A PHILOSOPHICAL APPROACH TO DECISION-MAKING FOR STERILISING MENTALLY DISORDERED ADULTS

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ABSTRACT

The issue of sterilisation of mentally disordered persons has never been considered by the courts or the legislature of Malaysia. This thesis examines how the law of tort of Malaysia should look at sterilisation of mentally disordered adults. In this connection, the history of compulsory sterilisation in other jurisdictions, the way the existing legislative framework of Malaysia views the question of consent and medical treatment, as well as how the sterilisation cases in England, Canada, Australia, New Zealand and the US have developed are all looked into with a view of forming a legal proposition using a philosophical approach. It is proposed that the best interests test is not necessarily the best test and that it could be overly dependent on the value system of the decision-maker. Many of the factors that are considered important to the best interests test may not have good basis for comparison and they have contributed to the medicalisation of many legal and ethical issues. The principle of autonomy and the principle that non-therapeutic sterilisation can never be performed without the consent of the patient are the two principles that should be used to safeguard the interests of the mentally disordered adults. These two principles are used to propose a set of guiding principles for decision-makers in Malaysia after taking into consideration the existing regulatory conditions in Malaysia.

ABSTRAK

Isu sterilisasi orang sakit mental tidak pernah dipertimbangkan oleh mahkamah ataupun perundangan Malaysia. Tesis ini mempertimbangkan bagaimana undang-undang tort di Malaysia wajar menangani isu sterilisasi orang dewasa yang sakit mental. Sehubungan dengan ini, sumber-sumber berikut ditelitikan untuk membentukkan suatu usul perundangan dengan menggunakan pendekatan falsafah: (a) sejarah di lain-lain negara yang melakukan sterilisasi wajib; (b) struktur perundangan Malaysia tentang izin dan rawatan perubatan dan (c) pendekatan undang-undang yang digunakan dalam kes-kes sterilisasi di England, Kanada, Australia, New Zealand dan Amerika Syarikat. Tesis ini mencadangkan bahawa ujian kepentingan terbaik bukan semestinya ujian yang paling baik dan ia terlalu tergantung kepada sistem nilai pembuat keputusan. Banyak faktor yang dianggap penting dalam ujian kepentingan terbaik sebenarnya tidak menpunyai asas pembandingan yang berpatututan dan ini telah menyumbang kepada penukaran banyak isu etika dan perundangan kepada isu perubatan. Dua prinsip berikut wajar digunakan untuk melindungi kepentingan orang dewasa yang sakit mental: (a) prinsip autonomi; dan (b) prinsip bahawa sterilisasi yang tidak berdasarkan faktor terapeutik tidak harus dilakukan,. Setelah mangambilkira keadaan perundangan di Malaysia, dua prinsip ini digunakan untuk mencadangkan suatu set prinsip-prinsip panduan untuk pembuat keputusan di Malaysia.

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Chapter 1

Introduction

1.1 Introduction

At first glance, the topic of "sterilisation of mentally disordered adults" seems charged with emotion. Perhaps it should not be so, since many sterilisation procedures are carried out on mentally healthy adults. The question is not so much whether or not mentally disordered adults should be sterilised, but whether or not such procedure should be performed on this group of persons without their consent.

Sterilisation is chosen as the focus of this thesis for a few reasons. Firstly, sterilisation is different from most of the other medical procedures. The Law Reform Commission of Canada acknowledges this fact in its working paper on sterilisation –

> "Sterilization as a medical procedure is distinct, because except in rare cases, if the operation is not performed, the physical health of the person involved is not in danger, necessity or emergency not normally being factors in the decision to undertake the procedure. In addition to its being elective it is for all intents and purposes irreversible."[1]

The above paragraph is particularly true in the case of sterilisation of mentally disordered persons.

Secondly, sterilisation occupies a unique position in medical law as it involves some of the most difficult moral and ethical issues of our time, such as the conflict between paternalism and autonomy, the conflict between sexual and procreative freedom, as well

[1] Law Reform Commission of Canada, *Sterilization – Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper 24), (Ottawa: Law Reform Commission of Canada, 1979), at page 3

as the continuing influence of eugenicist and discriminatory thinking.[2] Advancement in clinical trials has brought ethical and moral issues to the forefront of modern medical law. The relatively long history of sterilising the mentally disordered has offered us decades of debates on these difficult questions. The rapid development in medical science means that these debates will only become increasingly relevant in the years to come.

Thirdly, although large-scale sterilisations for eugenic purposes are no longer promoted, sterilisations will remain relevant so long as the prospect of population explosion continues to haunt the world. No one knows if compulsory sterilisation laws will make a comeback in the near future in the name of population control.[3] In fact, there have been allegations that forced sterilisations have been used as a method of implementing the one-child policy in China.[4] In 1983, a massive campaign of compulsory birth control surgeries was carried out in China, which reportedly produced, amongst others, 21 million sterilisations.[5] In India, as a result of the incentives offered by the Indian government, at least 2.3 million males and females had submitted to sterilisation by March 1967.[6] It has been reported that Roma women in Slovakia are still being sterilised against their will due to the fears of Roma overpopulation in Slovakia.[7] In 2006, the district magistrate in Allahabad in India ordered thousands of school teachers

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[2] Davies, Michael, *Textbook on Medical Law*, 2nd ed., (London: Blackstone Press, 1998), at page 392

[3] It was suggested that as our resources continue to shrink and our earthly neighbourhood becomes more crowded, compulsory sterilisation may someday be as common as compulsory immunisations: Reilly, P.R., "Eugenic Sterilization in the United States", *Genetics and the Law III - National Symposium on Genetics and the Law*, Ed., Aubrey Milunsky and George J. Annas, (New York: Plenum Press, 1985), at page 239

[4] Society for the Protection of Unborn Children, "Population Control: China's One Child Policy", 8 November 2005 <http://www.spuc.org.uk/lobbying/population-control-china>

[5] See footnote 4 above

[6] Meyers, David W., "Compulsory Sterilisation and Castration", *Medical Law and Ethics*, Ed., Sheila McLean, (Ashgate: Dartmouth, 2002), at page 282

[7] The Center for Reproductive Rights and Centre for Civil and Human Rights of Poradňa, *Body and Soul – Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia*, (New York: The Center for Reproductive Rights, 2003), at page 54, and Richterova, Katarina, "Slovakia investigates allegations that Romany women were sterilised without consent", *Insight Central Europe*, 21 October 2005, 21 January 2008 <http://incentraleurope.radio.cz/ice/issue/71955>

to find two volunteers for sterilisation as a solution to India's population explosion.[8] The magistrate called population explosion "the root cause of all evils".[9]

The various forms of sterilisation procedures are considered in Chapter 2 to provide a basic understanding of the different medical procedures available. The history of sterilising mentally disordered persons is examined in the same chapter, as history has continued to affect the way the judges and commentators respond to this issue.

Malaysia does not have any legislation on sterilisation. Therefore, in Chapter 3, the Malaysian criminal law, mental health law, law on persons with disabilities and other relevant laws in Malaysia are scrutinised to establish the impact of existing legislative framework on the issue of sterilising mentally disordered adults.

Chapters 4, 5 and 6 provide a chronological account of the development of cases on sterilisation of mentally disordered persons in the UK, Canada, Australia, New Zealand and the US. Chapter 4 shows how cases in various jurisdictions responded to the history of sterilising mentally disordered persons by moving away from protecting the state's interest to upholding the human rights of the patient. Many principles and factors initially applied for the purpose of protecting the interests of mentally disordered persons eventually became inseparable from the party who has the jurisdiction to decide on the issue. Chapters 5 and 6 outline the development of case law which gives many decision-making power to the doctors, resulting in the obscuring of the boundaries between medical issues and social issues.

[8] *Sunday Star* (Kuala Lumpur), 26 February 2006, 47
[9] See footnote 8 above

The reasons behind the medicalisation of social issues are examined in Chapter 7. Chapter 8 discusses two principles, namely the principle of autonomy and the dichotomy between therapeutic and non-therapeutic sterilisation, which can effectively safeguard the interests of the mentally disordered person. In Chapter 9, a set of guiding principles which decision-makers in Malaysia could adopt, after taking into consideration both the conditions unique to Malaysia as well as the development of the law in other jurisdictions, are recommended.

1.2 Definitions

Meaning of "adults"

This thesis focuses on mentally disordered adults and not minors mainly because they involve different jurisdictional issues and different considerations insofar as the capacity to consent is concerned. In any event, the principles relevant to the substantive law of sterilisation are the same regardless of the age of patients. The word "adult" in this thesis refers to a person who has attained the age of majority, which is 18 years of age pursuant to Section 2 of the Age of Majority Act 1971.[10]

Meaning of "consent"

Since the focus of this thesis is on consent, it should be stressed at the outset that a procedure performed "without the consent of a patient" is not synonymous to a procedure performed "against the wishes of a patient". The absence of consent can be due to the inability to consent or the refusal to consent. A person who lacks the capacity to consent may nevertheless wish to be sterilised.

[10] Act 21

The concept of consent emanates from the principle of autonomy, which provides that every person has the right to determine what should be done with his own body. The principle of autonomy is of such importance that consent is an exception to the inviolability of a person's body.[11] That is the reason consent is one of the most important areas of medical law, as doctors are able to perform medical procedures on their patients' body because of the consent of their patients. The standard of disclosure of risks by doctors has been the subject of numerous high profile litigations, such as the Malaysian case of *Foo Fio Na* v *Dr Soo Fook Mun & Anor*,[12] precisely because of the impact such disclosure has on the decision of a patient to consent or not consent to a proposed medical procedure.

The issue of consent is examined in this thesis from the angle of the law of tort and not criminal law. However, since the law on sterilisation remains a blank slate in Malaysia, the status of consent in the Malaysian criminal law is also examined.[13] It should however be remembered that consent in the law of tort is not always the same as consent in criminal law. As acknowledged by Lord Mustill in *Airedale NHS Trust* v *Bland*,[14] there is a point at which consent in general ceases to form a defence to a criminal charge.[15]

Definition of "mentally disordered"

The term "mentally disordered" is used for this thesis as it is the term commonly used in the laws of Malaysia to refer to persons with mental deficiency. Section 66 of the

[11] See Paragraph 8.1 of Chapter 8
[12] [2007] 1 MLJ 593
[13] See Chapter 3
[14] [1993] 1 All ER 821
[15] The example used by Lord Mustill was where one person cut off the hand of another, it was no answer to say that the amputee consented to what was done.

Interpretation Acts 1948 and 1967[16] defines the term "mentally disordered person" to mean "a person of unsound mind or an idiot". This definition does not seem to be very informative, therefore for the purpose of this thesis, the definition of "mentally disordered" in the yet-to-be-in-force Mental Health Act 2001[17] is adopted. Section 2(1) of the Mental Health Act 2001[18] defines "mental disorder" as –

> "any mental illness, arrested or incomplete development of the mind, psychiatric disorder or any other disorder or disability of the mind however acquired; and 'mentally disordered' shall be construed accordingly…"

The phrase "incomplete development of the mind" in the above definition seems to cover persons with sub-average intellectual ability, or in other words, the mentally retarded persons. Categorisation of persons with mental health problems is never as straightforward as it seems due to the wide range and variety of mental illnesses.[19] For example, the Mental Health Ordinance[20] of Hong Kong distinguishes between "mental handicap" and "mental disorder". The former means "sub-average general intellectual functioning with deficiencies in adaptive behaviour", while the latter refers to mental handicap associated with "abnormally aggressive or seriously irresponsible conduct".[21] Another category of "mental incapacity" was created in the same legislation to refer to "mental disorder or mental handicap".[22] This category covers persons with dementia or

[16] Act 388
[17] Act 615
[18] See footnote 19 above
[19] For instance, in 1910, Henry Herbert Goddard of the Vineland New Jersey Training School, at the 34th annual meeting of the American Association for the Study of the Feebleminded, presented a "new" classification system that included the classification of "moron" for persons who tested between 8 and 12 years on the Binet intelligence test, for the purpose of subjecting such persons to involuntary sterilisation: Wehmeyer, Michael L., "Eugenics and Sterilization in the Heartland" (2003) Volume 41, Number 1 *Mental Retardation* 57, at page 59
[20] Chapter 136
[21] Section 2(1)
[22] See footnote 23 above

psychosis.[23] Although it is not clear if the definition of "mental disorder" in the Mental Health Act 2001[24] is wide enough to cover all the three categories of persons under the Hong Kong legislation, the term "mentally disordered" in this thesis should be read to cover all these persons.

