# Surrogacy Arrangements in Ontario

## Guidance for Hospitals, Second Edition
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ONTARIO HOSPITAL ASSOCIATION

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# Disclaimer

This resource document was prepared as a general guide to assist hospitals and health care providers in understanding legislation relating to surrogacy arrangements. The material in this resource document is for general information only and may need to be adapted by hospitals and health care providers to accommodate their unique circumstances. This document reflects the interpretations and recommendations regarded as valid at the time of publication based on available information. It is not intended as, nor should it be construed as, legal or professional advice or opinion. Hospitals and individuals concerned about the applicability of the materials are advised to seek legal or professional counsel. The OHA will not be held responsible or liable for any harm, damage, or other losses resulting from reliance on, or the use or misuse of the general information contained in this resource guide.

# Table of Contents

# Foreword

The first edition of this guidance document was released in December 2015. Almost a year later, the Ontario government passed the *All Families Are Equal Act, 2016* – legislation which introduced significant changes to the determination of parentage, including in surrogacy cases.

The second edition of this guidance document incorporates an overview of these legislative changes, together with their potential impact on clinical care and hospital management of surrogacy cases. The most substantial changes in the second edition are to the discussion of decision-making for children born of surrogacy arrangements, particularly with respect to substitute decision-making and parental rights and responsibilities. A number of new complexities have been introduced based on the number of intended parents who may be involved, and the effect of the surrogacy agreement on relationships between parties, including the hospital. Birth registration processes have also changed substantially following the passage of the new legislation, with more guidance available to assist intended parents.

Additionally, the second edition clarifies issues around public health insurance coverage, an especially important operational aspect of surrogacy cases.

In Part 2 of this edition, the fictional scenario has also been updated to account for the potential social reality of the new legislation, such as the involvement of four intended parents. The scenario explores the complexities of the new legislation, to facilitate understanding and compliance.

A new Part 3, a Surrogacy Process Checklist, has been added to this edition. This checklist has been prepared to assist hospitals and clinicians in determining the relevant legal requirements and processes that should be considered in the context of managing surrogacy pregnancies and births.

It is hoped that this resource will provide practical and timely guidance to assist clinicians and hospitals as they navigate ongoing and emerging challenges in the surrogacy context.

# Introduction

## Overview and Key Terms

**Surrogacy** is an arrangement where an individual (the **surrogate**) carries an embryo or fetus that was conceived by means of an assisted reproduction procedure, with the intention of surrendering the child (or children) at birth (or shortly thereafter) to another person (or people) – the **intended parent(s)** (sometimes called the commissioning parents or the rearing parents).[1]

A child born through a surrogacy arrangement has genes derived from one or more donors of reproductive material, and may or may not be related genetically to the surrogate:

- In a **gestational surrogacy** situation, the surrogate is implanted with embryos that bear no genetic relationship to her, which have usually been created from gametes provided by the intended parent(s).

- In a **genetic (or "traditional") surrogacy** situation, a child is conceived through artificial insemination of the surrogate. The surrogate will bear a genetic connection to the child.

In these guidance materials, the term "**surrogacy**" refers to both gestational surrogacy and genetic (or "traditional") surrogacy.

The term "**clinician**" is used throughout these guidance materials to refer to individuals providing care and treatment to patients in a hospital setting, including employees of the hospital, and those to whom the hospital board has granted practice privileges (for example, physicians, registered nurses in the extended class, and midwives).

## Purpose of these Guidance Materials

Surrogacy arrangements may involve a myriad of clinical, legal, financial and ethical issues in the hospital setting. These guidance materials are intended to help hospital clinicians and administrators navigate some of the complexities around surrogacy arrangements, and to assist them in developing internal practices and policies to guide clinical and operational decision-making. The ethical considerations that may arise in surrogacy arrangements have informed the overall content; however, a detailed examination of these concerns is beyond the scope of these materials.

**Part 1** provides an overview of the legal landscape for surrogacy issues in Canada, from the perspective of hospital-based practice. It outlines the relevant legal considerations and processes that hospital clinicians and administrators should take into account as they manage surrogacy pregnancies and births.

**Part 2** presents a series of case scenarios (based on a fictional account of a surrogate and intended parents) together with guidance around leading practices for some of the most common and most challenging surrogacy issues. It also addresses strategies, from an inter-professional perspective, to effectively accommodate surrogacy arrangements.

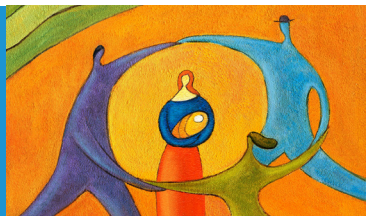
**Part 3** contains a Surrogacy Process Checklist to assist hospitals and clinicians in managing legal requirements and relationships between the parties involved.

**Part 4** contains a list of helpful tools and resources for further guidance on surrogacy issues.

**Part 5** contains an appendix with excerpts of applicable legislation.

1 *Assisted Human Reproduction Act* (S.C. 2004, c. 2), section 3

# Part 1: The Legal Landscape



## A. The General Legal Framework for Surrogacy Arrangements in Canada

This section examines the legal framework underlying surrogacy arrangements in Canada, and in particular, discusses provincial and federal legislation regulating surrogacy-related practices.

### Federal Legislation

The *Assisted Human Reproduction Act*[2] (AHRA) is the principal piece of federal legislation governing surrogacy arrangements in Canada.

By creating general prohibitions on certain conduct, the AHRA regulates how private arrangements between surrogates and intended parent(s) may be structured. For example, the AHRA specifies that:

- **No person may perform a medical procedure to assist an individual under the age of 21 to become a surrogate**: no one may counsel, induce or perform any medical services to assist an individual to become a surrogate, knowing or having reason to believe that the female person is under 21 years of age.[3]

- **Commercial surrogacy is prohibited**: an individual may not be paid (or otherwise remunerated) to be a surrogate.[4] Despite this general prohibition on commercial surrogacy, the AHRA provides legislative authority to regulate the reimbursement of a surrogate's pregnancy-related expenditures."[5]

- **Arranging and advertising commercial surrogacy services is also prohibited**: no one may accept payment (or other remuneration) for arranging for the services of a surrogate; and no one may advertise for commercial (paid) surrogacy services.[6]

- **The validity of surrogacy arrangements is a matter of provincial law**: a surrogacy agreement must follow the laws of the province where the agreement is signed.[7] In Ontario, the substance of a surrogacy agreement cannot be enforced in court; however, the agreement can be used as evidence of the intentions of the parties with respect to the parentage of children born through a surrogacy arrangement.[8]

While the AHRA sets the general parameters for surrogacy arrangements, it does not provide specific guidance to hospitals for managing surrogacy pregnancies and births. This is likely because the primary issues for clinicians and hospitals managing surrogacy cases relate to consent to treatment and parentage, which are issues addressed in

2 *Assisted Human Reproduction Act* (S.C. 2004, c. 2) (AHRA)

3 AHRA, section 6(4)

4 AHRA, section 6(2)

5 Section 12 of the AHRA specifies that a surrogate may receive reimbursement in accordance with the Regulations (which underwent public consultation in July-September 2017) for an "expenditure incurred in relation to her pregnancy" – this may include certain out-of-pocket expenses. For further information on reimbursements related to surrogacy pregnancies, review the Health Canada Info Sheet "Prohibitions Related to Surrogacy" (July2013)

6 AHRA, section 6(2)

7 AHRA, section 6(5)

8 *Children's Law Reform Act*, R.S.O. 1990, c. C.12, section 10(9) (CLRA)

provincial laws. However, in developing their own surrogacy-related policies, hospitals might want to take into account some or all of the following guiding principles of the AHRA:[9]

- The health and well-being of children born through the application of assisted human reproductive technologies must be given priority in all decisions respecting their use;
- The health, safety, dignity and rights of those who use assisted human reproductive technologies must be effectively promoted and secured;
- Persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status; and
- Human individuality and diversity, and the integrity of the human genome, must be preserved and protected.

Other legal issues related to surrogacy arrangements are governed by provincial law, as further described below.

## Provincial Legislation

In Ontario, provincial legislation plays a significant role in governing surrogacy arrangements and the determination of parentage.

In November 2016, the provincial government passed the *All Families Are Equal Act* [10] (AFEA). This legislation amended the *Children's Law Reform Act* [11] (CLRA), the *Vital Statistics Act* [12] (VSA), and a number of other provincial statutes – with the stated aim of "ensuring that the legal status of parents is recognized clearly and equitably, whether they are LGBTQ2+ or straight, and whether their children were conceived with or without assistance."[13]

**Amendments to the CLRA (through the passage of the AFEA) resulted in a number of changes to the laws around parentage generally, and established a specific regime for determining parentage for children born through a surrogacy arrangement.**

The CLRA now sets out the criteria that a surrogacy agreement must meet in order to attract the provisions on parentage in surrogacy birth situations. For ease of reference, a surrogacy agreement that meets the criteria outlined in the CLRA will be referred to as a "valid" surrogacy agreement in these guidance materials. See **Part 5** for an excerpt of the relevant legislative provisions.

As further described in **Part B** below, amendments to the CLRA also created a framework for the surrogate's consent to relinquish parentage of a child (including related issues around parental rights and responsibilities, as explained below); and outlined the circumstances in which joint decision-making between the surrogate and the intended parent(s) would be required.

Other surrogacy-related legal issues governed by provincial law include: the hospital's relationship with the parties involved, registration of births, public health care coverage, and health information privacy and confidentiality concerns. For further information on these issues, see **Parts B and C** below.

> **NOTE:** Although there may be inter-provincial (Canadian) or inter-jurisdictional (international) aspects to some surrogacy arrangements, Ontario and/or Canadian law still regulates surrogacy births in the province in these situations. For further guidance on key considerations relating to non-resident parties, see **Part D** below.

9 AHRA, section 2

10 *All Families Are Equal Act (Parentage and Related Registrations Statute Law Amendment)*, 2016, S.O. 2016, c. 23 (AFEA)

11 CLRA

12 *Vital Statistics Act*, R.S.O. 1990, c. V.4

13 News Release, "Ontario Passes Law Ensuring Equal Recognition for All Parents and Children" (November 2016)

## B. The Hospital's Relationship to the Surrogate Mother and the Intended Parent(s)

This section addresses the hospital's relationship to the parties involved in the surrogacy arrangement – namely the surrogate and the intended parent(s). It is intended to provide a general overview of the relevant considerations for managing clinical care and decision-making. If one or more of the parties to the surrogacy arrangement do not reside in Canada, there may be additional issues to consider. For an overview of these issues, refer to **Part D** below.

### i. Defining the Patient Relationship: the *Public Hospitals Act*

Surrogacy pregnancies and births may present some challenges in defining the clinical care relationship, and in particular, in understanding to whom a clinician's treatment obligations are owed.

The *Public Hospitals Act* [14] (PHA) defines who is considered to be a "patient" for the purposes of treatment at a hospital. Section 20 provides that a hospital must accept a person as a patient if:

(a) The person has been admitted to the hospital pursuant to the regulations; and

(b) The person requires the level or type of hospital care for which the hospital is approved by the regulations.

Regulation 965 under the PHA[15] provides that an individual may only be admitted to a hospital when a specified regulated health professional makes an order to do so, on the basis that the admission is clinically necessary.

Section 21 of the PHA allows hospitals to refuse to admit as a patient any individual who is not a resident or a dependent of a resident of Ontario (unless life would be endangered by the refusal).

For the purpose of surrogacy arrangements, according to the PHA, only the surrogate and the child (or children) born to the surrogate are considered to be patients of the hospital.

Although other individuals (including the intended parent(s) and/or the partner of the surrogate) may have an important role to play throughout pregnancy and childbirth, ultimately, the hospital's central treating obligation is only to those who are considered patients.

This means that clinicians should discuss choices about pregnancy, labour and delivery with the surrogate, and seek her consent for treatment. Medical care should be provided in her best interests. The surrogate retains decision-making authority over all aspects of her own medical care, including in relation to the gestating fetus. Following the birth of the child or children, parentage rights are generally shared equally between the surrogate and the intended parents until the child is seven days old, unless otherwise specified in a valid surrogacy agreement.[16] This issue is further discussed in **Part (ii) below**.

