Involuntary Sterilisation

by

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Two papers delivered by Mr. Douglas Graham Q.C. and
Mr. Peter Renou on 1st October 1988 at the
Royal Australian College of Surgeons.
The Chairman of the meeting was
The Hon. Mr. Justice Tadgell.

Mr. Chairman:
Let me start with a quotation:

> 'We must, if we are to be consistent, and if we're to have a real pedigree herd, mate the best of our men with the best of our women as often as possible, and the inferior men with the inferior women as seldom as possible, and keep only the offspring of the best. And no-one but the rulers must know what is happening, if we are to avoid dissension in our Guardian breed.'

This was written some two thousand four hundred years ago. It is taken from Plato's *Republic*[1]. Views of a similar kind gained much currency only a century ago when Sir Francis Galton, a cousin of Darwin, published his celebrated work 'Enquiries into Human Faculty', and set in train the eugenic movement. This movement had enormous influence in the United States so that by the 1920s, some 30 States had enacted laws providing, in varying circumstances, for the compulsory sterilisation of persons suffering from serious mental handicaps and disorders, and, in some jurisdictions, of habitual criminals.

Not surprisingly such legislation attracted challenges based upon the constitutional guarantees in State constitutions and in the Bill of Rights itself. The high-water mark of the eugenic movement in the United States was the 1926 judgment of the Supreme Court of the United States delivered by Oliver Wendell Holmes J. in *Buck* v. *Bell*[2]

This was an appeal to the Supreme Court of the U.S. from the Supreme Court of Appeals of Virginia. The appellant, Carrie Buck was an inmate in the State Colony for Epileptics and the Feeble-minded, the respondent being the superintendent of that institution. The appellant was a feeble-minded white woman, the daughter of a feeble-minded mother in the same institution and the mother of an illegitimate feeble-minded child. She was 18 years old at the time of the original hearing by the circuit court in 1924.

The proceedings arose out of a Virginia Act of 1924 which provided for the sterilisation of the inmates of certain State institutions by vasectomy or salphingectomy. The Act recited that the health of the patient and the welfare of society may be promoted in certain cases by the sterilisation of mental defectives, and that the

State was supporting in various institutions many defective persons who, if now discharged, would become a menace but if incapable of procreating might be discharged with safety and become self-supporting with benefit to themselves and to society. The Act laid down detailed procedures to be followed before an inmate could be sterilised, provisions being made for the appointment of a guardian of the inmate in all cases, for a hearing by the board of the institution of the superintendent's application for an order for sterilisation and for an appeal through the hierarchy of courts against any such order.

This Act was an example of a eugenic statute. The case came to the Supreme Court on the basis of a challenge to the Act which, it was submitted, contravened the 14th Amendment by denying the appellant due process of law and the equal protection of the law. The challenge failed.

In delivering the judgment of the Court, Holmes J. at p. 207 said:

> 'We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world if, instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. *Jacobson* v. *Massachusetts*, 197 U.S. 11, 49, L. ed. 643, 25 Sup. Ct. Rep. 358, 3 Ann. Cas. 765. Three generations of imbeciles are enough.'

Since this decision there has been a notable retreat from that view. Thus in 1942 the Supreme Court struck down an Oklahoma statute which provided for the compulsory sterilisation of men thrice convicted of felony on the basis that such a law denied the constitutional right to procreate[3]. Given that Court's views upholding the sanctity of the individual's right of choice in relation to matters such as contraception[4] and abortion[5] it seems unlikely that the views expressed in *Buck* v. *Bell* would find favour

today. Nonetheless a recent count disclosed that 14 States continued to have eugenic laws on their statute books[5].

The demise of eugenics as a respectable theory was under way before it was wholly discredited by the hideous experimentation carried on under that name in Nazi Germany.

But that demise itself created problems for lawyers and medical practitioners alike, because a procedure in any case which smacked of eugenics came to be viewed with great concern and suspicion.

Nevertheless it has come to be recognised in many jurisdictions that sterilisation procedures may properly and lawfully be undertaken upon persons who, by reason of mental incapacity, are unable to give consent to the procedure. The Courts have recognised that a distinction exists between compulsory sterilisation where the procedure is dictated or compelled by the State pursuant to statute, and involuntary sterilisation where the procedure is undertaken upon persons who are not themselves able to consent but whose own best interests require it[7]. This position has been reached in many cases through the decisions of the Courts unaided by legislation, and a study of the course of decision provides a fascinating insight into the decision-making process and into the profound differences of judicial opinion which emerge when such difficult issues confront the Courts.

In the remainder of this Paper I shall briefly trace several streams of judicial thinking in the United States on the topic of involuntary sterilisation of the mentally incompetent, then refer to a striking conflict of opinion at the highest judicial levels in Canada and the United Kingdom, and go finally to the legal position in Victoria.

In all of the cases which have come before the Courts the form of proceedings has involved the invocation of the jurisdiction which courts exercising equitable jurisdiction have in respect of the persons and property of infants and children and of those who, by reason of mental infirmity, are denied the capacity to make competent decisions on their own behalf. This jurisdiction derives at least in part from the medieval concept of the Sovereign as *parens patriae* and of the exercise of the functions and responsibilities arising from that position in respect of those subjects in need of special care and protection by the Lord Chancellor as delegate of

the Sovereign[8]. The concept underlying the exercise of the Lord Chancellor's jurisdiction was said by Lord Eldon in 1827 to be:

> 'the obvious necessity that the law should place somewhere the care of individuals who cannot take care of themselves, particularly in cases where it is clear that some care should be thrown round them.'[9]

That jurisdiction was commonly invoked in respect of wards of court and in many of the cases which have come before the courts the applicant has sought an order that the intended patient be made a ward of court and a further order which would provide the court's authority for sterilisation.