1.3 Research methodology

The research methodology chosen for this thesis is library-based literature review. The materials reviewed include law reports, statutes, legal and medical journals, textbooks, theses, news articles, conference papers and various online resources.

Early review revealed the total absence of reported cases in Malaysia with regard to sterilisation. Other medical cases in Malaysia are less relevant to this thesis as unlike other medical procedures, sterilisation of mentally disordered persons is not always performed for the purpose of avoiding physical danger. Factors which are indisputably relevant to determine best interest in normal medical procedures become debatable in the context of sterilisation of mentally disordered persons.

In order to formulate a set of workable guidelines for decision-makers, the historical development of events, legislations and cases on sterilisation of mentally disordered persons in other jurisdictions are examined. While the focus insofar as legislations and cases are concerned is on those of the Commonwealth jurisdictions, a wider net is cast insofar as historical events are concerned. This is because the history of one jurisdiction may influence the courts in another jurisdiction, especially when part of the history of sterilising mentally disordered persons overlaps with that of the Second World War.

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[23] Hung, C.H.R., "Mental Handicap and Mental Health (Amendment) Ordinance 1997", Volume 10, *Hong Kong Journal of Psychiatry*, No 4, 10 August 2005 <http://www.hkjpsych.com/Mental_Handicap.pdf>, at page 15

[24] See footnote 19 above

The approach used in analysing events, legislations and cases is largely jurisprudential or philosophical as the aim of the thesis is to develop a policy on how decisions on sterilising mentally disordered adults should be made. History always provides useful insights when it comes to policy development, hence the deliberate attempt at chronological analysis of the cases studied in this thesis.

That is not to say Malaysia-based materials are not considered. Until and unless a specific legislation on sterilisation is passed in Malaysia, all policies must be in line with the general legal framework that is currently in force and that may have an impact on this issue. Existing legislations that may be relevant are therefore looked into. In the absence of specific sterilisation cases in Malaysia, Malaysian cases are used mainly as analogy or to support established legal principles.

Attempt has been made to state the law as at March 2008, but developments after that have been included where possible.

Chapter 2

Forms of Sterilisation Procedures and the History of Sterilising Mentally Disordered Persons

2.1 Forms of sterilisation procedures

A sterilisation procedure is usually understood as one that renders an otherwise healthy and presumed fertile person incapable of being a parent.[1] The first part of this chapter describes in brief the various forms of sterilisation procedures for male and female patients.

2.1.1 Male sterilisation

The only form of male sterilisation in use is vasectomy. This is a relatively simple surgical procedure with a high degree of success in reversibility.[2] Vasectomy involves the cutting of the vas deferens, which is the duct that conducts sperm from the testicles to the penis.[3] No hospitalisation is usually required for vasectomy.[4]

Castration is another method of male sterilisation, but it is no longer in use today. Castration is known medically as orchiectomy and it involves the removal of the testes or male sex organs themselves. This procedure however goes beyond sterilisation as it affects the sexuality of the male concerned.

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[1] It should however be noted that modern reproductive technology can assist women who have been sterilised by method such as tubal ligation to have a child: The Law Reform Commission of Western Australia, *Report on Consent to Sterilisation of Minors*, (Project No 77 Part II), (Perth: The Law Reform Commission of Western Australia, 1994), at page 14

[2] Inter-Governmental Coordinating Committee Southeast Asian Regional Cooperation in Family and Population Planning, "Sterilisation and abortion procedures", *Proceedings of the First Meeting of the IGCC Expert Group Working Committee on Sterilisation and Abortion*, (Penang, 3-5 January 1973), at page 3

[3] The Law Reform Commission of Western Australia, see footnote 1 above

[4] Inter-Governmental Coordinating Committee Southeast Asian Regional Cooperation in Family and Population Planning, see footnote 2 above, at page 5

2.1.2 Female sterilisation

One of the most common methods of sterilising a woman is tubal ligation. This procedure involves severing or tying the Fallopian tubes which would otherwise carry fertilised egg to the womb for implantation.[5] A newer method involves the insertion of tiny coils into each Fallopian tube which will form scar tissue that blocks the egg from meeting sperm.[6] According to the experts in *Re M (a minor) (wardship: sterilization)*[7] and *Re P (a minor) (wardship: sterilization)*,[8] tubal ligation by occlusion of the Fallopian tubes was reversible in the majority of cases. There are two methods of tubal ligation: laparoscopic[9] ligation and surgical ligation.[10] A patient who has undergone a tubal ligation procedure may be asked to remain in a hospital for a day.[11] It should also be noted that in Islamic communities, tubal occlusion is preferred to the cutting of the Fallopian tube.[12] According to the consent advice issued by the Royal College of Obstetricians and Gynaecologists, the risks of laparoscopic tubal occlusion include uterine perforation; injuries to the bowel, bladder or blood vessels (three in every 1,000); death as a result of complications (one in every 12,000); bruising and shoulder-tip pain.[13]

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[5] The Law Reform Commission of Western Australia, see footnote 1 above
[6] American College of Obstetricians and Gynecologists, *Special Ethical Considerations Inherent with Sterilization Procedures*, 10 July 2007, 20 January 2008 <http://www.medicalnewstoday.com/articles/76299.php>
[7] [1988] 2 FLR 497
[8] [1989] 1 FLR 182, [1989] Fam Law 102
[9] Laparoscopic surgery is a surgical technique which is also called keyhole surgery (when natural body openings are not used), bandaid surgery or minimally invasive surgery (MIS). Laparoscopic surgery involves making three or four small incisions in the abdomen. A laparoscope (an instrument that allows the interior of the abdomen to be viewed) is inserted through one of the incisions into the abdominal cavity. This approach is intended to minimise operative blood loss and post-operative pain, and speeds up recovery times. However, the restricted vision, difficult handling of the instruments (hand-eye coordination), lack of tactile perception and the limited working area can increase the possibility of damage to surrounding organs and vessels, either accidentally or through the difficulty of procedures:Women's Health Queensland Wide, *Hysterectomy*, (Sprill Hill: Women's Health Queensland Wide, 2005
[10] The Law Reform Commission of Western Australia, see footnote 1 above
[11] *Surgeries Specific to Women*, Web Health Care, 21 January 2008 <http://www.webhealthcenter.com/general/women_health_surgery.asp#tubal>
[12] Inter-Governmental Coordinating Committee Southeast Asian Regional Cooperation in Family and Population Planning, see footnote 2 above, at page 6
[13] Royal College of Obstetricians and Gynaecologists, *Consent Advice 3: Laparoscopic Tubal Occlusion*, (London: Royal College of Obstetricians and Gynaecologists, October 2004)

There are at least four other types of procedures, each of which if performed on females can result in sterility. The first is ovariectomy, which involves the removal of the ovaries. Ovariectomy is the female equivalent of orchiectomy. The ovaries are responsible for the production of ripe ovum each month, and the production of the female sex hormones, progesterone and oestrogen. Removal of ovaries is commonly performed for the treatment of women for gynaecological abnormalities and disease. Besides having the effect of sterilisation, this procedure may result in ovarian hormone deficiency, which would require long-term hormone replacement therapy. This is a controversial treatment that is hardly performed for the purpose of sterilisation.[14]

The second is hysterectomy. Hysterectomy is the surgical removal of the body and cervix of the uterus. It can be performed using three different methods, namely abdominal hysterectomy,[15] vaginal hysterectomy[16] and laparoscopic[17] hysterectomy. The risk factors and recovery consequences involved for each of these methods differ. Although this procedure is a more invasive sterilisation procedure than tubal ligation, it is sometimes preferred as it also causes the cessation of menstruation. Due to the surgical risks involved, hysterectomy is not likely to be recommended in cases where there is obesity, poor general health or any other disease. According to the consent advice issued by the Royal College of Obstetricians and Gynaecologists, the abdominal hysterectomy carries the same risk of death as other operations, which is one in every

[14] The Law Reform Commission of Western Australia, see footnote 1 above, at page 15
[15] This procedure is sometimes called laparotomy or coeliotomy, and it involves an incision through the abdominal wall to gain access into the abdominal cavity: Women's Health Queensland Wide, *Hysterectomy*, (Sprill Hill: Women's Health Queensland Wide, 2005
[16] A vaginal hysterectomy is the removal of the uterus, cervix, Fallopian tubes and ovaries through an incision in the deepest part of the vagina: *Surgeries Specific to Women*, Web Health Care, 21 January 2008 <http://www.webhealthcenter.com/general/women_health_surgery.asp#tubal>
[17] See footnote 9 above

4,000.[18] Further, two women in every hundred undergoing abdominal hysterectomy will experience at least one of the following complications: damage to the bladder and/or the ureter (0.7%); damage to the bowel (0.04%); haemorrhage requiring blood transfusion (1.5%); return to theatre for additional stitches (0.6%); pelvic abscess or infection (0.2%); venous thrombosis or pulmonary embolism (0.4%).[19] Frequent risks of abdominal hysterectomy include wound infection and bruising; frequency of urination; delayed wound healing; keloid formation; inconclusive evidence of early menopause.[20] Hospitalisation for uncomplicated abdominal hysterectomy is three to five days; and two to three days for vaginal or laparoscopic hysterectomy.[21]

Salpingectomy also has the effect of sterilisation. Salpingectomy is the surgical removal of one or both of a woman's Fallopian tubes. Although salpingectomy is usually used to treat ectopic pregnancy[22] or infected Fallopian tubes,[23] the removal of both the Fallopian tubes[24] would have the effect of sterilisation. Indeed, salpingectomy was the sterilisation procedure contemplated in some of the legislation on compulsory sterilisation in the US.[25]

The fourth type of procedure is endometrial ablation. This is the surgical removal of the mucous lining of the uterus, the endometrium,[26] by searing it with a laser. This

[18] Royal College of Obstetricians and Gynaecologists, *Consent Advice 4: Abdominal Hysterectomy for Heavy Periods*, (London: Royal College of Obstetricians and Gynaecologists, October 2004)
[19] See footnote 18 above
[20] See footnote 18 above
[21] Women's Health Queensland Wide, *Hysterectomy*, (Sprill Hill: Women's Health Queensland Wide, 2005
[22] Ectopic pregnancy occurs when a fertilised egg was implanted in the Fallopian tube instead of inside the uterus.
[23] This condition is known as salpingitis.
[24] Removal of both the Fallopian tubes is also known as bilateral salpingectomy.
[25] It appears from cases such as *Buck* v *Bell* (1927) 274 US 200 and *Skinner* v *Oklahoma* (1942) 316 US535 that salpingectomy was listed as a sterilisation procedure for females in the sterilisation legislation in the state of Virginia and the state of Oklahoma. See Paragraph 2.2.1 below.
[26] The endometrium is the uterine membrane in mammals which is thickened in preparation for the implantation of a fertilised egg upon its arrival into the uterus.

procedure is a relatively new procedure that results in cessation of menstruation and, incidentally, sterilisation.[27]

Some modern contraceptive devices, such as intrauterine device[28] or intra uterine system,[29] may render their users infertile for up to five years if their usages are monitored closely. As these methods do not generally involve invasive procedures,[30] they are not considered "sterilisation" for the purpose of this thesis.

2.2 The history of sterilising mentally disordered persons

Surgical sterilisation has been practised for at least 180 years. It was originally used for the protection of women whose life and health were threatened by a pregnancy or delivery.[31]

The development of the laws on sterilisation of mentally disordered persons in many jurisdictions cannot be adequately examined without first understanding the history of sterilising mentally disordered persons. Contrary to popular belief, the practice of sterilising mentally disordered persons was not started by the Nazis. As to be seen below, large-scale sterilisations of mentally disordered persons first occurred in the United States (US).

