatals en raison de la grande diversité des situations et des réactions observées chez les femmes qui portent des enfants[147]. Qui plus est, plusieurs études récentes en psychologie, impliquant de larges cohortes, ont démontré que l'absence de lien gestationnel avec la mère n'avait aucun impact négatif sur la relation entre parents et enfants[148]. En fait, la seule différence révélée par les chercheurs, entre les familles dont les enfants étaient issus de la gestation pour autrui et celles ayant conçu leur enfant naturellement, était une meilleure qualité de liens entre les mères et les enfants de trois ans issus de la gestation pour autrui[149]. Les couples ayant recours à la gestation pour autrui sont des parents réellement motivés, qui désirent leur enfant et qui l'accueillent dès sa naissance. De nombreuses études ont d'ailleurs démontré que les parents qui avaient recours à la gestation pour autrui et à d'autres techniques de procréation telle que la fécondation *in vitro* avaient démontré des compétences parentales supérieures à d'autres parents en raison de leur démarche, de leur profonde implication et du désir qui les avait animés d'avoir des enfants[150].

L'argument selon lequel la gestation pour autrui mène à un abandon est par ailleurs fragile. Les gestatrices disent éprouver une grande satisfaction d'avoir accompli une mission qui, avec le temps, devient moins contractuelle et s'apparente davantage à un don. C'est pourquoi elles ne vivent pas la remise de l'enfant aux demandeurs comme un abandon, mais bien comme le cadeau ultime offert à ceux avec lesquels elle a tissé des liens parfois très intimes, en particulier avec la mère intentionnelle[151]. Finalement, les femmes interrogées ont affirmé ne pas se considérer comme étant les mères des enfants qu'elles portent pour autrui, mais plutôt comme des fées ou comme leurs nourrices. Elles affirment que ces grossesses étaient plus faciles à mener que lorsqu'elles portaient un enfant pour elles-mêmes[152].

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146 Le philosophe Philippe Descamps affirme que, pour ancrer la théorie de la différence des sexes, le discours bioéthique a forgé de nouvelles essences, voire même des idoles avec des notions telles que la fusion primordiale entre le fœtus et la mère, l'ombilic ou la notion d'amour matriciel. Ce discours laisse supposer que l'amour maternel est tout entier guidé par la nature, par la gestation. L'attachement de la mère à l'enfant serait donc entièrement lié à sa physiologie. Philippe Descamps, *L'utérus, la technique et l'amour,* Paris, Presses Universitaires de France, 2008, à la p. 134.

147 C'est ce que relève par exemple le Sénat français. Voir *Rapport du Sénat*, *supra* note 49 à la p. 61.

148 Susan Golombok *et al.*, «Non-Genetic and Non-Gestational Parenthood: Consequences for Parent-Child Relationships and the Psychological Well-Being of Mothers, Fathers and Children at Age 3» (2006) 21 Human Reproduction 1918 à la p. 1922 [Golombok, «Non-genetic»] ; Susan Golombok *et al.*, «Surrogacy Families: Parental Functioning, Parent-Child Relationships and Children's Psychological Development at Age 2» (2006) 47 Journal of Child Psychology & Psychiatry 213 à la p. 220 [Golombok, «Surrogacy families»].

149 Golombok, «Non-Genetic», *ibid.* à la p. 1922.

150 Golombok, «Surrogacy families», *supra* note 148 à la p. 219 ; Frank van Balen, «Child Rearing Following in vitro Fertilization» (1996) 37 Journal of Child Psychology and Psychiatry 687 ; Golombok *et al.*, «Families with Children Conceived by Donor Insemination : A Follow-up at Age 12» (2002) 73 Child Development 952-68.

151 Teman, *Birthing*, *supra* note 16 à la p. 209.

152 Delaisi de Parseval et Collard, *supra* note 2 à la p. 46. Elly Teman a noté que les gestatrices utilisaient des métaphores mécanicistes pour décrire leur utérus en qualifiant leur ventre de four à pain, de serre ou de machine à bébé. Plutôt qu'y voir une déshumanisation ou une chosification du corps, à l'instar d'un certain discours féministe sur les procréations assistées, Teman qualifie d'intelligente la façon dont ces femmes jonglent avec la technologie, l'idée de nature et celle du corps. Elle y voit une forme de subversion et une preuve que les émotions et la nature ne contrôlent pas leur destinée. Si elles adhérent au discours patriarcal et se considèrent comme étant principalement des mères (elles avaient toutes en moyenne 2,54 enfants avant de porter pour autrui), elles s'assurent que la «nature maternelle» ne se manifeste que lorsqu'elles le désirent, c'est-à-dire quand il s'agit de leurs propres enfants. Voir Teman, *Birthing*, *supra* note 16 au chapitre 1 aux pp. 31-53.

En ce qui concerne le spectre des litiges sans fin et l'idée selon laquelle la gestatrice pourrait décider de garder le bébé, il s'agit d'une idée éloignée de la réalité. En dépit d'affaires spectaculaires telle que celle de *Baby M.* aux États-Unis dans les années 1980 et d'autres cas plus récents rapportés de temps à autre dans la presse, plus de 99% des femmes rendent le bébé aux parents intentionnels sans présenter de difficultés psychiques particulières[153]. En ce sens, malgré l'infime nombre de litiges impliquant une gestatrice refusant de remettre l'enfant, les batailles judiciaires et l'attention médiatique disproportionnée qu'ils suscitent démontrent la prégnance de l'idéologie occidentale voulant qu'une mère normale aime naturellement le bébé qu'elle porte et que l'abandonner est contre-nature. La contrepartie de cette croyance est que le bébé porté par autrui ne peut être réellement aimé par sa mère d'intention qui ne lui a pas fait le cadeau de son ventre. Cette orientation donne à réfléchir sur les idées entretenues à l'égard de toutes les parentés non génétiques et laisse voir la force du naturalisme en matière familiale. L'idée dominante est toujours que l'amour porté aux enfants découle naturellement d'un lien physique, charnel, à tout le moins pour les mères. La paternité a toujours été comprise comme étant relative, contingente, négociable et éminemment culturelle alors que l'on insiste pour réduire la maternité au ventre et à la chair à défaut de quoi, craignons-nous, les mères cesseront d'aimer leurs enfants. Ce raisonnement prouve bien une confusion entre la notion de géniteur et de parent alors que le rôle de père ou de mère ne s'est jamais résumé au seul lien biologique.[154]

En ce qui concerne l'argument voulant qu'il n'existe pas d'études sur la question de la gestation pour autrui, nous répondrons rapidement. Il semble que cet argument resurgisse dès lors qu'il existe un malaise face à une pratique de parenté qui bouleverse les représentations sociales dominantes. Ainsi, l'absence d'études a été invoquée *ad nauseam* dans le débat entourant la reconnaissance de l'homoparenté au Québec, alors même que des spécialistes étudiaient ces familles depuis une quarantaine d'années. Cette étude juridique, qui ne fait qu'effleurer les recherches en sciences sociales, démontre bien que nous disposons de nombreuses données sur la gestation pour autrui. Par ailleurs, rares sont les auteurs qui dénoncent l'absence d'études prouvant de façon définitive que l'hétérosexualité ou le lien biologique serait une garantie quelconque pour un développement sain des enfants ou pour garantir de quelconques capacités parentales.

Cela dit, la menace de la chosification de l'enfant semble refaire surface chaque fois qu'une anxiété survient dans le domaine de la procréation. Que ce soit à l'égard de la gestation pour autrui, de l'insémination artificielle des femmes seules, plus âgées ou lesbiennes, dès qu'une catégorie de personnes ne pouvant procréer de façon traditionnelle cherche à entrer en parenté, un discours transforme leur désir légitime d'avoir un enfant[155] en coupable et égoïste «droit à l'enfant»[156]. Nous avons longuement discuté de ce phénomène dans d'autres textes et croyons que cet argument est tellement éculé qu'il n'est pas nécessaire de s'y arrêter plus longuement. Afin de clore ce débat, il suffira de citer la psychanalyste française Delaisi de Parseval, spécialiste des procréations assistées, qui écrit avec deux autres professeures que «le désir d'enfant n'est pas ce sentiment futile et égoïste que certains se plaisent à stigmatiser»[157].

En ce qui concerne le trafic d'enfant, les commentaires sur les risques d'exploitation des femmes peuvent trouver application. Il est juste d'affirmer que les États ont la responsabilité de lutter contre ce fléau. Il ne suffit pourtant pas d'interdire la gestation pour autrui pour faire disparaître la possibilité du trafic. De même que pour l'adoption internationale ou le don d'organes, les risques d'abus ne font dire à personne qu'il faille tout simplement cesser de trouver des famil-

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153 Teman, *Birthing*, *supra* note 16 à la p. 3.

154 Descamps, *supra* note 146 à la p. 113 ; Marie-France Bureau, *Le droit de la filiation entre ciel et terre : étude du discours juridique québécois*, Cowansville, Yvon Blais, 2009, à la p. 20 [Bureau, *Filiation*].

155 Marie-France Bureau, «L'union civile et les nouvelles règles de filiation : contrepoint discordant ou éloge de la parenté désirée» (2003) 105 R. d. N. 901 [Bureau, «Union»].

156 Bureau, *Filiation*, *supra* note 154 aux pp. 203-05.

157 Brandac, Delaisi de Parseval et Depadt-Sebag, *supra* note 31 au para. 9.

les aux enfants adoptables ou mettre un terme à la pratique de la circulation des organes[158]. Les risques d'abus évidents dans ces domaines, comme dans celui de la gestation pour autrui, militent au contraire pour un encadrement étatique visant à protéger les parties vulnérables.

4. La protection de l'ordre public et de l'intérêt général

Au Québec comme en France, les contrats de gestation pour autrui sont illicites parce que «contraires à l'ordre public»[159]. Or, en droit civil, la caractéristique de l'ordre public est de s'intéresser non pas aux intérêts particuliers mais bien à l'intérêt général. On pourrait supposer que l'usage qu'une personne fait de son corps relève davantage de la sphère intime et de l'individualité que de l'intérêt de la société, mais force est de constater que ce n'est pas l'orientation qui a été privilégiée par le droit privé en France et au Québec.

Le principe de la dignité humaine, consacré à l'article 3 du *Code*, à la *Charte des droits et libertés de la personne*[160] et érigé au rang de principe constitutionnel en France, est au cœur de cette problématique. La sauvegarde de la dignité humaine, encore une fois, aurait pu se traduire par davantage de liberté quant aux usages corporels, mais une analyse des normes et du discours juridique révèle plutôt un courant contraignant, prohibitif et limitatif.

En effet, de nombreuses normes visent aujourd'hui, au nom du principe de la dignité, à limiter les pouvoirs de la personne sur son corps. La jurisprudence, les divers comités d'éthique et les interventions législatives qui se sont succédés dans ce domaine depuis les années 70 témoignent de la mise en place de ce qu'une auteure a appelé l'ordre public corporel[161]. Ainsi, lorsque les experts de la bioéthique justifient la prohibition des contrats de gestation pour autrui, c'est au nom de valeurs éthiques et particulièrement au nom du principe de la dignité humaine[162]. Les normes bioéthiques qui entourent la procréation, dont la primauté de la personne humaine, le droit à l'intégrité et à l'inviolabilité viseraient donc essentiellement à assurer ce principe fondamental. Or, s'il est central, le principe de dignité n'est ni précis ni approprié comme Stéphanie Hennette-Vauchez l'a bien démontré[163]. Le philosophe Ruwen Ogien va même jusqu'à affirmer qu'il s'agit d'une notion «dangereuse et inutile»[164].

En plus du caractère flou et ambigu de la notion de dignité et de la difficulté d'en déterminer le contenu, le fait de l'ériger en principe lui confère le statut de principe moral transcendant. Hennette-Vauchez cite la gestation pour autrui en exemple : «L'interdiction de la maternité de substitution est bien de type général et absolu, et expliquer cette interdiction par sa contrariété au principe de la dignité de la personne humaine, c'est bien comprendre ce dernier comme un étalon transcendant»[165]. Or, elle constate que d'autres pays occidentaux qui partagent des valeurs culturelles avec la France autorisent pourtant ce type de contrat. Cela l'amène à conclure que le législateur ne cherche pas tant à interdire des pratiques contraires à la dignité qu'à préserver une représentation limitative des droits qu'une personne peut avoir sur son corps. La protection de la personne humaine entendue de cette façon explique, comme Descamps et Ogien l'ont

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158 Pour une discussion sur l'argument de la pente fatale, concernant les dérives supposées vers la marchandisation, on consultera Ruwen Ogien, *La vie, la mort, l'État. Le débat bioéthique*, Paris, Grasset, 2009 à la p. 76 et s.

159 Avis, *supra* note 11 à la p. 65.

160 *Charte des droits et libertés de la personne*, L.R.Q. c. C-12, art. 4.