### ii. Decision-Making for the Child Born of a Surrogacy Arrangement

**General guidance on the legislative framework for decision-making for care and treatment**

a) The application of the *Health Care Consent Act, 1996*

In Ontario, the *Health Care Consent Act*, 1996[17] (HCCA) governs patient consent for all health care treatment. The HCCA requires that a clinician obtain informed consent before administering treatment. A clinician may rely on a presumption of capacity for consent to treatment, unless

14 *Public Hospitals Act*, R.S.O. 1990, c. P.40

15 R.R.O. 1990, Regulation 965 ("Hospital Management Regulation")

16 HIROC Risk Note, "Surrogacy – Practical Considerations (Ontario)" September 2017. Note that the situation differs when there are more than four intended parents, as described in part (b) below

17 *Health Care Consent Act*, 1996, SO 1996, c 2, Sch A (HCCA)

there are reasonable grounds to believe that the person is incapable with respect to the treatment.[18]

The presumption of capacity applies to all persons, regardless of age. Given the lack of maturity, if the patient is an infant, there are "reasonable grounds" to believe that the infant is incapable with respect to the treatment(s) being proposed. When a patient is deemed incapable of making a treatment decision, a substitute decision-maker (SDM) may give consent on that person's behalf.[19]

A hierarchy for substitute decision-making is set out in the HCCA.[20] This hierarchy sets out an order of who is most "highly ranked" (or best placed) to make treatment decisions on behalf of an incapable person as follows:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.

2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.

3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.

4. The incapable person's spouse or partner.

5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent. (emphasis added)

6. A parent of the incapable person who has only a right of access.

7. A brother or sister of the incapable person.

8. Any other relative of the incapable person.

It is highly unlikely that the infant born of a surrogacy arrangement will have a SDM that fits into one of #1-4 above. The highest ranking SDM is therefore almost certainly going to be a "parent" of the child.

While the HCCA sets out the general parameters for substitute decision-making in Ontario, the CLRA provides additional specific requirements that account for: (1) the passage of time since the child's birth, and (2) the number of intended parents involved as parties to the surrogacy agreement. These requirements are further described below.

b) The application of the *Children's Law Reform Act*

Through the passage of the AFEA, the CLRA now sets out important parameters for decision-making related to children born through surrogacy arrangements. The passage of time since the child's birth is a significant consideration.

Where a valid surrogacy agreement is in place,[21] the CLRA provides formal recognition for the surrogate and intended parent(s) to share in the rights and responsibilities of parentage from the time of the child's birth until the child is seven days old.[22]

These rights and responsibilities may include making health care decisions on behalf of the child (i.e. shared substitute decision-making authority), given that a "parent" of the incapable infant is a ranking SDM under the HCCA.

18 HCCA, section 4(2) and 4(3)

19 HCCA, section 20

20 See sections 20-24 of the HCCA

21 See section 10(2) CLRA for the requirements of a valid surrogacy agreement. Relevant excerpts are provided in Appendix A

22 CLRA, sections 10(4) and 10(5)

Following the passage of seven days, status as a "parent" (i.e. who has substitute decision-making authority) may change, contingent on the surrogate formally relinquishing her entitlement to parentage.

**IMPORTANT:** The computation of time is determined by the *Legislation Act*[23] and the term "days" has a specific meaning. In this particular context, the counting of "days" excludes the day on which the child is born. For example, assuming a child is born on Monday, January 1, the computation of seven days begins on Tuesday, January 2 with each day (including weekends) being counted as one day. Accordingly, the child would be seven "days" old on Monday, January 8.

The number of intended parents who are parties to the surrogacy agreement is another important factor. Where there are four or fewer intended parents and a valid surrogacy agreement is in place, the CLRA allows for recognition of parentage without the need for a court order, after the passage of seven days. In situations where there are five or more intended parents, different decision-making considerations apply. The parties to the surrogacy agreement are required to apply to court for a declaration of parentage. The surrogate and the intended parents must share the rights and responsibilities of parentage until the court makes the declaration.[24] The surrogacy agreement can be considered as evidence of an intended parent's intention to be a parent of the child contemplated by the agreement. [25]

**Additionally, it is critical to note that the parties to the surrogacy agreement may depart from some of the legal requirements in the CLRA through their written surrogacy agreement, for the period covering the first seven days of the child's life.**[26]

For further information on the role of the surrogacy agreement, see section (iii) below.

Application to surrogacy arrangements in hospitals – practical considerations

a) Identification of the appropriate SDM

At an early stage in managing a pregnancy, clinicians should identify the most appropriate SDM(s) for the child based on a contextual assessment of the legal requirements, and may wish to consider the factors outlined below.

As indicated above in the HCCA framework, a child's parent(s) may give consent to treatment on behalf of a child. Ontario legislation (namely the *Vital Statistics Act* and the CLRA) recognizes the birth parent (i.e. the surrogate) as a parent of the child, irrespective of whether she has a genetic relationship to the child.[27] Accordingly, the surrogate is legally considered to be one of the SDMs for the child, subject to the additional considerations set out below. The surrogate's consent should be sought for issues relating to the care and treatment of the child immediately following birth (including newborn access and feeding). Other SDMs for the child may vary, depending on the particulars of the surrogacy agreement, and usually include one or more of the intended parents.

*Circumstances where there are four or fewer intended parents:*

Where the parties have a valid surrogacy agreement in place,[28] in circumstances where there are four or fewer intended parents, the surrogate and the intended parents share equally in substitute decision-making authority, from

23 *Legislation Act*, S.O. 2006, c. 21, Sched. F, section 89(3)

24 CLRA, section 11(3)

25 CLRA, section 10(9)

26 CLRA, section 10(5)

27 *Vital Statistics Act*, R.S.O. 1990, c. V.4 (section 1, definition of "birth") and *Children's Law Reform Act*, R.S.O. 1990, c. C.12, where section 6(1) states that the "birth parent" of a child shall be recognized in law to be a parent of the child, subject to any relinquishment of parentage by the surrogate

28 See section (iii) for further guidance on the role of the surrogacy agreement

the time of the child's birth until the child is seven days old.[29]

After the passage of seven days, the surrogate may relinquish in writing her entitlement to parentage, and the intended parents become SDMs. The intended parents automatically become recognized in law as parents (and SDMs) of the child, without the need for further court action. If the surrogate refuses to relinquish parentage after seven days, or is otherwise unable to do so, any party to the surrogacy agreement may apply to the court for a declaration of parentage.[30]

**It is important for hospitals and clinicians to recognize these complexities related to substitute decision-making authority, and to be mindful of the passage of time to ensure that they identify and consult the appropriate individuals in any decisions relating to the care and treatment of the child.**

The parties may also stipulate in their surrogacy agreement that a different arrangement of parental rights and responsibilities will apply during the first seven days of the child's life.[31] For example, the surrogacy agreement may provide that the intended parents assume all parental rights and responsibilities (such as substitute decision-making authority) from the moment of the child's birth. In this situation, as discussed in section (iii) below, clinicians may wish to confirm that the surrogate has consented to this decision-making arrangement.

Notably, the surrogate cannot consent to relinquish her legal status as a parent before the child is seven days old. This means that she remains the child's legal guardian, with attendant rights and responsibilities, until that status is formally relinquished. Also note that any provision of the surrogacy agreement respecting parental rights and responsibilities has no effect after the passage of seven days.[32] This means that the parties cannot rely on the surrogacy agreement to enforce parental rights and responsibilities after the first seven days of the child's life.

**Chart A** (page 9) provides an outline of relevant decision-making considerations, informed by the CLRA, where there are four or fewer intended parents.

*Circumstances where there are five or more intended parents:*

With a valid surrogacy agreement in place, in circumstances where there are five or more intended parents, the surrogate and the intended parents must apply to court for a declaration of parentage. This declaration of parentage cannot be made until the child is born, and requires that the surrogate consent in writing to relinquish her entitlement to parentage of the child.[33]

From the time of the child's birth until the court makes a declaration of parentage, the surrogate and the intended parents are all considered parents and therefore will be equally-ranking SDMs under the HCCA. In these rare circumstances, clinicians may need to involve at least six individuals (the surrogate and at least five intended parents) in decision-making related to the child's care and treatment. Given the number of people that may be involved, clinicians may wish to consult legal counsel for situation-specific advice, as appropriate.

**NOTE:** It is also open to parties in these circumstances to stipulate that a different arrangement of parental rights and responsibilities will apply until the court makes a declaration of parentage.[34] For example, the surrogacy agreement may provide that the intended parents assume rights and responsibilities as parents (including substitute decision-making authority) from the moment of the child's birth, before a legal declaration of parentage is made. In this situation, as discussed in section (iii) below, clinicians may wish to confirm that the surrogate has consented to this arrangement.

29 CLRA, section 10(5). See section (iii) below for further guidance on the role of the surrogacy agreement

30 CLRA, section 10(6). See part (b) below for further guidance on situations where the surrogate mother refuses to relinquish parentage status after the passage of seven days

31 CLRA, section 10(5)

32 CLRA, section 10(5)

33 CLRA, sections 11(1) and 11(5). Note that a court may dispense with the requirement of the surrogate's consent, if the applicable circumstances are met (see CLRA, section 11(6))

34 CLRA, section 11(3)

**Chart B** (page 10) provides an outline of relevant decision-making considerations informed, by the CLRA, where there are five or more intended parents.

b) Other relevant considerations for substitute decision-making

In the absence of a parent being an SDM, any other relative of the child will probably be the next ranking SDM. A relative is defined in the HCCA as someone who is "related by blood, marriage or adoption."[35]

All SDMs must make care and treatment decisions that are in the best interests of the child. The HCCA outlines the relevant considerations for determining what constitutes best interests, including consideration of potential treatment outcomes, benefits and risks of the treatment, and whether a less restrictive or less intrusive treatment is available.[36]

The HCCA also requires that the SDM be capable, available and willing to assume the responsibility of giving or refusing consent on behalf of the child.[37] As discussed above, the SDMs for decisions related to the care and treatment of the child may vary, depending on the circumstances of each particular surrogacy arrangement.

In some situations, the surrogate may indicate that she is unwilling to give or refuse consent to treatment on behalf of the child. If so, the other equally-ranked SDM(s) (typically one or more intended parents) will continue to have substitute decision-making authority, and can provide consent for treatment decisions on behalf of the child, without the surrogate participating. Clinicians may wish to document discussions around consent and treatment, including any SDM choosing not to participate, in the medical records of the surrogate and/or the child.

In rare cases, the surrogate mother may refuse to relinquish her entitlement to parentage after the passage of seven days. In these situations, the surrogate mother retains her legal status as a parent of the child (and as SDM), to the exclusion of the intended parents, until the court makes a determination regarding the parentage status of the surrogate mother and the intended parents.

Managing relationships between appropriate SDMs in a surrogacy situation may be challenging, given the number of parties involved and the complexity of the legislation in this area.[38] There may be potential for conflict between the various individuals who are considered to be the child's parents. In some circumstances of conflict between SDMs, it may be appropriate to involve the Public Guardian and Trustee of Ontario and/or apply to the Consent and Capacity Board for a hearing.[39]

In situations of potential or actual disagreement between the parties regarding substitute decision-making and/or the child's medical treatment, hospitals and clinicians may wish to consult legal counsel for situation-specific advice, as appropriate.

Hospitals and clinicians may wish to review the **Surrogacy Process Checklist** in **Part 3** of these guidance materials to further understand relevant legal requirements and processes.

Resources on conflict resolution strategies are provided in **Part 4** of these materials.