Sterilisations were first promoted in the US as an alternative to institutionalisation.[32] The underlying rationale of such practice was the 19th century theory of eugenics,[33]

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[27] The Law Reform Commission of Western Australia, see footnote 1 above, at page 17
[28] Intrauterine device is also known as IUD or coil. It is a small plastic and copper device that is fitted inside the uterus to prevent fertilisation and implantation of an egg.
[29] This is also known as the IUS. It is essentially an IUD containing slow-release progestogen.
[30] An IUD or IUS is fitted using a thin applicator tube.
[31] See footnote 2 above, at page 3
[32] Goldhar, Jeff, "The Sterilization of Women with an Intellectual Disability" (1991) 10 *University of Tasmania Law Review* 157, at page 161

which argued that mental illness, intellectual disability, epilepsy, criminality, alcoholism and pauperism were hereditary. Those who possessed such traits should therefore not be allowed to procreate. The followers of social eugenics further argued that public education, health care and social services interfered with Darwin's theory of "survival of the fittest".[34] It was thus suggested that the human unfit should not be allowed to procreate in order to restore the "survival of the fittest" among humans.[35]

The Nazis did not start the trend of sterilising mentally disordered persons on eugenics ground, but some claimed that they indirectly ended it.[36] It is widely believed that it was the "success" of the German policy that contributed to the decline of the eugenics movement by 1939.[37]

The following paragraphs outline the history of sterilising mentally disordered persons in the US, Canada, Europe, Japan and Australia.

2.2.1 The US

The experience of the US demonstrates the impact court decisions can have on the lives of the people. It could be said that it was the US Supreme Court's decision in *Buck* v

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[33] Eugenics is a "science" that deals with the improvement (by control of human mating) of hereditary qualities of a race or breed.
[34] Goldhar, Jeff, see footnote 32 above
[35] See footnote 34 above
[36] It should however be noted that Nazi sterilisation policy did not curtail sterilisation programs in the US, as more than one half of all eugenic sterilisations occurred after the Nazi program was fully operational: Reilly, P.R., "Eugenic Sterilization in the United States", *Genetics and the Law III - National Symposium on Genetics and the Law*, Ed., Aubrey Milunsky and George J. Annas, (New York: Plenum Press, 1985), at pages 235, 236
[37] Goldhar, Jeff, see footnote 32 above, at page 163. However, it has been said that there is no evidence to support the argument that stories of Nazi horrors halted American sterilisation efforts. The factors contributing to the sharp decline in the number of eugenic sterilisations in the US following the onset of the Second World War include manpower shortages, the closure of Eugenics Record Office, the cessation of activities of the Human Betterment Foundation and the decision of the US Supreme Court in *Skinner* v *Oklahoma* (1942) 316 US 535 to strike down an Oklahoma law that permitted certain thrice-convicted felons to be sterilised: Reilly, P.R., see footnote 36 above, at pages 236, 237

Bell[38] that opened the floodgates to wholesale sterilisation of the "feeble-minded". In that case, Dr Bell of the Virginia State Colony for Epileptics and Feeble-minded authorised the sterilisation of 18-year-old Carrie Buck. Carrie Buck was a mildly retarded woman. Her mother was similarly afflicted. Carrie herself had given birth to an allegedly retarded child Vivien, who was 19-month-old at that time. The US Supreme Court accepted the eugenic arguments that since both Carrie's daughter and mother were feeble-minded, Carrie and the society would benefit from her sterilisation. Justice Oliver Wendell Holmes 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 their lesser sacrifices, often not felt to be such by those concerned, in order to prevent our society 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."[39]

Carrie Buck was the first person to be forcibly sterilised under the Virginia Eugenical Sterilization Act (1924) (US). The rate of sterilisations in Virginia escalated following the Supreme Court's upholding of the law in *Buck* v *Bell* in 1927.[40]

However, Virginia was not the first US state to pass sterilisation law. The first state sterilisation law was passed in 1907 by the Indiana legislature.[41] The law was passed to

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[38] (1927) 274 US 200
[39] See footnote 38 above, at page 207
[40] Wehmeyer, Michael L., "Eugenics and Sterilization in the Heartland" (2003) Volume 41, Number 1 *Mental Retardation* 57, at page 57

"prevent procreation of confirmed criminals, idiots, imbeciles, and rapists'".[42] This law was declared unconstitutional by the Supreme Court of Indiana in 1921. Indiana passed a second law in 1927[43] and that was ruled constitutional. As of 1 January 1928, Indiana had sterilised 120 persons without their consent.[44]

As of the same date, Virginia had sterilised only 17 persons. Virginia was in fact the 21st state to pass such legislation. Besides Indiana, the other 19 states that enacted involuntary sterilisation laws prior to Virginia were Washington, California, Connecticut, Nevada, Iowa, New Jersey, New York, North Dakota, Kansas, Michigan, Wisconsin, Nebraska, Oregon, South Dakota, New Hampshire, North Carolina, Alabama, Montana and Delaware.[45] The case of *Buck* v *Bell*[46] accelerated the pace of legislation. In 1929, nine more states adopted similar laws. These laws were usually passed by a large majority vote.[47]

However, almost all sterilisations performed in the US up to 1932 occurred in the state of California.[48] The figure was 7,548.[49] Up to 1 January 1938, the number of involuntary sterilisations performed in California alone was 12,180, followed by 2,916 in Virginia, 1,915 in Kansas, 1,815 in Michigan, 1,459 in Minnesota and 1,218 in

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[41] Sterilization Law (1907) (Chapter 215) (Indiana, US)
[42] Preamble of Sterilization Law (1907) (Chapter 215) (Indiana, US)
[43] Sterilization Law (1927) (Chapter 241) (Indiana, US)
[44] Goseney, E.S. and P.B. Pooponoe, *Sterilization for human betterment: A summary of the results of 6,000 operations in California, 1909 – 1929* (1929), at page 185, quoted by Wehmeyer, Michael L, see footnote 40 above
[45] Wehmeyer, Michael L, see footnote 40 above
[46] See footnote 38 above
[47] Reilly, P.R., see footnote 36 above, at pages 231, 234
[48] The statute in California that was passed on 10 August 1909 provided for the "sterilization of the insane and feeble-minded inmates of state hospitals and of convicts and idiots in state institutions". See Landman, J.H., Human sterilization: The history of the sexual sterilization movement, (1932), at page 58, quoted by Wehmeyer, Michael L, see footnote 40 above
[49] Landman, J.H., see footnote 48 above, at page 59, quoted by Wehmeyer, Michael L, see footnote 40 above, at page 58

Oregon.[50] Unlike other states that covered "confirmed criminals, idiots, imbeciles and rapists", the focus of California was on sterilising the insane.[51] By 1967, a total of 60,291 Americans had been subjected to forced sterilisation, simply because they were mental deficients or had mental illness.[52]

By 1937 both the American Neurological Association and the American Medical Association had criticised the overwhelming emphasis on heredity as a cause of mental retardation, mental illness, pauperism, epilepsy and other disabilities.[53] In 1942, the US Supreme Court declared that reproduction is a fundamental human right.[54] This decision initiated legislative and judicial actions that prohibited sterilisation of persons with mental disabilities. In 1950, sterilisation bills that were considered in four states were all rejected.[55]

Sterilisation reappeared in the US in the 1960s as a punishment for illegitimacy, poor parenting and fiscal irresponsibility. Consent was required if federal funds were to be used to pay for the procedure. However, this requirement was ignored in the sterilisation of thousands of native American women.[56] In 1979, federal regulations provided that federal funds cannot be used for the sterilisation of mentally incompetent person.[57]

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[50] Human Betterment Foundation, *Report to the Board of Trustees of the Human Betterment Foundation for the year ending February 8, 1938*, quoted by Wehmeyer, Michael L, see footnote 40 above, at page 58
[51] Reilly, P.R., see footnote 36 above, at page 231
[52] Meyers, David W., "Compulsory Sterilisation and Castration", *Medical Law and Ethics*, Ed., Sheila McLean, (Ashgate: Dartmouth, 2002), at page 270
[53] *Re Eve* (1986) 31 DLR (4th) 1, at page 23
[54] *Skinner* v *Oklahoma* (1942) 316 US 535
[55] Reilly, P.R., see footnote 36 above, at page 237
[56] Kevles, Daniel, "The Sterilization of Mental Defectives", Report of the Federal Health Council, 1933, as quoted by Goldhar, Jeff, see footnote 32 above, at page 165
[57] 42 C.F.R. §50.201-210 (1979) (US)

2.2.2 Canada

In Canada, sterilisation legislation used to exist in the province of Alberta and the province of British Columbia. Under the Alberta Sexual Sterilization Act, S.A. 1928, (Canada)[58] the Eugenic Board of Alberta could consent to a sterilisation of mentally defective patient, if they were satisfied that procreation would result in mental disease to progeny or involve a risk of mental injury to the person or progeny. There was no need for the patients to consent. Applications were often initiated by parents and most sterilisations took place before puberty. The Eugenics Board of Alberta authorised 2,822 sterilisations in its 45 years of history.[59] Alberta repealed its Sexual Sterilization Act (Canada)[60] in 1972.

The British Columbia Eugenics Board could order sterilisation if all members of the board unanimously decided that the inmate of a provincial institution would be likely to produce children with serious mental disease or mental deficiency. Consent of the patient had to be obtained if the patient was deemed capable of giving consent. This law was used much less often than the one in Alberta and was repealed in 1973.[61]

2.2.3 Europe

Germany under the rule of Nazi introduced a sterilisation law on 14 July 1933.[62] Whoever suffering from one of the following disorders was liable to be sterilised under that law: innate mental deficiency, schizophrenia, recurrent (maniac-depressive) insanity, hereditary epilepsy, hereditary St. Vitus' Dance (Huntingdon's chorea), hereditary blindness, hereditary deafness, severe hereditary bodily deformity or severe

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[58] c.37 (Alberta, Canada)
[59] Law Reform Commission of Canada, *Sterilization – Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper 24), (Ottawa: Law Reform Commission of Canada, 1979), at pages 27-28
[60] See footnote 58 above
[6161] Law Reform Commission of Canada, see footnote 59 above, at pages 28-29
[62] Law for the Prevention of Hereditarily Diseased Offspring of 14 July 1933 (1933 Reichsgesetzblatt, Part I, page 529, Vol. V, page 880) (Germany)

and chronic alcoholism.[63] By the end of the Second World War, over 400,000 individuals had been sterilised under the German law and its revisions, out of which more than 32,000 were sterilised on ground of feeble-mindedness.[64] Another report charged that from 1934 to 1945, the Nazis sterilised 3,500,000 people.[65] The German eugenicists said that they "owed a great debt to the American precedence",[66] although the German interest in eugenics had roots that twined with 19th-century European racial thought.[67] The law was abolished by the Allies in 1946.[68]

The practice of forced sterilisation in Sweden was made public in August 1997.[69] Between 1935 and 1976, some 62,000 "genetically inferior" people in Sweden were forcibly sterilised.[70] It has been said that most of these people were women who were labelled as mentally defective.[71]

Besides Sweden, legislation authorising eugenic sterilisation also existed in Denmark, Switzerland, Norway, France and Finland.[72] Denmark enacted a law in 1935 to provide for voluntary and compulsory castration of sexual offenders and psychotics. Between 1929 and 1956, Denmark castrated some 600 men under such law.[73] According to a

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[63] P1 Clause 2 of the Law for the Prevention of Hereditarily Diseased Offspring of 14 July 1933 (1933 Reichsgesetzblatt, Part I, page 529, Vol. V, page 880) (Germany)
[64] Biesold, H., *Crying hands: Eugenics and deaf people in Nazi Germany*, (1988), quoted by Wehmeyer, Michael L, see footnote 40 above, at page 58 and Rohani Abu Bakar As-Syafie Alhaj, *Sterilisation: Law and Practice in Malaysia*, (Academic Exercise LLB, University of Malaya, Kuala Lumpur, 1984)
[65] Reilly, P.R., see footnote 36 above
[66] Kevles, D.J., *In the name of eugenics: Genetics and the uses of human heredity*, (1995), at page 69, quoted by Wehmeyer, Michael L, see footnote 40 above, at page 58
[67] Reilly, P.R., see footnote 36 above
[68] Meyers, David W., see footnote 52 above, at page 281
[69] Tsuchiya, Takashi, "Eugenic Sterilizations in Japan and Recent Demands for Apology: A Report" (1997) Vol. 3, No. 1 *Newsletter of the Network on Ethics and Intellectual Disability* 1
[70] Raye, K.L., "Violence, Women and Mental Disability", Women's Rights Advocacy Initiative, Mental Disability Rights International, 1999, 21 January 2008 <http://www.mdri.org/report%20documents/violencewomenmd.doc>
[71] Webster, Charles, "Eugenic sterilisation: Europe's shame" (1997) Issue 3 *Healthmatters*, 1 April 2007 <http://www.healthmatters.org.uk/issue31/eugenicshame> . It has also been said that these women were labelled as mentally defective although they most probably had only minor physical or social disabilities.
[72] Green, L.C., "Sterilisation and the Law" (1963) Vol. 5 No.1 *Malaya Law Review* 105, at page 113 and Reilly, P.R., see footnote 36 above
[73] Meyers, David W., see footnote 52 above, at page 281

report, Switzerland was the first country to translate eugenic theory into legislation when in 1888 it sanctioned surgical castration for those with mental disabilities and sexual neuroses.[74] Around late 1920s to 1930s, Norway sterilised about 2,000 people, consisting mostly of those deemed mentally handicapped or insane.[75]

