

Non-Consensual Sterilisation of the Intellectually Disabled in the Australian Context: Potential for Human Rights Abuse and the Need for Reform

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Introduction

Perhaps the most universally marginalised group of people is the intellectually disabled. Considered historically as "imbeciles", "idiots" or "sub-human", these people were not deemed worthy of the rights bestowed upon "normal" citizens. Society is more enlightened today, but discriminatory attitudes, well illustrated by cases concerning non-consensual sterilisation, unfortunately remain. Non-consensual¹ sterilisation is a particularly sensitive issue for all involved, concerning as it does complex questions of moral, social and political character. The implications of a decision to sterilise a person are far-reaching, extending beyond the immediate physical consequences to interference with such basic human rights as the right to bodily integrity and the right to human dignity. Such a decision must not be made lightly. International human rights law has an important role to play in encouraging international uniformity, and acting as a model for domestic legislatures.

The history of intellectually disabled people is a history of marginalisation, oppression and abuse. The eugenics movement² emerged in the late nineteenth century, advocating notions deeply grounded in Social Darwinism. Not least amongst its aims was that the unfit - the "feeble minded, insane, epileptic, diseased, blind, deaf (and) deformed (including the crippled)" - were to be bred out of existence.³ The word "eugenics" conjures up images of the Nazi sterilisation programs of the 1930s and 1940s where eugenics courts forced

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1 Refers to the situation where a person lacks competence to give a valid consent and a substitute decision-maker is required.

2 The word "eugenics" is derived from the Greek word meaning "well-born" Canadian Law Reform Commission Report No 24 (1974), *Sterilisation*, p 25. The *Oxford English Dictionary* defines it as "pertaining or adapted to the production of fine offspring, esp. in the human race".

3 The Model Sterilisation Law of Harry Laughlin (a version of which was adopted in Nazi Germany), cited in Bajema C, *Eugenics Then and Now* (1976).

hundreds of thousands of disabled people to be sterilised,⁴ but what many fail to realise is that eugenics was occurring contemporaneously on a massive scale in the United States and Britain, and in fact continued well into the 1970s.⁵ In 1925, the United States Supreme Court in the infamous case of *Buck v Bell*,⁶ ruled in favour of the constitutional validity of sterilisation laws in Virginia in a case concerning the proposed sterilisation of an 18-year-old institutionalised woman. She was the daughter of a mentally retarded mother and the mother of an illegitimate mentally retarded child. Holmes J, giving the judgment of the court, 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 one 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.... Three generations of imbeciles are enough.⁷

Similar judicial attitudes prevailed elsewhere in the common law world, continuing, although perhaps not in quite so extreme a form, until relatively recently. It is only really in the last two decades that the issue of sterilisation abuse has attracted the attention of feminists, academics and human rights activists. Despite extensive literature on the topic, little of any practical import seems to have been achieved. To a large extent, the reproductive rights movement has failed to address the ways in which sterilisation abuse has affected disabled women.⁸ To most feminists of the 1970s, "reproductive rights" meant the right of women *not* to reproduce, and thus be treated as more than just reproducers. Today, although the phrase "reproductive rights" encompasses the right *to* reproduce, to be protected against sterilisation and contraceptive abuse and to decide how to give birth,⁹ there is little practical support for this expanded definition to be found in Australian law.

4 Chase, (1980) cited in Arditti R, Duelli Klein R and Minden S (eds), *Test-Tube Women: What Future for Motherhood?* (1984), p 286.

5 Canadian LRC, n 2 above.

6 *Buck v Bell* 274 US 200 (1927).

7 *Buck v Bell*, *ibid.* By the late 1930s, 41 US States had compulsory sterilisation laws for, and prohibited the marriage of, the "insane and feeble-minded". And by the 1960s and 1970s, "voluntary" sterilisation had become a State "tool" to repress various minority groups, most notably black and Puerto-Rican women: Clarke, "Subtle Forms of Sterilisation Abuse" in Arditti et al, n 4 above, pp 191-92. For example, in 1970, the sterilisation rate for black women was more than twice as high for white women: Trombley S, *The Right to Reproduce: A History of Coercive Sterilisation* (1988), p 177.

8 Finger, "Claiming all of our Bodies: Reproductive Rights and Disability", in Arditti et al, n 4 above.

9 Himmelweit, "More Than a Woman's Right to Choose?" (1988) 29 *Feminist Review* 38. The definition has only recently been expanded.

While it is proposed to evaluate the Australian domestic law on non-consensual sterilisation in the light of existing international human rights principles, it will be shown that international human rights law has failed to protect adequately the reproductive rights of intellectually disabled people. Although it would appear that international human rights law does encompass a general right to reproduce, or at least a right against non-consensual sterilisation,¹⁰ the instruments specific to intellectually disabled people are wholly inadequate in defining the circumstances in which these rights can be restricted (ie the circumstances in which non-consensual sterilisation is justifiable). It is therefore a somewhat meaningless exercise merely to measure Australian law against these instruments, and a broader comparative approach, based on general human rights principles, is necessary.

The paper is divided into three main sections. The first section deals with the "existence" or otherwise of the right to reproduce (and other rights relevant to the issue of non-consensual sterilisation)¹¹ in both international human rights law and the domestic jurisdiction of common law States.¹² It exposes the shortcomings of the international human rights instruments relevant to the intellectually disabled, and the dangers of judicial reasoning that denies the existence of reproductive rights for the intellectually disabled. The second section considers the dangers of sterilisation and the issue of the restriction of reproductive rights, and offers a critique of the traditional common law justifications for such restriction. The third section focuses on the recent High Court decision of *Secretary, Department of Health and Community Services v JWB and SMB*,¹³ providing an analysis of the judgment and discussing the implications of its failure to give substance to the "best interests" criterion.¹⁴ The author suggests a possible test (based on dicta by Brennan J) to rectify this deficiency of the common law, a test which could form the basis of new human rights instruments and domestic legislation. Australian legislation, in particular the Victorian Guardianship and Administration Board Act 1986, is examined in the light of human rights principles and the proposed test, and suggestions are made for its amendment. The paper concludes with a discussion of the need for comprehensive international guidelines.

10 Below, pp 206-08.

11 The phrase "reproductive rights" will be used throughout the paper to refer to the "right to reproduce" (if indeed such a right exists) and these other related rights.

12 The latter will take the form of a general historical appraisal of the common law in Australia, the UK and the USA.

13 (1992) 175 CLR 218. Referred to hereinafter as *Marion's case*.

14 This is the current test used by Australian courts in deciding whether or not to approve the non-consensual sterilisation of an intellectually disabled person.

The Right to Reproduce

Is there a "right to reproduce" recognised in international human rights law?

Although there is no specific "right to reproduce" articulated in any international document, it can be argued that several more general rights support it by implication. Article 1 of the Universal Declaration of Human Rights¹⁵ states that: "All human beings are born free and equal in dignity and rights" and article 3, that: "Everyone has the right to life, liberty and security of person". Article 5 prohibits "torture or ... cruel, inhuman or degrading treatment or punishment". With regard to article 5, the United Nations Educational Scientific and Cultural Organisation (UNESCO) has indicated that compulsory sterilisation need not amount to cruel and unusual punishment before it can be rejected as a violation of human rights.¹⁶ Article 7 speaks of the right of all people to be equal before the law, to have equal protection before the law and against any discrimination in violation of the Universal Declaration.