35 HCCA, section 20(10)

36 HCCA, section 21(1) and (2)

37 HCCA, section 20(2). See section 20(2) for other factors that affect the requirements for substitute decision-making

38 For example, additional considerations for ascertaining the appropriate SDM might also apply from the rules for establishing paternity in the CLRA

39 For example, see section 20(6) of the HCCA, which outlines when the Public Guardian and Trustee may become involved in substitute decision-making

## CHART A: Substitute Decision-Making for Children Born of A Surrogacy Arrangement Relevant Considerations Where There Are Four or Fewer Intended Parents

This chart is intended to assist hospitals and clinicians in determining the relevant considerations for substitute decision-making for children born of a surrogacy arrangement with a valid surrogacy agreement in place. It does not represent an exhaustive outline of all applicable legal and clinical issues.

| | Fewer than seven days have passed since the birth of the child | More than seven days have passed since the birth of the child |
|---|---|---|
| Issue | Considerations | Considerations |
| Legal parentage status | The surrogate cannot consent to relinquish her legal status as a parent before the child is seven days old. This means that she remains the child's legal guardian, with attendant rights and responsibilities, until that time. | The surrogate may relinquish in writing her entitlement to parentage, making her legally no longer a parent, and the intended parents will become recognized in law as parents of the child, without the need for court action.<br><br>If the surrogate refuses to relinquish her entitlement to parentage, the surrogate retains the legal status as parent until the court makes a determination. |
| Shared decision-making | The surrogate and the intended parents share in the rights and responsibilities of a "parent", thereby sharing equally in substitute decision-making authority, from the time of the child's birth until the child is seven days old.<br><br>***Note that parties may depart from this requirement through prior valid agreement.*** | The surrogate may relinquish in writing her entitlement to parentage (which will include substitute decision-making authority), and in so doing, that authority rests with the intended parents. This process can be completed without the need for court involvement.<br><br>If the surrogate refuses to relinquish her entitlement to parentage, the surrogate retains the rights and responsibilities of parentage until the court makes a determination. |
| Role of the surrogacy agreement | The surrogacy agreement can be used by the parties to determine who has parental rights and responsibilities. | Any provision of the surrogacy agreement respecting parental rights and responsibilities has no effect after the passage of seven days. This means that the parties cannot rely on the surrogacy agreement to enforce who has parental rights and responsibilities after the first seven days of the child's life. |
| Role of the CLRA | The CLRA applies to regulate the relationships between the parties involved. It creates a mechanism for recognizing intended parents as sharing in the rights and responsibilities of parentage of the newborn, if a valid surrogacy agreement exists and it does not provide otherwise. | The CLRA applies to regulate the relationships between the parties involved, as the surrogacy agreement has no effect with respect to parental rights and responsibilities. |

## CHART B: Substitute Decision-Making for Children Born of A Surrogacy Arrangement Relevant Considerations Where There Are Five or More Intended Parents

This chart is intended to assist hospitals and clinicians in determining the relevant considerations for substitute decision-making for children born of a surrogacy arrangement with a valid surrogacy agreement in place. It does not represent an exhaustive summary of all applicable legal and clinical issues.

| | Prior to court declaration respecting parentage of the child | Following court declaration respecting parentage of the child |
|---|---|---|
| Issue | Considerations | Considerations |
| Legal parentage status | The surrogate and the intended parents share rights and responsibilities of parentage from the time of the child's birth until the court makes a declaration of parentage. | The surrogate must consent in writing to relinquish entitlement to parentage of the child, following which the court will make a determination regarding parentage. |
| Shared decision-making | The surrogate and the intended parents share equally in substitute decision-making authority, from the time of the child's birth until the court makes a declaration of parentage.<br><br>***Note that parties may depart from this default arrangement by outlining differently in a prior valid surrogacy agreement.*** | The court's declaration of parentage will name one or more individuals as parents of the child, and if more than one, they are considered equally-ranked substitute decision-makers. |
| Role of the surrogacy agreement | The surrogacy agreement can be used by the parties to determine who has parental rights and responsibilities.<br><br>Through a valid surrogacy agreement, the surrogate and the intended parents may depart from the default arrangement of sharing equally in the rights and responsibilities of parentage. | The declaration of parentage prevails over the surrogacy agreement. |
| Role of the CLRA | The CLRA applies to regulate the relationships between the parties involved. | The CLRA applies to regulate the relationships between the parties involved, subject to the terms of the declaration of parentage. |

## iii. The Role of the Surrogacy Agreement

**General guidance**

According to the CLRA, the term "surrogacy agreement" means "a written agreement between a surrogate and one or more persons respecting a child to be carried by the surrogate, in which, (a) the surrogate agrees to not be a parent of the child, and (b) each of the other parties to the agreement agrees to be a parent of the child." [40]

Any agreement (verbal or written) between the surrogate and the intended parent(s) is a private matter between those parties. Under the CLRA, the substance of the surrogacy agreement is not legally enforceable.[41] The hospital cannot be compelled to comply with the surrogacy agreement and any treatment or care elements are not binding on clinicians. This means that all elements of the surrogacy agreement are subject to the relevant legal and professional obligations of the hospital and its clinicians.

Though they may choose to acknowledge or confirm that a valid surrogacy agreement is in place, it is not recommended that hospitals and/or individual clinicians review or verify the agreement, or provide comment on the merits (or substance) of the surrogacy agreement. [42]

As highlighted in the HIROC Risk Note on Surrogacy, "it is not the role of health care providers or the health care organization to validate parenthood or enforce an agreement, but to ensure the best possible care and treatment is provided to the surrogate and child while complying with surrogacy legislation." [43]

However, given the importance of the surrogacy agreement to determinations of parentage and substitute decision-making, clinicians may wish to make reasonable inquiries prior to relying on the parties' assertions that the agreement is valid. They may wish to confirm that neither party disputes the validity of the agreement (i.e. that the required provisions of the CLRA have been met),[44] including the requirement that the parties have obtained independent legal advice. A **Surrogacy Process Checklist** has been provided in **Part 3** to assist clinicians with these discussions.

If contacted by legal counsel for the intended parent(s) and/or another third party, hospitals should respect the confidentiality and privacy of the surrogate, and seek her consent to share any personal health information. Clinicians may wish to consult with their hospital's legal counsel regarding any issues that arise.

Legal documents (such as a surrogacy agreement) do not typically form part of the medical health records of the surrogate and/or the child. However, in some circumstances, a surrogacy agreement may contain useful clinical information on the arrangement between the parties involved, and it may be a helpful reference source for clinicians. Clinicians may wish to consider whether or how to appropriately document the contents of the surrogacy agreement. For example, clinicians may wish to document a number of key elements of the agreement, including:

- Any decisions of the surrogate and the intended parents to depart from shared parental rights and responsibilities (see further details below);
- The name(s) of all intended parents;
- Any relevant decisions as to substitute decision-making authority;
- Any relevant health care decisions for the surrogate and the child or children born through the surrogacy arrangement (for example, prenatal testing, breastfeeding and other treatment decisions); and
- Whether the surrogate consents to share her personal health information (including information about the gestating fetus or fetuses) with the intended parents.

40 CLRA, section 10(1)

41 CLRA, section 10(9)

42 HIROC Risk Note on Surrogacy (see footnote 16)

43 HIROC Risk Note on Surrogacy (see footnote 16)

44 Refer to Appendix A for an outline of the relevant provisions

These elements may be documented as part of antenatal birth plan discussions with the surrogate and/or intended parents, which again highlights that it is not necessary for the hospital to maintain a copy of the surrogacy agreement. See **Part 3** for a **Surrogacy Process Checklist** that may assist hospitals and clinicians in managing legal considerations around the surrogacy agreement.

**Clarifying parental rights and responsibilities**

Although the surrogacy agreement is not legally binding on the hospital and its clinicians, it can nevertheless play an important role in clarifying parental rights and responsibilities.

For example, as noted above, the parties to a surrogacy agreement may agree in writing to depart from some of the legal requirements set out in the CLRA.

Upon identifying a surrogacy pregnancy, clinicians may wish to raise the issue of parental rights and responsibilities at an early stage of managing care and treatment of the surrogate. As part of this discussion, clinicians should consider addressing the following issues:

- Clarifying that the hospital and/or clinicians are not responsible for reading or confirming the overall validity of the surrogacy agreement, including whether the legal requirements of the CLRA have been met.[45] If there are any disputes regarding the validity of the surrogacy agreement, they should be resolved between the parties, as appropriate;[46]

- Explaining that the elements of the surrogacy agreement are subject to the legal and professional obligations of the hospital and its clinicians with respect to the provision of care and the consent to care. The hospital's central treating obligations are to the surrogate, fetus and the child (or children), as they are considered patients of the hospital. Any disputes between SDMs regarding the care and treatment of the child can be resolved in accordance with the hospital's conflict resolution processes and/or appropriate legal avenues;

- Confirming the surrogate's decisions with respect to her rights and responsibilities as a SDM for the child. For example, clinicians may wish to clarify whether she has agreed in writing with the intended parent(s) to give up substitute decision-making authority that she would otherwise have under the CLRA for the first seven days of the child's life.[47] In such cases, clinicians should clearly document this decision in the relevant medical records, and take reasonable steps to satisfy themselves that they may rely on this information (i.e. being aware of obvious signs of duress or coercion);

  AND

- Identifying other SDMs based on the number of individuals who are party to the surrogacy agreement and the requirements of the CLRA, and ensuring that names and contact information are recorded in accordance with hospital processes. However, clinicians may also wish to highlight that it is not the role of clinicians or the hospital to clarify or confirm "legal parenthood."

Given the potential complexity of surrogacy arrangements, including the involvement of multiple SDMs, hospitals and clinicians should also clarify the expectations of the surrogate and the intended parent(s) with respect to hospital processes. These considerations are further explained below and also outlined in **Part 3**, the **Surrogacy Process Checklist**.

45 For example, whether the surrogate received independent legal advice before entering into the agreement, as required by section 10(2) CLRA. See Appendix A for the relevant excerpts

46 In some cases, it may be appropriate to encourage the parties to seek separate and independent legal advice

47 Note that the CLRA does not expressly permit the surrogate to relinquish her legal status as a parent before the child is seven days old, even though she may agree to a different arrangement of parental rights and responsibilities before the child is seven days old, through a written surrogacy agreement

## iv. Involvement of Intended Parent(s) in Treatment and Care Decisions

Depending on the circumstances of the surrogacy arrangement, the intended parent(s) could become involved in labour, delivery and newborn care. The hospital may still reserve the right to limit the number of people in the birthing and post-partum rooms, depending on its own internal policies. When considering whether or how to involve the intended parent(s), the hospital may wish to review the framework for substitute decision-making outlined in the HCCA and, if there is a valid surrogacy agreement, discuss who will be recognized as sharing in the rights and responsibilities of a parent after the child is born (see **part ii** above).

While recognizing that the intended parent(s) are not patients of the hospital, clinicians may choose to make some arrangements (with the consent of the surrogate, where appropriate) to reflect the involvement of the intended parent(s). Some of the issues that hospitals may wish to consider include:

- *An early referral and consultation with a program appointee (for example, a social worker or clinical nurse specialist)*: the involvement of a program appointee may help the parties involved to better understand the hospital's processes around surrogacy births; and may provide an opportunity to discuss any issues and manage expectations at an early stage of the pregnancy. These pre-natal discussions may also provide an occasion to reach consensus on decision-making for care, treatment and discharge of the child following birth, and to sign any appropriate documentation.

- *Hospital accommodation options that would allow the intended parent(s) to have easier access to the newborn child.* These may include:

  – Considering the intended parent(s) as visitors of the child and accommodating them on the post-partum unit;

  – Enabling the intended parent(s) to stay as a support person in the surrogate's room;

  – Accommodating the intended parent(s) in a care-by-parent room (a separate room on the unit available for parents to stay with the child until discharge); or

  – Providing the intended parent(s) with information on accommodation facilities outside of the hospital.

- *Identification options for the intended parents*: to facilitate secure access to the post-partum unit, the hospital may choose to provide identification wristbands for the intended parent(s), and/or ensure that copies of their identification documents are placed on the child's health record.

- *Breastfeeding by the intended mother*: if the intended mother is planning to breastfeed the child or use donated expressed milk while in hospital, the hospital may wish to provide certain supports to the intended parent(s), which may include:

  – Education around the risks and benefits of inducing lactation and/or the possibility of the child requiring supplementation;

  – Discussing potential requirements around testing of donated expressed milk and/or recent serology on the intended mother if she is inducing lactation; and/or

  – A referral to a lactation consultant and/or other community resources for further information and guidance.

As outlined above, intended parent(s) may play an important role as SDMs for the child(s).

**Each surrogacy situation is unique, and hospitals may choose among a variety of options to accommodate the parties involved, based on existing policies and practices, and the particular circumstances of each case.**

At times, given the complexities involved, disagreement or conflict may result. Clinicians may wish to consult legal counsel for situation-specific advice, as appropriate.

Hospitals and clinicians may wish to review the **Surrogacy Process Checklist** in **Part 3** of this guidance document to further understand relevant legal requirements and processes.

Resources on conflict resolution strategies are provided in **Part 4** of these materials.

## C. Key Operational Considerations

### i. Registration of births under the *Vital Statistics Act*

**General Context**

The *Vital Statistics Act*[48] (VSA) is the province's primary piece of legislation for registration and identification of individuals.

Generally, clinicians are required to register births by giving notice to the Registrar General of Ontario. This requirement is outlined in section 1 of Regulation 1094 under the VSA:

> (1) Upon the birth in Ontario of a child, the following persons shall give notice of the birth under section 8 of the Act in accordance with subsections (2) and (3) of this section, unless a person in attendance at the birth gives the notice in accordance with subsection (4):
>
> 1. Each legally qualified medical practitioner or midwife who attends at the birth, except if another legally qualified medical practitioner or midwife who attends at the birth gives the notice.
>
> 2. The nurse or other person in attendance at the birth, if no legally qualified medical practitioner or midwife is in attendance at the birth.
>
> (2) The notice of birth given under subsection (1) shall be in the form that the Registrar General approves.
>
> (3) The person giving the notice of birth under subsection (1) shall mail or deliver it to the Registrar General within two business days after the birth.

The documentation transmitted to the Office of the Registrar General usually takes the form of a "Notice of Live Birth or Stillbirth" (Form 1 under the Regulation) and is completed in the hospital setting by the appropriate clinician. Subsequently, the intended parents of the child must certify the birth by completing a separate "Statement of Live Birth" (Form 2 under the Regulation) and submit this form to the Office of the Registrar General.