The United Kingdom (UK) nearly followed her European counterparts in implementing sterilisation law. In fact, the founder of eugenics was none other than Francis Galton, the cousin of British scientist Charles Darwin.[76] The eugenicists managed to obtain support from two government reports, namely the Wood Report on Mental Deficiency of 1929 and the Report on Sterilisation of 1934 (Brock Report). The Wood Report claimed that the incidence of mental deficiency had doubled since 1908 and this finding supported the claims of eugenicists about "the rapid decline in national intelligence".[77] By the time the Brock Report was prepared in 1934, 10 Western nations had either introduced, or were in the process of introducing sterilisation laws. The Brock Committee embraced the view of the Wood Committee and believed that the following persons should be sterilised: those who were mentally defective or had suffered from mental disorder, those who were or were believed to be carriers of grave physical disabilities, or those likely to transmit mental disorder or defect. Brock Committee recommended sterilisation when it was consented by the person or a relative, but rejected "compulsory sterilisation".[78] However, the movement to introduce wide-ranging sterilisation laws eventually collapsed due the failure to obtain the supports of

[74] Aronson, Stanley M., "The state's right to sterilize", *The Providence Journal*, 25 June 2006, 21 January 2008 <http://www.shns.com/shns/g_index2.cfm?action=detail&pk=ARONSON-06-25-06>
[75] Raye, K.L., see footnote 70 above
[76] See also Reilly, P.R., see footnote 36 above, at page 227
[77] Webster, Charles, see footnote 71 above
[78] "Compulsory sterilisation" in the Brock Report referred to situations where the law authorised a sterilisation without the recipient or family knowing or consenting to it or where it was performed notwithstanding objections by the recipient or family: Goldhar, Jeff, see footnote 33 above, at page 167

political parties. The public opinion, which was affected by the high profile Nazi sterilisation, could have further contributed to the collapse.[79]

The absence of sterilisation law does not mean that eugenic sterilisation was never performed in the UK. In 1932, at a conference sponsored by the Committee for Legalising Eugenic Sterilisation in Leicester, it was reported that "blind persons and individuals suffering from other forms of transmissible defect had undergone voluntary sterilisation with satisfactory results".[80] Lord Denning has, in an *obiter dictum* in the case of *Bravery* v *Bravery*,[81] expressed his view that sterilisation to prevent the transmission of a hereditary disease would be lawful.

2.2.4 Japan

It has been said that over 38,000 eugenic sterilisation operations were performed in Japan in 1938 alone.[82] Between 1948 and 1996, more than 16,500 women and men in Japan were sterilised without their consent pursuant to the Eugenic Protection Law (Japan)[83] introduced in 1948. That law was enacted "to prevent birth of inferior descendants from the eugenic point of view, and to protect life and health of mother, as well".[84] It is clear that the law was introduced for at least two purposes: first for eugenic purpose, and then for the protection of pregnant women. Under the Eugenic Protection Law (Japan), sterilisation could be performed without the patient's own consent for the purpose of preventing hereditary transmission of diseases. Decisions to perform sterilisation on such ground could be made by the Eugenic Protection Commission and the doctor. A review procedure was provided for under the law before

[79] Webster, Charles, see footnote 71 above
[80] Webster, Charles, see footnote 71 above
[81] [1954] 3 All ER 59, at page 67
[82] Green, L.C., see footnote 72 above
[83] No. 156 of 13 July 1948 (Japan)
[84] Article 1 of the Eugenic Protection Law No. 156 of 13 July 1948

such sterilisations could be carried out. No review procedure was however necessary for sterilisation of non-hereditary mental deficiency provided such procedure was consented to by the patient's parent or guardian. The Eugenic Protection Law (Japan) was repealed in 1996.[85]

It has been reported that during the time the Eugenic Protection Law (Japan) was in force, most of the sterilisations were performed by hysterectomy rather than by tubal ligation,[86] as the purpose of the surgery was not only sterilisation but also the cessation of menstruation for easy care. Further, although the Eugenic Protection Law (Japan) did not permit the "removing of reproduction grand",[87] doctors preferred taking the ovary in order to cause the "loss of femininity".[88]

2.2.5 Australia

Australia was not shielded from the wave of eugenics movement which swept the Western world in the earlier part of last century. Many prominent doctors openly called for sterilisation of the unfit.[89] Sterilisation of human unfit was even hailed as "one of the most scientific and rational methods of preventing some of the economic loss and social disaster produced by the rapid multiplication of the unfit".[90] Sterilisations of women with an intellectual disability were justified on the basis that the operation was in their best interest.[91]

The government reports of New South Wales, South Australia and Victoria between 1981 and 1982 concluded that doctors were performing unnecessary sterilisations on

[85] See footnote 84 above and Tsuchiya, Takashi, see footnote 69 above
[86] See Paragraph 2.1.2 of this Chapter
[87] Article 2 of the Eugenic Protection Law No. 156 of 13 July 1948 (Japan)
[88] Tsuchiya, Takashi, see footnote 69 above
[89] Goldhar, Jeff, see footnote 33 above, at pages 172, 174
[90] See footnote 89 above
[91] See footnote 89 above

people with an intellectual disability. However, no statistics were kept, and consent, if given, was by a third party.[92] A psychiatric superintendent of a large institution for persons with intellectual disability wrote in 1982 about the vast numbers of sterilisation operations performed on retarded adults without their informed consent, often with the consent of their parents or next of kin.[93]

[92] Goldhar, Jeff, see footnote 33 above, at page 157
[93] West, Rosemary, "Medico-Legal problems associated with Vasectomy on Adult Retarded Male", *Letter to Assistant Director, Institutional Services, MRD*, 1982, quoted by Goldhar, Jeff, see footnote 33 above, at page 175

Chapter 3

Legality of Sterilising Mentally Disordered Adults in Malaysia under the Existing Legislative Framework

Unlike Singapore, Malaysia has not introduced any legislation to specifically address the issue of sterilisation.[1] In Malaysia, there is no legislation sanctioning compulsory sterilisation. It also appears that there has been no case in Malaysia which requires the courts to examine the legality of a sterilisation procedure, whether or not performed on a mentally disordered adult. Although it is likely that the courts will look at the relevant case law of other Commonwealth countries if an opportunity arises for them to consider such issue, these cases can only be examined in the light of the current law in Malaysia.

This chapter examines the legal position of the sterilisation of mentally handicapped adults in Malaysia within the existing legislative framework.

3.1 Criminal law

The legal position of sterilisation of mentally handicapped adults under the criminal law is not only relevant for the determination of criminal liability, but it also provides a useful guide in civil proceedings.[2]

Abortion and sterilisation compared

It is first necessary to determine if the sterilisation procedure *per se* would be legal under the criminal law of Malaysia. In the event sterilisation, like abortion, is

[1] Singapore has legalised sterilisation procedure (performed under certain circumstances) since the end of 1974 through Voluntary Sterilisation Act (Cap. 347, 1985 Ed) (Singapore)

[2] However, the fact that an action is prohibited criminally may not necessarily mean that under no circumstances the act is permitted under the law of tort. For instance, in the UK, although a child capable of being born alive is protected by the criminal law from intentional destruction (Infant Life (Preservation) Act 1929) and by the Abortion Act 1967 from termination, the child is not protected from the decision of a competent mother not to allow medical intervention to avert the risk of death.

prohibited by law, it would be illegal even if it is performed with consent. The question of consent will then be totally irrelevant, and so does the distinction between voluntary and involuntary sterilisation. The case of abortion serves as a useful illustration here.

Section 312 of the Penal Code of Malaysia[3] provides that whoever causes a woman with child to miscarry shall be punished.[4] The Explanation in that section further provides that a woman who causes herself to miscarry is within the meaning of section 312.[5] It is therefore clear that consent of the woman to her own miscarriage is not a defence to the crime under section 312. This is reinforced by section 91 of the Penal Code[6], which expressly provides that the exceptions of consent in sections 87, 88 and 89[7] is not applicable to acts which are offences independently of any harm which they may cause to the person giving the consent, and abortion is expressly listed as an example of such acts in the Illustration.[8]–

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[3] Act 574 Rev. 1997

[4] Section 312 of the Penal Code (Act 574 Rev. 1997) reads: -

> "Whoever voluntarily causes a woman with child to miscarry shall be punished with imprisonment for a term which may extend to three years, or with fine, or with both; and if the woman is quick with child, shall be punished with imprisonment for a term which may extend to seven years, and shall also be liable to fine.
>
> *Explanation* – A woman who causes herself to miscarry is within the meaning of this section.
>
> *Exception* – This section does not extend to a medical practitioner registered under the Medical Act 1971 [Act 50] who terminates the pregnancy of a woman if such medical practitioner is of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the mental or physical health of the pregnant woman, greater than if the pregnancy were terminated."

[5] See footnote 4 above

[6] See footnote 3 above

[7] Sections 87, 88 and 89 of the Penal Code (Act 574 Rev. 1997) provide exceptions to offences when the act complained of is done with consent. See footnotes 17, 29 and 32 below.

[8] Section 91 of the Penal Code (Act 574 Rev. 1997) reads: -

> "The exceptions in sections 87, 88 and 89 do not extend to acts which are offences independently of any harm which they may cause, or be intended to cause, or be known to be likely to cause, to the person giving the consent, or on whose behalf the consent is given.
>
> *ILLUSTRATION*
>
> Causing miscarriage, except in cases excepted under section 312, is an offence independently of any harm which it may cause or be intended to cause to the woman. Therefore it is not an offence "by reason of such harm"; and the consent of the woman, or of her guardian, to the causing of such miscarriage does not justify the act."

The Penal Code[9] does not contain any provision on sterilisation akin to the one on abortion in section 312. In fact, the word "sterilisation" does not appear in the Penal Code[10] at all. In the UK, although Denning LJ considered sterilisation in itself an unlawful act in *Bravery* v *Bravery*,[11] that minority view had not been followed.[12]

A sterilisation procedure therefore falls within the general provisions on "hurt" in Chapter XVI of the Penal Code,[13] in relation to "Offences Affecting the Human Body".[14] The offences categorised as "hurt" are not independent of any harm which it may cause, since section 319 provides that –

> "Whoever causes bodily pain, disease or infirmity to any person is said to cause hurt."

The offences under the category of "hurt" therefore do not fall within section 91. In other words, the exceptions on consent in sections 87, 88 and 89, as to be seen below, remain applicable to such acts. It can therefore be concluded that unlike abortion, sterilisation *per se* is not illegal in Malaysia. The distinction between voluntary and involuntary sterilisation thus remains relevant.

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[9] See footnote 3 above
[10] See footnote 3 above
[11] [1954] 1 WLR 1169, at page 1181
[12] See the majority judgment in *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B.* (*'Marion's Case'*) (1992) 175 CLR 218, at page 234
[13] See footnote 3 above
[14] "Hurt" is dealt with from sections 319 to 338 of the Penal Code (Act 574 Rev. 1997)

Is sterilisation performed with consent a crime?

When can sterilisation be legally performed under the Malaysian criminal law? The answer depends on the exact scope of the "consent" exceptions in sections 87, 88 and 89 of the Penal Code.[15]

a. It is not a crime if sterilisation does not amount to grievous hurt (Section 87)

Section 87 of the Penal Code[16] provides that nothing, which is not intended or is not known by the doer to be likely to cause death or grievous hurt, is an offence if it is inflicted on an adult who has given consent to suffer that harm.[17] That means the consent of a person to suffer a harm is a defence if it is not intended or is not likely to cause death or grievous hurt.