161 C'est la thèse soutenue par Stéphanie Hennette-Vauchez, *supra* note 122 aux pp. 380 et s. Les auteurs Edith Deleury et Dominique Goubeau soutiennent également cette théorie et relèvent au Québec la mise en place «d'un ordre public de protection de la personne dans sa dimension corporelle», Le droit des personnes physiques, 4e édition, Cowansville, Yvon Blais, 2008 à la p. 109.

162 Avis, *supra* note 11 à la p. 69 ; *Rapport du Sénat*, *supra* note 49 aux pp. 56-57.

163 Hennette-Vauchez, *supra* note 122 aux pp. 393 et s.

164 Ogien, *supra* note 158 à la p. 87.

165 *Supra* note 122 aux pp. 401-02.

illustré, que l'on criminalise et interdit toutes sortes de pratiques sans vérifier si un préjudice quelconque est réellement causé[166]. Il s'agit de ce qu'Ogien a qualifié de vision morale maximaliste de la bioéthique qui tend à créer des crimes sans victimes. Cette vision limitative de la liberté est caractéristique de l'ensemble de l'orientation normative de l'ordre public corporel, mais il nous apparaît encore plus frappant dans le contexte de la gestation pour autrui. En effet, non seulement la gestation pour autrui bouleverse-t-elle des représentations culturelles du corps, elle remet également en question les *a priori* sur la maternité, voire même sur l'essence de la féminité. On préfère alors limiter la liberté des individus avec des normes juridiques contraignantes plutôt que d'affaiblir les croyances que nous entretenons à propos de l'amour maternel ou de l'amalgame opéré entre nature, reproduction et filiation[167].

Marcela Iacub a très bien illustré, dans son ouvrage de 2004 sur l'histoire juridique de la maternité en France, les transformations juridiques des dernières décennies[168]. À partir de la jurisprudence et des transformations normatives depuis 1804, la chercheure démontre l'orientation générale de ces mutations juridiques. La légalité de la maternité est passée de la réalité juridique du mariage vers une légalité fondée sur la vérité biologique, le ventre et l'accouchement.

Le discours bioéthique a eu pour effet de réintroduire le corps de la femme dans le droit. En se biologisant ainsi, le droit de la famille s'est naturalisé. La nouvelle importance accordée au corps sexué, au corps reproducteur féminin[169], fait de l'utérus le critère suprême de la maternité et renforce l'idée lacanienne de la femme/nature opposée à l'homme/culture. Dans ce contexte, la gestation pour autrui apparaît nettement comme une pratique déviante. Le discours bioéthique et même le travail empirique sur cette pratique témoignent en fait d'un malaise, d'une anxiété à propos de l'unicité maternelle.

Qu'une femme puisse porter l'enfant qu'une autre élèvera implique en effet de remettre en cause la sacralité du lien entre une femme et le fœtus qu'elle porte. Si les femmes normales ont un lien fusionnel avec le bébé qu'elles portent, que nous dit la gestation pour autrui sur les motivations de celles qui décident d'y recourir ? L'anthropologue Elly Teman nous fournit une réponse intéressante en critiquant les études empiriques grâce à une approche constructiviste[170]. L'auteure démontre que la plupart des travaux scientifiques sur les motivations des mères porteuses s'appuient sur un double biais : celui de la naturalité et de la normalité des liens mère/enfant. Avec pour résultat que les femmes qui choisissent de porter des enfants pour autrui sont dépeintes comme étant anormales, sans égard au fait qu'aucune étude n'a, à ce jour, démontré un quelconque problème ou une particularité chez ces femmes[171].

Cette tentative de chercher néanmoins des anomalies démontre en fait que les chercheurs n'évoluent pas en vase clos et que leurs études sont des produits historiquement et culturellement situés[172]. Finalement, ce biais essentialiste dans les études qualitatives, de même que la récurrence des arguments contre la gestation pour autrui dans le discours bioéthique, en disent plus sur la centralité des préconceptions et des représentations culturelles de la maternité que sur la pratique elle-même, ou sur l'expérience vécue par les femmes impliquées dans ces arrangements procréatifs[173].

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166 Descamps, *supra* note 146 à la p. 89.

167 Bureau, *Filiation*, *supra* note 154 aux pp. 188 et s. ; Descamps, *supra* note 146 à la p. 113.

168 Iacub, *supra* note 124.

169 Bureau, *Filiation*, *supra* note 154 aux pp. 188 et s.

170 Teman, «Social», *supra* note 137.

171 Les études ont en fait toutes conclu que les gestatrices étaient des femmes dans la norme et non différenciées dans leurs caractéristiques personnelles et psychologiques : Teman, *Birthing*, *supra* note 16 à la p. 3.

172 Teman, «Social», *supra* note 137 à la p. 1105.

173 *Ibid.* à la p. 1106.

CONCLUSION

D'un droit civil qui concevait la personne de façon abstraite et psychologique, pour reprendre les termes de Jean Carbonnier[174], la bioéthique a eu pour effet de distinguer juridiquement la personne de son corps[175]. Cette nouvelle dualité entre le corps et la personne introduit la sacralité de la personne humaine. Ce ne sont pas tant les personnes que le droit cherche à protéger par ce dispositif, mais la personne humaine entendue comme l'espèce humaine entière. En ce sens, contrairement à l'éthique qui se veut prospective, la bioéthique cherche à protéger des valeurs sacrées *a priori*[176]. On lui donne alors pour mission de préserver une vie véritablement humaine, de préserver l'essence et la valeur des êtres humains ce qui, pour la femme, signifie sa spécificité reproductive, bref son utérus.

Il ne faut pas sous-estimer cette tendance actuelle qui consiste à mettre en amont du droit des principes de nature et de biologie qui commanderaient les solutions juridiques auxquelles le législateur devrait se plier. L'idée d'un ordre naturel surplombant les normes juridiques ne se pose pas uniquement dans le domaine de la gestation pour autrui, mais témoigne plutôt d'une tendance lourde à vouloir attribuer au droit des fonctions anthropologiques. Or, sauf à questionner cette idée, nous risquons d'essentialiser des rôles et de perdre de vue l'autonomie du droit qui n'est ni déterminé par la nature ni inféodé à la science.

En ce sens, la gestation pour autrui nous invite à repenser des notions comme celle de maternité et nous force à repenser sa fameuse certitude. Son unicité est possiblement un leurre. Mais admettre que la filiation et la parenté relèvent d'un amalgame d'éléments que sont la biologie, l'intention et la culture permet de légitimer la place de tous les protagonistes impliqués, qu'il s'agisse des mères d'intention, des mères génétiques, des pères ou des parents adoptifs. Dans tous les cas, élargir les possibles en matière de parenté et légitimer la démarche de ceux qui ont recours à des tiers pour réaliser un projet parental ne pourra, à terme, que créer un meilleur avenir pour les nombreux enfants qui émergent de cette matrice.

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174 Jean Carbonnier, «Terre et Ciel dans le droit du mariage» dans *Le droit privé français au milieu du XX^e siècle, études offertes à Georges Ripert*, t. 1, Paris, Librairie générale de droit et de jurisprudence, 1950, 325.

175 Descamps, *supra* note 146 à la p. 87.

176 *Ibid.* à la p. 85.

STATUTORY GOOD-FAITH IMMUNITY FOR GOVERNMENT PHYSICIANS: COGENT POLICY OR A DENIAL OF JUSTICE?

Andrew Flavelle Martin[*]

Recent events such as the SARS outbreak and the controversy over pediatric forensic pathology in Ontario have increased awareness and scrutiny of physicians employed by the government, including medical officers of health, coroners, and pathologists. At common law, physicians are held to a standard of care that can be summarized as reasonable professional competence. Statutory provisions effectively neutralize this standard of care for government physicians by providing civil immunity so long as they act in "good faith". The appropriateness of this protection from civil liability is assessed in this paper.

The author argues that statutory good-faith immunity is inconsistent with the requirements that these positions be held by licensed doctors; indeed, it is a common provision of legislation for government employees that is not appropriate to the special case of government physicians. The Ontario statutory and case law is canvassed in relation to the powers and duties of coroners, forensic pathologists, and medical officers of health. It is then demonstrated that this statutory good-faith immunity is applied to the vast majority of public actors in Ontario. Within this context, the historic and current policy rationales for the immunity are assessed with reference to the recent judgments of the Supreme Court of Canada and the Ontario Court of Appeal establishing a tort of negligent investigation by police. The author then assesses how the common law of tort would apply to government physicians if these provisions were repealed.

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"To deny a remedy in tort is, quite literally, to deny justice."

- The Right Honourable Beverley McLachlin, Chief Justice of Canada[1]

INTRODUCTION

Events of recent years have increased both public awareness and political scrutiny of the work of physicians performing public functions. In 2003, the outbreak of Severe Acute Respiratory Syndrome ("SARS") illustrated the importance of public health as a medical discipline.[2] In response to the SARS experience, the federal government commissioned an advisory committee led by Dr. David Naylor, and the Ontario government appointed a commission under Justice Archie Campbell, to examine the handling of SARS and make recommendations to strengthen public health programs and policy.[3] Not long after SARS, death investigation—the discipline of coroners and forensic pathologists—attracted attention. In April 2007, the Office of the Chief Coroner for Ontario publicly confirmed serious problems with the work of once-renowned pediatric forensic pathologist Dr. Charles Smith.[4] The government chose Justice Stephen Goudge of the Ontario Court of Appeal to lead a public inquiry that would "conduct a systemic review … in order to make recommendations to restore and enhance public confidence in pediatric forensic pathology in Ontario and its future use in investigations and criminal proceedings."[5] A span of a few years had brought public examinations of three different kinds of government physicians: medical officers of health, coroners, and forensic pathologists.

Despite the merits of these examinations, a major issue remains unaddressed. The three reports were fundamentally concerned with the quality of public health and death investigation, two areas in which physicians play crucial roles. As a generalization, "[c]ivil liability is widely used in Canada as a mechanism to ensure quality of health services."[6] However, none of the

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1 *Hill v. Hamilton-Wentworth Regional Police Services Board*, 2007 SCC 41, [2007] 3 S.C.R. 129 at para. 35, 285 D.L.R. (4th) 620, aff'g (2005), 76 O.R. (3d) 481, 259 D.L.R. (4th) 676 (C.A.) [*Hill* (S.C.C.) cited to S.C.R.; *Hill* (C.A.) cited to O.R.].

2 See e.g. Nola M. Ries, "Quarantine and the Law: The 2003 SARS Experience in Canada: A New Disease Calls on Old Public Health Tools" (2005) 43 Alta. L. Rev. 529; Roxana Salehi & S. Harris Ali, "The Social and Political Context of Disease Outbreaks: The Case of SARS in Toronto" (2006) 32 Canadian Pub. Pol'y 373.

3 National Advisory Committee on SARS and Public Health, *Learning from SARS: The Renewal of Public Health in Canada* (Ottawa: Health Canada, 2003) (Chair: Dr. David Naylor), online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf> [*Naylor Report*]; Commission to Investigate the Introduction and Spread of SARS in Ontario, *Final Report* (Toronto: Queen's Printer for Ontario, 2006) (Commissioner: Justice Archie Campbell), online: Ontario Ministry of Health and Long-Term Care <http://www.health.gov.on.ca/english/public/pub/ministry_reports/campbell06/online_rep/index.html> [*Campbell Report*].

4 Office of the Chief Coroner, Backgrounder: Public Announcement of Review of Criminally Suspicious and Homicide Cases Where Dr. Charles Smith Conducted Autopsies or Provided Opinions (Toronto: Ministry of Community Safety and Correctional Services, 2007), online: Legislative Library, Legislative Assembly of Ontario <http://www.ontla.on.ca/library/repository/mon/17000/272655.pdf> [Coroner, "Backgrounder"].

5 Inquiry into Pediatric Forensic Pathology in Ontario, online: Ontario Ministry of the Attorney General, <http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/>; *Inquiry into Pediatric Forensic Pathology in Ontario Report* (Toronto: Ontario Ministry of the Attorney General, 2008) (Commissioner: the Honourable Stephen T. Goudge), online: Ontario Ministry of the Attorney General <http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/report/index.html> [Goudge Report]; O.C. 826/2007 at 2-3 (Order in Council establishing the Goudge Inquiry), in Goudge Report, vol. 4 at 678-79, online: Ontario Ministry of the Attorney General <http://www.attorneygeneral.jus.gov.on.ca/english/news/2007/20070425-pi-oic-en.pdf>.

6 Tracey Epps, "Regulation of Health Care Professionals" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 3d ed. (Markham: LexisNexis Canada, 2007) 69 at 75, citing M.J. Trebilcock, D. Dewees & D. Duff, *Exploring the Domain of Accident Law: Taking the Facts Seriously* (New York: Oxford University Press, 1996) at 96.

three reports questioned in any detail the dramatic extent to which government physicians, specifically medical officers of health, coroners, and forensic pathologists, are protected from civil liability.[7] At common law, the standard of care that applies to doctors is "that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing."[8] Legislation effectively lowers this standard by providing civil immunity to government physicians so long as they act in "good faith". Thus, doctors with duties and powers arguably much greater than a typical practitioner are subject to a much lower standard of care.