The pattern of judicial decision in the United States was relatively uniform over a period until 1979. In cases decided in ten jurisdictions the Courts almost consistently held that the powers of the court under the *parens patriae* jurisdiction did not enable it to authorise the involuntary sterilisation of a mentally incompetent person regardless of the dictates of the interests of such a person[10]. In some of those cases there can be detected a concern on the part of the Court that a decision to grant an authorisation in such circumstances might not only exceed the jurisdiction of the court but involve an infringement by the very order of the court itself of the civil rights of the mentally incompetent person so as to breach the immunity normally accorded to judges and to expose the judges to legal action at the suit of the incompetent.

In 1978 the United States Supreme Court delivered its decision in the landmark case of *Stump* v. *Sparkman*[11]. The facts of this case illustrate the dangers inherent in the process of judicial authorisation of sterilisation.

The mother of the respondent had applied by petition to the Indiana Circuit Court for authority to have her daughter, then aged 15, sterilised. The reasons advanced were that the respondent was somewhat mentally retarded, although she was attending the ordinary public school and progressed with other children of her age, that she had left home on occasions to associate with older youths and young men and stayed overnight with them, and that the mother believed that it would be in the best interests of the respondent to have a tubal ligation performed. The application was unsupported by any medical evidence. There

was no State legislation dealing with sterilisation other than of persons in institutions.

The application was heard informally, the appellant judge being neither robed nor in his courtroom. The initiating petition was not given a court proceeding number nor placed on the Court file in the clerk's office. The hearing took place without notice to the respondent and in her absence. No guardian was appointed. The judge simply endorsed his approval upon the petition. The procedure was carried out in the local hospital, the respondent having been led to believe that she was having her appendix removed. The respondent later brought proceedings against the parties involved, including the judge, for infringement of her civil rights.

It is a long-established rule in common law jurisdictions that a judge is immune from legal proceedings against him in respect of actions taken in his judicial capacity and within the jurisdiction of the court of which he is a member. The court of which Judge Stump was a member was one of full and general jurisdiction and the Supreme Court held that an order such as that which he had made was within that court's jurisdiction. Hence he enjoyed judicial immunity and the action failed. But the authority of the courts of the United States to make such orders was plainly established.

Following this decision the Courts in a number of States were prepared to grant orders authorising the involuntary sterilisation of mentally incompetent persons. In a series of cases in the period 1980 to 1983 the highest courts of the States of Washington[12], New Jersey[13], Alaska[14], Colorado[15], Massachusetts[16], Maryland[17], Pennsylvania[18] and Indiana[19] held that such orders could be made. Early in that sequence of decisions the Courts set out careful rules to be observed by judges at first instance in exercising this part of the *parens patrae* jurisdiction, and those rules were, in the main, adopted, sometimes with refinements, in later cases. The decision of the Supreme Court of New Jersey in *Re Lee Ann Grady*[13] is an illuminating example from this course of decision. The facts were typical of those which recur in the cases.

The subject of this application was a girl aged 19 suffering seriously with Down's Syndrome (trisomy 21). She was unable to read or write and had very limited abilities to count or converse. She could perform only the simplest personal and domestic tasks. However she did not suffer some of the physical disorders

associated with the condition. Her appearance was almost normal, as was her life expectancy and her physical maturation had not deviated significantly from that of other adolescents. Her sexual development had progressed normally in the physical sense but her severe mental impairment had prevented the emotional and social development of sexuality. She had no significant understanding of sexual relationships or marriage. As the evidence in the earlier case of *Re C.D.M.*[14] had indicated, victims of Down's Syndrome are characteristically highly susceptible to being sexually victimised by virtue of their innocent, trusting and loving nature. In that case the evidence showed that if the subject were to have a child there was at least a 50 per cent chance that it would be born with Down's Syndrome and if the father suffered from the disorder it was virtually certain that the child would be so afflicted. She would not understand her condition if she became pregnant; she would not be able to care for a baby and indeed would require lifetime supervision in caring for herself. Her parents with whom she lived had provided for birth control by oral contraception. However they were concerned that she achieve a life which was less dependent upon her family and hoped to place her in a sheltered work group and eventually in a group home for retarded adults. They regarded dependable and continuous contraception as essential and, with their physician's advice, sought her sterilisation at the local hospital which, however, refused to undertake the procedure.

Careful procedural safeguards were observed at the direction of the primary judge. A guardian ad litem was appointed to represent the subject's interests whilst the Public Advocate and the Attonery-General intervened to represent the interests of the public and of the State. The primary judge ordered that the parents be permitted to exercise substituted judgment on behalf of their daughter, setting out and applying a set of guidelines which he formulated. [It is to be noted that these guidelines did not refer to the best interests of the subject, the public interest or the medical need for the procedure or its desirability.]

The Public Advocate and the Attorney-General appealed to the Supreme Court of New Jersey which allowed the appeal and remanded the case for reconsideration upon the basis of standards which it formulated.

The Court reviewed the decisions of courts in other States and observed that the weight of authority was against it, referring to the many cases when it had been held that courts lacked the power to grant relief without legislative authority.

The standards adopted by the Court were closely modelled on those formulated by the Supreme Court of the State of Washington in the earlier case of *Re Guardianship of Hayes*[12]. First, it is for the court not the parents to determine the need for sterilisation. In doing so it is necessary for the court to be satisfied that sterilisation is in the best interests of the incompetent person. Secondly there must be full and careful procedural safeguards and adequate medical and psychological evaluations. While the incompetent person need not be present, the judge should personally meet with him or her to obtain his own impressions of competency. Thirdly the court must find that the individual lacks the capacity to make a decision about sterilisation and that the incapacity is unlikely to improve in the foreseeable future. Finally the court must be satisfied by clear and convincing proof that sterilisation is in the best interests of the incompetent person. In doing so the court must take into account at least the following factors:

(1) The possibility that the incompetent person can become pregnant. There need be no showing that pregnancy is likely. The court can presume fertility if the medical evidence indicates normal development of sexual organs and the evidence does not otherwise raise doubts about fertility.
(2) The possibility that the incompetent person will experience trauma or psychological damage if she become pregnant or gives birth and, conversely, the possibility of trauma or psychological damage from the sterilisation operation.
(3) The likelihood that the individual will voluntarily engage in sexual activity or be exposed to situations where sexual intercourse is imposed upon her.
(4) The inability of the incompetent person to understand reproduction or contraception and the likely permanence of that inability.
(5) The feasibility and medical advisability of less drastic means of contraception, both at the present time and under foreseeable future circumstances.