**Completing the "Notice of Live Birth or Stillbirth" in surrogacy cases**

The "Notice of Live Birth or Stillbirth" must be completed and submitted to the Registrar General within two business days of the child's birth. As this occurs before the child is seven days old, the surrogate still maintains legal entitlement to parentage under the CLRA.[49] In addition, as indicated above, Ontario law recognizes the birth parent (surrogate) as the child's parent. As such, the "Notice of Live Birth or Stillbirth" should be completed with the name and details of the surrogate.

The "Notice of Live Birth or Stillbirth" serves as a legal record of the birth of a child in Ontario, but does not necessarily serve as a record of parentage.

As indicated below, the intended parent(s) are required to complete a separate process to notify the Registrar General of the surrogate birth.

As such, the names of the intended parents do not need to appear on the "Notice of Live Birth or Still Birth".

**Additional guidance available for intended parents**

The Government of Ontario has provided detailed guidance to assist intended parent(s) in certifying the birth by completing the "Statement of Live Birth" in surrogacy cases. This includes the relevant forms, and additional documentation that may be required to complete the birth

48 *Vital Statistics Act*, R.S.O. 1990, C. V.4

49 CLRA, section 10(5)

registration process. Further information is available at: Registering a birth in Ontario.

More information on registering a birth with multiple parents and/or a surrogacy agreement is also available through the Service Ontario contact centre at 1-800-461-2156 (outside of Toronto) or 416-325-8305 within the Greater Toronto Area.

As noted in **Part B**, discussions around determination of parentage may be complex, and there may be potential for conflict between the various individuals who may be considered to be the child's parents. Clinicians may wish to consult legal counsel for situation-specific advice, as appropriate.

### ii. Discharge Processes

The discharge process for children born of a surrogacy arrangement may vary depending on how many days have passed since the child's birth. In addition, it is also important to consider the particular circumstances of each surrogacy arrangement.

If fewer than seven days have passed since the child's birth, the surrogate still retains legal parentage status. As such, her consent should be sought to discharge the newborn into the care of the intended parents. As a leading practice, this consent should be provided in writing to the hospital, and documented in the appropriate health records.

If more than seven days have passed since the child's birth, the surrogate may have formally relinquished her legal entitlement to parentage, in writing to the intended parents. The hospital should confirm whether this process has been completed before discharging the newborn into the care of the intended parent(s). If there is any doubt, as a leading practice, clinicians should obtain the written consent of the surrogate to discharge the child into the care of the intended parents or another individual. The surrogate's decisions with respect to discharge of the child should be documented in the appropriate health records.

In some situations, the surrogate may be discharged prior to the passage of seven days, while the child remains in hospital for care and treatment. As noted above, the surrogate retains legal authority as a parent of the child until she formally relinquishes that status. Clinicians should consider the circumstances of the surrogacy arrangement, and obtain the surrogate's consent for any care and treatment decisions, as appropriate. Clinicians should also consult with other appropriate SDMs (likely the intended parents) as a shared substitute decision-making arrangement may be in place (see **Part B**). Prior to discharging the surrogate, the hospital may wish to ensure that her most current contact information is on file, in the event of any disputes or emergencies.

If the child is being discharged into the care of the intended parents(s), as a leading practice, hospitals may wish to consider placing copies of appropriate documentation on the newborn's health record. This documentation may include:

- Each of the intended parent's contact information (permanent and temporary, if applicable); and
- Each of the intended parent's photo identification (for example, a passport).

Newborn care, car seat and other discharge requirements (for example, follow up medical appointments) should also be reviewed with the intended parent(s).

**Each surrogacy situation is unique, and the discharge process may vary depending on the circumstances of the surrogacy arrangement, the health condition of the surrogate and/or the child, and existing hospital policies and practices.**

When planning for discharge, clinicians may wish to consult with legal counsel for situation-specific advice, as appropriate.

## iii. Issues Relating to Public Health Insurance Coverage

**General Context**

A surrogacy pregnancy and birth may give rise to issues around public health insurance coverage under the Ontario Health Insurance Program (OHIP) or other Canadian provincial/territorial health insurance plans. In particular, questions may arise with respect to how the costs of hospital, physician and other clinician services should be billed for labour, delivery and newborn care.

The *Health Insurance Act*[50] (HIA) and its regulations govern publicly-insured medical services for eligible residents of Ontario. The cost of these services is billed through OHIP. OHIP covers a wide range of health services deemed "medically necessary" pursuant to the HIA.[51]

For more information, see the OHIP Eligibility Fact Sheet from the Ministry of Health and Long-Term Care (MOHLTC) (June 2015).

**OHIP Eligibility for Newborn Children**

To gain OHIP coverage, an individual must meet the eligibility requirements as set out in Regulation 522 under the HIA. In general, to be eligible for Ontario health insurance coverage, a person must:

- Have Canadian citizenship or other immigration/residency status as listed in the Regulation;
- Make his or her primary place of residence in Ontario; and
- Be physically present in Ontario no less than 153 days in any given 12-month period.

In the case of children, the residency of child's parents is a significant factor in determining OHIP eligibility for the child. Generally, for Ontario-born children to be eligible for OHIP, the child's parent(s) must show that they make Ontario their primary place of residence.

However, as described below, the process for determining OHIP eligibility may differ when a child is born through a surrogacy arrangement.

**Implications for surrogacy arrangements**

When managing surrogacy pregnancies and births, clinicians should review the protocols outlined in the Ontario Health Care Coverage Child Registration Form (Form 4440 – 82), as provided by Service Ontario, and the Child Registration Manual for Birthing Hospitals, as provided by the Ontario Ministry of Government and Consumer Services.

> **NOTE:** The Ontario Health Coverage Child Registration Form (Form 4440-82) cannot be used for children born through surrogacy arrangements (even if the intended parent(s) are Ontario residents). As detailed on this Form, intended parents should apply in person at a Service Ontario Centre in order to confirm that the child is eligible for OHIP coverage.

As a leading practice, hospitals may wish to issue a standard template letter to the intended parent(s), confirming the surrogacy birth. The intended parents may then present this letter (along with other required documentation) in person at a Service Ontario Centre to apply for OHIP coverage for their child.

In this template letter, the hospital may wish to include the following information:

- First name of the child
- Last name of the child (i.e. the last name of at least one of the intended parents)
- Child's sex
- Child's date of birth
- Location of birth (i.e. the name and address of the hospital)

50 *Health Insurance Act*, R.S.O. 1990, C. H.6

51 *Health Insurance Act*, section 11.2

- Name of the birth parent (surrogate)
- Signature of someone authorized to sign on behalf of the hospital or clinician attending the birth.

It may be prudent to confer with the hospital's finance department and/or legal counsel regarding any health care insurance coverage issues. Hospitals can direct the surrogate and/or the intended parent(s) to the nearest Service Ontario Centre for general questions about OHIP eligibility. A list of Service Ontario locations can be found here.

**Further guidance for intended parents**

The hospital may also wish to provide further guidance to the intended parent(s) regarding the OHIP registration process for children born of surrogacy arrangements. In particular, when attending at a Service Ontario Centre to apply for OHIP coverage for the child, the intended parent(s) will also require additional documentation as outlined below:

One of the following documents authorizing the intended parent(s) to register the child for health coverage:

- A document signed by the birth parent/surrogate that gives authorization/consent to the intended parent(s) to register the surrogate child for OHIP and access the personal health information of the child. The document should include:
  - Date
  - Name of the child
  - Name(s) of the intended parent(s)
  - Name and signature of birth parent/surrogate

OR

- A declaration of parentage declaring the intended parent(s) to be the legal parent(s) of the child.

The intended parent(s) will also need to support their identity and residency in Ontario with the following original documents:

- A document from List 2 of the OHIP Document List that shows the name and residential address of the intended parent(s); AND
- A document from List 3 of the OHIP Document List that shows the name and signature of the intended parent(s) to confirm his/her identity.

The OHIP Document List can be found here.

> **NOTE:** Where non-resident parties are involved in the surrogacy arrangement, there may be additional issues to consider regarding OHIP coverage. For an overview of these issues, see **Part D** below.

## iv. Privacy and Personal Health Information

As a patient of the hospital, the surrogate is entitled to privacy and confidentiality of her personal health information (PHI), as required by the *Personal Health Information Protection Act, 2004* (PHIPA).[52] PHIPA governs the collection, use and disclosure of patients' PHI within the health care sector. Under the legislation, health information custodians are required to take measures to safeguard the patient's PHI from inadvertent and/or unauthorized access, use and disclosure.

**PHI about the surrogate cannot be shared with the intended parent(s) without the surrogate's express or implied consent.[53]**

The surrogate may also determine how much information is to be shared with the intended parent(s) about the gestating fetus.[54]

After the baby is born, the intended parents gain status as SDMs for the child if they share in the rights and responsibilities of a parent as set out in the CLRA, and may

52 *Personal Health Information Protection Act* (PHIPA), 2004, S.O. 2004, c. 3, Sched. A

53 PHIPA, section 18

54 HIROC Risk Note on Surrogacy (see footnote 16)

become entitled to disclosure of PHI about the child on this basis.[55] As the surrogate may be an equally-ranked SDM for the first seven days of the child's life,[56] it is important to also consider her role in the disclosure of PHI about the child.

Further details about PHI and the requirements under PHIPA can be found on the website of the Information and Privacy Commissioner of Ontario: https://www.ipc.on.ca/english/PHIPA/

Each surrogacy situation is unique, and the processes around disclosure of PHI may vary depending on the circumstances of the surrogacy arrangement and the SDMs involved. When deciding whether or how to share PHI about the surrogate and/or the child, clinicians may wish to consult with legal counsel for situation-specific advice, as appropriate.

## D. Key Considerations Relating to Non-Residents

**This section identifies some of the relevant issues that may arise when non-resident parties are involved in a surrogacy arrangement.**

### i. Risk Management Issues

There are two potential scenarios where non-residents of Canada may be involved in surrogacy arrangements: (1) where the surrogate is not a Canadian resident; and (2) where the intended parent(s) are not Canadian residents.

From a risk management and liability insurance perspective, there are some common considerations that apply in both scenarios, as outlined below.

Where one of the parties to a surrogacy agreement (i.e. the surrogate or the intended parents) are non-residents of Canada, the hospital should make some advance arrangements regarding their involvement in labour, delivery and newborn care. Hospitals should address particular considerations that may arise in the event of a future medical-legal dispute (relating to the management of the pregnancy, newborn delivery, care, treatment and/or other issues) between the hospital, clinicians, and non-resident parties.

To assist hospitals and clinicians in managing these issues, the Canadian Medical Protective Association (CMPA) and the Healthcare Insurance Reciprocal of Canada (HIROC) have developed joint Governing Law and Jurisdiction Agreements (GLJAs). These forms are "designed to assist in establishing Canadian jurisdiction for any potential legal actions that may result from care or treatment provided by health care organizations to non-residents."[57] These forms are intended to be signed by non-resident parties (or their SDMs).

The GLJAs do not prevent or prohibit the surrogate and/or intended parent(s) from launching legal action in their country of origin. Rather, they are legal agreements that allow the parties to confirm in advance how any disputes will be resolved, by specifically identifying the particular set of laws (i.e. Ontario and/or Canadian laws) that will apply in those situations and the forum in which the case will be decided (i.e. Ontario courts). This may help to ensure better risk protection for the hospital and its clinicians, should a legal action be commenced outside of Canada.

**Considerations for using GLJAs**

HIROC and the CMPA expect that when the surrogacy arrangement involves parties who permanently reside outside of Canada, hospitals and staff members with practice privileges will obtain a signed GLJA from those parties.[58]

55 See PHIPA, section 5 for further information

56 Unless otherwise specified in the surrogacy agreement

57 Joint HIROC/CMPA Communique – "Governing Law and Jurisdiction Agreement," (March 2014)

58 Joint HIROC/CMPA Communique – "Governing Law and Jurisdiction Agreement" (see footnote 43)

It is contemplated that the GLJA will generally be signed by the non-resident patient who is being treated (however, see the "Note" section below for further considerations where non-resident intended parents are involved). This agreement should be signed as early as possible in the course of the parties' interactions, before treatment is initiated – for example, as part of the pre-natal consultations between clinicians, the intended parent(s) and the surrogate, as appropriate.

There are several kinds of forms available for use, depending on the particular circumstances:

- **Governing Law and Jurisdiction Agreement for Health care Organizations:** to protect health care organizations (including hospitals), their employees and staff members with practice privileges treating non-residents of Canada. Note that physicians and midwives providing health care and treatment in a health care organization setting are specifically included in the health care organization form, and receive the benefit of protection under that form. They are not respectively required to also have the Physicians in Private Practice form completed or the Midwives in Private Practice Form completed (see below).