This reduced liability of government physicians is a critical public policy issue. Ultimately at stake are the responsibility of government physicians to the public and the responsibility of the governments that employ them. These go to the fundamental core of public law, the relationship between the individual and the state. Ideally the state and its servants will not harm the individual. Indeed, the Naylor Report, the SARS Commission, and the Goudge Inquiry focused on how to prevent or at least reduce that harm. Nonetheless, the question remains: when such harm does occur, who should bear the cost?

In this paper, I argue that statutory good-faith immunity for government physicians is fundamentally inconsistent with the expectation of professional competence by licensed doctors. Instead, it is a relatively standard legislative provision that is not appropriate in the particular contexts of death investigation and public health. While this issue is not unique to Ontario, that province will be the primary focus because the SARS and Charles Smith affairs were centred there.

This argument will proceed in four parts. First, the relevant statutory and case law in Ontario will be canvassed. I will consider the powers, duties, and good-faith immunity provisions, first of coroners and forensic pathologists, and then of medical officers of health. I will also survey the immunities granted to physicians at large corresponding to general duties imposed by statute. The second part argues that the Ontario immunity provisions for government physicians are more likely to be an application of standard practice than the result of conscious consideration of the special context of government physicians. I begin by demonstrating the ubiquity of similar provisions among Ontario statutes. I then consider the legislative history of the acts governing coroners, forensic pathologists, and medical officers of health. The third part evaluates the historical and current policy rationales for good-faith immunity provisions. I explain how parallel jurisprudence from the Ontario Court of Appeal and the Supreme Court of Canada, recognizing the tort of negligent investigation by police, can be harnessed to reject these rationales. The fourth part considers how the common law of tort liability would apply to government physicians in the absence of statutory immunity.

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[7] The *Naylor Report*, *supra* note 3 does not consider this issue. The second interim report of the SARS Commission considers it very briefly and concludes that the protection should be extended to additional actors in the public health system: *Campbell Report*, *supra* note 3, vol. 5, at 19, 65-66, 69. The issue was also addressed briefly in a research paper prepared by Professor Lorne Sossin for the Goudge Inquiry, *Accountability and Oversight for Death Investigations in Ontario* (Toronto: Goudge Inquiry, 2008) at 33-34, online: Ontario Ministry of the Attorney General <http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/policy_research/pdf/Sossin_Accountability-and-Oversight.pdf>. Professor Sossin's analysis will be discussed below. While Commissioner Goudge recommended several legislative amendments, he did not address the provision that provides immunity from civil liability: Goudge Report, *supra* note 5, vol. 3 at 288, 309-12, 338-39 (Recommendations 1, 12-14, 17, 38). The issue of good-faith immunity in the context of coroners has recently been raised by at least one journalist: Natalie Alcoba, "Picking up the Pieces: Those Whose Lives Were Shattered by Charles Smith Have Little Recourse" *National Post* (12 December 2009) A14.

[8] *Crits and Crits v. Sylvester et al.*, [1956] O.R. 132 at 143, 1 D.L.R. (2d) 502 (C.A.) [*Crits* (C.A.) cited to O.R.], aff'd [1956] S.C.R. 991, 5 D.L.R. (2d) 601, quoted in Ellen I. Picard & Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Toronto: Thomson, 2007) at 225 (as "[t]he classic statement").

I
STATUTORY GOOD-FAITH IMMUNITY FOR PHYSICIANS

I begin by canvassing the law on statutory immunity for physicians, primarily in Ontario. I will first consider coroners and forensic pathologists and then medical officers of health. In each case, I will survey the extensive powers and duties involved as well as the immunity provisions. I then provide some broader context by examining the major duties imposed by statute on physicians at large and the extent to which corresponding immunity is given.

A. Coroners and Forensic Pathologists

Coroners in Ontario are physicians with substantial duties and powers. A coroner must be a "legally qualified medical practitione[r]," both upon appointment and in order to keep the position.[9] Indeed, the *Coroners Act* imposes a duty on the College of Physicians and Surgeons of Ontario to inform the Chief Coroner if any coroner ceases to hold a valid medical licence.[10] Coroners investigate virtually all unnatural deaths, and deaths in various institutions, in order to establish "how … when … where … and by what means the deceased came by his or her death."[11] In order to do so, coroners have broad powers of entry, search, and seizure.[12] Obstruction of a coroner is an offence punishable by fine and/or imprisonment.[13] As part of an investigation, a coroner can commission an autopsy or other tests.[14] These tests and investigations can be critical evidence in criminal prosecutions. Coroners can order inquests "in the public interest," at which any evidence or person can be summoned.[15]

The forensic pathologist performs a discrete complementary role to that of the coroner. Under the *Coroners Act*, pathologists are required to be physicians with specializations in pathology.[16] Parallel to the provision concerning coroners, the Act imposes a duty on the College of Physicians and Surgeons of Ontario to notify the Chief Forensic Pathologist if a pathologist is no longer in good standing.[17] The pathologist has a duty to perform an autopsy where one is ordered by a coroner.[18] This obligation comes with a broad power of entry, not only of places where the body is, but also of places from which the pathologist believes (on reasonable and probable grounds) the body has been removed.[19] Moreover, this power can be exercised not only where a warrant for the autopsy has been issued by the coroner, but also in the absence of a warrant where the pathologist reasonably believes such a warrant will be issued.[20]

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9 *Coroners Act*, R.S.O. 1990, c. C.37, s. 3 (The *Coroners Amendment Act, 2009*, S.O. 2009, c. 15, received royal assent on 5 June 2009. And all sections but s. 4 came into force on 27 July, 2009 and s. 4 came into force on 16 December 2010.). The *Legislation Act, 2006*, S.O. 2006, c. 21, Sched. F, s. 87 provides that in Ontario legislation, "legally qualified medical practitioner" and similar terms "mean a member of the College of Physicians and Surgeons of Ontario".

10 *Coroners Act*, *ibid.*, s. 3(3).

11 *Ibid.*, ss. 10, 15, 31(1).

12 *Ibid.*, s. 16.

13 *Ibid.*, ss. 16(6), 55.

14 *Ibid.*, s. 28.

15 *Ibid.*, ss. 20, 40. See also ss. 22.1, 26, 27, 30-52. As will be discussed further below, the role of a coroner at a coroner's inquest is a quasi-judicial function that would not attract liability in negligence at common law.

16 *Ibid.*, s. 1(1) (This definition of pathologist, like every mention of the term "pathologist" in the Act, was absent prior to the *Coroners Amendment Act, 2009*, *supra* note 9).

17 *Ibid.*, s. 7.1(2).

18 *Ibid.*, s. 28(1), (3).

19 *Ibid.*, s. 28(4).

20 *Ibid.*

While these powers of coroners and forensic pathologists are extensive, the corresponding liability is minimal. Section 53 of the *Coroners Act* provides as follows:

> No action or other proceeding shall be instituted against *any person exercising a power or performing a duty under this Act* for any act done *in good faith* in the execution or intended execution of any such power or duty or for any alleged neglect or default in the execution *in good faith* of any such power or duty.[21]

It is critically important to note that section 53 does more than provide good-faith immunity to the coroner or forensic pathologist. It also ensures that the Crown is immune from vicarious liability for the acts of that person on its behalf, again so long as good faith cannot be disproved. This result occurs because of the interaction of section 53 of the *Coroners Act* with the *Proceedings Against the Crown Act*.[22] Section 5 of *PACA* makes the Crown vicariously liable in tort for its agents and servants; however, it also precludes Crown liability where those servants and agents are not personally liable.[23] Thus, section 53 precludes recovery not only from the coroner or forensic pathologist, but also from the Crown. This immunity has two key features: it requires only good faith, and it applies to a power or duty under the Act.[24]

The *Coroners Act* illustrates the potential uncertainty over the scope of good-faith immunity. "Good faith" has been recognized as a term that must be interpreted in its specific context.[25] In general, "[i]f there is one word that delineates or characterizes the expression 'good faith', it is 'honesty'."[26] In granting summary judgment against a claim asserting bad faith of a pathologist acting under the *Coroners Act*, Justice MacKinnon adopted the following definition of good faith from *Black's Law Dictionary*:

> a state of mind consisting in (1) honesty in belief or purpose, (2) faithfulness to one's duty or obligation, (3) observance of reasonable commercial standards of fair dealing in a given trade or business, or (4) absence of intent to defraud or to seek unconscionable advantage.[27]

Good faith thus involves honesty or absence of malicious intent. However, a unanimous 2004 decision of the Supreme Court broadened the circumstances in which an absence of good faith can be inferred:

> [T]he concept of bad faith can and must be given a broader meaning that encompasses *serious carelessness or recklessness*. Bad faith certainly includes intentional fault ... Such conduct is an abuse of power for which the State, or sometimes a public servant, may be held liable. However, *recklessness implies a fundamental breakdown of the orderly exer-*

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[21] *Ibid.* [emphasis added] (Prior to the *Coroners Amendment Act, 2009*, *supra* note 9, s. 53 read as follows: "No action or other proceeding for damages lies or shall be instituted against *a coroner or any person acting under the coroner's authority* for an act done by him or her *in good faith* in the performance or intended performance of *any power or duty under this Act or the regulations*, or for any neglect or default in the performance in good faith of any such power or duty" [emphasis added].).

[22] R.S.O. 1990, c. P.27 [*PACA*].

[23] *Ibid.* This is a codification of common law: see Peter W. Hogg & Patrick Monahan, *Liability of the Crown*, 3d ed. (Toronto: Carswell, 2000) at 120 (citing cases from the U.K. and Australia: "Unless such a clause expressly preserves the vicarious liability of the Crown, the clause will also immunize the Crown from liability"); see also Karen Horsman & Gareth Morley, eds., *Government Liability Law and Practice*, looseleaf (Aurora: Canada Law Book, 2009) at 5.50.10.

[24] Sossin, *supra* note 7 at 33; see also Horsman & Morley, *ibid.* at 5.50.

[25] *McAlpine v. H.(T.)* (1991), 57 B.C.L.R. (2d) 1 at para. 35, 82 D.L.R. (4th) 609, 7 C.C.L.T. (2d) 113 (C.A.); *R. v. Devereaux* (1996), 147 Nfld. & P.E.I.R. 108, 112 C.C.C. (3d) 243 at 254 (Nfld. C.A.) [*Devereaux* cited to C.C.C.].

[26] Devereaux, *ibid.* at 255.

[27] *Burns v. Johnston*, [2003] O.T.C. 290, [2003] O.J. No. 1452 at para. 26 (Sup. Ct. J.) (QL) [*Burns I*] quoting Bryan A. Garner, ed., *Black's Law Dictionary*, 7th ed. (Minnesota: West, 1990) at 701, action via amended statement of claim dismissed, [2003] O.T.C. 549 (Sup. Ct. J.) [*Burns II*].

> *cise of authority to the point that absence of good faith can be deduced and bad faith presumed*. The act, in terms of how it is performed, is then inexplicable and incomprehensible to the point that it can be regarded as an actual abuse of power, having regard to the purposes for which it is meant to be exercised.[28]

The Ontario Court of Appeal has recently addressed the relationship between the wrongness of a decision and bad faith: "[w]hile a wrong decision, even a very wrong decision cannot be equated to a decision made in bad faith, a decision may be so clearly wrong on the merits as to provide some evidentiary support for a finding of bad faith."[29] Thus good faith is also negated by "recklessness" or "serious carelessness", even in the absence of demonstrable malice, and can be questioned where a decision is "clearly wrong".

However, a second element must also be met to obtain good-faith immunity: that the conduct at issue was in the exercise of a power or duty under the Act. This element of section 53 has arisen in the context of forensic pathologists. In *Burns v. Johnston*, at issue was whether a pathologist was liable in negligence for providing an oral opinion of cause of death to the police before receiving toxicology results.[30] The plaintiff was charged with murder based on that opinion, and the charge was withdrawn when the pathologist later changed the cause of death to drug overdose.[31] At that time, section 28(2) of the *Coroners Act* required the autopsy report to be made "in writing only to the coroner who issued the warrant, the Crown Attorney, the regional coroner and the Chief Coroner."[32] Nonetheless, Justice Manton found that such communication between coroners and police was common practice, reasonable, and "necessary if feasible", and thus covered by section 53.[33] The Ontario Court of Appeal came to the opposite conclusion in *Reynolds v. Kingston (City) Police Services Board*.[34] A murder charge based on a pathologist's oral report to police was withdrawn after a second autopsy.[35] Without mentioning the decision in *Burns*, the Court of Appeal characterized the provision of an oral opinion to police as "[c]ontrary to s. 28(2) of the [*Coroners*] Act."[36]

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[28] *Finney v. Barreau du Québec*, 2004 SCC 36, [2004] 2 S.C.R. 17 at para. 39, 240 D.L.R. (4th) 410 [citations omitted; emphasis added]. An extended version of this passage is quoted in Horsman & Morley, *supra* note 23 at 5.50.20.