(6) The advisability of sterilisation at the time of the application rather than in the future. While sterilisation should not be postponed until unwanted pregnancy occurs, the court should be cautious not to authorise sterilisation before it clearly has become an advisable procedure.
(7) The ability of the incompetent person to care for a child, or the possibility that the incompetent may at some future date be able to marry and, with a spouse, care for a child.
(8) Evidence that scientific or medical advances may occur within the forseeable future which will make possible either improvement of the individual's condition or alternative and less drastic sterilisation procedures.
(9) A demonstration that the proponents of sterilisation are seeking it in good faith and that their primary concern is for the best interests of the incompetent person rather than their own or the public's convenience.'

But while the Courts in several States grappled with the problems themselves the Supreme Court of Wisconsin, in the majority judgment of a bitterly divided court in *Re Guardianship of Eberhardy*[20], decided that the lower courts of that State should refrain from exercising jurisdiction in such cases until the Legislature had had the opportunity of considering the whole matter and, after public hearings, decided whether to enact enabling legislation.

The Court disagreed with the views of the lower courts that they lacked the power to make orders authorising sterilisation in the absence of a grant of jurisdiction by the Legislature, holding that those courts had been invested by the State Constitution and the relevant statutes with as full and ample a jurisdiction as possible both in law and equity.

The Court considered that the question was whether there was a method by which others, acting in the best interests of the person concerned, can make the decision. If the Court were to decide that the subject in this case should be sterilised it would be deciding her best interests but it would also be deciding at the same time that it was appropriate and not contrary to public policy to make the order. The Court referred to the very limited amount of medical evidence of a general nature which was before it, the limited information which it had concerning alternative contraceptive techniques and their effect, the possible availability of new

contraceptive techniques, the likelihood of retarded persons giving birth without serious trauma and of then becoming good parents and the lack of any involvement in the proceedings before the courts of the public or of groups representing the interests of retarded or incompetent persons. Hence the Court concluded that it was not the appropriate forum for making policy decisions in a sensitive area. The legislature through the hearing processes and with its ability to obtain the assistance of informed persons and to respond to community views was far better equipped. The majority quoted Frankfurter J. in *Sherrer* v. *Sherrer* (1948), 334 U.S. 343, 365 as follows:

> 'Courts are not equipped to pursue the paths for discovery of wise policy. A court is confined within the bounds of a particular record, and it cannot even shape the record. Only fragments of a social problem are seen through the narrow windows of a litigation. Had we innate or acquired understanding of a social problem in its entirety, we would not have at our disposal adequate means for constructive solution. The answer to so tangled a problem ... is not to be achieved by ... judicial resources ...'

The court considered itself to be entitled both to recognise the existence of the jurisdiction and to direct the lower courts of the State to refrain from exercising it until the legislature had had the opportunity of considering the whole question and to take the decision which was a public policy decision that should be taken by the people or their elected representatives.

Coffey J. dissented on the ground that the Courts did not have the jurisdiction which the majority was prepared to accord to them, and criticised the majority because of the far-reaching implications of their view concerning the existence of a power in the Courts to make decisions in such matters. He said (p. 903)

> 'Under the radical expansion of judicial power announced by the majority, will our already overburdened judicial system next face the prospect of a new flood of public policy litigation dealing with issues of who is to receive the benefit of a medical breakthrough? Today, the ever expanding field of medical research is almost taxed to the limits of its fiscal capacity in covering the costs of the professional and highly technical

> services involved in such areas as cancer research and heart, eye, kidney and liver transplants. Will courts order hospitals to expand their facilities so as to accommodate all who need or want the benefits of new treatment and/or surgical procedures, and will doctors be ordered to administer and/or perform them? Will the courts take it upon themselves to choose those persons who will receive the benefit of the various medical research programs and refuse others? And, in the area of organ transplants, will the courts decide not only who will receive organs, but also who will donate? Will judges decide on the basis of their belief as to who will be the most productive members of our society in the future or will other factors such as finances and social or political influence be the basis for decision? Will the courts not be faced if we follow the logical process of reason with the question as to why society should not assume control over the individual and subordinate him or her to its own ideas of what is good for the human race? We are opening the door to a never ending series of problems without a rational, moral or ethical solution.'

Day J. dissented on the ground that the courts did have jurisdiction and should not refrain from exercising it. This judgment is a superb example of the American judicial dissent, full of barbed criticisms of the majority opinion. He had begun his judgment in these terms (p. 906)

> 'Two thousand years ago a judge, clothed with the power and authority to do justice, but sensing the political winds ('willing to content the people' as the ancient word puts it), washed his hands and said to the people: 'See ye to it.' Today, the majority of this court, in my opinion, withholds justice from Joan Eberhardy. It turns to the legislature, the 'representatives of the people,' and says in effect, 'you see to it.' Washing its hands and turning the demand for justice over to the legislature demeans this court, denigrates its role, and makes a mockery of its powers.'

He concluded by saying (p. 911)

> 'Maybe someday, even in Wisconsin, those with power to do justice will not ask for the wash basin.'

Meanwhile in Canada the important case of *Re Eve*[21] had come before the Supreme Court of Prince Edward Island. As in similar cases in the United States the court's *parens patriae* jurisdiction was invoked in an application for an order authorising the sterilisation of a 24 year old mentally incompetent female, and, by majority, the Full Court of the Province in 1981, granted the order. The cause was taken on appeal to the Supreme Court of Canada[22] where, in a unanimous decision of all nine judges delivered by La Forest J. in 1986, the appeal was allowed and the order was set aside. The conclusions of the Court were as follows:

(1) The *parens patriae* jurisdiction may be used to authorise the performance of a surgical operation necessary for the health of a mentally incompetent person.
(2) Although the scope or sphere of operation of the *parens patriae* jurisdiction may be unlimited and the categories of case in which it may be exercised are never closed, it by no means follows that the discretion to exercise the jurisdiction is unlimited.
(3) There was no evidence in the present case that failure to perform the operation would have any detrimental effect on Eve's physical or mental health, and hence the operation should not have been authorised.
(4) La Forest J. expressed the next conclusion in terms which should be quoted:

> 'The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilisation without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly the procedure should never be authorised for non-therapeutic purposes under the *parens patriae* jurisdiction.' (p. 32).