In the International Covenant on Civil and Political Rights (ICCPR),¹⁷ article 17 prohibits arbitrary or unlawful interference with a person's "privacy, home or correspondence", and article 9 states the right to security of person. Article 23(2) recognises the "right of men and women of marriageable age to marry and to found a family". Article 1 of the International Covenant on Economic, Social and Cultural Rights¹⁸ states that: "all peoples have the right of self-determination" and to "freely pursue their ... social and cultural development". Although rather tenuous, some authors have suggested that these encompass a right to reproduce.¹⁹

The Convention on the Rights of the Child²⁰ applies to human beings below the age of 18 years old. Article 2 states that all rights apply without discrimination of any kind (including on the ground of disability). Article 3(1) states that all actions concerning the child shall take account of his/her "best interests". Article 3(2) is somewhat worrying in its application to the sterilisation of mentally disabled children. In ensuring the child's protection and care, State parties can take into account the rights and duties of his/her parents/guardians/carers, and to this end take all appropriate legislative and administrative measures. The "best interests" criterion is thus fallible in that it can easily degenerate into "social convenience". Article 16 requires protection from interference with privacy, and article 19, protection from all forms of

15 GA Res 217 A (III) (1948).

16 *Human Rights Aspects of Population Programmes with Special Reference to Human Rights Law* (UNESCO, 1977), p 115.

17 GA Res 2200 A (XXI) (1966).

18 GA Res 2200 A (XXI) (1966).

19 Horn, cited in Shaw, "Sterilisation of Mentally Handicapped People: Judges Rule OK?" (1990) 53 *Modern Law Review* 91 at 94.

20 GA Res 44/25 (1989), Annex.

maltreatment by parents or other carers (which could encompass non-consensual sterilisation). Finally, article 23 states that a disabled child has the right to enjoy a "full and decent life, in conditions which ensure dignity ... and promote the child's active participation in the community".

Taken together, these important international Conventions appear to support a right to choose whether or not to reproduce. At the very least, they afford protection to the individual against any arbitrary or discriminatory treatment or against interference with bodily integrity, which obviously could encompass involuntary sterilisation.

There are two General Assembly Declarations on the rights of disabled persons. In addition to their lesser status of Declarations²¹ – although to Australia's credit they have both been incorporated in the Human Rights and Equal Opportunity Commission Act 1986 – they are rather vague. Article 1 of the Declaration on the Rights of Mentally Retarded Persons²² states that "the mentally retarded person has, to the *maximum degree of feasibility*, the same rights as other human beings".²³ Article 6 affords the "right to protection from exploitation, abuse and degrading treatment".²⁴ With regard to the derogation of rights of mentally disabled people, article 7 is particularly inadequate. It reads:

Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain *proper legal safeguards* against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.²⁵

What exactly is meant by "qualified experts"? And what use is "periodic review" in the case of an irreversible sterilisation operation? Most importantly, the failure to define with any degree of precision the form and content of the "proper legal safeguards" renders article 7 of little guidance to domestic legislatures attempting to regulate non-consensual sterilisation.

21 A declaration in this context merely denotes a resolution of the UN General Assembly intended to affirm a significant principle, but unlike a convention, is not a proper formal instrument of a multilateral and binding character. Starke J, (ed), *Introduction to International Law*, 10th ed (1989).

22 GA Res 2856(XXVI) (1971). Incorporated as Schedule 4 of the Human Rights and Equal Opportunity Commission Act 1986.

23 Article 1, *ibid*, emphasis added.

24 Article 6, n 22 above.

25 Article 7, n 22 above.

The Declaration on the Rights of Disabled Persons²⁶ adopts article 7 of the previous Declaration, unfortunately without further elaboration. Article 4 reads:

Disabled persons have the same civil and political rights as other human beings; paragraph 7 of the Declaration on the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.

Article 3, in comparison with article 1 of the 1971 Declaration, declares unqualified rights for disabled people:

Disabled persons have the inherent right to respect for their human dignity. [They have] ... the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.²⁷

Article 10 states that disabled persons "shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature".²⁸

Together, these declarations grant full rights to disabled people, yet authorise the restriction of these rights whenever "necessary" in accordance with "proper legal safeguards". Presumably, the definition of these terms is left to domestic legislatures, hardly an adequate state of affairs when one of the main objects of international human rights law is to achieve uniformity across nations. Overall, the declarations are wholly inadequate in safeguarding the rights of intellectually disabled people.

Historical appraisal of the "right to reproduce" at common law

Several judges in cases involving the sterilisation of intellectually disabled females have made comments in support of the existence of a "right to reproduce". La Forest J in the Canadian Supreme Court case of *Re Eve* referred to the "fundamental right to bear a child".²⁹ Nicholson CJ, the dissenting judge in the Australian case of *Re Marion*,³⁰ decided that authorisation of a court for a sterilisation operation on an intellectually disabled child was necessary, because "sterilisation involves the irreversible removal of a basic human right, namely the opportunity to reproduce".³¹ Similarly, in *Re Jane*,³² at first instance, Nicholson CJ identified two rights

26 Declaration on the Rights of Disabled Persons, GA Res 3447(XXX) (1975). Included as Schedule 5 of the Human Rights and Equal Opportunity Commission Act 1986.

27 Article 3, *ibid*.

28 Article 10, n 26 above.

29 (1986) 31 DLR (4th) 1. It was held here that non-therapeutic sterilisation would never be authorised. It should be noted that the court spoke of therapeutic/non-therapeutic rather than "best interests", unlike the Australian and English cases.

30 *Re Marion* (1990) 14 Fam LR 427 (Full Court Family Court).

31 *Ibid*, p 448. The majority did not refer to such a right.

32 (1988) 94 FLR 2.

recognised by the common law: the fundamental principle that every person's body is "inviolable",³³ and the right or liberty to reproduce or to choose not to do so.³⁴ In the English case of *Re D*,³⁵ Heilbron J, in refusing to authorise the sterilisation of an 11-year-old girl, said: "The type of operation proposed is one which involves the deprivation of a basic human right".³⁶ However, the fact that all these judges went on to determine what course of action was in the girls' "best interests" indicates that they did not regard this as an absolute right.

Some authors have emphasised the absolute nature of the right to reproduce. Professor Michael Freeman writes that the "natural and fundamental right to procreate ... should not be overridden on paternalistic grounds".³⁷ Certainly the social, moral and emotional implications of the removal of the ability to reproduce would suggest that it is a fundamental right, to be restricted in only the most extreme circumstances.³⁸

Others take the view that *prima facie* the right to reproduce exists for intellectually disabled people, but that it becomes irrelevant when the person fails to comprehend its import. Lord Hailsham in *Re B*³⁹ said:

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.⁴⁰

This is a classic "thin end of the wedge" argument. It is only a short step to a more dangerous argument, that all liberties of intellectually disabled people

33 Ibid, p 8.

34 Ibid, p 9. Ross-Jones J in *Re Elizabeth* (1989) 13 Fam LR 47 agreed that court authorisation was necessary for the removal of these rights via sterilisation.