Since section 87 does not apply to action that is likely to cause death or grievous hurt, if the performance of a sterilisation procedure amounts to grievous hurt, section 87 cannot be used as justification.[18]

Whether or not sterilisation amounts to "grievous hurt" depends on the definition of "grievous hurt". Section 320 of the Penal Code[19] states that –

> "The following kinds of hurt only are designated as 'grievous':

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[15] See footnote 3 above

[16] See footnote 3 above

[17] Section 87 of the Penal Code (Act 574 Rev. 1997) reads: -

> "Nothing, which is not intended to cause death or grievous hurt, and which is not known by the doer to be likely to cause death or grievous hurt, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, to any person above eighteen year of age, who has given consent, whether express or implied, to suffer that harm, or by reason of any harm which it may be known by the doer to be likely to cause to any such person who has consented to take the risk of that harm.
>
> *ILLUSTRATION*
>
> A and Z agree to fence with each other for amusement. This agreement implies the consent of each to suffer any harm which, in the course of such fencing, may be caused without foul play; and if A, while playing fairly, hurts Z, A commits no offence."

[18] In Singapore, s.9 of the Voluntary Sterilisation Act (Cap. 347, 1985 Ed) (Singapore) expressly excludes any treatment for sexual sterilisation by a registered medical practitioner from the definition of grievous hurt under sections 87 and 320 of the Penal Code (Cap.224, 1985 Ed) (Singapore).

[19] See footnote 3 above

(a) emasculation;

(b) permanent privation of the sight of either eye;

(c) permanent privation of the hearing of either ear;

(d) privation of any member or joint;

(e) destruction or permanent impairing of the powers of any member or joint;

(f) permanent disfiguration of the head or face;

(g) fracture or dislocation of a bone;

(h) any hurt which endangers life, or which causes the sufferer to be, during the space of twenty days, in severe bodily pain, or unable to follow his ordinary pursuits."

The word "emasculation" is not defined in the Penal Code.[20] It has not been defined in cases. The Shorter Oxford Dictionary defines the word as "the action of depriving of virility; the state of impotence".[21] Ratanlal & Dhirajlal's Law of Crimes provides that the term means "the depriving a person of masculine vigour, castration".[22] It appears that "emasculation" is applicable to male rather than female. Further, it is not clear from these definitions if the word can or was meant to cover modern methods of sterilisation which do not generally affect sexual capability.[23]

The word "member" in "privation of any member or joint" and the "destruction or permanent impairing of the powers of any member or joint" refers to male sexual organ.[24] Nevertheless, it is unlikely that the modern sterilisation procedure can be said

[20] See footnote 3 above
[21] *The Shorter Oxford English Dictionary on Historical Principles*, 3rd Ed., (Oxford: Clarendon Press, 1973)
[22] *Ratanlal & Dhirajlal's Law of Crime*, 25th Ed., (New Delhi: Bharat Law House, 2002), at page 1652
[23] See Paragraph 2.1 of Chapter 2 and Ahmad Ibrahim, *Law and Population in Malaysia*, (Medford: The Fletcher School of Law and Diplomacy, Tufts University, 1977), at page 26
[24] See Green, L.C., "Sterilisation and the Law" (1963) Vol. 5 No.1 *Malaya Law Review* 105, at page 129. Green said that although the term "member" *prima facie* is used to indicate the limbs, in law it is frequently employed to indicate the male sexual organ.

to cause "privation", "destruction" or "permanent impairing of the powers" of the male sexual organ. As mentioned in Paragraph 2.1.1 of Chapter 2, male sterilisation usually takes the form of vasectomy and it does not result in the severance of the male sexual organ, neither does it impair the functioning of the organ.

It is also unlikely that sterilisation can cause the person sterilised to be in "severe bodily pain" or be "unable to follow his ordinary pursuits" for as long as twenty days.[25] It is therefore doubtful if sterilisation can be considered as causing "grievous hurt" under the Penal Code.[26] However, it may be worth noting that in 1959, the advice of the Attorney General was sought and he advised that sterilisation "would appear to fall within the first and fifth categories in the definition of grievous hurt in Section 320 of the Penal Code".[27]

It is nevertheless clear that female sterilisation most probably does not amount to "grievous hurt".[28] The exception in section 87 may therefore be used to justify sterilisation of a female adult (above 18 years of age) who has expressly or impliedly consented to the procedure.

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[25] See Paragraph 2.1 of Chapter 2 on discussion of various sterilisation methods. None of the method requires hospitalisation of more than seven days.

[26] See footnote 3 above and Rohani Abu Bakar As-Syafie Alhaj, *Sterilisation: Law and Practice in Malaysia*, (Academic Exercise LLB, University of Malaya, Kuala Lumpur, 1984)

[27] Shamsuddin Bin Abdul Rahman, "Policy Outlook in Malaysia for Sterilization and Post-conception Control of Fertility", *Proceedings of the First Meeting of the IGCC Expert Group Working Committee on Sterilisation and Abortion*, (Penang, 3-5 January 1973), at page 22

[28] In the early days, it was thought that castration would diminish bodily vigour and thereby render a man less capable of fulfilling his military duties. Therefore castration was explicitly regarded as a felony. Since women did no military service then, it is unlikely that sterilisation of female will amount to felony: Green, L.C., see footnote 24 above, at pages 115, 116, 126

b. If sterilisation amounts to grievous hurt, it is not a crime if it is performed in good faith (Section 88)

In any event, even if sterilisation amounts to grievous hurt, doctors can still rely on the exception in section 88, which applies to any act which is not intended to cause death.[29] Besides consent, two additional criteria need to be fulfilled: firstly the act must be done for the benefit of the person, and secondly the act must be done in good faith.

Therefore, regardless of whether or not sterilisation amounts to grievous hurt, a doctor can justify the operation if it is done in good faith for the benefit of the patient, and with the consent of the patient. With regard to the meaning of "good faith", section 52 of the Penal Code[30] provides that nothing "is said to be done or believed in good faith which is done or believed without due care and attention".

The requirement that the operation must be for the benefit of the patient is likely to exclude sterilisations performed solely for eugenic purposes or solely for the benefit of the society at large. It is not clear if sterilisation for a "contraceptive" purpose can be covered by section 88, as it has been argued by some that contraceptive sterilisation may be for a mere pecuniary benefit and as such not covered by the section.[31] However, it is submitted that sterilisation for contraceptive purposes can be for the benefit of the patient, especially since many would agree that limiting the number of children a person may be highly beneficial to a person and the benefit is probably beyond pecuniary. In

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[29] Section 88 of Penal Code (Act 574 Rev. 1997) reads: -

> "Nothing, which is not intended to cause death, is an offence by reason of any harm which is [*sic*] may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given a consent, whether express or implied, to suffer that harm, or to take the risk of that harm.
>
> *ILLUSTRATION*
>
> A, a surgeon, knowing that a particular operation is likely to cause the death of Z, who suffers under a painful complaint, but not intending to cause Z's death, and intending in good faith, Z's benefit, performs that operation on Z, with Z's consent. A has committed no offence."

[30] See footnote 3 above

[31] Ahmad Ibrahim, see footnote 23 above, at page 26. The explanation to section 92 of Penal Code (Act 574 Rev. 1997) provides that "[m]ere pecuniary benefit is not benefit within the meaning of sections 88, 89 and 92".

any event, it is beyond doubt that sterilisation for the purpose of treating an existing medical condition would fall within section 88.

c. Consent can be given by person other than the patient if sterilisation does not amount to grievous hurt (Section 89)

Having established the circumstances under which consent amounts to exception to an offence, the question becomes whether or not consent can be given by a third party. Section 89 outlines various circumstances when consent can be given by a person other than the patient.[32] Two categories of persons are named, namely a person under twelve years of age, and a person of unsound mind. For both categories, the guardian or other person having lawful charge of that person can consent to such acts other than the intentional causing of death; the doing of anything likely to cause death other than to prevent death or hurt; the voluntary causing of grievous hurt other than to prevent death or hurt; or the abetment of any offence.

Section 89 seems to suggest that a person of "unsound mind" can be sterilised if it is done in good faith for the benefit of the patient as long as his or her "guardian" or "other

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[32] Section 89 of Penal Code (Act 574 Rev. 1997) reads: -

> "Nothing, which is done in good faith for the benefit of a person under twelve years of age, or of unsound mind, by or by consent, either express or implied, of the guardian or other person having lawful charge of that person, is an offence by reason of any harm which it may cause, or be intended by the doer to cause, or be known by the doer to be likely to cause, to that person:
>
> Provided that this exception shall not extend to –
> (a) the intentional causing of death, or to the attempting to cause death;
> (b) the doing of anything which the person doing it knows to be likely to cause death for any purpose other than the preventing of death or grievous hurt, or the curing of any grievous disease or infirmity;
> (c) the voluntary causing of grievous hurt, or to the attempting to cause grievous hurt, unless it be for the purpose of preventing death or grievous hurt, or the curing of any grievous disease or infirmity;
> (d) the abetment of any offence, to the committing of which offence it would not extend.
>
> *ILLUSTRATION*
>
> A, in good faith, for his child's benefit, without his child's consent, has his child cut for the stone by a surgeon, knowing it to be likely that the operation will cause the child's death, but not intending to cause the child's death. A is within the exception, in as much as his object was the cure of the child."

person having lawful charge" of that person consents to it. It is not clear at this stage who these persons are insofar as mentally disordered adults are concerned. In any event, it must be remembered that this is only the case if sterilisation does not amount to "grievous hurt".

Further, the fact that section 89 deals specifically with a person of unsound mind should not be interpreted to mean that an adult of unsound mind necessarily cannot give valid consent under section 87 or section 88. This view is supported by section 90 of the Penal Code,[33] which provides that –

> "A consent is not such a consent as is intended by any section of this Code –
>
> …
>
> (b) if the consent is given by a person who, from unsoundness of mind or intoxication, is unable to understand the nature and consequence of that to which he gives consent; or
>
> (c) unless the contrary appears from the context, if the consent is given by a person who is under 12 years of age."

Unlike a person who is under 12 years of age, a consent given by a person of unsound mind can still amount to a consent since the test in section 90(b) is the ability of the person "to understand the nature and consequence of that to which he gives his consent". Therefore, section 89 only applies to a person of unsound mind who is unable to consent due to his inability to understand the nature and consequence of the action.

Nevertheless, if sterilisation amounts to "grievous hurt", section 89 does not apply. The guardian or person with lawful charge of a person of unsound mind cannot consent to

[33] See footnote 3 above

the sterilisation of a person on any medical ground. The medical condition that sterilisation aims to prevent or cure must be one that can cause death or grievous hurt or is "grievous" in nature. This appears to be a more stringent test than the test in section 88, as a guardian cannot consent to inflicting grievous hurt on a person of unsound mind even if he or she believes in good faith that the procedure is for the benefit of such person.

d. It is not a crime if sterilisation is performed without consent in an emergency (Section 92)

There are circumstances where a sterilisation of mentally disordered person can proceed even without the consent of the guardian or the person having lawful charge. The governing provision is section 92 of the Penal Code,[34] and it dispenses with the need to obtain consent when there is an emergency, provided that the circumstances must be such that consent is impossible and that the act must be done for the person's benefit and in good faith. Similar to section 89, section 92 also does not apply to the intentional

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[34] Section 92 of Penal Code (Act 574 Rev. 1997) reads, amongst others,: -

> "Nothing is an offence by reason of any harm which it may cause to a person for whose benefit it is done in good faith, even without that person's consent, if the circumstances are such that it is impossible for that person to signify consent, or if that person is incapable of giving consent, and has no guardian or other person in lawful charge of him from whom it is possible to obtain consent in time for the thing to be done with benefit:
>
> Provided that this exception shall not extend to –
> (a) the intentional causing of death, or to the attempting to cause death;
> (b) the doing of anything which the person doing it knows to be likely to cause death for any purpose other than the preventing of death or grievous hurt, or the curing of any grievous disease or infirmity;
> (c) the voluntary causing of hurt, or to the attempting to cause hurt, for any purpose other than the preventing death or hurt;
> (d) the abetment of any offence, to the committing of which offence it would not extend.
>
> *ILLUSTRATION*
>
> …
> (c) A, a surgeon, sees a child suffer an accident which is likely to prove fatal unless an operation be immediately performed. There is not [*sic*] time to apply to the child's guardian. A performs the operation in spite of the entreaties of the child, intending in good faith, the child's benefit. A has committed no offence.
> …
> *Explanation* - Mere pecuniary benefit is not benefit within the meaning of sections 88, 89 and 92."

causing of death; the doing of anything likely to cause death other than to prevent death or hurt; the voluntary causing of hurt other than to prevent death or hurt; or the abetment of any offence.