The reasons given for this final and far-reaching conclusion were expressed thus:

> 'Nature or the advances of science may, at least in a measure, free Eve of the incapacity from which she suffers. Such a possibility should give the courts pause in extending their power to care for individuals to such irreversible action as we are called

upon to take here. The irreversible and serious intrusion on the basic rights of the individual is simply too great to allow a court to act on the basis of possible advantages which, from the standpoint of the individual, are highly debatable. Judges are generally ill-informed about many of the factors relevant to a wise decision in this difficult area. They generally know little of mental illness, of techniques of contraception or their efficacy. And, however well presented a case may be, it can only partially inform. If sterilisation of the mentally incompetent is to be adopted as desirable for general social purposes, the legislature is the appropriate body to do so. It is in a position to inform itself and it is attuned to the feelings of the public in making policy in this sensitive area.'

The following year a similar case came before the English Courts. In *Re B (a Minor)*[23] an application of a kind similar to those dealt with in many of the cases already considered came before the court and was granted by the single judge whose decision was unanimously upheld both by the Court of Appeal and the House of Lords.

It was an application by the local authority, supported by the child's mother for an order that the child be made a ward of court and that authority be given for the child to be sterilised. This application was opposed by the Official Solicitor acting as the child's guardian ad litem. The application was commenced in June 1986 at a time when the child was just 17, was heard by Bush J. in January 1987 and, following a hearing by the Court of Appeal in March 1987 was finally disposed of by the House of Lords at the end of April 1987.

The child was moderately mentally handicapped with very low intelligence. She could dress herself and had been taught to cope with menstruation. In some skills she had attained or could hope to attain the standard of a child of 5 or 6. She did not link sexual intercourse with the birth of a child and would be wholly unable to look after a child if she bore one. She would have no maternal instincts. If she became pregnant she would be very disturbed but it would be undesirable for her to undergo abortion if she did become pregnant, although it would also be undesirable for a pregnancy to run its full course. Because of her irregular periods and obesity there was a risk that pregnancy would not be discovered

until it would be too late to undertake abortion. Because of her disturbed condition it would be necessary that any child be delivered by Caesarian section, but because she had a high pain threshold it was likely that she would pick at a surgical wound and tear it open. The alternative would be delivery under heavy sedation involving risk to the unborn child.

The child was also an epileptic, her epilepsy being controlled by anti-convulsant drugs. In addition she took another drug to control her irregular periods and pre-menstrual tension. She had a history of reacting badly to medication and of refusing to accept it. In the circumstances the only form of contraception apart from sterilisation was the progesterone pill which was undesirable because of uncertainty about its long term side effects, high failure rate compared with other contraceptive pills, and likelihood of incompatibility with the other drugs which she was taking.

The child could never give informed consent to sexual intercourse, to a course of contraception, to sterilisation or to abortion. Nevertheless she had normal sexual drive and inclinations and had shown herself vulnerable to the approaches of men. In line with current practice it was desired to avoid her being institutionalised and to maximise her ability to enter and participate in the life of the wider community.

All the judges who dealt with the case considered that the application should be granted. All the judges considered that the Court had the power in its *parens patriae* jurisdiction to authorise the sterilisation, that the paramount consideration was the welfare of the child and that the only issue was the best interests of the child.

The case excited great public interest and much comment. In the House of Lords three of the Law Lords emphatically denied the claims made in the public domain that the proposed sterilisation was an application of eugenic theory. Lord Oliver said (p. 207):

> 'My Lords, none of us is likely to forget that we live in a century which, as a matter of relatively recent history has witnessed experiments carried out in the name of eugenics or for the purpose of population control, so that the very word 'sterilisation' has come to carry emotive overtones. It is important at the very outset, therefore, to emphasise as strongly as it is possible to do

> so, that this appeal has nothing whatever to do with eugenics. It is concerned with one primary consideration and one alone, namely the welfare and best interests of this young woman, an interest which is conditioned by the imperative necessity of ensuring, for her own safety and welfare, that she does not become pregnant.'

See also Lord Hailsham LC (p. 202) and Lord Bridge (p. 204). Lord Oliver posed the question which arose for decision (p. 208) as follows:

> 'Here then is the dilemma. The vulnerability of this young woman, her need for protection, and the potentially frightening consequences of her becoming pregnant are not in doubt. Of the two possible courses, the one proposed is safe, certain but irreversible, the other speculative, possibly damaging and requiring discipline over a period of many years from one of the most limited intellectual capacity. Equally it is not in doubt that this young woman is not capable and never will be capable herself of consenting to undergo a sterilisation operation. Can the court and should the court, in the exercise of its wardship jurisdiction, give on her behalf that consent which she is incapable of giving and which, objectively considered, it is clearly in her interests to give?'

Having carefully reviewed all the evidence Lord Oliver, with whose opinion all the other Law Lords agreed, expressed his conclusion (p. 212) as follows:

> '. . . I desire to emphasise once again that this case is not about sterilisation for social purposes; it is not about eugenics; it is not about the convenience of those whose task it is to care for the ward or the anxieties of her family; and it involves no general principle of public policy. It is about what is in the best interests of this unfortunate young woman and how best she can be given the protection which is essential to her future well-being so that she may lead as full a life as her intellectual capacity allows. That is and must be the paramount consideration as was rightly appreciated by Bush J. and by the Court of Appeal. They came to what, in my judgment, was the only possible conclusion in the interests of the minor.'