35 [1976] Fam 185 at 193. Apart from this judgment, there is little or no recognition of a right to reproduce in English law: Grubb & Pearl, "Sterilisation and the Courts" (1987) 46 *Cambridge Law Journal* 439.

36 Ibid, p 193.

37 Freeman, "For Her Own Good" (1987) 84 *Law Society Gazette* 949, cited in Grubb & Pearl, n 35 above, p 446. He criticised the decision in *Re B* [1988] AC 199, discussed above, as "unacceptable".

38 One of the leading US cases in this context is *In re Grady* [1981] NJ 426 A 2d 467. The court held that judicial authorisation was necessary to carry out a sterilisation of an intellectually disabled girl because (at 471-72): "Sterilisation may be said to destroy an important part of a person's social and biological identity - the ability to reproduce. It affects not only the health and welfare of the individual but the well-being of all society. Any legal discussion of sterilisation must begin with an acknowledgment that the right to procreate is 'fundamental to the very existence of the race'. This right is 'a basic liberty' of which the individual is forever deprived through unwanted sterilisation."

39 [1988] AC 199.

40 Ibid, p 213. Similarly, Lord Bridge in *Re F* [1989] 2 All ER 545 at 548 decided that since the girl was "incapable of ever exercising that right", its loss would mean nothing to her.

are dependent upon usages that others consider valuable.⁴¹ Equally as dangerous is the "social responsibility" approach, which says that if people want to exercise their "rights" they must take responsibility for the consequences, otherwise they are merely imposing burdens upon society.⁴² From this perspective, utilitarian considerations are relevant not only to the decision whether or not to restrict a right, but to whether the right exists at all.

According to McLean, by denying rights to "certain people on the ground that they may not ... recognise their worth [is to minimise] the status of reproduction as a human right".⁴³ A human right is something a person has regardless of whether they can exercise that right autonomously or value it consciously.⁴⁴

The High Court in the most recent case on non-consensual sterilisation, *Marion's case*,⁴⁵ has denied the existence of a *fundamental* right to reproduce, stating that it is recognising "the right to personal inviolability[,] ... not more".⁴⁶ However, it remains a fact that there is a significant body of judicial opinion recognising the right to reproduce. Even if one concludes that the right does not exist at common law, the rights to bodily integrity and to equal protection before the law most certainly do and are equally applicable to the issue of non-consensual sterilisation. Once it is established that intellectually disabled persons possess reproductive rights which, like most rights, are not absolute, one must consider the circumstances in which these rights may be restricted. Under what circumstances, if any, should non-consensual sterilisation be performed?

The Restriction of Reproductive Rights: The Dangers of Sterilisation and Critique of Traditional Justifications for It

The greater the danger involved in a course of action, the better the reasons must be in support of it. Non-consensual sterilisation is dangerous on a number of fronts; apart from the obvious physical risk involved in the sterilisation operation (particularly hysterectomy), there may be adverse psychological consequences and sexual and racial discrimination.

41 Feldman, "Rights, Capacity and Social Responsibility" (1987) 16 *Anglo-American Law Journal* 97.

42 Feldman, *ibid*. He states that if people are not willing or able to bring up their offspring, then the "right to reproduce is no more than a right to impose unquantified burdens on other members of society.... We need not dignify that with the name of 'right' any more than we need describe a person suffering from a sexually transmitted disease as having a right to satisfy sexual desires with other non-consenting people" (at 113).

43 McLean, "The Right to Reproduce" in Campbell T et al (eds), *Human Rights: From Rhetoric to Reality* (1986), pp 99, 112.

44 Heginbotham, "Sterilising People with Mental Handicaps" in McLean S (ed), *Legal Issues in Human Reproduction* (1989).

45 Note 13 above. See discussion, below pp 215-18.

46 Note 13 above, p 254.

Far more women than men are sterilised, despite the fact that the operation is more dangerous than a vasectomy for men.⁴⁷ In some instances female sterilisation may be justified on medical grounds, but in others a protective and paternalistic attitude towards woman's sexuality and fertility is evident. For example, in the case of *Re F*⁴⁸ the House of Lords unanimously approved the sterilisation of a 36-year-old severely intellectually disabled woman, who had formed an "entirely voluntary"⁴⁹ sexual bond with another patient, P. The medical evidence excluded the possibility of other forms of contraception, and held that pregnancy would threaten F's progress. Despite the fact that P had apparently formed several sexual relationships with other patients, and the absence of evidence that F's relationship with him was "entirely voluntary", there was no question of P's sterilisation. This sort of scenario could amount to discrimination on the ground of sex, in contravention of several international documents.⁵⁰

There is also the possibility of discrimination on racial grounds, as has been the case in the United States, where a disproportionate number of Hispanic women and women of colour have been subjected to sterilisation.⁵¹

The assumption that severely intellectually disabled people have no conception of sexuality, parenthood and sterilisation has been discredited by research. For example, Sabagh and Ederton⁵² found that sterilised intellectually disabled people tended to perceive sterilisation as a symbol of reduced or degraded status, leading to negative self-perceptions and withdrawal from society. This runs counter to several international documents, for example article 23 of the Convention on the Rights of the Child⁵³ and article 3 of the Declaration on the Rights of the Disabled.⁵⁴ Justifying State intervention to the extent of depriving a person of the right to procreate also denies that person the opportunities to exercise the responsibilities accompanying that right. In doing so, this reinforces the separateness and inferior status of the person.

Given these real and potential dangers, justifications for non-consensual sterilisation must necessarily be of high calibre. In the past, intellectually disabled people have often been denied rights, or had their rights removed for unsatisfactory reasons. Many of the traditional common law justifications for non-consensual sterilisation are unsound from a rights-based perspective. For ease of organisation, they have been divided into two main groupings -

47 Shaw, n 19 above.

48 [1989] 2 All ER 545.

49 Ibid, per Lord Brandon, p 549.

50 For example, article 10 of the Declaration on the Rights of Disabled Persons, n 26 above; articles 2 and 7 of the Universal Declaration of Human Rights.

51 Clarke, n 7 above.

52 Cited in Canadian LRC Report, n 2 above.

53 GA Res 44/25 (1989), Annex.

54 Note 26 above.

"benefits to society and State", and "benefits to the intellectually disabled individual".

Benefits to society and State

In the past, eugenic beliefs have formed the basis of arguments for the non-consensual sterilisation of intellectually disabled people. The assumption that some individuals are more socially useful and desirable than others is based upon a belief in the inheritability of traits such as intellectual disability and mental illness.⁵⁵ The Canadian Law Reform Commission⁵⁶ has concluded that there is insufficient scientific evidence to support the inheritability argument. First, intellectual disabilities are caused by a variety of interacting factors, only one of which is genetic. Even where it is the primary factor, which is very difficult to ascertain in any case, a person's offspring will not necessarily be born with intellectual disabilities.⁵⁷ Second, in order to significantly reduce the number of intellectually disabled people in the world, sterilisation would have to be performed on all outwardly normal carriers of genetic abnormalities, some 10 per cent of the population.⁵⁸ Hardly a viable option, even for eugenicists.