[29] *Rosenhek v. Windsor Regional Hospital*, 2010 ONCA 13, 257 O.A.C. 283 [*Rosenhek*], leave to appeal refused, [2010] S.C.C.A. No. 89, aff'g [2007] O.J. No. 4486 (Sup. Ct. J.) (QL).

[30] *Supra* note 27. Note that this case occurred before the class of persons covered by s. 53 was extended by the *Coroners Amendment Act*, *supra* note 9. However, the change in language does not go to the issues in the case. See the previous version of s. 53, *supra* note 21. For a discussion of s. 53 in the context of the relationship between the coroner and the police, see Andrew Flavelle Martin, "Beyond the Goudge Inquiry: Is the Coroner Part of 'The Crown' for *Stinchcombe* Disclosure Obligations?" (2009) 67 U.T. Fac. L. Rev 9 at 31-32.

[31] *Burns II*, *ibid.* at paras. 4, 27.

[32] *Coroners Act*, *supra* note 9, quoted in *Burns II*, *ibid.* at para. 29. Note that this part of s. 28 is no longer in force after the *Coroners Amendment Act*, *supra* note 9. The current s. 29(1) governing the reporting of results by the pathologist omits the word "only": "The pathologist who performed the *post mortem* examination of a body under section 28 shall forthwith report in writing his or her findings from the *post mortem* examination and from any other examinations or analyses that he or she conducted to the coroner who issued the warrant, the regional coroner and, if the pathologist who performed the *post mortem* examination is not the Chief Forensic Pathologist, the Chief Forensic Pathologist." It is unclear how this non-exclusive list of persons to whom the report is to be made will affect the recurrence of a challenge parallel to that in *Burns*. The phrase "in writing" may still be interpreted to preclude oral reporting.

[33] *Burns II*, *ibid.* at paras. 30-35.

[34] 2007 ONCA 166, 84 O.R. (3d) 738, 280 D.L.R. (4th) 311 [*Reynolds* cited to O.R.].

[35] *Ibid.* at paras. 1-6.

[36] *Ibid.* at para. 1, referring to the *Coroners Act*, *supra* note 9. Note that the pathologist sought to strike the statement of claim by asserting the common-law doctrine of witness immunity. The Court found that witness immunity did not necessarily apply to the pathologist's death-investigation functions before his testimony, and the issue would need to be resolved at trial. However, witness immunity is not statutory and so is outside the focus of this paper.

The matter is further complicated by the research program and policy roundtables of the Goudge Inquiry. In his report, Professor Sossin stated that "[t]he third stage of the death investigation consists of the pathologist communicating the results of the autopsy to the coroner (and, where appropriate, to the police)."[37] He did not elaborate on the meaning of "where appropriate". Mark Sandler, Special Counsel, Criminal Law, framed a panel discussion of the issue as though the oral reporting of the tentative findings to the police was accepted as appropriate, and only its content and documentation were in issue:

> [A]t the end of the autopsy, the forensic pathologist completes his or her examination and then speaks to the police officers. And the question arises: What should the forensic pathologist be saying to the police at that stage and whether what they're saying to the police should be captured in writing.[38]

While there was consensus around the importance of making a record of these communications to allow their disclosure to the defense, the oral reporting itself had wide support from the police and Crown Attorney panelists.[39] Indeed, Commissioner Goudge wrote that the provision of a preliminary opinion was not "necessarily wrong" and could be useful, although a written record of the opinion should be kept.[40]

This disagreement over the precise breadth of section 53 of the *Coroners Act*, specifically whether an oral report by the pathologist is allowed, or expected, or mandated, demonstrates a critical aspect of statutory immunity for government physicians.[41] It also reveals a larger underlying issue. Even if the particular action taken by a government physician is in the performance of a power or duty under the relevant legislation, should he or she escape civil liability for taking that action negligently? Ultimately, it is preferable for that determination to result not from an exercise in statutory interpretation as in *Burns*, but instead from a normative policy choice.

Some, but not all, of the regimes governing death investigation in other Canadian jurisdictions have provisions parallel to section 53. In the four provinces with medical examiner systems,[42] where medical examiners must be physicians and the chief medical examiner must be a pathologist, there are no good-faith immunity provisions.[43] Other than Ontario, P.E.I. is the only jurisdiction in which coroners must be physicians,[44] and those coroners also enjoy good-faith immunity.[45] Of the remaining coroner jurisdictions, New Brunswick and the Yukon provide no immunity,[46] Saskatchewan, B.C. and Quebec provide good-faith immunity,[47] and in the

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37 Sossin, *supra* note 7 at 14.

38 Goudge Inquiry, *Transcripts*: *Roundtables* (12 Feb. 2008) at 192, online: IIS7 <http://mail.tscript.com/trans/pfp/feb_12_08/index.htm>.

39 *Ibid.* at 205-06, 262-64.

40 Goudge Report, *supra* note 5, vol. 2 at 174-75.

41 Sossin, *supra* note 7 at 34 (uncertainty around the scope of s. 53 contributes to corresponding uncertainty in "the extent to which civil suits may provide an effective forum for accountability and oversight").

42 Under the traditional coroner system, developed in England and imported to Upper Canada prior to confederation, coroners were not doctors. In contrast, a defining feature of the medical examiner system of death investigation—which originated in the U.S. in the 20th century—was the requirement that medical examiners be doctors, usually pathologists. See Randy Hanzlick, *Options for Modernizing the Ontario Coroner's System* (Toronto: Goudge Inquiry, 2008) at 5, 16-17, 37-38, online: Ontario Ministry of the Attorney General <http://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/policy_research/pdf/Hanzlick_Options-for-Modernizing.pdf>.

43 *Fatality Investigations Act*, S.N.S. 2001, c. 31, ss. 3-4; *Fatality Inquiries Act*, C.C.S.M. c. F52, ss. 1- 2; *Fatality Inquiries Act*, R.S.A. 2000, c. F-9, ss. 5, 7; *Fatalities Investigations Act*, S.N.L. 1995, c. F-6.1, ss. 2-4. To be precise, Manitoba provides statutory immunity to the Chief Medical Examiner with regard to the disposal of inquest exhibits, and the provision does not require good faith: *Fatality Inquiries Act*, C.C.S.M. c. F52, s. 33.

44 *Coroners Act*, R.S.P.E.I. 1988, c. C-25.1, ss. 3-4.

45 *Ibid.*, s. 53.

46 *Coroners Act*, R.S.N.B. 1973, c. C-23; *Coroners Act*, R.S.Y. 2002, c. 44.

Northwest Territories, and Nunavut, the immunity applies unless the coroner "acted in bad faith or without reasonable and probable cause."[48]

B. Medical Officers of Health

A medical officer of health ("MOH") or an associate medical officer of health must be a physician, where physician is defined as "a legally qualified medical practitioner," with a community medicine fellowship or other academic training in public health.[49] Furthermore, the Chief Medical Officer of Health ("CMOH") and Associate Chief Medical Officer of Health are each required to have been a physician for at least five years.[50] In addition to these qualifications, every MOH has a duty to "keep himself or herself informed in respect of matters related to occupational and environmental health."[51] Thus, the qualifications required of an MOH are more extensive than those of a coroner.

The significant powers and duties of MOHs reflect these qualifications. MOHs have a duty to inspect or order inspection of their territory, including places used for food storage or service or as boarding houses, and have broad powers of entry to do so.[52] Obstruction of such an investigation is an offence.[53] Where there is a health hazard, the MOH can require remedial measures.[54] The MOH has the power to seize and destroy "any substance, thing, plant or animal other than man" constituting a hazard.[55] The MOH also has extensive powers to quarantine individuals or classes of individuals, as well as the power to compel their examination or treatment without consent.[56] If such an order for quarantine, examination, or treatment is not followed, a judge can order that person detained for that purpose with the assistance of the police.[57] The CMOH has significant additional powers to those of the MOHs. If the CMOH certifies "an immediate risk", the Minister can declare any premises a quarantine facility and order any medical supplies seized.[58] Similarly, the CMOH can require the release of any health records necessary if there is "an immediate and serious risk."[59] In case of "an immediate risk", the CMOH can issue a mandatory directive "respecting precautions and procedures" to any health professional or facility.[60]

Subsection 95(1) of the *Health Protection and Promotion Act* ("*HPPA*") provides, similarly to section 53 of the *Coroners Act*, as follows:

> No *action or other proceeding for damages or otherwise* shall be instituted against the Chief Medical Officer of Health or the Associate Chief Medical Officer of Health, a member of a board of health, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector or an employee of a board of health who is working under the direction of a medical officer of health for any act done *in good faith* in the execution or the intended

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47 Coroners Act, 1999, S.S. 1999, c. C-38.01, s. 59; An Act respecting the determination of the causes and circumstances of death, R.S.Q. 1983 c. R-0.2, s. 16; Coroners Act, S.B.C. 2007, c. 15, s. 62(2).

48 *Coroners Act*, R.S.N.W.T. 1988, c. C-20, s. 60.

49 *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, as am. by S.O. 2007, c. 10, ss. 1, 64 [*HPPA*]; *Qualifications of Boards of Health Staff*, R.R.O. 1990, Reg. 566, s. 1.

50 *HPPA*, *ibid.*, ss. 81(2), 81.1(3).

51 *Ibid.*, ss. 12(1), 81(3).

52 *Ibid.*, ss. 10, 41, 43.

53 *Ibid.*, ss. 42, 100-101.

54 *Ibid.*, s. 13.

55 *Ibid.*, s. 19.

56 *Ibid.*, s. 22.

57 *Ibid.*, ss. 35, 36.

58 *Ibid.*, ss. 77.4, 77.5.

59 *Ibid.*, s. 77.6.

60 *Ibid.*, s. 77.7.

> execution of *any duty or power under this Act* or for any alleged neglect or default in the execution in good faith of any such duty or power.[61]

However, unlike the *Coroners Act*, the section proceeds to preserve the liability of the Crown notwithstanding *PACA*.[62] Similarly, boards of health remain liable.[63] Section 95(1) has been applied to protect MOHs from liability regarding an alleged failure to address pollution from a metal refinery[64] and inspections of a lodging house for the elderly.[65] However, these applications of the immunity are very straightforward and provide little material for analysis. In particular, none of the SARS cases have involved section 95 immunity.[66]

Statutory good-faith immunity in the public health context applies in most Canadian jurisdictions. The crown and individuals are explicitly immune in Alberta, Quebec, and Saskatchewan;[67] individuals are immune, and thus the Crown immune, in Manitoba, Nova Scotia, and

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61 *Ibid.*, s. 95(1) [emphasis added]. Note that prior to the 2007 amendment, which followed a recommendation by the Campbell Commission to extend the coverage of this immunity to all public health actors (*Campbell Report*, *supra* note 3), s. 95 only covered "a member of a board of health, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector".

62 *Ibid.*, s. 95(1.1); *PACA*, *supra* note 22.

63 *Ibid.*, s. 95(3). Note that prior to the 2007 amendments, the individuals protected by s. 95(1) were most often employees of boards of health and not the provincial government, so Crown liability was not at issue—s. 95(3) preserved vicarious liability. The addition of subsection 95(1.1) was necessary to extend the preservation of vicarious liability for the new Crown agents, such as the CMOH, added to s. 95(1). Note also that protection for MOHs equivalent to s. 95(1) and (3) under the *HPPA* is found in s. 9(1) and (3) of the *Mandatory Blood Testing Act, 2006*, S.O. 2006, c. 26. However, the MOH has no decision-making role in the process other than determining that the application for testing "meets the requirements of the regulations" (s. 3). Due to the lack of a substantive role for the MOH under the Act, and the absence of case law, these provisions will not be discussed further.

64 *Pearson v. Inco Ltd.*, [2002] O.T.C. 515, 33 C.P.C. (5th) 264 at paras. 88-92 (Sup. Ct. J.), aff'd (2004), 183 O.A.C. 168, 44 C.P.C. (5th) 276 (Div. Ct.), rev'd on other grounds (2006), 78 O.R. (3d) 641, 261 D.L.R. (4th) 629 (C.A.) (this case was a proposed class action involving the health effects of pollution emitted by the refinery, and the MOH was alleged to have failed in her duties to inspect, investigate, and eliminate the relevant health hazards).

65 *St. Elizabeth Home Society v. Hamilton (City)*, [2005] O.T.C. 1074, [2005] O.J. No. 5369 at para. 95 (Sup. Ct. J.) (QL) (this was a complex case in which the Society claimed, among other things, that the MOH and the city's public health department were negligent in their investigations of complaints about the level of care at the home and in their enforcement of the relevant by-laws).