The House of Lords had been referred to the Canadian decision of *Re Eve* and in particular to the emphatic proposition of La Forest J. Of this Lord Hailsham (pp. 203–204) said:

> 'I find, with great respect, their conclusion, at p. 32, that the procedure of sterilisation should never be authorised for non-therapeutic purposes totally unconvincing and in startling contradiction to the welfare principle which should be the first and paramount consideration in wardship cases. Moreover, for the purposes of this present appeal I find the distinction they purport to draw between 'therapeutic' and 'non-therapeutic' purposes of this operation in relation to the facts of the present case above as totally meaningless, and, if meaningful, quite irrelevant to the correct application of the welfare principle. To talk of the 'basic right' to reproduce of an individual who is not capable of knowing the causal connection between intercourse and childbirth, the nature of pregnancy, what is involved in delivery, unable to form maternal instincts or to care for a child appears to me wholly to part company with reality.'

Lord Bridge (p. 205) said:

> 'This sweeping generalisation seems to me, with respect, to be entirely unhelpful. To say that the court can never authorise sterilisation of a ward as being in her best interests would be patently wrong. To say that it can only do so if the operation is 'therapeutic' as opposed to 'non-therapeutic' is to divert attention from the true issue, which is whether the operation is in the ward's best interest, and remove it to an area of arid semantic debate as to where the line is to be drawn between 'therapeutic' and non-therapeutic treatment.'

See also Lord Oliver (p. 212).

It seems that the Courts of this country have not had to address the many difficult problems dealt with in the cases previously considered. In Victoria the Legislature has recently passed the Guardianship and Administration Board Act 1986 which provides a formal statutory structure whereby certain major medical procedures may be undertaken in the case of a represented person subject to the consent of the Board and of the guardian of such a person[24]. A 'represented person' includes any person who has attained the age of 18 in respect of whom a guardianship order is in

effect and who suffers from a mental disability[25]. A 'major medical procedure' is to include sterilisation[26]. The Act provides for the conduct of a hearing by the Board before its consent may be granted upon notice to the represented person, that person's guardian and the Public Advocate[27]. The Board is empowered to give its consent if it is satisfied that it would be in the best interests of the represented person to do so[28]. In the case of a person who is a patient for the purpose of the Mental Health Act 1986 the same procedures must be followed[29]. It is interesting to note that neither of those Acts contains any provision which displaces the *parens patriae* jurisdiction of the Supreme Court and that there does not appear to be any legislation dealing with the involuntary sterilisation of persons under the age of 18 who are not patients under the Mental Health Act 1986. Thus circumstances may yet arise where the jurisdiction of the Supreme Court is invoked in one of these difficult and distressing cases.

REFERENCES

1 Plato, *The Republic*, (Lee translation, 1954).
2 (1926), 274 U.S. 200.
3 *Skinner* v. *Oklahoma* (1942), 316 U.S. 538.
4 *Griswold* v. *Connecticut* (1965), 381 U.S. 479; *Eisenstadt* v. *Baird* (1972), 405 U.S. 438.
5 *Roe* v. *Wade* (1973), 410 U.S. 113.
6 Arkansas; Connecticut; Delaware; Georgia; Maine; Mississippi; North Carolina; Oklahoma; Oregon; South Carolina; Utah; Vermont; Virginia; West Virgina.
See Article 'Sterilising the Retarded: Constitutional, Statutory and Policy Alternatives', Sherlock and Sherlock, (1982), 60 N. Carolina Law Rev. 943.
7 *Re Grady* (1981), 426 A. (2nd) 467, 473.
8 A full account of the origins of the *parens patriae* jurisdiction is contained in the judgment of La Forest J. in *Re Eve* (1986), 31 D.L.R. (4th) 1, 13–16.
9 *Wellesley* v. *Duke of Beaufort* (1827), 2 Russ. 1, 20.
10 *Smith* v. *Command* (1925), 204 N.W. 140 ( ); *Holmes* v. *Powers* (1968), 439 S.W. (2nd) 579 (Kentucky); *Frazier* v. *Levi* (1969), 440 S.W. (2nd) 393 (Texas); *Wade* v. *Bethesda Hospital* (1971), 337 F. Supp. 671 (Ohio); *Re Guardianship of Kemp* (1974), 118 Cal. R. 64 (California); *Re M.K.R.* (1974), 515 SW (2nd) 467 (Missouri); *A.L.* v. *G.R.H.* (1975) 325 N.E. (2nd) 501 (Indiana); (overruled in *Re P.S. by Harbin*); *Re S.C.E.* (1977), 378 A. (2nd) 144 (Delaware); *Re Application of A.D.* (1977), 394 N.Y. Supp. (2nd) 139 (New York); *Re Guardianship of Tully* (1978), 146 Cal.R.266 (California); *Hudson* v. *Hudson* (1979, 373 S.(2nd) 310 (Alabama).
Cf. the decision of a single judge in *Re Frances Sallmaier* (1976), 378 N.Y. Supp. (2nd) 989. See also *Strunk* v. *Strunk* (1969), 445 S.W. (2nd) 145, dealing with an involuntary kidney transplant.
11 (1978), 435 U.S. 349.
12 *Re Guardianship of Hayes* (1980), 608 P. (2nd) 635.

13 *Re Lee Ann Grady* (1981), 426 A. (2nd) 467.
14 *Re C.D.M.* (1981), 627 P. (2nd) 607.
15 *Re A.W.* (1981) 637 P. (2nd) 366.
16 *Re Mary Moe* (1981), 432 N.E. (2nd) 712.
17 *Wentzel* v. *Montgomery General Hospital* (1982), 447 A. (2nd) 1244.
18 *Re Terwilliger* (1982), 450 A. (2nd) 1376.
19 *Re P.S.* (1983), 453 N.E. (2nd) 969.
20 (1981), 307 N.W. (2nd) 881.
21 (1981), 115 D.L.R. (3rd) 283.
22 (1986), 31 D.L.R. (4th) 1.
The reason why 5 years elapsed between the decision of the Full Court of the Supreme Court of Prince Edward Island and the decision of the Supreme Court of Canada does not appear from the Reports.
23 [1987] 2 All E.R. 206 (Bush J. and C.A.); [1988] A.C. 199 (H.L.). The case was heard at first instance in January 1987, by the Court of Appeal in March 1987 and finally disposed of by the House of Lords at the end of April 1987.
24 See Guardianship and Administration Board Act 1986, s. 37(19 and s. 38(1).
25 See ibid, s. 3 (definitions of 'disability' and 'represented person').
26 See ibid, s. 3 (definition of 'major medical procedure'); s. 37(3) (power of Board to issue guidelines specifying major medical procedures) and guidlines to be issued by the Board.
27 See ibid., s. 38.
28 See ibid., s. 42.
29 See Mental Health Act 1986 s. 3 (definition of 'patient'), s. 83(1) (definition of 'non-psychiatric treatment'); s. 85(1) and s. 86(2), (3)(a) and (4).