It would appear that section 92 allows for the sterilisation of mentally disordered adults who are incapable of giving consent to be performed in the case of an emergency. The operation must be done in good faith for the benefit of the patient. However, the operation can only be carried out to prevent death or hurt. This is the case even if sterilisation does not amount to grievous hurt. Sterilisation of mentally disordered adults can therefore be performed without the consent of any person, so long as all the following four conditions are satisfied: -

(1) it is impossible for the patient to signify consent, or if the patient is incapable of giving consent;
(2) it is performed in good faith for the benefit of the patient;
(3) it is not possible to obtain the consent of guardian or other person in lawful charge of the patient in time for the procedure to be performed with benefit; and
(4) it is for the purpose of preventing death or hurt.

Summary

The legal position of sterilisation of mentally disordered adults depends on whether or not sterilisation amounts to grievous hurt under the Penal Code.[35] If sterilisation does not amount to grievous hurt, sterilisation can be performed on a mentally disordered adult who consents to it, so long as the person is able to understand the nature and consequence of sterilisation.[36] There is no requirement of "good faith". In cases where

[35] See footnote 3 above
[36] Sections 87 and 90 of the Penal Code (Act 574 Rev. 1997)

the mentally disordered adult is unable to give consent due to his or her inability to understand the nature and consequence of sterilisation, sterilisation can take place so long as it is done in good faith for the benefit of the adult and the consent is given by his or her guardian or other person having lawful charge of him or her.[37] Such procedure need not be for the purpose of preventing death or grievous hurt, or curing of a grievous disease. Sterilisation of mentally disordered adults can be performed without the consent of any person, so long as firstly, it is impossible for the patient to signify consent, or if the patient is incapable of giving consent; secondly, it is performed in good faith for the benefit of the patient; thirdly, it is not possible to obtain the consent of guardian or other person in lawful charge of the patient in time for the procedure to be performed with benefit; and finally it is for the purpose of preventing death or hurt.[38]

If sterilisation amounts to grievous hurt, the sterilisation can be justified on a mentally disordered adult who had consented to it and was able to understand the nature and consequence of sterilisation, and the operation was done in good faith for the benefit of the mentally disordered adult.[39] In cases where the mentally disordered adult fails to give consent due to his or her inability to understand the nature and consequence of sterilisation, the sterilisation can take place under the same conditions as the case where sterilisation does not amount to grievous hurt, provided the sterilisation is performed for the purpose of preventing death or grievous hurt, or the curing of any grievous disease or infirmity.[40] Sterilisation of mentally disordered adults can be performed without the consent of any person under the same conditions as the case where sterilisation does not amount to grievous hurt.[41]

[37] Sections 89 and 90 of the Penal Code (Act 574 Rev. 1997)
[38] Section 92 of the Penal Code (Act 574 Rev. 1997)
[39] Sections 88 and 90 of the Penal Code (Act 574 Rev. 1997)
[40] Sections 89 and 90 of the Penal Code (Act 574 Rev. 1997)
[41] Section 92 of the Penal Code (Act 574 Rev. 1997)

3.2 Mental health legislation

The Mental Health Act 2001[42] received the royal assent on 6 September 2001 and was published in the *Gazette* on 27 September 2001. Unfortunately, this piece of legislation has not come into force to date. Therefore, the mental health legislation that is currently applicable to peninsular Malaysia remains the Mental Disorders Ordinance 1952.[43]

The Mental Disorders Ordinance 1952[44] governs the admission of mentally retarded persons into institutions. It does not deal with the question of whether or not sterilisation of mentally disordered adults can be carried out. It does not consider the question of consent to medical treatment. No provision in the Ordinance suggests that sterilisation can be used as a condition for the release of mentally disordered persons.[45] However, it appears that the Court may appoint one or more committees to take lawful charge of the "person and estate" of a mentally disordered person pursuant to section 10 of the Ordinance,[46] which states –

> "(1) If the Court finds that the person who is alleged to be mentally disordered is of unsound mind and incapable of managing himself and his affairs, the Court may, if it shall think fit, appoint a committee or committees of the person and estate of such person and may make such order, if any, as to the remuneration of the committee or committees out of such person's estate, and as to the giving of security by the committee or committees, as to the Court may seem fit.
>
> (2) If the Court finds that the person who is alleged to be mentally disordered is incapable of managing his affairs, but is not dangerous to himself or to others,

[42] Act 615
[43] Ord. 31 of 1952
[44] See footnote 44 above
[45] See Mimi Kamariah, "Rights of Mentally Retarded Persons In Domestic Relations" [1980] 7 JMCL 201, at page 212
[46] See footnote 44 above

the Court may appoint a committee of his estate, without appointing a committee of his person."

Therefore, it would appear that the "person having lawful charge" of a mentally disordered adult who could give consent to treatment on his or her behalf under the relevant provisions of the Penal Code[47] would be such court appointed committee or committees "of his person".[48]

It is perhaps helpful at this juncture to consider the relevant provisions of the yet-to-be-in-force Mental Health Act 2001.[49] Section 58 of Mental Health Act 2001[50] contains a provision similar to section 10 of the Mental Disorder Ordinance 1952.[51] However, section 77 of Mental Health Act 2001[52] is the more relevant provision as it deals with the giving of consent for surgery, etc. Section 77 reads as follows –

"**77.** (1) Where a mentally disordered person is required to undergo surgery, electroconvulsive therapy or clinical trials, consent for any of them may be given –

(a) by the patient himself if he is capable of giving consent as assessed by a psychiatrist;

(b) by his guardian in the case of a minor or a relative in the case of an adult, if the patient is incapable of giving consent;

(c) by two psychiatrists, one of whom shall be the attending psychiatrist, if there is no guardian or relative of the patient available or traceable and the patient himself is incapable of giving consent.

[47] See footnote 3 above
[48] See Paragraph 3.1 above
[49] See footnote 43 above. Although the Mental Health Act 2001 (Act 615) is not yet in force, it was applied by the High Court of Kuala Lumpur in a case on the estate of a lunatic in *Tan Guek Tian* v *Tan Kim Kiat @ Chua Kim Kiat* [2007] 3 MLJ 521
[50] See footnote 43 above
[51] See footnote 44 above
[52] See footnote 43 above

(2) For purposes of subsection (1), it shall be the duty of the registered medical practitioner concerned to ensure that informed consent is first obtained from the patient himself under paragraph (1)(a) before invoking paragraph (1)(b) or (1)(c).

(3) In cases of emergencies, consent for surgery or electroconvulsive therapy may be given –

(a) by the guardian or a relative of the patient; or

(b) by two medical officers or two registered medical practitioners, as the case may be, one of whom shall preferably be a psychiatrist, if there is no guardian or relative of the patient immediately available or traceable.

(4) Except for subsections (1) and (2), no consent is required for other forms of conventional treatment.

(5) In determining whether or not a mentally disordered person is capable of giving consent under paragraph (1)(a), the examining psychiatrist shall consider whether or not the person examined understands -

(a) the condition for which the treatment is proposed;

(b) the nature and purpose of the treatment;

(c) the risks involved in undergoing the treatment;

(d) the risks involved in not undergoing the treatment; and

(e) whether or not his ability to consent is affected by his condition."

It is not clear if the section applies to sterilisation procedure. Section 77(1) and (3) contains the word "surgery". The word "surgery" is not defined in the Mental Health Act 2001.[53] Ordinarily, as shown in Paragraph 2.1 of Chapter 2, sterilisation almost invariably involves surgery. However, besides "surgery", section 77(1) and (3) also apply to "electroconvulsive therapy". Electroconvulsive therapy is a kind of treatment

[53] See footnote 43 above

common for treating various mental illnesses. If we apply the rule of *ejusdem generis*,[54] then the word "surgery" should be construed as the surgery meant for treatment of mental condition, in which sterilisation is clearly not one.

Additionally, if "surgery" covers surgery other than those meant for treatment of mental condition, it would not be appropriate to involve only psychiatrists (section 77(1)(c)) when the patient is incapable of giving consent and no guardian or relative of the patient is available or traceable. Further, section 77(4) provides that no consent is required for "other forms of conventional treatment" except for those listed in section 77(1) and (2). The phrase "conventional treatment" is not defined. It is, however, very likely that "conventional treatment" refers to treatment that are traditionally used to treat a person with mental illness. The term cannot be construed in any wider sense since something should only be "conventional" with regards to something specific rather than general. If such construction is correct, then it should follow that the word "surgery" in section 77(1) is also one of the forms of conventional treatment, since section 77(4) is supposed to cover the "other" forms.

Therefore, it is unlikely that the requirement of consent for the sterilisation of mentally disordered adults is governed by section 77 of the Mental Health Act 2001.[55] Notwithstanding that, section 77 remains a significant provision as it acknowledges that a mentally disordered person does not necessarily lack capacity to consent. The status of a mentally disordered person itself does not determine the competence of a person to

[54] The rule of *ejusdem generis* applies to restrict general words to things of the same nature as the particular things which have been mentioned, where the particular things named have some common characteristic which constitutes them a genus, and the general words can be properly regarded as in the nature of a sweeping clause designed to guard against accidental omissions: *Moore* v *Magrath* (1774) 1 Comp 9 at page 12 per Lord Mansfield; *Lambourn* v *McLellan* [1903] 2 Ch 268

[55] See footnote 43 above

consent to treatment. The idea of "informed consent" [56] has been specifically incorporated into section 77(2). It has been said that the incorporation of such concept in the Mental Health Act 2001[57] is influenced by Principle 11 of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.[58] Section 77(5) is also important as it lays down, for the first time in any legislation in Malaysia, the factors that should be taken into account when determining whether or not a mentally disordered person is capable of giving consent. It is submitted that informed consent and the list in section 77(5) should be used as a guide for anyone who has to determine if sterilisation of mentally disordered adults should be performed.

Section 77 is also important in another setting. Insofar as consent to medical treatment is concerned, this section reflects the importance of the views of family members in Malaysia. Section 77(1)(b) provides that in the case of an adult, consent for surgery, electroconvulsive therapy or clinical trials may be given by "a relative" if the patient is incapable of giving consent. The word "relative" is defined in section 2(1) of the Mental Health Act 2001[59] as follows –

> ""relative" means any of the following persons of or above eighteen years of age:
>
> (a) husband or wife;
>
> (b) son or daughter;
>
> (c) father or mother;
>
> (d) brother or sister;

[56] See Chapter 8 and Chapter 9 for more discussion on the concept of "informed consent".
[57] See footnote 43 above
[58] GA res. 46/119, 46 UN GAOR Supp. (No. 49) at 189, UN Doc. A/46/49 (1991). See Harun Mahmud Hashim, "Human Rights of the Mentally Ill in Malaysia", *Proceedings of the 4th Mental Health Convention*, (Johor Bahru, 23-24 August 2002).
[59] See footnote 43 above

(e) grandparent;

(f) grandchild;

(g) maternal or paternal uncle or aunt;

(h) nephew or niece."

It is uncertain if such a wide definition of the word "relative" should be taken as a codification of the existing medical practice in Malaysia. The fact that even uncle, aunt, nephew or niece can consent to treatment on behalf of a mentally disordered adult is of concern, especially since section 77 does not impose any condition on how such person should exercise this power. This further confirms that section 77 should not be read in such a way so as to cover sterilisation of mentally disordered adults, as opposed to only the procedures to treat mental condition.

3.3 Contracts Act 1950

Section 12 of the Contracts Act 1950[60] provides, *inter alia*, that: -

"(1) A person is said to be of sound mind for the purpose of making a contract if, at the time when he makes it, he is capable of understanding it and of forming a rational judgment as to its effect upon his interests.

(2) A person who is usually of unsound mind, but occasionally of sound mind, may make a contract when he is of sound mind.

…

ILLUSTRATIONS

(a) A patient in a mental hospital, who is at intervals of sound mind, may contract during those intervals.