It has also been argued that society cannot afford the economic burden placed on it by those unable to care for themselves, and that therefore such people should not be allowed to procreate. To sterilise someone as insurance against an unwanted pregnancy resulting from under-resourced care in the future is to adopt a clearly utilitarian argument. Economic and convenience considerations must not be factors in deciding whether or not to restrict a human right. Even the rather vague article 7 of the 1971 Declaration would not permit economic utilitarianism as a basis for the derogation of an intellectually disabled person's rights.

Few people today would openly admit to holding beliefs which so obviously disregard basic human rights. Economic considerations, however, probably play a larger role than may appear on the surface.

Benefits to the intellectually disabled individual

It is beyond dispute that sterilisation may, in some circumstances, be beneficial to an intellectually disabled person, but cases are rarely clear-cut. The argument that non-consensual sterilisation benefits intellectually disabled individuals themselves is one that has been advanced not only by those representing the State but also by parents and carers. This is not to suggest that parents and carers always behave selflessly, because this is obviously not the case, but they are more likely to hold the interests of the individual at heart.

55 Canadian LRC Report, n 2 above, p 26.

56 Note 2 above.

57 Ibid.

58 Ibid, p 41. It has been estimated that 89 per cent of all inherited mental deficiency is transmitted by persons who are not so affected.

For some intellectually disabled women, pregnancy and childbirth are dangerous due to the existence of various diseases, or to a series of prior births by caesarian section. There are also diseases of a hereditary nature which make it probable that a child will be still-born. Where the medical evidence of therapeutic benefit is indisputable, sterilisation is justified. Unfortunately, however, medical evidence rarely lends itself to pigeon-holing by the courts, and in most cases it is by no means clear that sterilisation is beneficial to the individual.

Particularly problematic are cases in which it is alleged that sterilisation is necessary for reasons of personal hygiene.⁵⁹ There are some major problems in establishing that the benefit to the person is great enough to warrant such an intrusion of bodily integrity, and that the sterilisation is not merely intended for the benefit of others. La Forest J in *Re Eve* said: "I cannot agree that a court can deprive a woman of [the privilege to give life] for purely social or other non-therapeutic purposes without consent".⁶⁰

It is likely that if menstruation is an insurmountable problem for the woman, she will also require help with urinary and fecal control, which have stronger implications for personal hygiene than menstruation. A social taboo should not be allowed to impinge upon a human right. In the case of *Re a Teenager*,⁶¹ the evidence put forward by the parents of a severely intellectually disabled girl was largely circumstantial. The alleged phobic reaction to blood was never demonstrated, and their assertion that she would never be able to deal with menstruation in a hygienic fashion could not be confirmed since she had not begun to menstruate. Evidence was proffered by witnesses for the girl suggesting that proper management practices could be implemented or at least tried. Despite this, sterilisation was approved. Caution is necessary to ensure that the rhetoric of therapeutic benefit does not obfuscate the fact that the motivation for intervention may be more pragmatic than anything else.

Some argue that sterilisation liberates the intellectually disabled woman sexually and protects her from the possible consequences of sexual assault.⁶² Both arguments are deficient. Although it may be the case that restrictions on sexual activity are placed on intellectually disabled people who are not sterilised (as an alternative to training in contraception), this practice does not justify their being sterilised.⁶³ Something of a moral irony is involved here. Care-givers are often content to permit an invasive procedure such as

59 For example, the Ontario Association for the Mentally Retarded classified this as non-therapeutic whereas many physicians would define it as therapeutic: cited in Bowker, "Minors and Mental Incompetents: Consent to Experimentation, Gifts of Tissue and Sterilisation" (1981) 26 *McGill Law Journal* 951 at 975.

60 *Re Eve*, n 29 above, p 31 (emphasis added).

61 (1988) 13 Fam LR 85.

62 The second part of the argument was advanced by Cook J in *Re a Teenager*, n 61 above.

63 Canadian LRC, n 2 above.

sterilisation, yet object to explicit sex education and contraceptive regimes. As to the second argument, it is difficult to see how sterilising a woman protects her from sexual abuse. What it protects is society from the burden of caring for a child born as a result, and the abuser from some of the risks of discovery.⁶⁴

Equally as unconvincing is the argument that intellectually disabled people cannot cope with parenthood and should therefore be protected from it, the thinly disguised rationale being that these people do not make good parents. Inevitably the "fitness to parent" issue will be value-laden, and an area in which the courts are arguably not equipped to venture.⁶⁵ Yet it is becoming increasingly prevalent in the judgments of sterilisation cases, sometimes overtly, and sometimes, one suspects, as the hidden underlying rationale. For example, in *Re B*,⁶⁶ a case involving the sterilisation of a 17-year-old woman (Jeanette) with a moderate degree of intellectual disability, the House of Lords held unanimously that sterilisation should be authorised. One of the three factors forming the basis of this decision was Jeanette's lack of "maternal instincts". One can only wonder at what the judge had in mind here. What would a non-intellectually disabled 17-year-old woman have to demonstrate before being classed as possessed of maternal instincts? Further, no information was offered about why Jeanette's sex education (if she had had any) had failed to overcome her ignorance of one of the outcomes of sexual intercourse.⁶⁷ Nor was there any explanation of the fact that her carers were able to manage the medicinal regime necessary to control her epilepsy, yet were unable to supervise the use of an oral contraceptive.⁶⁸

Given the prevalence (at least until relatively recently) of reasoning such as this, it is somewhat dangerous to rely upon judicial enlightenment in the area of non-consensual sterilisation of the intellectually disabled. The complexity of the issues involved and the potentially drastic physical, emotional and social consequences of sterilisation suggest that some sort of guidance regarding the considerations to be taken into account in deciding whether or not to authorise the sterilisation of an intellectually disabled person

64 Shaw J, n 19 above.

65 McLean questions the involvement of judges "of uncertain qualification in such speculative matters as parenting competence": see "Women, Rights and Reproduction" in McLean S (ed), *Legal Issues in Human Reproduction* (1989), p 213 at 225.

66 Note 39 above. Jeanette had the speech of a two-year-old and the understanding of a six-year-old. Another case which overtly used impressions about fitness for parenting in reaching the conclusion that the sterilisation of an intellectually disabled woman could be authorised was *T v T and Another* (unreported), cited in McLean, n 44 above, p 225.

67 Lee and Morgan, "Sterilisation and Mental Handicap: Sapping the Strength of the State?" (1988) 15(3) *Journal of Law and Society* 229. See also Norrie, "Sterilisation of the Mentally Disabled in English and Canadian Law" (1989) 38 *International and Comparative Law Quarterly* 387 at 388.

68 The reason given for this was that "it would not be possible in the light of her swings of mood and considerable strength to ensure the administration of the necessary daily doses", per Lord Hailsham, n 39 above, p 212.

is vital. This role should be filled by international human rights law, but the inadequacy of the relevant instruments renders this impossible.