Mr. Peter Renou

Mr. Chairman,
I wish to discuss sterilisation from the point of view of the medical practitioner who must obtain consent before carrying out the procedure.

In his paper 'Informed Consent and Patients with Impaired Mental Functioning' Alan Rassaby states 'The law tells us the medical practitioner may not treat any person without that person's informed consent or, in the event of incapacity, without the informed consent of a person legally authorised to consent on their behalf. For consent to be effective, there must be reasonable disclosure to the patient about the treatment including any associated risk, and the consenting party must have voluntarily consented and be competent to consent. Every medical intervention is prima facie illegal and informed consent constitutes a defence to an action in battery. The philosophical basis for informed consent is respect for the autonomy of the individual'[1].

In our community the individual has the right to be sterilised so that he or she may enjoy sexual intercourse without the risk of unwanted pregnancy. The intellectually impaired person also has this right although, in the past, many people would have disputed this. Intellectually impaired people are 'real people' who love and are loved, a point I often make when counselling families.

When obtaining consent for sterilisation of an intellectually impaired person the guiding principle is that the procedure should be carried out for the benefit of that person alone and no-one else. Clearly then this applies to the female who may need protection from pregnancy so I shall confine my remarks to female sterilisation.

The methods of sterilisation available fall into non-surgical and surgical groups. In the non-surgical group there are hormone therapies which interrupt egg production in the ovary or act at the level of the pituitary gland which is situated at the base of the brain and is the overall conductor and co-ordinator of the reproductive system. With all these therapies there are difficulties with administration and side-effects and none is permanent. A new treatment, based on immunisation, is being developed. The woman is immunised so she produces antibodies to her own Human Chorionic Gonadotrophin. This hormone is essential for the support of early pregnancy. When it is rendered inactive by antibodies the fertilised egg fails to implant in the uterus. The first human trials are just beginning so it will be four years, at least, before this form of contraception is available. In the animal trials it seems effective and safe and lasts six months. Re-immunisation can be performed at six monthly intervals.

The surgical procedures available are hysterectomy (removal of the uterus with conservation of the ovaries) and occlusion of the fallopian tubes. Hysterectomy, of course, leads to sterility and may be indicated if the girl or woman is unable to handle menstrual hygiene or if there is uterine pathology. It is a more major operation than tubal occlusion and is associated with greater morbidity, that is, a longer period of convalescence, more pain and suffering and a higher risk of complications. It is also irreversible. A basic principle of surgical treatment is that the operation selected should be the simplest to achieve the desired result.

Fallopian tube occlusion can be achieved by a variety of surgical procedures. At open surgery the fallopian tube may be ligated in

continuity, ligated and divided (cut and tied) or partially or wholly removed. The most popular method now is laparoscopic sterilisation. This is a closed procedure in which a telescope (the laparoscope) and an operating forceps are introduced through small stab wounds. Under vision the fallopian tubes are occluded by cautery with electrical diathermy, with rubber bands (as in docking lambs' tails) or with a small clip which resembled a clothes-line peg. The latter is the least traumatic of all procedures and has the lowest morbidity. The majority of patients require 4–24 hours in hospital and are fully recovered in 3–7 days.

Almost one hundred million women have had tubal sterilisation making it the most widely used contraceptive technique in the world[2]. Despite this huge experience the facts about sterilisation are not generally known to the lay world or, for that matter, to some medical practitioners. A patient consenting to sterilisation should be informed that the procedure is permanent, that failures occur, that regret occurs and that reversal is possible.

There are statistical difficulties in evaluating failure rates and probably the life-table analysis is the best method. The on-going prospective study conducted by the United States Centre for Disease Control has found an overall failure rate of 1.8 per 1,000 sterilised women at twelve months and 3.0 per 1,000 at twenty-four months[3]. No differences in failure rates are found when comparing surgical techniques but, when failures occur, the incidence of tubal ectopic pregnancy is greater than 50% if diathermy cautery was employed[4]. The ectopic pregnancy rate is much lower with other techniques and hence the preference for rubber bands and clips[5,6,7]. Regret following sterilisation occurs in 3–5% of women[8,9]. It is more likely in those sterilised soon after a pregnancy, in those advised to be sterilised for medical reasons and in those with pre-existing emotional disorders.

About 1% request a reversal procedure and this usually occurs after establishing a new relationship. The risk is greatest for women who are young, have an unhappy relationship or who decide on sterilisation whilst pregnant. However, pre-sterilisation counselling cannot prevent all reversal requests.

Two advances in the last two decades have improved the lost of these women. Spring-type fallopian tube slips were developed by Hulka in the United States of America and Filsche in the United Kingdom specifically to improve the prospects of reversal.

Micro-tubal reconstruction was pioneered by Peter Paterson of the Monash Medical Centre and he reports pregnancy rates greater than 80% in patients sterilised originally with rubber bands or clips[10].

This new development has changed the situation as regards involuntary sterilisation. The legal authorities whose opinions were discussed by Mr. Graham all based their arguments on the assumption that tubal sterilisation is irreversible. In the case of an intellectually impaired or mentally ill woman, to whom pregnancy would be disastrous, but in whom there may be a chance of improvement, tubal sterilisation may now be acceptable and hence preferable to unreliable contraception.