…"

[60] Act 136 Rev. 1974

Although not directly relevant to this thesis, section 12 of the Contracts Act 1950[61] recognises that a person who is usually of unsound mind may be of sound mind occasionally. This further supports the view that a mentally disordered person does not necessarily lack the capacity to give consent, as even the Contracts Act 1950[62] has expressly acknowledged that there could be times when a person who is usually of unsound mind can enter into a valid and binding contract. What is important is the setting of the parameters for determining the soundness of mind for such purpose, such as what section 12(1) of the Contracts Act 1950[63] has done.

3.4 Religious rulings, ministerial circulars and orders

Religious rulings

On 20 February 1977, at the 12th Islamic Scholar Conference of Malaysia, a fatwa on family planning programme was issued,[64] that sterilisation of male or female is strictly prohibited.[65] This fatwa was referred to again in another fatwa issued on 29 December 1991 at the 28th Session of the Fatwa Committee Convention.[66] This later fatwa concerns the Norplant System[67] in the National Family Planning Program. The fatwa permits the application of the Norplant System but it must be subject to the decision in the earlier fatwa in 1977 which prohibits sterilisation of both spouses.[68]

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[61] See footnote 61 above
[62] See footnote 61 above
[63] See footnote 61 above
[64] Keputusan Fatwa Muzakarah Jaw. Fatwa Majlis Kebangsaan bagi Hal Ehwal Agama Islam (Fatwa of the Malaysian National Fatwa Council) dated 20 February 1977
[65] The relevant paragraph of the fatwa is paragraph (a) and it reads "[m]emandulkan lelaki atau perempuan hukumnya adalah haram (sterilising male or female is strictly prohibited)". See also Rohani Abu Bakar As-Syafie Alhaj, see footnote 26 above
[66] Keputusan Fatwa Muzakarah Jaw. Fatwa Majlis Kebangsaan bagi Hal Ehwal Agama Islam (Fatwa of the Malaysian National Fatwa Council) dated 29 December 1991
[67] This is a contraceptive product which consists of six very small matchstick size capsules (made of silastix tubing) that are placed just under the skin of the upper arm: *Norplant System*, Ken Chisholm, 30 January 2009, LIVESTRONG.COM, Bellevue. 31 January 2009 <http://www.livestrong.com/article/14164-norplant-system/>.
[68] The earlier fatwa of 20 February 1977 is reproduced in the fatwa of 29 December 1991

Therefore, although sterilisation *per se* is not prohibited by the Penal Code,[69] sterilisation of a person who professes Islam in Malaysia is prohibited by fatwa. This is a particularly relevant fact in a country like Malaysia, where the majority of her population are Muslims.

Ministry of Health circular

Notwithstanding the prohibition of sterilisation in fatwa, sterilisation appears to be acceptable in practice. According to a Ministry of Health circular dated 25 July 1959, an operation to sterilise a person can be lawfully performed only in those circumstances where the operator honestly believes upon reasonable ground that sterilisation is necessary to preserve the life of, or to avert serious injury to, the physical or mental health of the patient.[70] A doctor should, amongst others, ensure that the patient's consent in writing is freely and fully given without influence by others.[71] The circular does not differentiate between Muslim and non-Muslim patients.[72] Nevertheless, the circular appears more stringent than the requirements in the Penal Code.[73] The Penal Code[74] appears to allow sterilisation done with the consent of the patient for any purpose (if sterilisation does not constitute causing grievous hurt), or if sterilisation amounts to causing of grievous hurt, it can nevertheless be performed with the consent of the patient so long as it is done in good faith for the benefit of the patient.[75]

[69] See footnote 3 above and Paragraph 3.1 of this Chapter.
[70] Ref. No. MH Cont. 401/7 of 25 July 1959, quoted by Ahmad Ibrahim, see footnote 23 above, at page 27 and by Shamsuddin Bin Abdul Rahman, see footnote 27 above, at pages 21-22
[71] See footnote 71 above
[72] See footnote 71 above
[73] See footnote 3 above and Paragraph 3.1 of this Chapter
[74] See footnote 3 above
[75] See Paragraph 3.1 of this Chapter

Fees (Medical) Order 1982[76]

In any event, sterilisation can be regarded as a widely accepted medical procedure in Malaysia and it is unlikely to be contrary to public policy. Order 7 and Schedule E of the Fees (Medical) Order 1982[77] specifies the charges for operations in government hospitals in Malaysia. The classification of operations is set out in Schedule I of the same order.[78] Various forms of sterilisation procedure are included in Schedule I. Amongst others, Wertheim's hysterectomy,[79] extended hysterectomy,[80] abdominal hysterectomy and vaginal hysterectomy are classified as Type B operations;[81] abdominal sterilization or minilaparotomy[82] is a Type D operation;[83] and vasectomy is a Type E operation.[84]

Staff Medical Scheme

Another document that can be used to show the acceptance of general public and the government towards sterilisation is the medical scheme for the staff of Universiti Utara

[76] P.U.(A) 359/82, pursuant to Sections 3 and 10 of the Fees Act 1951 (Act 209 Rev. 1978)
[77] See footnote 77 above
[78] See Order 18 of Fees (Medical) Order 1982 (P.U.(A) 359/82)
[79] A Wertheim's hysterectomy is only done for cancer of the cervix. The whole womb, the Fallopian tubes and ovaries, part of the vagina and lymph glands are removed: *Hysterectomy*, Surgery Door, 31 January 2009 <http://www.surgerydoor.co.uk/medical_conditions/Indices/H/hysterectomy.htm>
[80] Extended hysterectomy (modified radical hysterectomy) is a term used to describe a hysterectomy for endometrial cancer. Sometimes it involves a traditional hysterectomy with removal of the lymph glands and sometimes a slightly wider excision to prevent cutting through cancer during the operation: *Treatment*, 29 December 2004, WOMB. 31 January 2009 <http://www.womb.org.uk/Treatment.htm#Age>
[81] According to Schedule E, a Type-B operation costs RM1,500 for first class ward, RM600 for second class ward and RM100 for third class ward.
[82] Minilaparotomy is a form of tubal ligation. It is an abdominal surgical approach to the fallopian tubes by means of an incision less than 5 cm in length, so as to permanently occlude the fallopian tubes: EngenderHealth, *Minilaparotomy for Female Sterilization: An Illustrated Guide for Service Providers*, 2003, 1 November 2006 <http://www.engenderhealth.org/res/offc/steril/minilap/pdf/minilaparotomy_ch1-2.pdf>
[83] According to Schedule E, a Type-D operation costs RM300 for first class ward, RM150 for second class ward and RM20 for third class ward.
[84] According to Schedule E, a Type-E operation costs RM150 for first class ward, RM80 for second class ward and RM15 for third class ward.

Malaysia, which is a public university.[85] The scheme expressly covers "sterilisation" for the purpose of family planning.[86]

3.5 Persons with Disabilities Act 2008

Persons with Disabilities Act 2008[87] came into force on 7 July 2008.[88] It is the first law in Malaysia that deals specifically with persons with disabilities. Amongst others, this law recognises the importance of accessibility to health in enabling persons with disabilities to fully and effectively participate in society.[89]

It is not clear whether "persons with disabilities" under this new law covers mentally disordered persons. The term "persons with disabilities" is not defined, neither is the word "disabilities". It appears from section 22(3) that the Minister[90] may make regulations to prescribe who may be registered as persons with disabilities.[91] Since no regulation has yet to be made under this law, it remains to be seen whether all mentally disordered persons will be considered "persons with disabilities" for the purpose of this law.

In the event mentally disordered persons are considered "persons with disabilities", at least two sections of this law, namely section 35 and section 36, may be relevant for the purpose of sterilisation of mentally disordered persons. Section 35 states that persons with disabilities have the right to the enjoyment of health on an equal basis with persons

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[85] Skim Perkhidmatan Perubatan Staf Universiti Utara Malaysia (Universiti Utara Malaysia Staff Medical Service Scheme), 28 May 2007 <http://portal.uum.edu.my/portalbm/hebahan_pendaftar/skim_perubatan_staf_uum.pdf>

[86] See footnote 86 above, at page 6

[87] Act 685

[88] P.U.(B) 268/2008

[89] See the Preamble to Persons with Disabilities Act 2008 (Act 685)

[90] Section 2 of Persons with Disabilities Act 2008 (Act 685) defines "Minister" to mean "the Minister charged with the responsibility for social welfare".

[91] Section 22(3)(b) of Persons with Disabilities Act 2008 (Act 685)

without disabilities.[92] The word "health" is not defined, it can therefore be argued that the right to the enjoyment of health should include the right to have oneself sterilised. If persons without disabilities see sterilisation as a way to improve health, there is no reason persons with disabilities should be deprived of such procedure. Section 35 goes on to say that the National Council for Persons with Disabilities, the private sector and non-governmental organisation must take measures to ensure persons with disabilities have access to health services that are gender sensitive.[93]

Section 36 provides that the Government and the private healthcare service provider must make available "essential health services to persons with disabilities which shall include…prevention of further occurrence of disabilities …".[94] Since the word "disabilities" is not defined, it is not clear whether sterilisation will necessarily render a person "disabled" for the purpose of section 36(1). It is also not clear whether the "further" disabilities that should be prevented should be the same disabilities that rendered the person disabled in the first place. If sterilisation always amounts to further disabilities under the section, sterilisation of disabled person can never be carried out without contravening this provision. Such interpretation is however too restrictive and may be in direct conflict with section 35. It is therefore argued that this cannot be the intention of the legislature.[95]

In any event, the biggest anomaly to the Persons with Disabilities Act 2008[96] is perhaps the absence of enforcement provisions and sanctions to ensure compliance with the law.

[92] Section 35(1) of Persons with Disabilities Act 2008 (Act 685)
[93] Section 35(2) of Persons with Disabilities Act 2008 (Act 685)
[94] Section 36(1) of Persons with Disabilities Act 2008 (Act 685).
[95] Such interpretation does not take into account the situation where sterilisation is necessary to avoid danger to health, or situation where sterilisation is the wish of a disabled person of sound mind.
[96] See footnote 88 above.

Until and unless penalties are introduced, this law will remain at best a paper tiger and it is unlikely that the ambiguous provisions in this law will be clarified.

Chapter 4

Moving Away from the History: from Protecting the State's Interest to Protecting the Person's Interest

The history of sterilising mentally disordered persons in the US, as outlined in Paragraph 2.2 of Chapter 2, was driven mainly by the state's desire to reduce the number of "imbeciles" so as to improve the economic and social welfare of its people. The mentally disordered persons were expected to make this sacrifice in the interest of the general welfare of the state, especially since they were deemed not capable of appreciating the sacrifice.

As seen in Chapter 3, today most countries appear to have put that part of the history behind them. Many factors contributed to the decline of such practice, and perhaps the most significant factor insofar as the development of the law is concerned is the shift of emphasis from protecting the interest of the state to protecting the interest of the person. This is evident in the types of concepts and principles commonly used by the courts in their deliberation on sterilisation issues, notably human rights, the principle of autonomy, the best interests test and the distinction between therapeutic and non-therapeutic procedure.