Until more comprehensive international instruments are formulated, the reproductive rights of intellectually disabled people remain dependent upon domestic common law and legislation dealing with non-consensual sterilisation. Unfortunately, in Australia, neither is adequate. The hollowness of the Australian common law "best interests" test leaves the rights of intellectually disabled people involved in non-consensual sterilisation cases at the mercy of judicial discretion.⁶⁹ Despite the shortcomings of the most recent High Court pronouncement on non-consensual sterilisation, *Marion's case*,⁷⁰ the case is important both for its *ratio*, which reverses the prior highly unsatisfactory state of the law,⁷¹ and its *dicta*, which is useful in formulating a test for non-consensual sterilisation.

The Australian Approach

The Australian common law position: *Secretary, Department of Health and Community Services v JWB and SMB*

Facts and ratio

Marion, the subject of the High Court appeal, was a 14-year-old girl suffering from intellectual disability, severe deafness, epilepsy, ataxic gait and "behavioural problems".⁷² Her parents were successful in obtaining a declaration from the Full Court of the Family Court⁷³ that it was lawful for them to consent to the performance of a sterilisation on Marion without court authorisation, provided the operation was in the child's "best interests".⁷⁴ *Re Marion* left doctors in the invidious position of having to make a judgment as to whether Marion's parents were acting in her "best interests". But in a potentially even more invidious position was Marion, her rights at the mercy of well-meaning parents who may have lacked sufficient objectivity to make a fully fair and rational decision.⁷⁵

The Human Rights and Equal Opportunity Commission intervened in the appellate proceedings, arguing that an invasive surgical procedure which results in the removal of healthy reproductive organs of a young woman

69 Similarly, the State legislative regimes grant wide discretion to decision-makers to define "best interests". See discussion below, pp 222-24.

70 Note 13 above.

71 See discussion below under "The Australian common law position".

72 *Marion's case*, n 13 above, p 218. The appeal was brought by the Northern Territory Department of Health and Community Services.

73 *Re Marion*, n 30 above.

74 "Best interests" was undefined.

75 As Lord Donaldson commented in the case of *Re F* [1989] 2 All ER 545: "No one cast the slightest doubt upon the skill, bona fides or caring disposition of those who recommended and would have carried out the operation. They were simply blinkered to the possibility that they might be wrong."

incapable of giving her own consent, cannot lawfully be performed without the authority of the appropriate judicial body. This requirement, according to the Commission, represents a sufficient safeguard of the rights of the intellectually disabled in accordance with the Conventions and Declarations incorporated in schedules to the Human Rights and Equal Opportunity Commission Act 1986.⁷⁶

The High Court reversed *Re Marion* by requiring parents/guardians to obtain Family Court authorisation prior to arranging for their child to be sterilised.⁷⁷ This was said to ensure the protection of the child's "best interests".

Why court authorisation was held to be necessary

The majority of the court held that sterilisation must be distinguished from other medical or surgical procedures which do not require court authorisation. First, it is an irreversible procedure which deprives a woman of her "ability" to reproduce and interferes with her right to bodily integrity. Second, there is a "significant risk of making the wrong decision".⁷⁸ Third, the ethical, social and personal consequences of such a decision are particularly grave. The factors identified as contributing to the risk of a mistaken decision are the following:

(i) *The complexity of consent.* As the Committee on the Rights of Persons with Handicaps (SA) has stated: "There is nothing inherent in mental handicap that prevents a person from providing competent consent to a sterilisation".⁷⁹ The court held that there is no definite rule as to the age of capacity to consent; this must depend upon the particular child.⁸⁰ Intellectual disability is often surrounded by misconceptions involving an underestimation of a person's ability or future ability, especially with regard to matters of sexuality. Such

76 Schedule 4: Declaration on the Rights of the Mentally Retarded, n 22 above; schedule 5: Declaration on the Rights of the Disabled, n 26 above.

77 The basis for this is the welfare jurisdiction of the Family Court. According to the majority, the source of such jurisdiction is either s 64 of the Family Law Act – s 64(l) provides: "In proceedings with respect to the custody, guardianship or welfare of, or access to, a child ... (c) ... the court may make such order in respect of those matters as it considers proper, including an order until further order: – in conjunction with s 63(l) which confers jurisdiction on the Family Court "in relation to matters arising under this part" OR a wider range of sections in Pt VII.

78 Note 13 above, p 250.

79 *The Law and Persons with Handicaps*, vol 2 *Intellectual Handicaps* (1981), p 125.

80 *Marion's case*, n 13 above. They cite *Gillick v West Norfolk AHA* [1986] AC 112 as authority for the proposition that parental power to consent to medical treatment for a child decreases gradually as the child's capacities and maturity grows and that this rate of development depends on the individual child (n 13 above, p 237).

misconceptions can give rise to premature decisions.⁸¹ The case of *Re D*⁸² is illustrative here. The mother of an 11-year-old girl who suffered from Sotos syndrome, the consultant paediatrician and the consultant gynaecologist all agreed upon the desirability of the girl's sterilisation. Other professionals disagreed. In a subsequent action brought by a social worker on behalf of D, it was held that the proposed operation was not in D's best interests because evidence showed that D's physical and mental condition had already improved, and she may yet come to understand the implications of the operation.

(ii) "*Medicalisation*" of the issue. This raises two concerns. First, the court cannot assume, as Cook J did in *Re a Teenager*⁸³ that all medical practitioners will act with propriety. Second, as discussed above, the decision to sterilise is much more than just a medical issue.

(iii) *The decision may involve the possibly conflicting interests of parents and other family.* On this point, the majority judgment was disappointingly lenient, holding that the interests of other family members *are* relevant to a court's decision whether to authorise sterilisation. However, they held that in the case of conflict the child's interests should prevail.⁸⁴ The danger here is that the vague and undefined "best interests" criterion could be interpreted in future cases to allow sterilisations on utilitarian grounds. Unfortunately, the question of what constitutes "best interests" was not before the court,⁸⁵ although various judges offered *dicta* on this point.

The "best interests" criterion

The majority recognised the vagueness of the "best interests" criterion, yet upheld it as the governing test in non-consensual sterilisation cases. They emphasised that sterilisation must be a "step of last resort", which can only be authorised where all alternative, less invasive procedures have failed or will not alleviate the situation so that the child can lead a life in keeping with his or her needs and capacities.⁸⁶ They stated that authorisation will not be given for sterilisations proposed for contraceptive purposes.⁸⁷ As to future cases, the majority was content to leave it to "judges [to] ... develop guidelines to give further content to the phrase "best interests of the child".⁸⁸

Brennan J's dissent is more sensitive to human rights considerations than the majority judgment. He stressed the overwhelming need for substantive

81 As stated by the majority: "There is no doubt that some sterilisation operations have been performed too readily and that the capacity of a child to give consent (and, later, to care for a child) has been wrongly assessed both here and overseas" (n 13 above, pp 250-51).

82 [1976] 1 All ER 326.