This then is the information that should be disclosed to the consenting person. In addition, the specific and general complications for the procedure and anaesthetic should also be disclosed.

I now come to the voluntary nature of consent. In our society we assume that consent is voluntarily given but it is not always so. Family pressures are sometimes not apparent to the medical practitioner and I have had concern on occasions that an intellectually competent woman is consenting to sterilisation under duress from other family members. Sometimes it is blatant and overt, for example, 'my husband told me he would leave me if I become pregnant again'. Clearly an intellectually impaired woman is vulnerable to pressure as is shown in a case I will discuss later on.

The third question is how does one decide that a woman is competent to consent to sterilisation and what does one do if she is not? Renou's rules are as follows. Does the patient understand she has a problem and hence needs treatment? Is she able to understand the likely outcome of the treatment, both the desired effect and the undesired side-effects? Is she able to discriminate between different types of treatment assessing the benefits and disadvantage of each? Finally, does she understand the risk of complications?

If the woman is adult and not competent an application should be made to the Guardianship and Administration Board to appoint a guardian. Once a guardian has been appointed consent must be given by the guardian *and* the Board for 'a major medical procedure'. Although guidelines have not yet been issued by the

Board sterilisation will certainly be classified as 'a major medical procedure'. The same procedure must be followed in the case of a person who is a patient for the purposes of the Mental Health Act 1986.

In the case of a minor consent cannot be given for sterilisation by the parents but must be dealt with on a case to case basis with judicial authorisation[11]. It follows that it is the medical practitioner's duty to satisfy himself that the patient is neither a minor nor the subject of a guardianship order.

I would like now to illustrate this with the case histories of three intellectually impaired women. All were adult at the time of sterilisation being 39, 27 and 21 years respectively. All consented, apparently voluntarily, and consent of a close relative was also obtained as this was before 1986. The three cases had different outcomes.

Sue the daughter of friends of mine, is mildly mentally retarded. She lived with her parents, could read and write, could use public transport and could handle money for simple purchases. In her thirties she obtained a job in a shirt factory doing menial tasks and held the job for two or three years. The job did wonders for her self-esteem and she ventured farther out into the world. She met Peter who was also mildly retarded. He functions at a similar level but cannot read or handle money. He had a job as a municipal gardener. They decided to marry and just before the marriage Sue told me, one day during afternoon tea, that she intended to be sterilised. She said that she was certain she would be unable to care for and rear a child and that she and Peter would be happy together. Sue and her mother consented to the sterilisation and it was carried out when she was 39. Sue and Peter were then married and now live in a small, one bedroom, Housing Commission flat. They seem very happy. Sue manages the house, the cooking, the shopping and the money and Peter works as a gardener. They lead largely independent lives and the family take them out for regularly outings. Now, five years later, they appear to have no regrets. Sue has recently obtained voluntary work in a creche for young children. She is finding the work very rewarding and is making a useful contribution to the running of the creche.

The second case is of Jo and Willy. Jo, the wife, was sterilised at the age of 27 in 1979. She is mildly mentally retarded with an IQ in the 50–70 range. She has spent most of her life in institutions and

has little contact with her family. She met Willie in the hostel. He is similarly retarded and has regular contact with his family. He has worked in open industry but more recently in a sheltered workshop because of a recurrent peptic ulcer. Jo had been in the care of the same general practitioner for three years when she was sterilised. This was carried out just before her marriage after much discussion, according to the general practitioner.

In 1983, after four years of marriage, she requested sterilisation reversal so that they could have a child. They were carefully assessed by a general practitioner, a medical social worker, a gynaecologist, a consultant paediatrician of the Mental Retardation Division of the Health Commission and a geneticist. The geneticist was involved because of the need to assess the likely outcome for a child from the point of view of mental retardation and because of his experience and expertise in what happens to the children of retarded parents.

The assessment went on over a period of twelve months. Jo then ceased attending and it seemed that she was decided not to pursue the matter further. This is fortunate as it was the opinion of all concerned that Jo and Willy would not have been able to care for a child. They lived in a house in a terrible state. A roof leak remained unfixed for three years and they were barely able to run their lives despite great input from outsiders and family. They have since returned to a hostel.

It is unlikely that the surgeon would have offered sterilisation reversal or that the Guardianship and Administration Board would have consented as it is clear it would not have been in Jo's own best interest to have had a child. A side light is that the children of retarded parents usually reach a similar intellectual level to their parents. A happy aspect of this case is that Jo and Willy made the decision with counselling and did not reach the point of refusal.

The final case is of Jenny and Bill. At the age of 21, Jenny, who was midly retarded, attended the hospital and requested tubal ligation. She was supported by her general practitioner and social worker. She was living in a hostel and worked in a sheltered workshop. The gynaecologist was very experienced. Jenny had used oral contraception for five years and the gynaecologist was satisfied that she did not wish ever to have children, that she did not want to run the risk of becoming pregnant and having an

abortion and that she understood the implications of sterilisation. The social worker stated that 'she was unable to look after herself let alone a baby'. The consent of her parents was obtained although they had not seen her for four years. The procedure was carried out in August, 1978.

Exactly one year later Jenny attended the hospital requesting reversal of the sterilisation. However, she took it no further at that time. In 1983 she married Bill, who was also mildly mentally retarded, and soon after again attended the hospital requesting sterilisation reversal. In February, 1984 a diagnostic laparoscopy was carried out to assess the prospects for reversal. This was estimated at 70%. Bill's semen analysis was normal.

Over the next twelve months they were counselled and assessed for reversal. During these interviews Jenny claimed that she had had the sterilisation under duress. The superintendent of the hostel had told her that she could not stay there any longer if she did not have a tubal ligation. When this allegation was investigated it seemed quite likely to have been true. Jenny and Bill were seen by the gynaecologist, the geneticist, the social worker, psychiatrist and similar people in the Health Department. They seemed keen and Jenny followed up advice to lose weight and to gain experience with young children. All concerned felt that this couple could manage a child with some external help. They managed their household and affairs satisfactorily. The psychiatrist concluded 'at this point it would appear that while Jenny and Bill have significant intellectual handicaps, they appear to be well compensated for these handicaps and to be coping adequately with appropriate support. They appear well able to ask for help and well able to form relationships with people who might be helpful to them. They are able to show a degree of warmth and empathy and would appear capable of providing basic nurturance for a child. They are both very anxious about the prospect of having a child and to some extent have an idea of their limitations'.