66 The SARS cases generally do not involve claims against MOHs, so s. 95 immunity is not at issue: *Jamal Estate v. Scarborough Hospital - Grace Division* (2005), 34 C.C.L.T. (3d) 271, [2005] O.J. No. 3506 (Sup. Ct. J.) (QL), rev'd 2009 ONCA 376, 95 O.R. (3d) 760, 66 C.C.L.T. (3d) 188, leave to appeal refused, [2009] S.C.C.A. No. 30 [*Jamal Estate*]; *Henry Estate (Trustee of) v. Scarborough Hospital* (2005), 34 C.C.L.T. (3d) 278, [2005] O.J. No. 3505 (S.C.J.) (QL), rev'd 2009 ONCA 375, 66 C.C.L.T. (3d) 184, leave to appeal refused, [2009] S.C.C.A. No. 306 [Henry Estate]; *Laroza Estate v. Ontario* (2005), 257 D.L.R. (4th) 761, 34 C.C.L.T. (3d) 264 (Ont. Sup. Ct. J.), rev'd 2009 ONCA 373, 95 O.R. (3d) 764, 251 O.A.C. 119 [*Laroza Estate*]; *Abarquez v. Ontario* (2005), 257 D.L.R. (4th) 745, 34 C.C.L.T. (3d) 249 (Ont. Sup. Ct. J.), rev'd 2009 ONCA 374, 95 O.R. (3d) 414, 252 O.A.C. 267, leave to appeal refused, [2009] S.C.C.A. No. 297 [*Abarquez*]; see also *Williams v. Canada (Attorney General)* (2005), 76 O.R. (3d) 763 at para. 102 (Sup. Ct. J.), rev'd on other grounds, 2009 ONCA 378, 95 O.R. (3d) 401, 249 O.A.C. 150, leave to appeal refused, [2009] S.C.C.A. No. 298 (at trial Cullity J. noted that "no duties of care or acts of negligence are pleaded against the City's Medical Officer of Health") [*Williams*]. For a discussion of the private law duties of care owed by public health authorities and government, see Bernard M. Dickens, "Legal and Ethical Obligations of Public Health Authorities and Government" in Commission of Inquiry on Hormone Receptor Testing, *"Looking Forward..." Policy Papers*, vol. 2 (St. John's: Newfoundland and Labrador, 2009) at 11-19, online: CIHRT <http://www.cihrt.nl.ca/Final%20Report/index.pdf> [Dickens, "Legal and Ethical Obligations"].

67 *Public Health Act*, R.S.A. 2000, c. P-37, s. 66.1 as am. by S.A. 2002, c. 32, s. 12(12); *Public Health Act*, R.S.Q. c. S-2.2, s. 123; *The Public Health Act, 1994*, S.S. 1994, c. P-37.1, s. 68(1).

P.E.I.;[68] individuals are immune but the Crown is not immune in B.C. and New Brunswick.[69] The relevant statute is silent on immunity only in Newfoundland and two of the three territories; the recent *Public Health Act, 2007* of the Northwest Territories provides individual immunity, but is silent on Crown liability.[70] Other than the respective provisions regarding the Crown, the only variations of any import are that the P.E.I. provision and one of the two B.C. provisions refer to bad faith instead of good faith, and the Quebec provision applies only during a "public health emergency."[71]

C. Other Physicians Exercising Statutory Powers & Duties

It should be noted that similar statutory provisions protect physicians at large in their exercise of duties mandated by statute. For example, the *HPPA* creates a duty on doctors (and various other health professionals) to report to the MOH if any person they treat "has or may have a reportable disease."[72] Section 95(4) provides corresponding good-faith immunity for the reporting professional.[73] The effective scope of that section is limited, however, as described in the recent case of *Healey v. Lakeridge Health Corp.*:

> I do not find in these provisions, or in the scheme of *HPPA* as a whole, any implication of a legislative intention to relieve physicians and hospitals of liability for negligence in the event that, through a want of reasonable care, they fail to diagnose and report a case of TB in a timely manner.[74]

The *Mandatory Gunshot Wounds Reporting Act* creates a similar duty to report to the police any patient that is treated for a gunshot wound, and provides corresponding good-faith immunity.[75] Statutory good-faith immunity is also extended to the College of Physicians and Surgeons (and other Colleges), its Council and committees and panels, and the individuals acting under their authority, by the *Regulated Health Professions Act*, *1991*.[76] Thus, doctors involved in registration, complaints, discipline, incapacity, and reinstatements are protected.[77]

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[68] *The Public Health Act*, C.C.S.M. c. P210, s. 106(1); *Proceedings Against the Crown Act*, C.C.S.M. c. P140, s. 4; *Health Protection Act*, S.N.S. 2004, c. 4, s. 12; *Proceedings Against the Crown Act,* R.S.N.S. 1989, c. 360, s. 5; *Public Health Act*, R.S.P.E.I. 1988, c. P-30, s. 22.3 as am. by S.P.E.I. 2006, c. 17, s. 3; *Crown Proceedings Act*, R.S.P.E.I. 1988, c. C-32, s. 4.

[69] *Public Health Act*, S.B.C. 2008, ss. 28, 92; *Public Health Act*, S.N.B. 1998, c. P-22.4, s. 64.

[70] *Health and Community Services Act*, S.N. 1995, c. P-37.1; *Public Health and Safety Act*, R.S.Y. 2002, c. 176; *Public Health Act*, R.S.N.W.T. 1988, c. P-12 (Nu); *Public Health Act*, S.N.W.T. 2007, c. 17, s. 41.

[71] R.S.P.E.I. 1988, c. P-30, s. 22.3; *Health Act*, R.S.B.C. 1996, c. 179, s. 34.1; *Public Health Act*, R.S.Q. c. S-2.2, s. 123.

[72] *Supra* note 49, ss. 25, 26.

[73] HPPA, *ibid*.

[74] (2006), 38 C.P.C. (6th) 145 at paras. 62-63, [2006] O.J. No. 4277 (Sup. Ct. J.) (QL), Cullity J. [*Lakeridge Health*]. Note that Perell J. has recently granted in the same proceedings a partial motion for summary judgment against those persons who were informed of exposure to TB but were not infected: *Healey v. Lakeridge Health Corp.*, 2010 ONSC 725 at para. 13, 72 C.C.L.T. (3d) 261 (Sup. Ct. J.) (Perell J. held that the hospital had no duty of care to those persons, that there is no compensation available in law for psychological injury short of recognizable psychiatric illness, and that such damages would fail for remoteness).

[75] S.O. 2005, c. 9, ss. 2, 4.

[76] S.O. 1991, c.18, s. 38.

[77] *Health Professions Procedural Code*, being Sched. 2 of the *Regulated Health Professions Act, 1991*, *ibid*. (and by virtue of s. 4 of that Act, deemed part of the *Medicine Act, 1991*, S.O. 1991, c. 30); see e.g. *Deep v. Massel*, [2007] O.J. No. 2811 at paras. 17-23 (Sup. Ct. J.) (QL), aff'd 2008 ONCA 4, [2008] O.J. No. 18 (QL). Immunity for other administrative and quasi-administrative functions that may be performed by doctors or others, beyond the scope of this paper, are found in the *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H.20, s. 9, the *Independent Health Facilities Act*, R.S.O. 1990, c. I.3, s. 38, and the *Public Hospitals Act*, R.S.O. 1990, c. P.40, s. 13. For a discussion of bad faith in the context of a hospital board under the *Public Hospitals Act*, see *Rosenhek*, *supra* note 29 at paras. 26-35.

Two subtle variations on these schemes of statutory good-faith immunity are "reasonable grounds" and "gross negligence". The *Health Care Consent Act* provides civil immunity to physicians for treatment in the absence of consent, where there is not only a good-faith belief in consent but also reasonable grounds for that belief.[78] A similar requirement for immunity is found in the *Child and Family Services Act*, which imposes on physicians, among others, a duty to report child abuse or neglect.[79] It provides good-faith immunity unless the reporting physician "acts … without reasonable grounds for the suspicion."[80] The "gross negligence" variation of good-faith immunity is demonstrated by the *Good Samaritan Act, 2001* and the *Chase McEachern Act (Heart Defibrillator Civil Liability), 2007*.[81] These acts provide civil immunity to health professionals giving "emergency health care services or first aid" or using an automated defibrillator outside a hospital or equivalent facility in good faith, but only in the absence of "gross negligence".[82] These "reasonable grounds" and "gross negligence" variations demonstrate that the government is willing to require more than good faith for immunity when it imposes obligations on physicians at large.

II
GOOD-FAITH IMMUNITY AS A STANDARD LEGISLATIVE PROVISION

Far from being a unique feature of the health care field or the medical profession, good-faith immunity is a standard provision across many legislative regimes in Ontario. As between coroners and MOHs, some regimes cover the actor and the Crown while others protect only against personal liability; however, the latter scheme is much more common. For example, the vast majority of Ontario government ministries have personal, but not Crown, immunity.[83] Equivalent statutory schemes cover many other actors exercising important public functions, including: the Building Code and Building Materials Evaluation Commissions, building code officials and inspectors;[84] firefighters, the Fire Marshal, and the Fire Safety Commission;[85] the diagnostic and

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78 *Health Care Consent Act, 1996*, S.O. 1996, c. 2, s. 29(1).

79 R.S.O. 1990, c. C.11, s. 72(1)-(3), (5)(a) [*CFSA*].

80 *Ibid.*, s. 72(7) (The requirement of good faith is expressed as an absence of malice.).

81 *Good Samaritan Act, 2001*, S.O. 2001, c. 2 [*Good Samaritan Act*]; *Chase McEachern Act (Heart Defibrillator Civil Liability)*, 2007, S.O. 2007, c. 10, Sch. N [*Chase McEachern Act*].

82 *Good Samaritan Act, ibid.*, ss. 1-2; *Chase McEachern Act*, *ibid.*, s. 2. Section 2 of both Acts also requires the action to be "voluntarily and without reasonable expectation of compensation or reward".

83 *Ministry of Agriculture, Food and Rural Affairs Act*, R.S.O. 1990, c. M.16, s. 6; *Ministry of Citizenship and Culture Act*, R.S.O. 1990, c. M.18, s. 8; *Ministry of Community and Social Services Act*, R.S.O. 1990, c. M.20, s. 4; *Ministry of Consumer and Business Services Act*, R.S.O. 1990, c. M.21, s. 8; *Ministry of Correctional Services Act*, R.S.O. 1990, c. M.22, s. 12 (liability is also precluded "for any act of an inmate, parolee, probationer or young person while under his or her custody and supervision"); *Ministry of Economic Development and Trade Act*, R.S.O. 1990, c. M.27, s. 10; *Ministry of Energy Act*, R.S.O. 1990, c. M.23, s. 5; *Ministry of Government Services Act*, R.S.O. 1990, c. M.25, s. 15 (also covers the Queen's Printer for Ontario); *Ministry of Intergovernmental Affairs Act*, R.S.O. 1990, c. M.28, s. 7; *Ministry of Labour Act*, R.S.O. 1990, c. M.29, s. 4.1, as am. by S.O. 2006, c. 19, Sched. M, s. 4; *Ministry of Municipal Affairs and Housing Act*, R.S.O. 1990, c. M.30, s. 7; *Ministry of Natural Resources Act*, R.S.O. 1990, c. M.31, s. 5; *Ministry of Northern Development and Mines Act*, R.S.O. 1990, c. M.32, s. 5; *Ministry of Revenue Act*, R.S.O. 1990, c. M.33, s. 8; *Ministry of Tourism and Recreation Act*, R.S.O. 1990, c. M.35, s. 9; *Ministry of Transportation Act*, R.S.O. 1990, c. M.36, s. 9, as am. by S.O. 2006, c. 19, Sched. T, s. 9; *Ministry of Treasury and Economics Act*, R.S.O. 1990, c. M.37, s. 7. Notable examples of Ministry acts that do not provide good-faith immunity include the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26; *Ministry of the Solicitor General Act*, R.S.O. 1990, c. M.34; Ministry of the Attorney General Act, R.S.O. 1990, c. M.17 (the *Crown Attorneys Act*, R.S.O. 1990, c. C.49, s. 14.3(3) provides personal immunity in matters of property relating to criminal offences); see also Hogg & Monahan, *supra* note 23 at 120, n. 56 (the numerical results of a similar survey of Ontario ministries conducted as of 2000).

84 *Building Code Act, 1992*, S.O. 1992, c. 23, s. 31.

85 *Fire Protection and Prevention Act*, 1997, S.O. 1997, c. 4, s. 74.

therapeutic X-ray safety Director and inspectors;[86] and the Director of the Family Responsibility Office.[87] Examples of actors immunized under regimes that do not provide for Crown liability are the Ontario Health Quality Council[88] and Directors appointed under the *Accessibility for Ontarians with Disabilities Act, 2005*.[89] Furthermore, the immunity provided to the College of Physicians and Surgeons under the *Regulated Health Professions Act, 1991* is equivalent to that granted to the Law Society of Upper Canada.[90] The ubiquity of these provisions suggests that they may be accepted as standard legislative features.