83 (1988) 94 FLR at 223.

84 *Marion's case*, n 13 above, p 252.

85 *Ibid*, p 229.

86 *Ibid*, p 259.

87 *Ibid*, p 260.

88 *Ibid*.

criteria ("guidelines if not rules")⁸⁹ because: "the power to authorise sterilisation is so awesome, its exercise is so open to abuse, and the consequences of its exercise ... so irreversible ...".⁹⁰ His critique of the best interests test was trenchant:

... the best interests approach offers no hierarchy of values which might guide the exercise of a discretionary power to authorise sterilisation, much less any general legal principle which might direct the difficult decisions to be made in this area by parents, guardians, the medical profession and courts. It is arguable that, in a field where the law has not developed, where ethical principles remain controversial and where each case turns on its own facts, the law should not pretend to too great a precision.⁹¹

As to the content of the recommended substantive criteria, Brennan favoured the test of therapeutic medical treatment as enunciated in *Re Eve*. Brennan's definition is as follows: "[t]herapeutic medical treatment is calculated to enhance or maintain as far as practicable the physical or mental attributes which the patient naturally possesses; it is not calculated to impair or destroy those attributes and the capacities they afford".⁹² And with respect to "therapeutic" sterilisation: "When the purpose of a proposed sterilisation is therapeutic, the invasion of the child's physical integrity, the disquieting of her mind and any change in her self-perception are justified by the need to maintain to the maximum extent or to enhance the child's natural physical and mental attributes".⁹³ Non-therapeutic sterilisation, which necessarily involves a balancing of physical integrity and human dignity against social values, according to Brennan J, can never be justified because human dignity must always have priority over the interests and burdens of the carers and the State.

It is suggested that Brennan J's judgment goes too far by excluding "non-therapeutic" sterilisation in *all* circumstances. Where the medically justified therapeutic benefit to the person (which includes both physical and mental benefit) outweighs the potentially adverse psychological and social consequences, and where it is established that the operation is not designed merely for the purposes of the carers, non-therapeutic sterilisation may be supported on a rights-based analysis. Such a test requires the court/decision-maker to examine not only the physical necessity for, and impact of, sterilisation, but the mental and social consequences as well. This approach, which will be referred to as the "therapeutic balance test", is the most satisfactory from a rights-based perspective, and should be adopted at common law and as the basis for a legislative regime.

Marion's case is a very positive decision in that it recognises the desirability of an objective, independent assessment of each proposed sterilisation. But the issue of "best interests" remains undefined, at least until

89 Ibid, p 272.

90 Ibid.

91 Ibid, pp 270-71.

92 Ibid, p 274.

93 Ibid.

the conclusion of the Family Court.⁹⁴ Until this concept is defined adequately by either the common law or legislature, or better still abandoned in favour of the therapeutic balance test, it cannot be said that Australian law protects intellectually disabled people against *every form of abuse* as required by article 7 of the 1971 Declaration.⁹⁵

Analysis of existing legislation

Background

Apart from the fact that the Australian common law provides insufficient protection for the rights of the intellectually disabled, there are cogent reasons why a legislative regime is preferable in the realm of non-consensual sterilisation. Most parents will be unable to afford court proceedings, so the requirement of court authorisation could have the unintended effect of class discrimination. Delay is likely to cause inconvenience to all involved. Another problem is the alienating nature of the adversarial process itself, possibly inappropriate to the resolution of an issue as emotive and value-laden as non-consensual sterilisation.⁹⁶ The High Court majority in *Marion's* case has recommended legislative reform in the area of non-consensual sterilisation of intellectually disabled minors.⁹⁷

The process of legislative reform in the area of non-consensual sterilisation began in the early 1980s with the publication of three government reports on the sterilisation of intellectually disabled people.⁹⁸ All concluded that many sterilisations were unnecessary and often performed without the patients' knowledge, and that legislative reform was needed. For example, the Cocks Report concluded that:

We believe that sufficient abuse of intellectually handicapped people occurs in the area of sterilisation operations to justify legislative action.... We believe

94 That inquiry is continuing, and it is to be hoped that the court will lay down criteria for "best interests", rather than leaving it entirely to the discretion of future judges.

95 Note 22 above.

96 As Cook J noted in *Re a Teenager*, n 61 above, p 112: "[T]here was a strong undercurrent of criticism and subtle demotion of their [the parents'] essential worthiness as care-givers to the child".

97 Note 13 above, p 253. In Victoria, legislation exists only for intellectually disabled adults, the Guardianship and Administration Board Act 1986. See discussion, above.

98 *Report of the Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons* (the Cocks Report), (Govt Printer, Melbourne, 1982); *The Law and Persons with Handicaps*, vol 2 *Intellectual Handicap* (the Bright Report), (Govt Printer, SA, 1981); *Discrimination and Intellectual Handicap, A Report of the Anti-Discrimination Board of NSW*, (Govt Printer, NSW, 1981), cited in Blackwood, "Sterilisation of the Intellectually Disabled: The Need for Legislative Reform" (1991) 5 *Australian Journal of Family Law* 138.

that consent for all sterilisation operations upon represented persons whether therapeutic or not, should be sought from that board.⁹⁹

As a result, legislative reforms were implemented or are now proposed in all Australian jurisdictions, but they are far from uniform in their protection of the rights of intellectually disabled people. With regard to adult intellectually disabled people, the Victorian legislation is perhaps the most comprehensive, although it is far from perfect. The comprehensiveness of its annexed guidelines contrasts starkly with the legislation of other States. Only South Australia¹⁰⁰ and New South Wales¹⁰¹ have legislation which covers the sterilisation of minors, but it is by no means satisfactory from a rights-based perspective.

The following discussion will focus on the Victorian legislation, and it is not proposed to conduct a detailed analysis of legislation in other States. However, some of the main disparities and shortcomings will be noted for the purpose of comparison with international human rights law.

Objects of the Guardianship and Administration Board Act 1986 (Vic)

The intentions of parliament with respect to represented persons are set out in s 4(2) and are as follows:

- (a) the means which is the least restrictive of a person's freedom of decision and action as is possible in the circumstances is adopted; and
- (b) the best interests of a person with a disability are promoted; and
- (c) the wishes of a person with a disability are wherever possible given effect to.¹⁰²

Similarly, in the Mental Health Act 1986 (Cth), the purpose of s 86 is: "... to protect the best interests of patients by ensuring that they are not subjected unnecessarily to certain medical procedures".¹⁰³

99 Note 98 above, p 63, as cited in Blackwood, n 98 above, p 155.

100 Mental Health Act 1977 (SA) (hereinafter "SA Act"), amended in 1985 to extend protection to all people unable to consent to a sterilisation operation.

101 Disability Services and Guardianship Act 1987 (NSW) (hereinafter "NSW Act") Part 5 guarantees protection from unnecessary medical treatment to a person of or above the age of 16 (s 34), and s 20B of the Children (Care and Protection) Amendment Act 1987 (NSW) protects a child under 16.