'If they do have a child it will be most important that they have an appropriate supportive network of both professional and non-professional people. In particular, they will require the availability of somebody who knows about child-care and can help them with their anxieties about knowing what to do. It will also be important that a child growing up in their family situation have at least one

alternative family to relate to. This will become more and more an issue if the child is of normal intelligence and starts to require more than this couple could offer'. They also obtained letters of support from Jenny's sister, Bill's uncle and several neighbours.

The reversal was carried out in February, 1986. In September, 1986 a pregnancy of six weeks gestation was diagnosed. Jenny transferred to a hospital near her home for the confinement. However, in October she had a spontaneous miscarriage.

In February, 1987 Jenny returned to Casualty again six weeks pregnant. She had had a Rubella immunisation about four weeks previously and was concerned that it may harm the fetus.

However, she was reassured on this matter and the pregnancy continued normally. She was delivered of a son on the 29th September, 1987, almost exactly one year ago.

Jenny is coping with the baby — just. She needs daily contact with the Community Health Centre and has great anxiety about her inability to sort out whether the baby is ill or not. This has led to numerous ambulance dashes to the local hospital and to Jenny panicking and ringing the local Police Station for help. There have been difficulties co-ordinating the various authorities and institutions concerned. The police, particularly, and the Department of Community Services have expressed great reservations about the welfare of the baby. However, he continues to thrive despite it all. Jenny also gets frustrated and takes it out on the baby, for example, pulling his hair. However, she has not injured him.

As predicted Jenny needs much professional and non-professional support. She has many friends and good neighbourhood contacts. As the social worker said 'everybody around there knows and loves them'. He also said that 'Jenny is treading water'.

Whether Jenny loses custody of her baby as he grows and the problems become greater remains to be seen. Most of these couples do lose their children.

The first two cases were straightforward. In the third case of Jenny and Bill a number of issues are raised.

The first is the matter of consent under duress. Although it is likely pressure was applied, the important thing is that Jenny perceived it to be so. If Jenny's perception of duress had been revealed I am certain the gynaecologist would not have carried out the

sterilisation. Jenny later acknowledged that she had been told at the hospital that sterilisation would be done only if she wanted it and that other methods of contraception were available. A formal hearing for consent such as would be carried out by the Guardianship and Administration Board might have revealed this duress. It is also common for people with the intellectual capacity of Jenny to readily agree to suggestions put forward by people in authority.

In this case a method of sterilisation which was reliable and which offered the greatest chance of reversal was used. For surgical sterilisation the current techniques using clips are satisfactory from this point of view. The new immunological technique now being developed may be even better, although, the need to re-immunise the woman every six months may limit its usefulness. In Jenny's case the reversal was available and was successful.

The third issue is the appropriateness of the assessment process for sterilisation reversal. Bill had a semen analysis to confirm his fertility before subjecting Jenny to surgery. Then laparoscopy was carried out to assess the surgical feasability of reversal. Over the next twelve months Jenny and Bill were seen on a number of occasions by the appropriate experts and were given advice about what to expect and how to maximise their chances for successfully rearing a child. Jenny acted on this advice. An important point, I think, is that they had insight into their disability and its impact on child rearing. They were appropriately anxious and they took steps to obtain advice and assistance. The genetic assessment was to eliminate, as far as possible, a genetic disorder that may affect a child. The conclusion was that a child of Jenny and Bill would be likely to reach a similar intellectual level to theirs.

The final issue is does a couple such as Jenny and Bill have the right to have and rear a child? Some may argue that they do not, as a resulting child is very likely to be intellectually impaired and hence a burden on the community. The parents are likely to need further assistance and hence will be a greater burden on the community themselves. Looked at from Jenny and Bill's point of view they would claim the right to have a child like themselves. After all, we in this room have no doubt about our own right and even the desirability of us having children like ourselves.

I believe it was right and proper to help Jenny and Bill by reversing Jenny's sterilisation.

Mr. Chairman. Mr. Graham and I have not been able to inject much levity into the discussion this evening. Some of the cases referred to by Mr. Graham were tragic but others were not and the lot of intellectually impaired people is improving. Couples such as these are now living independent lives in the community with dignity. Some are raising children.

PETER M. RENOU.
1/10/88.

REFERENCES

1 Rassaby, A. Informed Consent and Patients with Impaired Mental Functioning, Symposium 6, Symposia Series — Informed Consent, Law Reform Commission of Victoria, 12/8/86.
2 Lisken L., Rinehart W. (eds), Population Reports Vol 13, No. 2, 1985, p. 125.
3 Ruben G., Liang A., De Stefano F., Layde P., Dicker (1982): Presented at Annual Meeting of the American Association of Gynecologic Laparoscopists.
4 Bhiwandiwala P.P., Mumford S.D., Feldblum P.J. (1982): American Journal of Obstrics and Gynecology 144:139.
5 Tatum H.J., Schmidt F.H., (1977): Fertility and Sterility 28:407.
6 McCausland A. (1980): American Journal of Obstetrics and Gynecology 136:97.
7 Chick P.H., Frances M., Paterson P.H., (1985): Clinical Reproduction and Ferility 3:81.
8 Wise D.J., Perkin G.J., Correy J.F. (1976): Australian and New Zealand Journal of Obstetrics and Gynaecology 16:173.
9 Whitelaw R.G. (1979): British Medical Journal 1:34.
10 Paterson P.H. (1985): Clinical Reproduction and Fertility 3:57.
11 Sterilisation of Intellectually Disabled Minors in News and Views. A.M.A. Victorian Branch News, June 1988.