- **Governing Law and Jurisdiction Agreement for Physicians in Private Practice:** to protect physicians working in private practice and providing health care and treatment to non-residents of Canada.

- **Governing Law and Jurisdiction Agreement for Midwives in Private Practice and Midwife Practice Group in Respect of Foreign Residents:** to protect midwives working in a private practice setting (for example, in midwifery-led birth centers, clinics and/or clients' homes) and providing health care and treatment to non-residents of Canada.

For sample copies of GLJA forms[59] see the Joint HIROC/CMPA Communique – Governing Law and Jurisdiction Agreement at www.hiroc.com

**NOTE**: As each surrogacy arrangement is unique, the risk management considerations may differ depending on the parties involved and the particular circumstances of the surrogacy agreement. In some cases, it may be necessary to use a modified version of a GLJA to ensure that the coverage provided by the form is appropriate – i.e. that the relevant parties' names are included. For example, in some circumstances, the standard wording of the GLJA might not apply where the non-residents in question are not the patients. Additionally, in some situations, it may be necessary to sign more than one GLJA to cover various risk and/or liability scenarios.

Hospitals, their employees and staff members with practice privileges should be aware of the risks involved if a GLJA is not signed and a legal action is commenced outside of Canada – i.e. the absence of insurance or legal assistance for matters successfully launched outside of Canada by the non-resident. They may wish to contact their legal counsel, HIROC or the CMPA, as appropriate, regarding modification of the GLJA to address particular scenarios, and with respect to specific risk management concerns; or to inquire about the extent of assistance provided in relation to medical-legal issues involving parties who are non-residents of Canada.

As noted in **Part B**, legal documents do not typically form part of the medical health records of the surrogate and the child. However, in some circumstances, a GLJA may provide a useful record for risk management purposes. Hospitals and clinicians may wish to consider how to document the existence and content of any GLJAs that are signed between the parties, both within maternal and within neonatal records.

59 Note that the forms are modified from time to time. Please review the most current copies of the form online here

## ii. Issues Relating to Public Health Insurance Coverage

As noted in **Part C**, in order to gain OHIP coverage, an individual must meet certain minimum eligibility requirements, as set out in Regulation 552 under the HIA. In general, if the intended parent(s) reside outside of Ontario, the child will not be eligible for OHIP coverage as the child's primary place of residence will not be in Ontario.

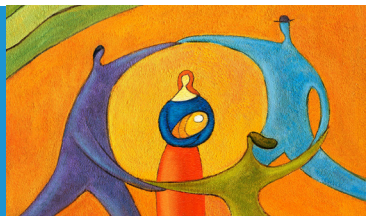
Intended parents who are insured by another Canadian province or territory should inquire with the health insurance plan of their home province or territory regarding health insurance coverage for their child. Further information about inter-provincial billing is available through the Ministry of Health and Long-Term Care Interprovincial Health Care INFO Bulletins at www.health.gov.on.ca

Hospitals may also wish to review the Ontario Hospital Reciprocal Billing Manual from the Ministry of Health and Long-Term Care, which discusses reciprocal billing for hospital services in the context of surrogacy arrangements. Queries can be directed to InterprovinceBilling.Moh@Ontario.ca

When Canadian non-resident parties or other international parties are involved, hospitals should discuss the status of provincial health care coverage and its financial implications with the surrogate and/or the intended parent(s) as early as possible in the management of the pregnancy. As outlined in **Part C**, the Ontario Health Coverage Child Registration (Form 4440-82) should not be used in surrogacy cases.

Clinicians may wish to confer with the hospital's finance department and/or legal counsel regarding any health care coverage issues. Hospitals may also wish to direct the surrogate and/or the intended parent(s) to the nearest Service Ontario Centre for general questions about OHIP eligibility. A list of Service Ontario locations can be found here: ServiceOntario.ca/findservices

# Part 2: Leading Practices for Managing Surrogacy Pregnancies And Births



This section is intended to provide general guidance around leading practices for managing surrogacy pregnancies and births – addressing both the legal and the clinical aspects within an inter-professional care framework.

Throughout this section, leading practices surrounding the most common and challenging surrogacy issues will be illustrated using a variety of scenarios involving Alexandra and Ashley, a fictional couple who would like to co-parent a child with another couple, Sam and Parker. Dana, a 24-year old woman, has agreed to act as a surrogate for the child.

As this is a gestational surrogacy, Dana has had an embryo transfer of an embryo created with oocyte and sperm from Alexandra and Parker. Dana bears no genetic connection to the child.

Alexandra and Ashley, together with Sam and Parker, have a detailed written surrogacy agreement that has also been signed by Dana. Among other details, the surrogacy agreement provides that the intended parents will assume substitute decision-making authority immediately after the birth of the child.

***Note:*** *Names, places and incidents in this section are used fictitiously. Any resemblance to actual events or locales or persons, living or dead, is entirely coincidental.*

## A. First Steps: Identification of Surrogacy Birth and Hospital's Role in the Surrogacy Agreement

*Dana is at 14 weeks gestation. She resides in Toronto and decides she would like to give birth in a nearby hospital in the city. After discussing this decision with the four intended parents, Dana visits the hospital to begin making arrangements. At this pre-natal consultation, she explains to the attending physician that they consulted a lawyer who helped them prepare a surrogacy agreement, and wonders if she should provide a copy of the agreement to the hospital for its records, to show that the intended parents will assume exclusive substitute decision-making authority immediately after the birth. Dana also inquires about next steps and whether any special arrangements will be required to accommodate a surrogacy birth.*

### Q How should the hospital communicate its relationship to the parties and the role of the surrogacy agreement, as it relates to clinical and operational decision-making?

**➔ The following considerations are suggested as part of the leading practice:**

At the outset, the hospital should clarify the expectations of the surrogate and the intended parents regarding management of the surrogacy pregnancy and birth, ideally at a meeting attended by all parties. The hospital may wish to confirm the surrogate's independent understanding of her rights and responsibilities – in particular, that she is a patient of the hospital and can direct care for herself and for the gestating fetus.

It is also important for the hospital to clarify that it will not review, comment on or enforce any agreements between the parties. Furthermore, it should be communicated that all elements of the surrogacy agreement are subject to relevant

legal and professional obligations of the hospital and its clinicians with respect to provision of care and consent to care.

Legal documents (such as a surrogacy agreement) do not typically form part of the medical health records of the surrogate and the child(s) born to her. However, in some circumstances, a surrogacy agreement may contain useful clinical information on the arrangement between the parties involved. It may be a helpful reference for the surrogate and the intended parents in discussions with clinicians. In some cases, clinicians may wish to consider whether or how to appropriately document the relevant contents of the surrogacy agreement, as raised in antenatal discussions about the birth plan.

Without commenting on the merits or substance, clinicians may wish to make reasonable inquiries prior to relying on the parties' assertions that the agreement is valid. They may wish to confirm that neither party disputes the validity of the agreement (i.e. that the required provisions of the CLRA have been met), including the requirement that the parties have obtained independent legal advice. A **Surrogacy Process Checklist** has been provided in **Part 3** to assist clinicians with these discussions.

## Q What other steps should the hospital take after identifying Dana as a gestational surrogacy patient?

➔ **The following considerations are suggested as part of the leading practice:**

The most responsible physician or midwife should request a consultation as early as possible from the relevant program appointee (this can include Social Work and/or the Clinical Nurse Specialist (CNS)) to meet with the surrogate and the intended parents to obtain information, discuss the birth plan, sign acknowledgments and/or relevant consent-related documentation, and review postpartum accommodation options. In this consultation, the surrogate should be made aware of her rights and responsibilities as a patient of the hospital and as the legal mother of the newborn, including her right to direct her care, and her right to privacy of her personal health information. To facilitate trust among the parties involved, it is important to provide a non-judgmental and supportive environment for these conversations.

The hospital may also wish to convey relevant information to the intended parents in their capacity as SDMs, to help manage expectations. This may include a discussion of substitute decision-making arrangements following the birth of the child, including whether the surrogate mother and intended parents have decided to depart from the default of sharing equally in the rights and responsibilities of parentage.

Each surrogacy situation is unique, and hospitals may choose among a variety of options to accommodate the parties involved, based on existing policies and practices, the SDMs for the child, and the particular circumstances of each case. Clinicians may wish to consult legal counsel for situation-specific advice, as appropriate.

Special processes may be required in the event that the hospital is not made aware of the gestational pregnancy until the surrogate presents for birth.

**Refer to Part 4 for resources on inter-professional care.**

## B. Pre-Natal Consultation: Conflict Management

*After the initial appointment at the hospital, the parties attend a follow-up consultation with a clinical nurse specialist (CNS) to discuss Dana's birth plan and expectations regarding child care. After obtaining the intended parents' contact information, the CNS asks Dana about her plans to have someone attend the birth. Dana had not thought about this previously, but realizes she would feel more at ease with her husband Christopher by her side, and is not really comfortable with anyone else attending. For their part, the intended parents were hoping to witness the birth of their child, and do not feel it is appropriate for Christopher to be present.*

### Q What strategies could be employed to manage any potential conflict between the surrogate and the intended parents?

**The following considerations are suggested as part of the leading practice:**

In surrogacy cases, disputes may arise over various aspects of the management of the pregnancy and post-birth care of the child. In this scenario, the care and treatment of the surrogate is central. In the event the parties cannot agree, the hospital and its clinicians should provide care in line with the surrogate's wishes and her best interests, as the central treating obligation is to her. The hospital should also consider any existing internal policies for managing births – for example, there may be a policy that speaks to limits on the number of support people in the birthing room, and access to the post-partum unit generally.

In addition, the hospital and its clinicians may also wish to use this opportunity to remind the intended parents of their role and involvement, particularly as relates to their substitute decision-making authority pertaining to the child (not the surrogate), once born. It may be helpful to review the framework for substitute decision-making outlined in the HCCA.

In some cases, identifying the most appropriate SDM(s) for the child might be a complex task, and there may be conflicting claims between the various parties involved. Clinicians may wish to consult with legal counsel for situation-specific advice, as appropriate.

**Refer to Part 4 for resources on conflict management.**

## C. International Intended Parents

*After discussing birth plans in this follow-up consultation, the conversation shifts to child care. While Alexandra and Ashley have family in Ontario and plan to move to Canada in the next couple of years, they presently live in France. Sam and Parker reside in Ontario for about half of the year, but travel frequently to France for work-related purposes. The intended parents want to confirm that the child will be eligible for health care coverage in Ontario, because the lawyer who prepared the surrogacy agreement had mentioned the child might not meet residency requirements for OHIP.*

### Q How should the hospital communicate information regarding OHIP coverage to the intended parents?

**The following considerations are suggested as part of the leading practice:**

As this is a surrogacy case, the child does not automatically qualify for OHIP coverage. The intended parents and the child must follow-up with Service Ontario, and provide proof to Service Ontario that they satisfy the eligibility requirements under the *Health Insurance Act* and Regulation 552.

The hospital should discuss the status of provincial health care coverage as early as possible, and make arrangements with the intended parents accordingly. The hospital may wish to confer with the finance department and/or review the relevant provisions of the Health Insurance Act and other guidance documentation (including the Child Registration Manual for Birthing Hospitals). The hospital may also direct the intended parents to the nearest Service Ontario Centre for further information about OHIP eligibility.

**Refer to Part 4 for legal and policy resources related to OHIP issues.**

## Q What are the leading practices for hospitals in dealing with international intended parents as they relate to health insurance coverage issues?

**The following considerations are suggested as part of the leading practice:**

The child does not automatically qualify for OHIP coverage in these circumstances. Hospitals should carefully review the relevant provisions of the *Health Insurance Act* and other guidance documentation (including the Child Registration Manual for Birthing Hospitals and the Ontario Health Coverage Child Registration Form – Form 4440-82) to understand the legal and policy context.

Form 4440-82 cannot be used for children born through surrogacy arrangements, regardless of the fact that one set of intended parents reside in Ontario for part of the year. As detailed on this Form, intended parents should apply in person at a Service Ontario Centre in order to confirm that the child is eligible for OHIP coverage.

Hospitals can choose to issue a standard template letter to the intended parents, confirming the surrogacy birth. The intended parents may then present this letter (along with other required documentation) in person at a Service Ontario Centre to apply for OHIP coverage for their child.

**Refer to Part 4 for legal and policy resources related to OHIP issues and conflict management.**

## Q What are the leading practices for hospitals in dealing with international parents as they relate to risk management issues?

**The following considerations are suggested as part of the leading practice:**

Hospitals and staff members with practice privileges should be aware of the possibility that international intended parents may commence a legal action in their country of origin (relating to the management of the pregnancy, newborn delivery, care, treatment and/or other medical-legal issues).

To help manage this potential risk, HIROC and CMPA expect that hospitals, their employees and credentialed staff will ensure that all non-resident parties to the surrogacy arrangement sign the applicable Governing Law and Jurisdiction Agreement (GLJA).