102 Guardianship and Administration Board Act 1986 (Vic) (hereinafter "Vic Act"). Division 6 - "Powers of Board with Respect to Medical Procedures" - has as its purpose "... to protect the best interests of represented persons by ensuring that they are not subjected unnecessarily to certain medical procedures" (s 36(1)). Similar purposes in the other State Acts are contained in the following sections: s 32 NSW Act; ss 4(c) and 63 Guardianship and Administration Act 1990 (WA); ss 4, 21(6) and (7) Adult Guardianship Act 1988 (NT); and ss 28d(2)(b) and (c) SA Act. The ACT and Tasmania have proposed legislation, which is modelled on the Victorian Act (per Blackwood, n 98 above).

103 Section 86(4) - "Prohibition of major procedures unless compliance with this section" - of the Mental Health Act 1986 (Cth). Section 86(3) states that a major medical procedure cannot be performed on a patient unless - (a) the patient has

At face value, these provisions are admirable from a human rights perspective, but the deciding factor must be their interpretation and application. The adequacy of the "best interests" criterion, contained in all the States' legislation, will be analysed below.

The guardianship requirement

The Victorian Act applies only to "represented" adults.¹⁰⁴ Section 37(1) states:

A medical practitioner must not carry out any procedure which is a major medical procedure on a represented person unless the consent of the *guardian* and the *board* has been obtained.¹⁰⁵

Similarly, the Western Australian and Northern Territory legislation applies only to represented persons.¹⁰⁶

Because there is no legal requirement to apply for a guardianship order when sterilisation is being considered, and the Board will only consider cases involving "represented persons", some intellectually disabled women will not be protected by s 37(1). This is in contravention of article 5 of the Declaration on the Rights of Mentally Retarded Persons,¹⁰⁷ which states that: "The mentally retarded person has a right to a qualified guardian when this is required to protect his [*sic*] personal well-being and interests". A doctor performing a sterilisation without the consent of the Board risks a finding of professional misconduct - liability may be criminal or civil. Nevertheless, it cannot be assumed that all doctors will act with propriety. There is thus a strong possibility for discrepant treatment in contravention of various international human rights laws. For example, article 7 of the Universal Declaration of Human Rights and article 26 of the ICCPR guarantee equal protection before the law, *without any discrimination*. Under the Victorian legislation, a person's protection depends wholly upon the conscientiousness of her or his carers.

It is also arguable that by not protecting minors, the Victorian legislation is discriminating on the ground of age, in contravention of article 2 of the Universal Declaration of Human Rights.¹⁰⁸ Why should an intellectually disabled child not have the protection of a law which applies to an

given informed consent; or (b) where the patient is a represented person to whom Division 6 of Part 4 of the Guardianship and Administration Board Act 1986 applies, the consent of the guardian and the Board as required is obtained.

104 Under s 19(1), an application for a guardianship order may only be made in respect of a person with a disability who has attained the age of 18 years.

105 The Board has defined "major medical procedure" as: a sterilisation; termination of pregnancy; or donation of non-regenerative tissue". "Directions and Information for Guardians Appointed by the Guardianship and Administration Board" (1992) - issued by the Board, 221 Drummond St, Carlton, Victoria.

106 WA Act s 57(1)(a); NT Act s 21(2).

107 Note 22 above.

108 Article 2 reads: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind ...".

intellectually disabled adult, when the latter may have no more personal autonomy than the child? If anything, intellectually disabled children are in even more dire need of legislative protection, since it is when they begin to mature sexually that sterilisation is most likely to be proposed. Decisions may be made prematurely, without proper consideration of possible improvement in mental capacity. To alleviate this problem, the legislation must include a requirement to apply for a guardianship order when sterilisation is being considered. The time-wasting and paperwork involved in applying for guardianship is lessened somewhat by the availability of temporary guardianship orders and the requirement that the applications be heard promptly.¹⁰⁹ The alternative solution is not to require a guardian to be appointed prior to a Board hearing. The South Australian Act applies to *any person* suffering from a mental illness or handicap unable to give consent, whether or not that person is under guardianship.¹¹⁰ It is suggested that this position is preferable to the Victorian one, and would remove the possibility of conflict with the stated human rights documents.

A further problem relating to the guardianship requirement under the Victorian Act is that only a restricted class of persons may apply for guardianship.¹¹¹ There is little justification for limiting those who may apply, and the restriction may result in the denial of legislative protection, for example where the pre-existing guardian refuses to apply to the Board.¹¹² On this point, the New South Wales Act is preferable, since applications may be made by "any person".¹¹³

Respect for the intellectually disabled person's wishes

In most cases coming before the Board, the person will be incapable of understanding the nature and effect of the sterilisation. However, the Board is required to ascertain the wishes of the represented person "*as far as is reasonably possible*",¹¹⁴ and if the person is capable of understanding the nature of the proposed operation, and of consenting or otherwise, the Board must give effect to the represented person's wishes.¹¹⁵ Such respect for autonomy is certainly desirable.

109 For example, the Vic Act s 40 and NT Act s 21(5) require the hearing to commence within 14 days of receiving the application. Despite this, the requirement would still act as a disincentive. Applications for temporary orders are made under s 32.

110 SA Act s 28a.

111 Vic Act ss 23 and 28 set out extensive criteria for deciding the suitability of the proposed guardian, and the Directions state that guardians "will generally be a family member or friend".

112 Blackwood, n 98 above.

113 NSW Act s 42(1).

114 Vic Act s 41(1). The NSW formulation may be preferable here, in that it is more specific: any refusal of treatment (however indicated), past or present, is a bar to the performance of that treatment: s 33(3).

115 Vic Act s 41(2).

Legislative criteria for "best interests"

This is perhaps the most important provision in terms of the rights of the intellectually disabled person. Unfortunately, it is also the area where the legislation is least satisfactory. None of the Acts define the vital words "best interests", seemingly content to leave it to the discretion of the respective boards.¹¹⁶ For example, s 42 of the Victorian Act states, without further elaboration: "If the Board is satisfied on hearing an application under section 38 that it would be in the *best interests* of the represented person it may by order consent to the major medical procedure".

A somewhat redeeming factor in relation to the Victorian legislation is the set of guidelines published by the Guardianship Board listing the criteria the Board should consider in deciding whether or not to consent to a proposed sterilisation.¹¹⁷ These guidelines benefit from hindsight, "hands-on" experience and extensive consultation and consideration.¹¹⁸ The criticism, of course, is that these guidelines are not included in the legislation, and thus the Board is not legally required to consider them. It is impossible to ascertain the degree to which the Board adheres to the guidelines, given the existence of the secrecy provision.¹¹⁹ The guidelines read, in part:

(1) he expressed wishes of the woman who is the subject of the application should be obtained and seriously considered.

(2) A woman with a disability has the right to the same treatment as other women of her age.

(3) Evidence is required that the woman the subject of the application is being given maximum opportunity to develop and receive education which would enable her to participate maximally in decisions which affect her life, for example sterilisation.

(4) The age of a woman needs consideration in so far as her future fertility and sexual development is concerned and the need not to make a premature decision affecting this part of her life.

(5) Evidence should be given that alternatives less restrictive of a woman's personal growth and freedom have been thoroughly explored.