The legislative origins of the immunity provisions in the *Coroners Act* and the *HPPA* demonstrate that they were not the subject of public debate, which suggests an absence of conscious policy consideration by legislators. The current section 53 of the *Coroners Act* was originally introduced in 1978 in *The Coroners Amendment Act, 1978 (No. 1.)*.[91] There is no mention of this provision in the legislative record.[92] On first reading, the Solicitor General described *The Coroners Amendment Act* as "basically housekeeping amendments required to update the act. There's no change in the principle of the bill but the amendments will help to clarify some provisions in the Coroners Act and assist the operation of the coroners office in certain areas."[93] More recently, the *Coroners Amendment Act, 2009* amended section 53 to provide good-faith immunity to all persons acting under the *Act*, not only coroners and their designates.[94] However, the legislative history contains no discussion, much less mention, of extending that protection, nor of whether good-faith immunity is appropriate for physicians.[95] Interestingly, this is despite the emphasis on accountability expressed by the Minister of Community Safety and Correctional Services on second reading: "The proposed legislation … would … establish the framework needed to hold pathologists *fully accountable* for their work."[96] Also missing in the legislative history is any consideration of adding a clause that would maintain Crown liability notwithstanding *PACA*. The legislative history of section 95 of the *HPPA* is similar. That provision was originally introduced in the *Health Protection and Promotion Act, 1983*,[97] but it was not mentioned in any of the corresponding legislative debates.[98] Insofar as parliamentary debates dem-

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86 Healing Arts Radiation Protection Act, R.S.O. 1990, c. H.2, s. 26.

87 Family Responsibility and Support Arrears Enforcement Act, S.O. 1996, c. 31, s. 59.

88 Commitment to the Future of Medicare Act, 2004, S.O. 2004, c. 5, s. 3.

89 S.O. 2005, c. 11, s. 30.

90 S.O. 1991, c. 18, s. 38. Cf. *Law Society Act*, R.S.O. 1990, c. L.8, s. 9.

91 S.O. 1978, c. 38, s. 17 [*The Coroners Amendment Act*], adding s. 44a to *The Coroners Act*, S.O. 1972 c. 98.

92 First reading: Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 59 (11 May 1978) at 2394. Second reading: No. 67 (23 May 1978) at 2729-33; No. 68 (23 May 1978) at 2739-55. Committee of the Whole: No. 79 (6 June 1978) at 3176-93; No. 90 (19 June 1978) at 3620-25. Third reading: No. 90 (19 June 1978) at 3638.

93 Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 59 (11 May 1978) at 2394 (Hon. George Albert Kerr).

94 *Coroners Amendment Act, 2009*, *supra* note 9, s. 27, amending s. 53 of the *Coroners Act*, *supra* note 9.

95 Ministerial statement & first reading: Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 79 (23 October 2008) at 3537-38, 3539-40. Second reading: No. 97 (2 December 2008) at 4369-78; No. 98 (3 December 2008) at 4407-14; No. 101 (9 December 2008) at 4569-71. Standing Committee on Justice Policy: JP-12 (12 March 2009) at JP-261 - JP-281; JP-13 (26 March 2009) at JP-283 - JP-294; JP-14 (2 April 2009) at JP-295 - JP-320; JP-15 (9 April 2009) at JP-321 - JP-338. Bill reported as amended: No. 136 (20 April 2009) at 6085-86. Third reading: No. 155 (28 May 2009) at 7017-26.

96 Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 97 (2 December 2008) at 4370 (Hon. Rick Bartolucci) [emphasis added].

97 S.O. 1983, c. 10, s. 94.

98 Ministerial statement & first reading: Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, No. 68 (8 June 1982) at 2435-36, 2452. Second reading: No. 93 (29 June 1982) at 3329-45, 3349-50. Committee of the whole: No. 211 (13 February 1983) at 7599-607. Third reading: No. 211 (13 February 1983) at 7607-09.

onstrate legislative purpose and intention, it is noteworthy that the addition of these provisions for government physicians was not mentioned once in the legislature.

In combination, the ubiquity of good-faith immunity provisions in Ontario legislation and the absence of any consideration of the appropriateness of such provisions in the relevant legislative record of both the *Coroners Act* and the *HPPA* suggest that the relevant sections of those Acts may be the result of a standard drafting approach, and not of a consideration of the particular context of government physicians.

III
ARGUMENTS FOR AND AGAINST GOOD-FAITH IMMUNITY

In this part, I evaluate the role of statutory good-faith immunity. I begin by assessing the historic and current basis for its use. I then turn to the arguments against such use, drawing on analyses by the Ontario Court of Appeal and the Supreme Court of Canada in *Hill*.

A. Historic and Current Policy Rationales for Good-Faith Immunity

While Ontario is a useful case study of statutory good-faith immunity, it is not unique or even unusual. As Professors Hogg and Monahan have observed, "[m]any statutes contain immunity clauses that relieve Crown servants for liability in tort for acts done in good faith in the intended execution of their duties."[99] Here I canvass the rationales for this policy.

Personal liability was historically considered necessary because the Crown was immune, and so otherwise the victim would not be able to collect damages.[100] Thus, modern Crown liability makes personal liability unnecessary.[101] The specific rationale for Crown liability is "loss shifting or spreading … among those who benefit from its services: the taxpayers."[102] However, due to *PACA* the default effect of providing the public actor with immunity is to provide that same immunity to the Crown. Professors Hogg and Monahan describe this as "indefensible as a matter of policy, because it leaves the innocent victim without redress."[103] Indeed, they suggest that even where the scope of the immunity is framed as one of statutory interpretation, judges may engage normative policy considerations by "giv[ing] the immunity clause an artificially narrow interpretation."[104] As noted above, the *HPPA* immunity regime for MOHs is different from that of the *Coroners Act*, as under the former the government remains liable for the acts of the immune physician. On this basis, the statutory immunity provided by the *Coroners Act* is problematic from an equity perspective—the person harmed by the negligence of an MOH has recourse against the government, but the one harmed by a coroner or forensic pathologist does not.

The more enduring reasoning behind immunity for public actors is that liability may have a net negative effect on the performance of their duties:

> [A]n effective public administration is best achieved when public officials who are given discretionary functions to perform, are free from intimidation of litigation and damages for the exercise of that function.... [I]t is better to risk misperformance, albeit in good faith, due

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99 Hogg & Monahan, *supra* note 23 at 120; see also Horsman & Morley, *supra* note 23 at 5.50 (who refer to "a myriad of provincial statutes").

100 Kurt J.W. Sandstrom, "Personal and Vicarious Liability for the Wrongful Acts of Government Officials: An Approach for Liability Under the Charter of Rights and Freedoms" (1990) 24 U.B.C. L. Rev. 229 at 262; see also Hogg & Monahan, *supra* note 23 at 117.

101 *Ibid.*

102 Sandstrom, *ibid.* at 261-62.

103 Hogg & Monahan, *supra* note 23 at 120.

104 *Ibid.*, citing e.g. *Beatty v. Kozak*, [1958] S.C.R. 177. Any such covert normative analysis is not apparent in *Burns*, *supra* note 27, or *Reynolds*, *supra* note 34.

> to no threat of civil responsibility for the misperformance, than to take no action at all based on a fear of such responsibility.[105]

Note that this concern is also reflected in the common law. For example, in its recent decision on malicious prosecution, the Supreme Court emphasized the importance of deference to prosecutorial discretion:

> [P]rosecutors are vested with extensive discretion and decision-making authority to carry out their functions. Given the importance of this role to the administration of justice, courts should be very slow indeed to second-guess a prosecutor's judgment calls when assessing Crown liability for prosecutorial misconduct. *Nelles* affirmed unequivocally the public interest in setting the threshold for such liability very high, so as to deter all but the most serious claims against the prosecuting authorities, and to ensure that Crown liability is engaged in only the most exceptional circumstances.[106]

This inaction due to the fear of litigation is often termed a "chilling effect".[107] Recall that the protection under section 95 of the *HPPA* was extended to a broader class of public servants in 2007, following the recommendation of the SARS Commission.[108] It was once called "naïve" to consider civil liability necessary to prevent "malicious or negligent acts"; instead, "deterrence should be deferred to the particular institution."[109] Indeed, Professors Hogg and Monahan identify the idea "that the government's internal disciplinary procedures would be effectively employed against incompetent or over-zealous public servants" as an assumption inherent to the assertion that civil liability of the individual "is an unpredictable and usually disproportionately severe penalty."[110]

The adverse impact of tort liability on job performance, including the chilling effect, is often cited as a concern for physicians at large as well as medical professionals more generally. The potential for liability may influence a physician to do things he would not otherwise do, such as run unnecessary tests—"positive defensive medicine"—or not to do things he would normally do, such as perform a procedure that commonly attracts malpractice litigation—"negative defensive medicine".[111] The latter is a specific application of the chilling effect. The most extreme manifestation of defensive medicine, just as any other chilling effect, is to discontinue a job or not to take it in the first place. This would include a practicing physician changing specialities or retiring from the profession, or a new physician choosing against certain specialties.[112] In his report, *Liability and Compensation in Health Care*, Dean Prichard made the following finding regarding defensive medicine:

> We find some support for the allegation that civil liability claims induce "defensive medicine" but that most of the allegations are exaggerated … [C]ivil liability claims have caused some physicians to take some undue precautions in some circumstances and in some cases

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105 Sandstrom, *supra* note 100 at 259. See also 263-64.

106 *Miazga v. Kwello Estate*, 2009 SCC 51, [2009] 3 S.C.R. 339 at para. 50 [*Miazga*], quoting from *Proulx v. Quebec (Attorney General)*, 2001 SCC 66, [2001] 3 S.C.R. 9 at para. 4 [*Proulx* emphasis in *Miazga*], referring to *Nelles v. Ontario*, [1989] 2 S.C.R. 170 [*Nelles*].

107 See e.g. *Hill* (S.C.C.), *supra* note 1 at para. 56.

108 *Health Systems Improvement Act, 2007*, S.O. 2007, c. 10, Sched. F, s. 18; *Campbell Report*, *supra* note 3, vol. 5 at 19, 65-68.

109 Sandstrom, *supra* note 100 at 265. With the benefit of experience unavailable to Sandstrom in 1990, it is instead his view that would now seem naïve. See, for example, the recent revelations of years of serious incompetence by pediatric forensic pathologist Dr. Charles Smith: Coroner, "Backgrounder", *supra* note 4.

110 Hogg & Monahan, *supra* note 23 at 191, including n. 27.

111 Bernard Dickens, "The Effects of Legal Liability on Health Care Providers" in *Liability and Compensation in Health Care: A Report to the Conference of Deputy Ministers of Health* (Toronto: University of Toronto Press, 1990) app. B, vol. 2, c. 5 at 8 [Dickens, "Prichard Report"].

112 *Ibid.* at 12-13.

> to restrict unduly the scope of their practices but … factors other than civil liability also contribute substantially to those decisions.[113]

Commissioner Goudge specifically discussed the difficulty in attracting physicians to practice forensic pathology.[114] In addition to "heavy workloads" and "poor remuneration", he cited "severe public scrutiny."[115] He recommended better funding for training and fellowships, opportunities for career advancement, reduced workloads to allow for research and teaching, more consistent compensation, more full-time positions, and "state of the art" facilities and equipment.[116] Notably, he never suggested that scrutiny was unwarranted or standards should be lowered; instead, the solution was to address the other factors making the profession unattractive. This is a good example to follow for government physicians in general—if indeed the removal of good-faith liability promotes a chilling effect, it can be offset by other means.

It should be noted that the Ontario Law Reform Commission questioned the long tradition of personal immunity for Crown servants in its *Report on the Liability of the Crown*.[117] One basic criticism was that the clauses were common but exhibited inconsistency: "there is no rhyme or reason to the existing pattern of statutory immunity clauses that are currently scattered through a large number of statutes. There are occasional departures from the more standard form of the clause and the clause is inexplicably missing altogether from some statutes."[118] The Report also criticized statutory immunity from a public law perspective:

> [T]he present law governing liability of the Crown … is opposed to popular and widely-held conceptions of government … [T]he government and its officials ought to be subject to the same legal rules as private individuals … This is a notion that lies at the heart of the "rule of Law" and of "constitutionalism" … [T]he Crown requires some unique powers and immunities in order to govern effectively … a long and powerful tradition requires that the scope of such powers and immunities should be carefully defined, and should be no broader than is necessary …[119]

The Report recommended that all statutory immunity provisions be replaced with an indemnity scheme—whether in statute or in contract—which is the mechanism open to most employers and employees where there is concern of a chilling effect.[120]

B. The Rejection of Parallel Policy Rationales by the Ontario Court of Appeal and the Supreme Court of Canada

While the policy rationale for legislation is typically not the province of the courts, both the Ontario Court of Appeal and the Supreme Court of Canada recently recognized a tort of negligent investigation by police.[121] The key policy arguments opposing a duty of care owed by police to suspects parallel those opposing liability for government physicians acting in good faith. More-

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113 *Ibid.*, vol. 1 at 19.

114 Goudge Report, *supra* note 5, vol. 3 at 302-07.

115 *Ibid.*, vol. 3 at 302.

116 *Ibid.*, vol. 3 at 303-07.