The GLJA does not prevent or prohibit the parties from commencing a legal action. Rather, a signed GLJA helps to establish the set of laws (i.e. Ontario and Canadian laws) and the forum (i.e. Ontario courts) that will apply if a legal dispute arises.

There are three different versions of GLJAs to cover various situations. Hospitals, employees and staff members with practice privileges should use the version of the GLJA that is most appropriate in their circumstances. In some cases, it might be necessary to use a modified version of a GLJA, or more than one GLJA, to ensure that the coverage provided is adequate for the circumstances. Best efforts should be made to ensure that a signed GLJA is in place before treatment is initiated – for example, it can be completed as part of the pre-natal consultations between clinicians, the intended parents and the surrogate, as appropriate.

Legal documents (such as a GLJA) do not typically form part of the medical health records of the surrogate and the child. However, in some circumstances, a GLJA may provide a useful record for risk management purposes. Hospitals and clinicians may wish to consider how to document the existence and content of any GLJAs that are signed between the parties.

Hospitals or clinicians can contact their legal counsel, HIROC or the CMPA, as appropriate, regarding modification of the GLJA for particular scenarios, specific risk management concerns and/or the extent of assistance provided in relation to medical-legal issues involving parties who are non-residents of Canada.

**Refer to Part 4 for legal and policy resources related to risk management.**

## D. Privacy Issues

*A few months before the expected birth date of the baby, Alexandra and Ashley decide to begin working on a baby scrapbook. At one of the pre-natal consultations, the nurse had given Dana an ultrasound where she learned that she was expecting twin girls. Alexandra and Ashley have since been looking forward to collecting pictures to preserve memories of their daughters at various stages of life. Alexandra calls the nurse to obtain copies of the ultrasound pictures for the scrapbook. She also asks the nurse for an update regarding Dana's overall state of health after Dana's recent clinical check-up.*

### Q Can the nurse disclose this information to Alexandra?

➔ **The following considerations are suggested as part of the leading practice:**

Pursuant to the *Personal Health Information Protection Act, 2004* personal health information about the surrogate and the gestating fetuses cannot be shared without the surrogate's express consent. This protection extends to the ultrasound images of the fetuses (as they are considered part of the surrogate's health record). The surrogate may direct how much information is shared with the intended parents and/or other third parties.

**Refer to Part 4 for resources on privacy issues.**

## E. Post-Birth: Legal Guardianship and Reporting Requirements

*The intended parents and Christopher all attend at the hospital when Dana gives birth to twin girls named Sandra and Erica. The twins are born prematurely at 30 weeks gestation, and require admission to the Neonatal Intensive Care Unit (NICU) due to health complications.*

*Shortly after the birth, the attending nurse gives Dana and the twin girls armbands that are identified with Dana's last name. Dana is confused as she believed that the intended parents would become the baby's legal guardians following the birth. When Dana inquires about this, she is advised that the physician completed the "Notice of Live Birth or Still Birth" using Dana's last name, and that the health records will also be so identified during the hospital stay.*

### Q How should the hospital communicate legal requirements around documentation and reporting of the surrogacy birth to Dana and the intended parents?

➔ **The following considerations are suggested as part of the leading practice:**

To manage expectations early on, the hospital can advise the parties at a pre-natal consultation that the child will be identified using the surrogate's last name, and that the hospital is legally required to provide the surrogate's name and details on the "Notice of Live Birth or Still Birth". The surrogate retains legal parentage status until seven days after the child's birth, irrespective of whether she has agreed to give up her substitute decision-making authority or other rights and responsibilities of parentage through the surrogacy agreement.

Clinicians may also wish to consider the possibility that the surrogate may be discharged while the child remains in hospital, and may wish to make arrangements to ensure continuity of identification of SDMs for the child. This could include ensuring that contact details of the intended parents are available in hospital records.

The hospital may also wish to advise the intended parents that they are required to complete a separate process to certify the birth with the Registrar General, and provide them with additional information, as appropriate.

## F. Postpartum Care

*Immediately following the birth of the twins, Dana informs the attending nurse that she does not wish to be involved in caring for the twins, including expressing breast milk to feed the children, who are still hospitalized in the NICU. The intended parents are upset, as their written surrogacy agreement with Dana had stipulated that Dana would provide expressed breast milk for the children for the first seven days of their lives, and that each of the intended parents would be involved in feeding the children.*

### Q What is the hospital's role in resolving the conflict between the parties with respect to this element of the surrogacy agreement?

➔ The hospital should refrain from commenting on the merits or content of the surrogacy agreement. It is also important to clarify with the intended parents that the hospital is not responsible for reviewing, confirming or enforcing the overall validity of the surrogacy agreement, or any of the agreement's contents including any care and treatment elements. If there are any disputes regarding the validity or substance of the surrogacy agreement, they should be resolved between the parties and/or their legal counsel, as appropriate.

The hospital may also wish to highlight that its central treating obligations are to the surrogate and the child(s), as they are considered patients of the hospital. Any disputes between SDMs regarding the care and treatment of the child can be resolved in accordance with the hospital's conflict resolution processes and/or appropriate legal avenues. In the interim, hospitals and clinicians are encouraged to provide the best possible care to the surrogate and the children, while complying with applicable legislation.

### Q How can the hospital otherwise accommodate the intended parent's wishes to be involved in caring for the children?

➔ Each surrogacy situation is unique, and hospitals may choose among a variety of options to accommodate the parties involved, based on existing policies and practices, the SDMs for the child, and the particular circumstances of each case. For example, clinicians may wish to consider hospital accommodation options that would allow the intended parents to have easier access to the newborn (such as a care-by-parent room) or facilitating secure access for the intended parents to the post-partum unit.

## G. Discharge

*Five days have passed since the birth of the twins, and they are still hospitalized in the NICU. However, Dana is ready for discharge and has made arrangements to go home. Meanwhile, Alexandra and Ashley have responded to Dana's refusal to provide expressed breastmilk by seeking out expressed donor milk, and have also asked about the possibility of inducing lactation.*

### Q How should the hospital respond to the requests to use expressed donor milk and/or induce lactation?

➔ **The following considerations are suggested as part of the leading practice:**

Generally speaking, the role of the surrogate as a SDM should be considered prior to the passage of seven days since the child's birth, and her consent should be sought, with respect to the care and treatment of the child.

In this case, the parties have agreed in writing (through their surrogacy agreement) that the surrogate will not participate in substitute decision-making, and will allow the intended parents to have exclusive substitute decision-making authority for the twins. Clinicians may wish to take reasonable steps to confirm that the surrogate's decision was informed and free of duress, prior to allowing the intended

parents to have exclusive substitute decision-making authority. These discussions should ideally take place in a pre-birth consultation.

The parties should be advised of the material risks and benefits of breastfeeding, and that if the intended mother(s) wish to breastfeed, the hospital may require current serology results. The intended mother(s) can also be referred to a lactation consultant or another community resource for an antenatal assessment.

Hospitals may also wish to provide further information on the material risks and benefits of expressed donor milk and referrals to community resources as appropriate.

## Q How can the hospital best manage discharge processes for the surrogate and the children who are still hospitalized?

**The following considerations are suggested as part of the leading practice:**

Ideally, this aspect of post-partum care would be discussed as early as possible, and consent obtained in advance to manage the expectations of the parties. Since fewer than seven days have passed since the child's birth, the surrogate still retains legal parentage status (even if she has given up her substitute decision-making authority through the surrogacy agreement). As such, her consent should be sought to discharge the newborn into the care of the intended parents. As a leading practice, this consent should be provided in writing to the hospital, and documented in the appropriate health records. Prior to discharging the surrogate, the hospital may wish to ensure that her most current contact information is on file, in the event of any disputes or emergencies.

In addition, as the children will later be discharged into the care of the intended parents(s), hospitals should consider placing copies of appropriate documentation on the children's health records. This documentation may include:

- Each of the intended parent's contact information (permanent and temporary, if applicable); and
- Each of the intended parent's photo identification (for example, a passport).

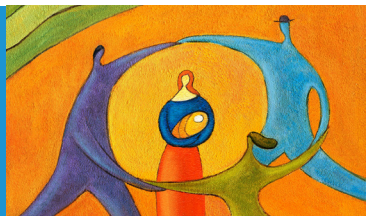
Newborn care, car seat and other discharge requirements (for example, follow up medical appointments) should also be reviewed with the intended parent(s).

# Summary and Conclusion

Surrogacy pregnancies and births may well introduce an additional layer of complexity into hospital operational and clinical practice; however, with appropriate support processes and policies in place, any potential challenges and conflict can be minimized. Hospitals are encouraged to develop organizational protocols that address patient needs and facilitate effective clinical care.

Although these guidance materials have attempted to address the most common issues that may arise, every surrogacy pregnancy and birth is unique. Hospitals are encouraged to apply the principles and leading practices outlined in these guidance materials in a manner that is best suited to individual circumstances.

# Part 3: Surrogacy Process Checklist



This checklist has been prepared to assist hospitals and clinicians in understanding relevant processes and requirements that should be considered in the context of managing surrogacy pregnancies and births. It is not intended to address treatment-related consent requirements arising from the *Health Care Consent Act, 1996*; but rather to identify various legal considerations that might emerge in managing relationships between the hospital, clinicians and the parties involved in a surrogacy arrangement.

**NOTE:** This checklist may be used to inform internal processes and policy development, but may not serve as an exhaustive overview of all legal requirements, or be representative of all potential complexities in a given surrogacy arrangement.

## The Surrogacy Agreement

**Discussions and documentation related to the surrogacy agreement should cover the following issues:**

- ☐ The surrogate and intended parents' understanding and acknowledgement that the hospital and/or clinicians are not responsible for reading or confirming the overall validity of the surrogacy agreement, including that all legal requirements have been met *
- ☐ The surrogate and intended parents' understanding and acknowledgement that all elements of the surrogacy agreement are subject to the relevant professional and legal obligations of the hospital and its clinicians
- ☐ The surrogate and intended parents' understanding and acknowledgement that all relevant elements of the surrogacy agreement, as communicated by parties, may be documented in her health record as part of a care and treatment plan

* Without probing into the legalities or reviewing the agreement, hospitals and clinicians may wish to make reasonable inquiries prior to relying on the parties' assertions that the surrogacy agreement is valid. Ideally at an early stage, hospitals and clinicians may wish to confirm that:

- ☐ The requirements of the CLRA for a valid surrogacy agreement have been met:
  - i) The surrogate and one or more persons entered into a written surrogacy agreement before the child was conceived;
  - ii) The surrogate and the intended parent(s) each received independent legal advice before entering into the agreement;
  - iii) There are no more than four intended parents who are parties to the agreement; and
  - iv) The child was conceived through assisted reproduction.
- ☐ There are no obvious signs of fraud, duress or coercion with respect to the surrogacy agreement

60 Note that if there are more than four intended parents, the surrogacy agreement will still be valid if the other requirements are met; however, a court process for determination of parentage will apply. See Chart B in these guidance materials and section 11 CLRA for further details

## Disclosure of Personal Health Information

**Discussion and documentation related to disclosure of personal health information should cover the following issues:**

- ☐ The surrogate's understanding and acknowledgement that her personal health information will be maintained confidentially, in accordance with the hospital's privacy policy and the requirements of the *Personal Health Information Protection Act, 2004*
- ☐ The surrogate's understanding and acknowledgement that she can choose to disclose personal health information about herself and/or the gestating fetus or fetuses to another individual, and that this decision will be documented in her health record
- ☐ The surrogate's understanding and acknowledgement that the hospital must have proper authorization to disclose her personal health information to another individual. This authorization requires express consent (verbally or in writing) from the surrogate
- ☐ The surrogate's consent to disclose personal health information should indicate the names of the individuals to whom disclosure is permitted, and the circumstances under which disclosure is permitted or not permitted

## Treatment Decisions For Children Born of Surrogacy Arrangements

**Discussion and documentation related to treatment decisions should cover the following issues:**

- ☐ (When applicable*) The surrogate's understanding and acknowledgement that she may have substitute decision-making authority for the child or children born to her and that the hospital and/or clinicians may be required to seek her consent for treatment decisions relating to child born to her
- ☐ (When applicable*) The surrogate's consent to relinquishing her status as a substitute decision-maker for the child or children born to her prior to the passage of seven days, and allowing individual or other individuals (typically the intended parents) to be exclusive substitute decision-makers
  - NOTE: While the hospital cannot be held responsible for enforcing that consent, the hospital and/or clinicians may be required to take reasonable steps to confirm that the surrogate's decision making was informed and free of duress
- ☐ (When applicable*) The surrogate's consent to allow other individuals to make particular care and treatment decisions (for example, breastfeeding the child or children born to her, or for antenatal testing)
  - NOTE: While the hospital cannot be held responsible for enforcing that consent, the hospital and/or clinicians may be required to take reasonable steps to confirm that the surrogate's decision making was informed and free of duress

* Parties to a surrogacy agreement may agree to their own arrangement of parental rights and responsibilities for the first seven days of the child's life, if a valid surrogacy agreement is in place.