116 See s 4(2) Vic Act, above. "Best interests" is also referred to in ss 23, 28, 36 and 42, but nowhere defined. The WA Act s 63(1) provides: "The Board may, by order, consent to the sterilisation of a represented person if it is satisfied that the sterilisation is in the best interests of the represented person". Again, there is no attempt at definition. Section 4(a) of the NT Act and s 4(2)(c) of the WA Act are much the same.

117 Guidelines on Division 6 - "Powers of the Board with Respect to Medical Procedures", published 6 August 1990. The extract here is obtained from Blackwood, n 98 above, p 164.

118 Blackwood, n 98 above.

119 Section 9 prohibits either direct or indirect recording of Board proceedings and communication of such with anyone except in the performance of official duties.

In relation to sterilisation operations, the Board suggested that the criteria set out by Nicholson CJ in *Re Jane*¹²⁰ should be given weight appropriate to the particular circumstances of the case. They are as follows:

(1) Independent medical and psychological evaluations by qualified professionals should be observed.

(2) The Board must be persuaded by clear and convincing proof that sterilisation is in the best interests of the person. In determining this issue the Board should consider at least:

- (a) the possibility that the person can become pregnant;
- (b) the possibility of trauma or psychological damage arising from pregnancy or birth (or conversely from the sterilisation operation);
- (c) the likelihood that the individual will voluntarily engage in sexual activity or be exposed to a situation where sexual intercourse is imposed upon her;
- (d) the inability of the person to understand reproduction or contraception and the likely permanence of that inability;
- (e) the feasibility and medical advisability of less drastic means of contraception both at the present time and the foreseeable future (for example, particular hormonal treatments);
- (f) the advisability of sterilisation at the time of the application rather than in the future;
- (g) the ability of the person to care for a child and the possibility that the individual may at some future date be able to marry and, with a partner, care for a child;
- (h) evidence of scientific or medical advances which may occur within the foreseeable future and make possible either an improvement of the individual's condition or alternative and less drastic sterilisation procedures;
- (i) a demonstration that the proponents of the sterilisation are seeking it in good faith, and that their primary concern is the best interest of the incompetent person, rather than their own or the public's convenience (for example, menstrual management).

Although deserving of praise for their attempt to codify the "best interests" criteria, parts of the guidelines do not measure up to the proposed "therapeutic balance test". It is evident from the *Re Jane* extract that social factors (societal values and the interests of the State and carers) are seen as relevant considerations in deciding the person's "best interests". Paragraphs (c), (d) and (e) indicate that non-consensual sterilisation for contraceptive purposes is envisaged, and para (g) harks back to the "fitness to parent" issue discussed earlier. Given the inclusion of factors relevant to "non-therapeutic"

120 (1988) 12 Fam LR 662.

sterilisation, the guidelines as they stand at present are insufficient from a rights-based perspective.

Conclusion

The existing Australian legislation, although obviously a marked improvement on the pre-existing state of non-regulation (apart from the common law), is far from uniform across the States, and falls short of protecting fully the reproductive rights of intellectually disabled people. The precarious position of intellectually disabled children, in particular, demands immediate legislative intervention. Unfortunately, however, international human rights law provides little guidance to domestic legislatures in this area.

The relevant human rights instruments are deficient with regard to the circumstances under which an intellectually disabled person's rights may be restricted. Only article 7 of the Declaration on the Rights of Mentally Retarded Persons (1971) addresses the issue specifically, but its wording is insufficiently precise to act as guidance for legislatures wishing to regulate the non-consensual sterilisation of intellectually disabled people.

In December 1991, the United Nations General Assembly, in an unprecedented move, adopted the "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care".¹²¹ This instrument represents an impressively detailed formulation of the rights of the mentally ill. It is not, however, designed for intellectually disabled people,¹²² in that it emphasises patient autonomy – often absent in the case of the intellectually disabled – rather than "best interests" or "therapeutic benefit". Severely intellectually disabled people are possibly even more universally marginalised and vulnerable than the mentally ill, the latter more likely to be capable of some degree of self-sufficiency. It is unfortunate that the United Nations has not seen fit to create Principles for the protection of intellectually disabled persons, which could function as a guide for new State or national legislation on non-consensual sterilisation.

The universal nature of human rights suggests that the ultimate solution to the problem of sterilisation abuse must begin at the international level. The

121 GA Res 46/119 (1991). The Human Rights Commission endorsed the draft body of the Principles in its resolution 1991/46 of 5 March 1991, after 11 years in genesis in the UN Commission on Human Rights, and more particularly, the Sub-Commission on the Prevention of Discrimination and Protection of Minorities: Delaney, "Autonomy Denied: International Human Rights and the Mental Health Act 1986 (Vic)" (1992) 18 *Melbourne University Law Review* 565.

122 "Mental illness" refers to a mental condition which has a particular cause or causes, and is not existent at birth, for example schizophrenia, depression and neuroses, whereas intellectual disability refers to "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour, and manifested during the developmental period": Canadian LRC Report, n 2 above, p 8.

United Nations must formulate the rights of intellectually disabled people more comprehensively. In particular, the criteria upon which to base a decision to sterilise a person must be prescribed, due to the existence of powerful influences having the potential to affect this decision. Such influences include: the interests of carers, of doctors who will be involved in the operation if it proceeds, scarcity of public resources for the care of intellectually disabled people, and the tendency to underestimate their capabilities and to regard them as undeserving of full human dignity.¹²³ Irreversible sterilisation involves the removal of reproductive rights. Its potentially devastating consequences require that it is restricted to cases where the therapeutic benefits outweigh the possible negative physical and psychological consequences (the "therapeutic balance test").

Lack of United Nations guidance is no excuse for inaction on the domestic front, however. The judiciary and legislature have an obligation to ensure the protection of the rights of the intellectually disabled. Although the High Court decision in *Secretary, Department of Health and Community Services v JWD and SMB*¹²⁴ represents a positive step towards this end, it by no means provides adequate human rights protection for intellectually disabled people in the area of non-consensual sterilisation. It remains to be seen how the courts will define "best interests". Uniform legislative regimes based on the Victorian model¹²⁵ would be preferable to the common law, given the problems associated with the latter. Individual State legislatures have only recently begun to respond to the problem of sterilisation abuse, but their solutions are discrepant and their protection of human rights patchy. The goal must be to expand and enhance the protection of the human rights of intellectually disabled people, and this can only be achieved through unified and committed action at both the international and domestic level.

Lucas Baron Human Rights Essay Competition

Lucas Baron, a Melbourne firm of Barristers and Solicitors, offers an annual prize of \$1000 for the best student essay on Human Rights Law in Australia. The prize is administered jointly by Lucas Baron and the Faculty of Law at the University of Melbourne. In 1992 and 1993 the prize was offered only to Victorian tertiary students who had not yet completed a Bachelor of Laws degree, but from 1994 the prize will be offered nationally.

123 These factors were mentioned by Brennan J in *Marion's case*, n 13 above, p 272.

124 (1992) 175 CLR 218.

125 Based on the amendments proposed in this paper.