117 Ontario Law Reform Commission, *Report on the Liability of the Crown* (Toronto: Queen's Printer for Ontario, 1989) [*OLRC Report*] (Not only was Professor Hogg the research director, but three commissioners are particularly noteworthy: Rosalie S. Abella, now Justice Abella of the S.C.C.; J. Robert S. Prichard, then Dean of the University of Toronto Faculty of Law, and a respected tort scholar; and Earl A. Cherniak, one of the province's leading litigators.).

118 *Ibid.* at 28 [citations omitted].

119 *Ibid.* at 2-3.

120 *Ibid.* at 27-29, 33.

121 *Hill* (S.C.C.) and *Hill* (C.A.), *supra* note 1. Note that while the S.C.C. split 6:3 on the existence of such a tort, the panel of the C.A. was unanimous on its existence and split 3:2 on whether it had been committed in the case at bar.

over, the roles of government physicians largely parallel those of police. Thus, the Courts' rejection of the arguments against a tort of negligent investigation by police provides an excellent basis for the rejection of arguments for good-faith immunity for government physicians.

In most of their duties and functions, coroners, forensic pathologists, and MOHs are similar to police. The core duties of the police include investigating possible offences and "laying charges and participating in prosecutions," as well as "preventing crimes and other offences" and "assisting victims of crime."[122] Outside those functions related to coroners' inquests, the coronial system functions as investigative agency, comparable to a police force.[123] Recall from above that coroners investigate unnatural deaths in order to establish "how … when … where … and by what means the deceased came by his or her death."[124] In doing so, coroners employ entry, search, and seizure powers.[125] The forensic pathologist, in performing any autopsy or other analysis ordered by a coroner, is an integral part of this investigative apparatus.[126] Recall that pathologists often provide oral reports to the police.[127] If the investigation reveals that the death was not due to natural causes, there is a statutory requirement that the Crown Attorney be informed.[128] Crown Attorneys are explicitly required to consider the information provided by coroners if that information may relate to criminal (or provincial) offences.[129]

In a similar manner, MOHs essentially function as the public health police with investigative and remedial powers. Recall from above that MOHs have a duty to inspect their territory, including places used for food storage or service or as boarding houses, and to investigate complaints about health hazards.[130] They have powers of entry, search, and seizure.[131] They exercise broad remedial powers to rectify health hazards that include ordering a property cleaned, closed, or vacated, or any thing destroyed.[132] Several of the matters that may be discovered in the course of an investigation constitute offences.[133] Where communicable diseases are at issue, MOHs similarly have broad remedial powers that include ordering any property closed or any person to submit to medical examination or treatment.[134]

Government physicians, as do the police, investigate offences and promote public safety—like police, often using extensive coercive powers over persons and property to do so. On this basis, the decisions in *Hill*—recognizing a tort of negligent investigation by police—can be instructively applied to government physicians. I turn now to those decisions.

At the Court of Appeal, the major argument against the duty of care was a "chilling effect" on police.[135] The core of this argument is that civil liability will discourage police from asserting their powers for fear of litigation. In his rejection of this assertion as "speculative and counterintuitive", Justice MacPherson explicitly invoked the example of medical professionals:

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122 *Police Services Act*, R.S.O. 1990, c. P. 15, s. 42(1)(b)-(c), (e).

123 I have made this argument in more detail and for a different purpose elsewhere. See Martin, *supra* note 32 at 31-33.

124 *Coroners Act*, *supra* note 9, ss. 10, 15, 31(1).

125 *Ibid.*, s. 16.

126 *Ibid.*, ss. 28-29.

127 *Rosenhek*, *supra* note 29.

128 *Coroners Act*, *supra* note 9, s. 18.1

129 *Crown Attorneys Act*, *supra* note 83, s. 11.

130 *HPPA*, *supra* note 49, ss. 10, 11.

131 *Ibid.*, ss. 19, 41.

132 *Ibid.*, ss. 13, 14.

133 *Ibid.*, s. 100 (e.g. failure to maintain and operate a food premise in accordance with the regulations, sale of diseased food or unpasteurized milk, or failure of the owner of a residential building to provide potable water and/or sanitary facilities: ss. 16-18, 20).

134 *Ibid.*, s. 22.

135 *Hill* (C.A.), *supra* note 1 at para. 53.

> [T]here are legal standards that already govern those investigations - for example, the reasonable and probable grounds standard for making an arrest.... Surgeons do not turn off the light over the operating room table because they owe a duty of care to their patients. They perform the operation, with care.[136]

As police are held to "legal standards" in the absence of tort liability, so too are physicians held to professional standards enforceable via disciplinary sanctions by the College of Physicians and Surgeons.[137] Thus, it is equivalently speculative that the same civil liability for negligence that other physicians routinely endure would influence the behaviour of government physicians in a way that professional liability does not. Related to the "chilling effect," and similarly rejected by the Court, was the "floodgates" assertion that litigation would unduly occupy the police.[138] While physicians may resent the time and effort spent defending their actions in court, near-total immunity given the low threshold of good faith is a facile and overbroad response.

In rejecting these arguments against a duty of care, the Court also recognized the positive dual role of such a duty, a role that would also apply to liability for government physicians: the need to balance police powers against the rights of those affected by the police, and the absence of an "alternative remedy".[139] The proposition that resort to the College of Physicians and Surgeons is an adequate response to erroneous harmful acts by government physicians is weakened by the characterization by Justice MacPherson: "the existence of a public complaints process that might result in the imposition of disciplinary sanctions is 'no alternative to liability in negligence.'"[140] Just as the reprimand or suspension of a police officer is no more than moral vindication for a complainant, so too is regulatory action against a government physician.[141]

The Court of Appeal held that instead of no liability, the correct response to policy concerns was "a carefully tailored standard of care";[142] thus, the Court also rejected the additional argument of the adequacy of malicious prosecution as a cause of action.[143] A standard of care incorporating "normal professional negligence" would be "not overly onerous" for police.[144] As it is the same standard of care typically applicable to physicians, it would seem similarly appropriate to government physicians. The normative argument made by Justice MacPherson was straightforward and eloquent:

> [a requirement of malice] would set the bar too high ... [T]here is another category of police misconduct that has the potential to cause serious harm to members of the public ... [T]he misconduct is anchored in very poor performance of important police duties. It is important to give some flesh and blood to this non-malicious category of police misconduct ... Should Canadian law not provide a cause of action in negligence to people [harmed by neg-

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136 *Ibid.* at para. 63.

137 It has been clearly established by the Health Professions Appeal and Review Board that coroners and pathologists as medical doctors are subject to regulation, including disciplinary action, by the College of Physicians and Surgeons of Ontario: Sossin, *Accountability and Oversight*, *supra* note 7 at 28, quoting *Between: DM (Complainant) and Charles Randal Smith, M.D. (Member Complained Against)* [2000] File #5421.

138 *Hill* (C.A.), *supra* note 1 at para. 64.

139 *Ibid.* at paras. 68-69.

140 *Ibid.* at para. 68, quoting *Odhavji Estate v. Woodhouse*, 2003 SCC 69, [2003] 3 S.C.R. 263 at para. 60, 233 D.L.R. (4th) 193.

141 See also Tracey Epps, "Regulation of Health Care Professionals" in Downie, Caulfield & Flood, eds., *Canadian Health Law and Policy*, *supra* note 6 at 75-76, contrasting discipline and civil liability with regard to compensation.

142 *Hill* (C.A.), *supra* note 1 at para. 70.

143 *Ibid.* at paras. 53, 72-81. Note that the elements of malicious prosecution established in *Nelles*, *supra* note 106, were recently re-visited in *Miazga*, *supra* note 106.

144 *Ibid.* at paras. 70-71.

> ligent police conduct]? Honest reflection about what happened to them suggests only one answer.[145]

In affirming this reasoning, Chief Justice McLachlin was more concise: "To deny a remedy in tort is, quite literally, to deny justice."[146] Justice MacPherson's reasoning on malice is similarly applicable to government physicians. Statutory good-faith immunity leaves the tort of negligence available only where there is bad faith, be it by malice or serious carelessness or recklessness.[147] There is a whole other "non-malicious category" of misconduct by government physicians that is not actionable.[148] It "has the potential to cause serious harm to members of the public" just as police negligence does.[149]

The Court of Appeal recognized key factors that would preclude liability in negligence, but held that such factors did not apply to police. The Court cited the propositions of the Supreme Court that a duty of care was less appropriate for policy reasons where the action was "in the nature of governmental or legislative policy-making" (as opposed to "operational") or "in the performance of a quasi-judicial function."[150] Note that these factors do apply to some of the functions of government physicians. For example, a major and publicly visible role of coroners is to hold inquests.[151] The role of a coroner at an inquest is quasi-judicial, as she essentially sits in place of a judge.[152] Similarly, a widespread quarantine of a whole class of persons could be a policy decision, and the CMOH's annual report "on the state of public health in Ontario" is partly of a policy nature.[153] How tort law would apply to these policy or quasi-judicial functions of government physicians will be considered further below.

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145 *Ibid.* at paras. 75, 77-78, 81.

146 *Hill* (S.C.C.), *supra* note 1 at para. 35. The extent to which tort law is an *efficient* mechanism for justice is beyond the scope of this paper. In his 1990 Report on Liability and Compensation in Health Care, Dean Prichard noted that tort was "a fundamental means of redress for injured patients" (Prichard Report, *supra* note 111, vol. 1 at 21). However, he also found that "only a modest percentage" of those injured by medical negligence, estimated at under ten percent, received such redress (*ibid.* vol. 1 at 5).

147 Note that the tort of misfeasance in public office could also be available where there is bad faith. The elements of this tort were recently re-stated by the Ontario C.A. in *Foschia v. Conseil des Écoles Catholique de Langue Française du Centre-Est*, 2009 ONCA 499 at para. 22, 266 O.A.C. 17, [2009] O.J. No. 2536 (QL). This tort requires three particular elements—"a public official who was exercising public functions", an unlawful act by that official, and an awareness by that official that the "conduct is unlawful and… is likely to injure the plaintiff." The four kinds of unlawful acts are "a breach of relevant statutory provisions, acting in excess of the powers granted to the public official, omitting to act in circumstances in which the public officer is under a legal duty to act, or acting for an improper purpose." The required awareness that he or she is doing one of these things would constitute bad faith, whether by malice, recklessness, or serious carelessness. For a recent finding of misfeasance in public office due to bad faith, see *Rosenhek*, *supra* note 29 at paras. 26-35.

148 *Hill* (C.A.), *supra* note 1 at para. 78.

149 *Ibid.* at para. 77.

150 *Hill* (C.A.), *ibid.* at paras. 67-68, citing *Cooper v. Hobart*, 2001 SCC 79, [2001] 3 S.C.R. 537 at paras. 37-38, 206 D.L.R. (4th) 193 [*Cooper*]. On the policy-operational distinction in the health care context, see also Dickens, "Legal and Ethical Obligations", *supra* note 66 at 9-11.

151 Inquests are governed by the *Coroners Act*, *supra* note 9, ss. 10, 15, 18-20, 22.1, 26-27, 30-52.

152 Among other things, the coroner determines standing (s. 41), makes any orders to maintain order (s. 47), administers oaths and affirmations (s. 49), makes orders to prevent abuse of process, limits inappropriate cross-examination, and excludes representatives the coroner finds to be incapable (s. 50). The determination of whether an inquest is necessary requires a consideration of the public interest as well as the objective issue of whether the circumstances of the death are known, and as such may also be regarded as quasi-judicial (ss. 20, 31(1)). This is reflected in the sections of the Act that came into force in December 2010, governing complaints about coroners, which specify that the decision whether to hold an inquest and how to schedule it, as well as a coroner's conduct and decisions at an inquest, cannot be the subject matter of a complaint (s. 8.4(3)).

153 *HPPA*, *supra* note 49, s. 81(4), as am. by S.O. 2004, c. 30, s. 1(2). A decision to order an individual examined, treated, and/or isolated is certainly an "operational" one, but the scale at which quarantine becomes a policy matter is an issue beyond the scope of this paper.

While Chief Justice McLachlin for the majority in the Supreme Court largely affirmed the reasoning of the Court of Appeal, she also addressed Justice Charron's dissenting argument that the proposed duty to suspects was irreconcilable with the established duty to the public.[154] The tension asserted by Justice Charron between these two duties has an equivalent for government physicians. Just as "it is always in the *interest* of individual members of society to be left alone rather than to be investigated by the police,"[155] so too is it in that interest not to be considered in the causation of a suspicious death by a coroner or pathologist, or not to be inspected or quarantined by an MOH. Thus, as Justice Charron held that "the suspect's interest is *always* at odds with the public interest,"[156] so too is it for those who are the target of the coercive powers of the coroner, pathologist, or MOH. Nonetheless, the "authority to make decisions in the public interest that are adverse to certain citizens" would not be seriously threatened if those physicians lacked good-faith statutory immunity, any more than if the police were subject to a tort of negligent investigation—only the ability to do so negligently without repercussion would be removed.[157] In this regard, Chief Justice McLachlin explained that the conflict between the interest in being left alone and the duty to the public arose because the wrong pair of elements was being weighed. The duty to the public "does not conflict with the presumed duty to take reasonable care toward the suspect … the suspect *is* a member of the public."[158] What was at issue was not "a duty to leave the citizen alone, but only a duty to investigate reasonably."[159] These comments are prescient to the liability of government physicians, as their duties to the public as a whole are consistent with, not opposed to, their duties to act without negligence toward particular members of the public.