## Legal Parentage Status

**Discussions and documentation related to legal parentage status and parental rights and responsibilities should cover the following issues:**

- ☐ The surrogate's understanding and acknowledgment that her name will appear on the "Statement of Live Birth or Still Birth"
- ☐ The surrogate's understanding and acknowledgement that although a surrogacy agreement is in place* she is still considered the legal parent until the child is at least seven days old or a court declaration provides otherwise
- ☐ The surrogate's understanding and acknowledgement that if the court makes a determination regarding legal parentage, the hospital and/or clinicians will be legally obligated to abide by that decision

* Parties to a surrogacy agreement may agree to their own arrangement of parental rights and responsibilities for the first seven days of the child's life, if a valid surrogacy agreement is in place.

## Discharge of Children Born of Surrogacy Arrangements

**Discussions and documentation related to discharge of children born of surrogacy arrangements should cover the following issues:**

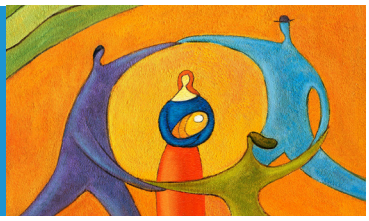
- ☐ The surrogate's understanding and acknowledgement that she may consent to allow the child or children to be discharged into the care of the intended parents, prior to or after the passage of seven days
- ☐ The surrogate's understanding and acknowledgement that this consent will be documented in the appropriate health records
- ☐ The surrogate's understanding and acknowledgement that her contact information will remain on file in the event that the clinician and/or hospital needs to contact her in relation to the care and treatment of the child or children born to her

## International Intended Parents

**When applicable, discussions and documentation related to international intended parents should cover the following issues:**

- ☐ Signed Governing Law and Jurisdiction (GLJA) forms from any non-resident patients who are receiving treatment. This includes the surrogate, where applicable
  - NOTE: The GLJA does not prevent litigation from being commenced against the hospital and its clinicians; but rather, establishes the particular set of laws that will apply in those situations (i.e. Ontario/Canadian laws) and the forum in which the case will be decided (i.e. Ontario courts)
  - FURTHER NOTE: Modified versions of the GLJA might be necessary to address unique risk management considerations that differ depending on the parties involved
- ☐ The intended parents' understanding and acknowledgment that the Ontario Health Coverage Child Registration (Form 4440-82) cannot be issued in surrogacy cases, and that intended parents will be required to apply separately for OHIP coverage

# Part 4: Tools and Resources



**Note:** *By clicking on the links below, you will be redirected to third party websites. Links and site content may change without notice. Please contact the external site owner for any questions regarding the website's content.*

## A. Legal and Policy Resources

**Risk Management Resources**

- Healthcare Insurance Reciprocal of Canada, Risk Management Note on Surrogacy (2017), available at www.hiroc.com
- Healthcare Insurance Reciprocal of Canada and the Canadian Medical Protective Association, Joint Communique – Governing Law and Jurisdiction Agreement (2014), available at www.hiroc.com

**Relevant Legislation**[61]

- *Assisted Human Reproduction Act*
- *Children's Law Reform Act*
- *Health Insurance Act* and Regulation 552
- *Health Care Consent Act*, 2006
- *Legislation Act*
- *Personal Health Information Protection Act*
- *Public Hospitals Act* and Regulation 965
- *Vital Statistics Act* and Regulation 1094

**Guidance on the Relevant Legislation**

- Health Canada Info Sheet, Prohibitions Related to Surrogacy (2013), available at www.hc-sc.gc.ca

**OHIP Fact Sheets from the MOHLTC**

- Ministry of Health and Long Term Care, OHIP Fact Sheet: OHIP Eligibility (2017), available at www.health.gov.on.ca
- Ministry of Health and Long Term Care, OHIP Fact Sheet: OHIP Eligibility of Canadian-Born Children of OHIP-ineligible Parents (2011), available at www.health.gov.on.ca

**Privacy-Related Resources**

- Information and Privacy Commissioner of Ontario, Your Health Privacy Rights in Ontario (2017), available at www.ipc.on.ca

## B. Clinical Care Resources

**Resources on Inter-Professional Care**

- Canadian Interprofessional Health Collaborative, A National Interprofessional Competency Framework (2010), available at www.cihc.ca
- Canadian Medical Association, Resources and Policy Statements on Collaborative Care (2013), available at www.cma.ca

61 Excerpts of the relevant legislation are provided in Part 5

- Ontario Hospital Association, Physician Leadership Resource Manual, Module 4 – Leading High Performing Teams (2013), available at www.oha.com

- Registered Nurses Association of Ontario, Best Practice Guideline: Developing and Sustaining Interprofessional Healthcare: Optimizing Patients/clients, Organizational, and System Outcomes (2013), available at www.rnao.ca

- University of Toronto, Centre for Interprofessional Education, Tools and Toolkits (2017), available at www.ipe.utoronto.ca

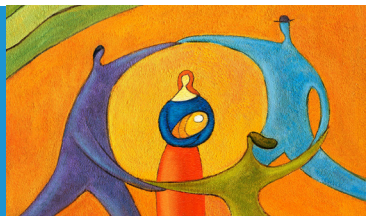
**Resources on Conflict Management**

- Canadian Medical Protective Association, Dealing With Conflict in the Doctor-Patient Relationship (2013), available at www.cmpa-acpm.ca

- Royal College of Physicians and Surgeons of Canada, Primer on Conflict Resolution (2017), available at www.royalcollege.ca

- Ontario Hospital Association, Physician Leadership Resource Manual, Module 4 – Leading High Performing Teams (2013), available at www.oha.com

# Part 5: Appendices



## ASSISTED *HUMAN REPRODUCTION ACT* (S.C. 2004 C. 2)

### Relevant Provisions

**Declaration**
**2.** The Parliament of Canada recognizes and declares that

*(a)* the health and well-being of children born through the application of assisted human reproductive technologies must be given priority in all decisions respecting their use;

*(b)* the benefits of assisted human reproductive technologies and related research for individuals, for families and for society in general can be most effectively secured by taking appropriate measures for the protection and promotion of human health, safety, dignity and rights in the use of these technologies and in related research;

*(c)* while all persons are affected by these technologies, women more than men are directly and significantly affected by their application and the health and well-being of women must be protected in the application of these technologies;

*(d)* the principle of free and informed consent must be promoted and applied as a fundamental condition of the use of human reproductive technologies;

*(e)* persons who seek to undergo assisted reproduction procedures must not be discriminated against, including on the basis of their sexual orientation or marital status;

*(f)* trade in the reproductive capabilities of women and men and the exploitation of children, women and men for commercial ends raise health and ethical concerns that justify their prohibition; and

*(g)* human individuality and diversity, and the integrity of the human genome, must be preserved and protected.

**Definitions**
**3.** The following definitions apply in this Act.

…

"surrogate mother"

"surrogate mother" means a female person who — with the intention of surrendering the child at birth to a donor or another person — carries an embryo or foetus that was conceived by means of an assisted reproduction procedure and derived from the genes of a donor or donors.

**Payment for surrogacy**
**6. (1)** No person shall pay consideration to a female person to be a surrogate mother, offer to pay such consideration or advertise that it will be paid.

**Acting as intermediary**
**(2)** No person shall accept consideration for arranging for the services of a surrogate mother, offer to make such an arrangement for consideration or advertise the arranging of such services.

**Payment to intermediaries**
**(3)** No person shall pay consideration to another person to arrange for the services of a surrogate mother, offer to pay such consideration or advertise the payment of it.

**Surrogate mother — minimum age**
**(4)** No person shall counsel or induce a female person to become a surrogate mother, or perform any medical procedure to assist a female person to become a surrogate mother, knowing or having reason to believe that the female person is under 21 years of age.

**Validity of agreement**
**(5)** This section does not affect the validity under provincial law of any agreement under which a person agrees to be a surrogate mother.

**Reimbursement of expenditures**
**12. (1)** No person shall, except in accordance with the regulations,

*(a)* reimburse a donor for an expenditure incurred in the course of donating sperm or an ovum;

*(b)* reimburse any person for an expenditure incurred in the maintenance or transport of an *in vitro* embryo; or

*(c)* reimburse a surrogate mother for an expenditure incurred by her in relation to her surrogacy.

**Receipts**
**(2)** No person shall reimburse an expenditure referred to in subsection (1) unless a receipt is provided to that person for the expenditure.

**No reimbursement**
**(3)** No person shall reimburse a surrogate mother for a loss of work-related income incurred during her pregnancy, unless

*(a)* a qualified medical practitioner certifies, in writing, that continuing to work may pose a risk to her health or that of the embryo or foetus; and

*(b)* the reimbursement is made in accordance with the regulations.

# *CHILDREN'S LAW REFORM ACT* (R.S.O. 1990 C. C.12)

## Relevant Provisions

**Rule of parentage**
**1. (1)** Subject to subsection (2), for all purposes of the law of Ontario a person is the child of his or her natural parents and his or her status as their child is independent of whether the child is born within or outside marriage.

**Birth parent**
**6 (1)** The birth parent of a child is, and shall be recognized in law to be, a parent of the child. 2016, c. 23, s. 1 (1).

**Exception, surrogacy**
**(2)** Subsection (1) is subject to the relinquishment of an entitlement to parentage by a surrogate under section 10, or to a declaration by a court to that effect under section 10 or 11. 2016, c. 23, s. 1 (1).

**Surrogacy, up to four intended parents**

**Definitions**
**10 (1)** In this section and in section 11,

"intended parent" means a party to a surrogacy agreement, other than the surrogate; ("parent d'intention")

"surrogacy agreement" means a written agreement between a surrogate and one or more persons respecting a child to be carried by the surrogate, in which,

*(a)* the surrogate agrees to not be a parent of the child, and

*(b)* each of the other parties to the agreement agrees to be a parent of the child. ("convention de gestation pour autrui") 2016, c. 23, s. 1 (1).

**Application**
**(2)** This section applies only if the following conditions are met:

1. The surrogate and one or more persons enter into a surrogacy agreement before the child to be carried by the surrogate is conceived.

2. The surrogate and the intended parent or parents each received independent legal advice before entering into the agreement.

3. Of the parties to the agreement, there are no more than four intended parents.

4. The child is conceived through assisted reproduction.

**Recognition of parentage**
**(3)** Subject to subsection (4), on the surrogate providing to the intended parent or parents consent in writing relinquishing the surrogate's entitlement to parentage of the child,

*(a)* the child becomes the child of each intended parent and each intended parent becomes, and shall be recognized in law to be, a parent of the child; and

*(b)* the child ceases to be the child of the surrogate and the surrogate ceases to be a parent of the child.

**Limitation**
**(4)** The consent referred to in subsection (3) must not be provided before the child is seven days old.

**Parental rights and responsibilities**
**(5)** Unless the surrogacy agreement provides otherwise, the surrogate and the intended parent or parents share the rights and responsibilities of a parent in respect of the child from the time of the child's birth until the child is seven days old, but any provision of the surrogacy agreement respecting parental rights and responsibilities after that period is of no effect.

**Failure to give consent**
**(6)** Any party to a surrogacy agreement may apply to the court for a declaration of parentage with respect to the child if the consent referred to in subsection (3) is not provided by the surrogate because,

*(a)* the surrogate is deceased or otherwise incapable of providing the consent;

*(b)* the surrogate cannot be located after reasonable efforts have been made to do so; or

*(c)* the surrogate refuses to provide the consent.

**Declaration**
**(7)** If an application is made under subsection (6), the court may,

*(a)* grant the declaration that is sought; or

*(b)* make any other declaration respecting the parentage of a child born to the surrogate as the court sees fit.

**Child's best interests**
**(8)** The paramount consideration by the court in making a declaration under subsection (7) shall be the best interests of the child.

**Effect of surrogacy agreement**
**(9)** A surrogacy agreement is unenforceable in law, but may be used as evidence of,

*(a)* an intended parent's intention to be a parent of a child contemplated by the agreement; and

*(b)* a surrogate's intention to not be a parent of a child contemplated by the agreement.

**Surrogacy, more than four intended parents**
**11 (1)** If the conditions set out in subsection 10 (2) are met other than the condition set out in paragraph 3 of that subsection, any party to the surrogacy agreement may apply to the court for a declaration of parentage respecting a child contemplated by the agreement.

**Time limit**
**(2)** An application under subsection (1) may not be made,

*(a)* until the child is born; and

*(b)* unless the court orders otherwise, after the first anniversary of the child's birth.