IV
AFTER GOOD-FAITH IMMUNITY FOR GOVERNMENT PHYSICIANS: A RETURN TO THE COMMON LAW OF TORT

I have discussed above how statutory good-faith immunity is inconsistent with the requirement that coroners, forensic pathologists, and MOHs be licensed physicians. It is inequitable that government physicians are held to a legislated standard of care that is lower than that required of all other physicians by the common law. However, the abolition of this statutory good-faith immunity would not mean that all harm done by government physicians would lead to liability in negligence. The equality that would result is the equal application of the common law of tort, not an equality of outcome. Potentially tortious conduct by government physicians and other physicians would both be judged according to the evolving common-law principles of tort. For example, as discussed above the role of a coroner in relations to inquests is a quasi-judicial function that would not incur liability in negligence.[160] In this section, I discuss how the law of negligence would apply to government physicians if statutory good-faith immunity were removed.

In the absence of statutory good-faith immunity, there will nonetheless be no liability where there is insufficient proximity to the harmed individual. The Ontario Court of Appeal has held that the high-level prevention of disease and promotion of health is a duty to the public at large and not to any particular member of the population. However, this does not preclude all tort liability in the public health sphere.

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154 *Hill*, *supra* note 1.

155 *Ibid.* at para. 140 [emphasis in original].

156 *Ibid.* at para. 131 [emphasis in original]. In the long term, forced examination and treatment may well be in the individual's interest; however, it certainly conflicts with autonomy.

157 *Ibid.* at para. 140.

158 *Ibid.* at para. 41 [emphasis added].

159 *Ibid.* at para. 42.

160 See *supra* notes 151, 152.

Justice Sharpe applied this private duty versus public duty distinction in the West Nile Virus case of *Eliopoulos v. Ontario (Minister of Health & Long Term Care)*[161] and in the SARS cases. In *Eliopoulos*, a negligence claim against the Ontario government for contracting the virus from a mosquito bite was struck as disclosing no cause of action.[162] Justice Sharpe held that the plaintiffs failed at the first stage of the *Anns/Cooper* test for a government's private duty of care, that of foreseeabilty and proximity—even if forseeabilty was assumed, there was no proximity.[163] The statute created a public law duty but not a private duty:

> [T]hese important and extensive statutory provisions create discretionary powers that are not capable of creating a private law duty … They are not aimed at or geared to the protection of the private interests of specific individuals. From the statement of purpose in s. 2 and by implication from the overall scheme of the *HPPA*, no doubt there is a general public law duty that requires the Minister to endeavour to promote, safeguard, and protect the health of Ontario residents and prevent the spread of infectious diseases. However, a general public law duty of that nature does not give rise to a private law duty sufficient to ground an action in negligence.[164]

Justice Sharpe also observed that the plaintiffs would have failed at the second stage of the *Anns/Cooper* test, i.e. that residual policy considerations made a private duty problematic.[165] He emphasized the importance of policy discretion at the macro level and implicitly invoked chilling-effect concerns:

> [T]o impose a private law duty of care … would create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health. Public health priorities should be based on the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits.[166]

Justice Sharpe similarly rejected the claims in the SARS cases.[167] In *Abarquez* he stated: "[W]hile Ontario is obliged to protect the public at large from the spread of communicable diseases such as West Nile Virus and SARS, Ontario does not owe … individual residents of the province who contract such diseases a private law duty of care giving rise [to] claims for damages."[168] From these cases, it is clear there is no private duty of care owed by the government to formulate its policies or determine its priorities so as to prevent the infection of specific members of the public.

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[161] (2006), 82 O.R. (3d) 321 at paras. 1-3, 276 D.L.R. (4th) 411 (C.A.) [*Eliopoulos*], leave to appeal refused, [2006] S.C.C.A. No. 514. Given that there was "no allegation of bad faith, misfeasance, or irrationality" (para. 5), it is not surprising that the action did not name the CMOH as a defendant.

[162] *Ibid.* at paras. 1-3.

[163] *Ibid.* at para. 9; *Cooper*, *supra* note 150, adopting *Anns v. Merton London Borough Council*, [1978] A.C. 728 (H.L.).

[164] *Eliopoulos, ibid.* at para. 17, referring to *HPPA*, *supra* note 49.

[165] *Ibid.* at paras. 31-33.

[166] *Ibid.* at para. 33.

[167] *Williams*, *supra* note 66 at paras. 28-31; *Laroza Estate*, *supra* note 66 at para. 6; *Henry Estate*, *supra* note 66 at para. 7; *Jamal Estate*, *supra* note 66 at para. 11; *Abarquez*, *supra* note 66 at para. 20.

[168] *Abarquez*, *supra* note 66 at para. 20.

However, this does not preclude liability where government physicians are negligent in their interactions with specific members of the public. In *Williams*, Justice Sharpe referred to potential negligence on the part of practicing physicians:

> [T]his result does not leave the plaintiff without a remedy if she can show that she suffered harm as a result of negligence at the operational level on the part of those responsible for the application and enforcement of the Directives; namely, health care facilities and health care professionals.[169]

In a similar manner, the improper exercise of powers of treatment or quarantine, or the failure to exercise those powers, could constitute negligence by an MOH.[170] Similarly, a coroner that negligently investigates a particular death such that the wrong person is charged or even convicted—or a pathologist that negligently conducts an autopsy to the same effect—could be liable to that person.[171]

Indeed, Justice Sharpe's subsequent decision in *Heaslip Estate v. Mansfield Ski Club Inc.* confirms that the calculus of negligence changes once a particular individual comes to the attention of the arms of the state.[172] *Heaslip Estate* involved the unavailability of an air ambulance to transfer a patient, and the allegation that the province failed to follow its policy for air ambulance allocation.[173] The motion judge struck out the claim against the province, applying *Eliopolous* in finding only a public duty and not a private duty; likewise, policy considerations, including a potential "chilling effect", would have gone against finding a duty.[174] Justice Sharpe, in overturning that decision, cited *Attis v. Canada (Minister of Health)* for the proposition that "once the government has direct communication or interaction with the individual in the operation or implementation of a policy, a duty of care may arise, particularly where the safety of the individual is at risk".[175] Thus, an MOH that becomes aware of a specific individual that could require quarantine, examination, or treatment, and negligently determines which steps are necessary or negligently enforces those steps, is in an analogous position.

These cases are consistent with the recognition of the Court of Appeal in *Hill* that policy-making and quasi-judicial functions are generally protected from liability in negligence.[176] High-level governmental decisions made regarding the general protection of the public against communicable diseases would likely not create a private duty of care.[177] However, that still leaves negligence applicable to a substantial range of operational performance regarding the exercise of statutory powers in the case of specific individuals.

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169 *Williams*, *supra* note 66 at para. 36.

170 Perell J.'s decision in *Lakeridge*, *supra* note 74, suggests there would be no liability to persons merely exposed, but not infected, by that negligence.

171 The Ontario C.A. has held that whether common-law witness immunity covers only the testimony of a pathologist, as opposed to the autopsy and the provision of an oral opinion to the police, must be considered on the specific facts (*Reynolds*, *supra* note 34 at para. 24). Thus, the effect of witness immunity on a negligence claim in the absence of statutory immunity remains to be seen.

172 2009 ONCA 594, 96 O.R. (3d) 401, 252 O.A.C. 1 [*Heaslip Estate*].

173 *Ibid.* at para. 17.

174 *Ibid.* at paras. 13-14.

175 *Ibid.* at para. 21, citing *Attis v. Canada (Minister of Health)*, 2008 ONCA 660, 93 O.R. (3d) 35, 300 D.L.R. (4th) 415 at para. 66, leave to appeal refused, [2008] S.C.C.A. No. 491.

176 *Hill* (C.A.), *supra* note 1.

177 See *Just v. British Columbia*, [1989] 2 S.C.R. 1228, 64 D.L.R. (4th) 689 [*Just*]. Justice Sharpe cited *Just* in *Heaslip Estate*, *supra* note 172 at para. 21 for the following: "The duty of care alleged here belongs within the established category of a public authority's negligent failure to act in accordance with an established policy where it is reasonably foreseeable that failure to do so will cause physical harm to the plaintiff".

CONCLUSION: AN INEQUITABLE DENIAL OF JUSTICE

Statutory good-faith immunity for coroners, pathologists, and MOHs is ultimately an inequitable denial of justice. The justice provided by tort law should be available to those harmed by any negligent physician.[178] Government physicians are required by statute to hold valid medical licences. The same statutes grant them extensive investigative and coercive powers and so create the potential for extensive harm. Nonetheless, they negate the common law competence standard of care for physicians with a good-faith requirement for civil immunity. This statutory good-faith immunity is common for government employees, and there is no evidence that its appropriateness in the special context of government physicians was actively considered during the legislative process. The reasoning of the Ontario Court of Appeal and the Supreme Court of Canada in recognizing a tort of negligent investigation by police suggests that liability in negligence is appropriate where a government employee exerts investigative and coercive powers over the individual. In particular, a disciplinary process is no substitute for civil liability, and speculation regarding a chilling effect should be given little weight. Moreover, there is no conflict of duties in the exercise of powers over the individual in the interests of the general public—the public is made up of such individuals.

There are two levels of changes that would address this inequity. At a minimum, governments should remove the distinction between those harmed by MOHs and those harmed by coroners or forensic pathologists. This would involve amending the immunity provision in the *Coroners Act* so that the government remains liable despite the physicians' personal immunity. The next level of action would be to remove good-faith immunity provisions from statutes governing government physicians. If the government remains concerned about the potential chilling effect, it could offset it by other means such as those suggested by Commissioner Goudge—better training, compensation, facilities, or equipment. It could also adopt an employer-employee indemnity provision as suggested by the *OLRC Report*—whether in statute or contract.[179]

The revocation of statutory good-faith immunity would restore the application of the common law of tort.[180] There would be no liability where there is only a duty to the public at large (such as in outbreaks of contagious diseases), or in policy or quasi-judicial matters (such as a coroners' inquest). However, the duties and functions directed toward specific individuals—particularly decisions concerning coercive quarantine, examination or treatment, or involvement in suspicious deaths—could give rise to liability.

The Naylor Report, the SARS Commission, and the Goudge Report each made valuable recommendations to reduce or prevent future harm in death investigation and public health. In their wake, it would be valuable to recognize the state's responsibility when such harm nonetheless occurs, by restoring Crown liability for the tortious conduct of coroners and pathologists. Doing so could indeed improve the quality of death investigation and public health services. Ending the Crown's *PACA*-created immunity under the *Coroners Act* would tend to improve the quality of death investigation, as it would no longer be in the state's financial interest to dedicate insufficient resources to the hiring, training, and supervision of the physicians involved. If the

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178 See *supra* note 146.

179 Indeed, McLachlin C.J.C. in *Hill*, *supra* note 1 at para. 59 recognized that such indemnity was common in the police context and would reduce the impact of any chilling effect: "[M]any police officers (like other professionals) are indemnified from personal civil liability in the course of exercising their professional duties, reducing the prospect that their fear of civil liability will chill crime prevention." See e.g. *Police Services Act*, *supra* note 122, s. 50. Also see *OLRC Report*, *supra* note 117.

180 To keep statutory immunity but add a further element of "reasonable grounds" or "gross negligence" would be a weak reform. Such standards may be appropriate when the government is imposing requirements on all physicians regardless of their expertise, but not where the government is hiring and empowering its own physicians on the basis of such expertise.

government went further and abolished good-faith immunity for government physicians, tort liability might play the same quality-enhancing role it does in health care.

In closing, it must be noted that there is nothing forcing the government to act. Statutory good-faith immunity provisions are certainly not unlawful. The majority of the Supreme Court held in 1994 that the legislative choice to limit Crown liability was to be addressed, if at all, at the ballot box: "If the Crown wishes to exempt itself from tortious liability … it is a simple matter to legislate to that effect, and to leave the propriety of that legislative action for the voters' consideration."[181] The core arguments for change are based on justice and equity. I adopt the observation of the *OLRC Report*—"the answer to the question why the government should relinquish many of the advantages that it now enjoys is very simple, yet compelling. It is the right and fair thing for good government to do."[182]

[181] *Swinamer v. Nova Scotia (Attorney General)*, [1994] 1 S.C.R. 445 at 461, 112 D.L.R. (4th) 18, Cory J. (Note that McLachlin J. [as she then was] did not sign on to the majority judgment, but instead wrote a short concurring opinion at 449-50. It is difficult to infer from her reasons whether she agreed with the quoted statement of Cory J. at that time.). An extended version of this passage is quoted in Horsman & Morley, *supra* note 23 at 5.50.10.

[182] *Supra* note 117 at 6.

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