**Parental rights and responsibilities**
**(3)** Unless the surrogacy agreement provides otherwise, the surrogate and the intended parents share the rights and responsibilities of a parent in respect of the child from the time of the child's birth until the court makes a declaration of parentage respecting the child.

**Declaration**
**(4)** If an application is made under subsection (1), the court may make any declaration that the court may make under section 10 and, for the purpose, subsections 10 (8) and (9) apply with necessary modifications.

**Post-birth consent of surrogate**
**(5)** A declaration naming one or more intended parents as a parent of the child and determining that the surrogate is not a parent of the child shall not be made under subsection (4) unless, after the child's birth, the surrogate provides to the intended parents consent in writing relinquishing the surrogate's entitlement to parentage of the child.

**Waiver**
**(6)** Despite subsection (5), the court may waive the consent if any of the circumstances set out in subsection 10 (6) apply

# *HEALTH INSURANCE ACT* (R.S.O 1990 C. H.6) AND REGULATION 552

## Relevant Provisions

**Definitions**
**1.** In this Act,

…

"resident" means a resident as defined in the regulations and the verb "reside" has a corresponding meaning; ("résident")

**Ontario Health Insurance Plan continued**
**10.** The Ontario Health Insurance Plan is continued for the purpose of providing for insurance against the costs of insured services on a non-profit basis on uniform terms and conditions available to all residents of Ontario, in accordance with this Act, and providing other health benefits related thereto.

**Right to insurance**
**11. (1)** Every person who is a resident of Ontario is entitled to become an insured person upon application therefor to the General Manager in accordance with this Act and the regulations.

…

**Insured services**
**11.2 (1)** The following services are insured services for the purposes of the Act:

1. Prescribed services of hospitals and health facilities rendered under such conditions and limitations as may be prescribed.

2. Prescribed medically necessary services rendered by physicians under such conditions and limitations as may be prescribed.

3. Prescribed health care services rendered by prescribed practitioners under such conditions and limitations as may be prescribed. **1996, c. 1, Sched. H, s. 8.**

## Regulation 552 under the *Health Insurance Act* ("General" Regulation)

### Relevant Provisions

**1.2** For the purposes of the Act and any regulation made under the Act, and despite any other meaning of the term "resident", resident means a person described in sections 1.3 to 1.14 who meets the requirements set out in this Regulation to be recognized as a resident, and for greater certainty, a person whose primary place of residence ceases to be Ontario ceases to be a resident, unless subsection 1.3 (2) applies.

**1.3 (1)** Upon application to be an insured person, a person must meet the following requirements in order to be considered a resident, unless subsection (2) or another provision of this Regulation provides otherwise:

1. The person must possess an eligible status set out in section 1.4. A person who has an eligible status, then loses it, is no longer a resident, but may regain resident status at a later date by meeting the necessary requirements at that time.

2. The person's primary place of residence must be in Ontario. For this purpose, the General Manager will consider a child under 16 years old to have the primary place of residence of a person who has lawful custody of the child unless the General Manager has information to the contrary.

**1.4** A person cannot be recognized as a resident, unless the person has one of the following eligible statuses:

1. Being a Canadian citizen.

2. Being a landed immigrant under the former Immigration Act (Canada), or a permanent resident under the Immigration and Refugee Protection Act (Canada).

...

**1.5 (1)** The following requirements must be met for a person to be continued to be recognized as a resident:

1. The person must be in Ontario for at least 153 of the first 183 days after becoming a resident, except for,

   …

   iii. a child to whom section 6 applies, or

   …

2. Except for those persons listed in subsection 1.3 (2), the person must continue to maintain his or her primary place of residence in Ontario.

3. Subject to sections 1.6 to 1.14, the person must be physically present in Ontario for at least 153 days in any given 12-month period.

**(2)** For the purposes of subsection (1), the General Manager will consider a child under 16 years old to be physically present with and have the primary place of residence of a person who has lawful custody of the child unless the General Manager has information to the contrary.

**5. (1)** Subject to subsection (2) and sections 6 to 6.3, and to subsection 11 (2.1) of the Act, a person shall only start receiving insured services once the General Manager is satisfied that he or she has been a resident for three full consecutive months, and has not stopped being a resident since meeting that three-month waiting period requirement.

**6. (1)** A newborn, who, on the date of his or her birth, meets the requirements to be a resident is exempt from the three-month waiting period for the three months immediately following the date of birth.

# *HEALTH CARE CONSENT ACT*, 1996 (SO 1996, C 2, SCH A)

## Relevant Provisions

**Capacity**
**4. (1)** A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

**Presumption of capacity**
**(2)** A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.

**Exception**
**(3)** A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.

**No treatment without consent**
**10. (1)** A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act

## Consent

**List of persons who may give or refuse consent**
**20. (1)** If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.

2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.

3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.

4. The incapable person's spouse or partner.

5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.

6. A parent of the incapable person who has only a right of access.

7. A brother or sister of the incapable person.

8. Any other relative of the incapable person.

**Requirements**
**(2)** A person described in subsection (1) may give or refuse consent only if he or she,

*(a)* is capable with respect to the treatment;

*(b)* is at least 16 years old, unless he or she is the incapable person's parent;

*(c)* is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;

*(d)* is available; and

*(e)* is willing to assume the responsibility of giving or refusing consent.

**Ranking**
**(3)** A person described in a paragraph of subsection (1) may give or refuse consent only if no person described in an earlier paragraph meets the requirements of subsection (2).

**Conflict between persons in same paragraph**
**(6)** If two or more persons who are described in the same paragraph of subsection (1) and who meet the requirements of subsection (2) disagree about whether to give or refuse consent, and if their claims rank ahead of all others, the Public Guardian and Trustee shall make the decision in their stead.

# *LEGISLATION ACT*

**Relevant Provisions:**
**89 (1)** Time limits that would otherwise expire on a holiday are extended to include the next day that is not a holiday.

…

**Number of days between events**
**(3)** A reference to a number of days between two events excludes the day on which the first event happens and includes the day on which the second event happens, even if the reference is to "at least" or "not less than" a number of days. 2006, c. 21, Sched. F, s. 89 (3).

# *PERSONAL HEALTH INFORMATION PROTECTION ACT* (S.O. 2004 C. 3 SCH A)

## Relevant Provisions

**Elements of consent**
**18. (1)** If this Act or any other Act requires the consent of an individual for the collection, use or disclosure of personal health information by a health information custodian, the consent,

*(a)* must be a consent of the individual;

*(b)* must be knowledgeable;

*(c)* must relate to the information; and

*(d)* must not be obtained through deception or coercion.

**Implied consent**
**(2)** Subject to subsection (3), a consent to the collection, use or disclosure of personal health information about an individual may be express or implied.

**Exception**
**(3)** A consent to the disclosure of personal health information about an individual must be express, and not implied, if,

*(a)* a health information custodian makes the disclosure to a person that is not a health information custodian; or

*(b)* a health information custodian makes the disclosure to another health information custodian and the disclosure is not for the purposes of providing health care or assisting in providing health care.

**Withdrawal of consent**
**19. (1)** If an individual consents to have a health information custodian collect, use or disclose personal health information about the individual, the individual may withdraw the consent, whether the consent is express or implied, by providing notice to the health information custodian, but the withdrawal of the consent shall not have retroactive effect.

**Conditional consent**
**(2)** If an individual places a condition on his or her consent to have a health information custodian collect, use or disclose personal health information about the individual, the condition is not effective to the extent that it purports to prohibit or restrict any recording of personal health information by a health information custodian that is required by law or by established standards of professional practice or institutional practice.

**Requirement for consent**
**29.** A health information custodian shall not collect, use or disclose personal health information about an individual unless,

*(a)* it has the individual's consent under this Act and the collection, use or disclosure, as the case may be, to the best of the custodian's knowledge, is necessary for a lawful purpose; or

*(b)* the collection, use or disclosure, as the case may be, is permitted or required by this Act.

# *PUBLIC HOSPITALS ACT* (R.S.O. 1990 C. P.40) AND REGULATION 965

## Relevant Provisions

**Admission of patients**
**20.** A hospital shall accept a person as an in-patient if,

*(a)* the person has been admitted to the hospital pursuant to the regulations; and

*(b)* the person requires the level or type of hospital care for which the hospital is approved by the regulations.

**Refusal of admission**
**21.** Nothing in this Act requires any hospital to admit as an in-patient,

*(a)* any person who is not a resident or a dependant of a resident of Ontario, unless by refusal of admission life would thereby be endangered; or

*(b)* any person who merely requires custodial care.

## Regulation 965 under the *Public Hospitals Act* ("Hospital Management Regulation")

## Relevant Provisions

**11. (1)** No person shall be admitted to a hospital as a patient except,

*(a)* on the order or under the authority of a physician who is a member of the medical staff;

*(a.1)* on the order or under the authority of a registered nurse in the extended class who is a member of the extended class nursing staff;

*(b)* on the order or under the authority of an oral and maxillofacial surgeon who is a member of the dental staff;

*(b.1)* if the person is being admitted for treatment by a dentist who is a member of the dental staff other than an oral and maxillofacial surgeon, on the joint order of the dentist and a physician who is a member of the medical staff; or

*(c)* on the order or under the authority of a midwife who is a member of the midwifery staff.

**(2)** No physician, registered nurse in the extended class, dentist or midwife shall order the admission of a person to a hospital unless, in the opinion of the physician, registered nurse in the extended class, dentist or midwife, it is clinically necessary that the person be admitted.

# *VITAL STATISTICS ACT* (R.S.O. 1990 C. V.4) AND REGULATION 1094

## Relevant Provisions

**Definitions**
**1.** In this Act,

…

"birth" means the complete expulsion or extraction from its mother of a fetus that did at any time after being completely expelled or extracted from the mother breathe or show any other sign of life, whether or not the umbilical cord was cut or the placenta attached; ("naissance")

"birth parent", in relation to an adopted person, means a person whose name appears as a parent on the original registration, if any, of the adopted person's birth and such other persons as may be prescribed; ("père ou mère de sang")

**Notice of birth**
**8.** If required by the regulations, a person who attends at the birth of a child in Ontario shall give notice of the birth in the manner, within the time and to the person prescribed by the regulations.

**Certification of birth**
**9. (1)** The parents of a child born in Ontario, or one of them in such circumstances as may be prescribed, or such other person as may be prescribed, shall certify the child's birth in the manner, including providing such information and documentation as may be prescribed, within the time and to the person prescribed by the regulations

## Regulation 1094 under the *Vital Statistics Act* ("General" Regulation)

**Relevant Provisions:**
**1. (1)** Upon the birth in Ontario of a child, the following persons shall give notice of the birth under section 8 of the Act in accordance with subsections (2) and (3) of this section, unless a person in attendance at the birth gives the notice in accordance with subsection (4):

1. Each legally qualified medical practitioner or midwife who attends at the birth, except if another legally qualified medical practitioner or midwife who attends at the birth gives the notice.

2. The nurse or other person in attendance at the birth, if no legally qualified medical practitioner or midwife is in attendance at the birth.

**(2)** The notice of birth given under subsection (1) shall be in the form that the Registrar General approves.

**(3)** The person giving the notice of birth under subsection (1) shall mail or deliver it to the Registrar General within two business days after the birth.

…

**2(3.2)** For the purposes of subsection 9 (1) of the Act, if a surrogate gives birth to a child in Ontario and the intended parents of the child and the surrogate have entered into a surrogacy agreement with respect to the child in accordance with the *Children's Law Reform Act*, no more than four intended parents under the agreement, and no other persons, are required to certify the birth

…

**(6.1)** If the intended parents of a child born in Ontario have entered into a surrogacy agreement with respect to the child in accordance with the *Children's Law Reform Act*, none of them shall certify the birth of the child or mail, deliver or submit the statement described in subsection (4) of this section until at least seven days after the birth.

…

**(11.2)** If the intended parents of a child born in Ontario have entered into a surrogacy agreement in accordance with section 10 of the *Children's Law Reform Act* with respect to the child and any of them have certified the birth under subsection 9 (1) of the Act, the Registrar General shall not register the birth under subsection 9 (3) of the Act unless,

*(a)* each of the intended parents who certified the birth consents to be included on the birth registration; and

*(b)* the intended parents provide to the Registrar General the following documents, together with the statement certifying the child's birth:

(i) a statutory declaration by the surrogate stating that the surrogate does not intend to be a parent of the child and has complied with section 10 of the Children's Law Reform Act, and

(ii) a statutory declaration by each of the intended parents who certified the child's birth stating that each of them intends to be a parent of the child and has complied with section 10 of the *Children's Law Reform Act*.

**(11.3)** Subsection (11.2) applies only if the intended parents are the parents of the child under section 10 of the *Children's Law Reform Act* without a court order.

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