4.1 Human rights

In 1942, 15 years after *Buck* v *Bell*[1] was decided,[2] the US Supreme Court had the chance to re-consider the question of sterilisation in the case of *Skinner* v *Oklahoma*.[3] In that case, it was recognised for the first time in the US court that sterilisation

[1] (1927) 274 US 200
[2] See Paragraph 2.2.1 of Chapter 2
[3] (1942) 316 US 535

involved basic civil rights of man. *Skinner* v *Oklahoma*[4] is about the sterilisation of a habitual criminal rather than a mentally disordered person. The Oklahoma's Habitual Criminal Sterilization Act (US)[5] provided that a person who had been convicted two or more times for felonies could be made sexually sterile. The US Supreme Court held that that law was unconstitutional for lack of due process and denial of equal protection of the law. Justice Douglas said the following on the relationship between basic civil rights and sterilisation –

> "We are dealing with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of human race. The power to sterilize, if exercised, may have subtle, far-reaching and devastating effect. … There is no redemption for the individual whom the law touches. … He is forever deprived of a basic liberty."[6]

In England, the case of *Re D (a minor) (wardship: sterilisation)*[7] also considered sterilisation operation as one that involves the deprivation of the right of a woman to reproduce. That case concerned an 11-year-old girl, D, who was suffering from the Sotos syndrome.[8] D was not as seriously retarded as some children suffering from mental handicaps. She had an intelligence quotient of about 80 and had the understanding of a child of about nine years of age. D's mother wanted a sterilisation operation to be performed on D because she was worried that D might be seduced and would give birth to an abnormal baby. D's mother also believed that D would be

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[4] See footnote 3 above
[5] 57 O.S. 1941 §§ 171-195
[6] (1942) 316 US 535, at page 541. The judges in that case did not condemn involuntary sterilisation, neither did they overrule *Buck* v *Bell* (1927) 274 US 200. It has been said that the law was struck down not because it involved sterilisation, but because it spared certain "white-collar" criminals from a punitive measure aimed at other thrice-convicted persons. See Reilly, P.R., "Eugenic Sterilization in the United States", *Genetics and the Law III - National Symposium on Genetics and the Law*, Ed., Aubrey Milunsky and George J. Annas, (New York: Plenum Press, 1985), at page 237
[7] [1976] Fam. 185, [1976] 1 All ER 326
[8] The signs and symptoms of the Sotos syndrome include accelerated growth during infancy, epilepsy, generalised clumsiness, unusual facial appearance, behaviour problems, certain aggressive tendencies and some impairment of mental function.

incapable of bringing up a child. An action was brought by an educational psychologist to the Family Division of the High Court in 1976 to prevent the proposed hysterectomy operation on D. The order to prevent the sterilisation of D was granted.

In 1986, the Supreme Court of Canada in the case of *Re Eve*[9] said that sterilisation amounted to a grave intrusion on a person's right. The judge in that case also placed significant emphasis on the serious implications of sterilisation as it removed from the person the privilege of giving birth. The case of *Re Eve*[10] concerned a mentally retarded girl, Eve, who was 24 years old. Eve's mother commenced the proceeding to seek permission to Eve's sterilisation by tubal ligation. Eve suffered from extreme expressive aphasia[11] and was at least mildly to moderately retarded. The application of Eve's mother was denied by the court of first instance but allowed by the Supreme Court of Prince Edward Island on appeal. The latter court ordered sterilisation by way of a hysterectomy. Eve's guardian *ad litem* appealed to the Supreme Court of Canada. The Supreme Court of Canada allowed the appeal and restored the decision of the court of first instance. However, the court considered the right to procreate and the right not to procreate and concluded that the choice between the two alleged constitutional rights was one the courts could not safely exercise.

4.2 Principle of autonomy and the best interests test

When we look at sterilisation from the human rights perspective, the emphasis would be on the rights of the person undergoing the sterilisation. This is closely linked to the principle of autonomy which provides that every person has the right to determine what should be done with his own body. Similarly, the best interests test, arguably the most

[9] (1986) 31 DLR (4th) 1, [1986] 2 SCR 388
[10] See footnote 9 above
[11] Expressive aphasia was a condition in which the patient was unable to communicate outwardly thoughts or concepts.

popular test used by courts when considering sterilisation matters, has to be applied for the best interests of the person undergoing the procedure and not anyone else. It can therefore be said that the main feature of the best interests test in the context of sterilisation is that the procedure can only be allowed if it is in the best interests of the patient himself or herself.

The way the best interests test has been applied, however, varies to a great extent. In the US, the Supreme Court of Washington considered a multitude of factors when deciding how a superior court should exercise its authority to grant a petition for the sterilisation of a severely mentally retarded girl of 16 years in the 1980 case of *Re Hayes*.[12] Justice Horowitz stressed that due to the serious effects of a sterilisation operation, all relevant factors must be carefully considered before the power can be exercised. The factors were consolidated into a set of guidelines, which consisted of three steps. The first was to find that the individual was incapable of making his or her own decision about sterilisation and was unlikely to develop such capacity in the foreseeable future. The second step was to show that the individual was physically capable of procreation, was likely to engage in sexual activity and that the disability rendered the person permanently incapable of caring for a child. The last step was to find that there were no alternatives to sterilisation. The following three sub-factors had to be proven for this last step, namely less drastic contraceptive methods were unworkable; the proposed method entailed the least invasion of the body of the individual; and current state of scientific and medical knowledge did not suggest either that a reversible sterilisation procedure would shortly be available or that science was on the threshold of an advance in the treatment of the individual's disability.[13] All these

[12] (1980) 608 P.2d 635

[13] Justice Stafford, in his partially dissenting judgment, saw this last step as rendering the "burden of proof so impossible of accomplishment that the forum cannot be used".

factors must be proved by clear, cogent and convincing evidence. The court did not order sterilisation in that case as the burden had not been met.

Almost all the English cases held that the sole principle for deciding whether or not sterilisation should be performed is whether or not the procedure is in the best interests of the patient.[14] However, unlike the US, not much guidelines were developed on how the best interests test should be applied. Many factors and principles have been considered during or alongside the application of the best interests test and it is not possible to work out from all these cases how one should apply the best interests test without compromising its certainty. The earlier cases determined the question of best interests purely based on facts, without providing any guideline that future decision-makers can rely on. One such case is *Re B (a minor) (wardship: sterilisation)*.[15]

Re B (a minor) (wardship: sterilisation)[16] was first brought to the Family Division of the High Court by the Sunderland Borough Council in 1986. Sunderland Borough Council applied for B to be made a ward of court and for the court to grant leave for B to undergo a sterilisation operation. B was a 17-year-old girl. She was mentally retarded, was prone to outbursts of aggression and was epileptic. She had a mental age of five or six. Her ability to understand speech is that of a six-year-old, but her ability to express herself was comparable to that of a two-year-old child. The five judges at the House of Lords unanimously dismissed the appeal on the ground that it was in B's best interests to have her sterilised. The facts of the case were examined in considerable

[14] See *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206; *T* v *T and Another* [1988] Fam 52, [1988] 1 All ER 613; *Re F (mental patient: sterilisation)* [1990] 2 AC 1, [1989] 2 All ER 545; *Re W (mental patient) (sterilisation)* [1993] 1 FLR 381, [1993] Fam Law 208; *Re HG (specific issue order: sterilisation)* 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403; *Re LC (medical treatment: sterilisation)* [1997] 2 FLR 258, [1997] Fam Law 604; *Re S (medical treatment: adult sterilisation)* [1998] 1 FLR 944, [1998] Fam Law 325; *Re X (adult sterilisation)* [1998] 2 FLR 1124, [1998] Fam Law 737; *Re Z (medical treatment: hysterectomy)* [2000] 1 FLR 523, [2000] Fam Law 321; *A National Health Trust* v *C (a patient by her friend the Official Solicitor)* (8 February 2000).
[15] [1988] 1 AC 199, [1987] 2 All ER 206
[16] See footnote 15 above

detail but the House of Lords provided no guidelines on how the conclusion that sterilisation was in the best interests of the girl was arrived, besides stressing that the distinction between non-therapeutic and therapeutic treatment, as well as the basic right of a person to reproduce, were wholly irrelevant to the question.[17] The same approach was followed by *T* v *T and Another*[18] and *Re HG (specific issue order: sterilisation)*.[19]

The landmark decision on sterilisation in Australia, the *Marion's Case*,[20] concerns minor person rather than adult. This is because most states in Australia have enacted legislation to deal with sterilisation of mentally disordered adults.[21] The majority of the

[17] The facts considered in that case include: B had the physical sexual drive and inclinations of a physically mature young woman of 17; B was vulnerable to sexual approaches and had once been found in a compromising situation in a bathroom; there was significant danger of pregnancy resulting from casual intercourse; it would be difficult to detect or diagnose pregnancy early in time for safe abortion to take place because B menstruated irregularly; B would not understand or be capable of easily supporting the inconveniences and pains of pregnancy; the process of delivery would likely be traumatic and would cause her to panic; the child would probably have to be delivered by Caesarian section but B would be likely to pick at the operational wound and tear it open due to her high intolerance to pain; B would be "terrified, distressed and extremely violent" during normal labour; B had no maternal instincts and was not likely to develop any; B had an antipathy to small children; B would not be able to raise or care for a child of her own.

[18] [1988] Fam. 52, [1988] 1 All ER 613. This is the first reported English case on sterilisation of mentally disordered adult. The action was brought by T's mother in 1987 to seek a declaration that it would not be unlawful to, amongst others, sterilise T. T was a girl of 19 years of age. Her mental condition is similar to that of B in *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206. The main difference lies in the fact that T was in fact pregnant and a declaration was also sought to terminate the pregnancy. In that case, Wood J followed *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206 but did not refer to *Re D (a minor) (wardship: sterilisation)* [1976] Fam. 185, [1976] 1 All ER 326, and gave three grounds for making the declaration. The first was the fact that T could never consent. The second was that the operations were in T's best interests. It appears from the judgment that this conclusion was based on "medical evidence". The third basis was that the operations would not be tortious acts.

[19] The judge in this case took into account the factors set out by Lord Templeman in *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206, and followed the House of Lords' decision in *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206, except that it added the anxiety of the carers into the equation of the best interests test. See Chapter 6 for the facts of this case.

[20] *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B.('Marion's Case')* (1992) 175 CLR 218, 66 ALJR 300

[21] Victoria (Guardianship and Administration Board Act 1986 (No. 58 of 1986)), New South Wales (Guardianship Act 1987 (Act 257 of 1987)), South Australia (Guardianship and Administration Act 1993 (No. 61 of 1993)), Northern Territory (Adult Guardianship Act 1988 (No. 45 of 1988)), Western Australia (Guardianship and Administration Act 1990 (No. 24 of 1990)) and Australian Capital Territory (Guardianship and Management of Property Act 1991 (No. 62 of 1991)) have court or tribunal instigated statutory third party consent requirements in relation to sterilisation of adults. See also Goldhar, Jeff, "The Sterilization of Women with an Intellectual Disability" (1991) 10 *University of Tasmania Law Review* 157, at page 158 and the Law Reform Commission of Western Australia, *Report on Consent to Sterilisation of Minors*, (Project No 77 Part II), (Perth: The Law Reform Commission of Western Australia, 1994), at pages 30-32

judges in the *Marion's Case*,[22] when considering the precise function of a court when asked to authorise sterilisation, said that the court had to decide if sterilisation was in the best interests of the child. Although the phrase "best interests of the child" was imprecise, it was confined by the notion of the "step of last resort". However, the majority rejected the fundamental right to reproduce as a basis for arriving at the decision. The judges chose to leave the following question open, namely whether there existed in the common law a fundamental right to reproduce which was independent of the right to personal inviolability.

Marion's Case[23] concerned a 14-year-old mentally retarded girl using the pseudonym of Marion. Marion suffered from mental retardation, severe deafness and epilepsy. Her parents applied to the Family Court of Australia for an order authorising performance of a hysterectomy and an ovariectomy on Marion. The hysterectomy was proposed for the purpose of preventing pregnancy and menstruation, whereas the ovariectomy was proposed to stabilise hormonal fluxes. The High Court of Australia was not asked to decide whether the operations were in Marion's best interests. Instead, the Court has to decide whether parents of a minor could lawfully authorise the carrying out of a sterilisation procedure in the Northern Territory without an order of a court. The majority judgment,[24] delivered by Mason CJ, Dawson J, Toohey J and Gaudron J, held that court authorisation is necessary as there were factors involved in a decision to authorise sterilisation which, in order to ensure the best protection of the interests of a child, should be decided by the court.

[22] See footnote 20 above
[23] See footnote 20 above
[24] The High Court of Australia produced a total of four judgments in respect of the *Marion's Case* (1992) 175 CLR 218, 66 ALJR 300.

An attempt to develop a method of determining best interests was made in Australia subsequent to the *Marion's Case*[25] in *L and GM* v *MM*.[26] In that case, the Australian Family Court considered the application for the performance of an abdominal hysterectomy on a 17-year-old girl called Sarah. Warnick J in that case examined each of the alleged benefits and detriments of the operation for Sarah in turn, and it covered the following headings: hygiene; proposed move to residential accommodation; risk of sexual abuse; pregnancy; removal of risk of uterine and cervical pathology; epileptic seizures during menstruation; Sarah's emotional state and pain about and during menstruation; the position of Sarah's carers; the parents' view, the risks of operation; and alternative procedures to prevent menstruation. The judge then made a list of the benefits and detriments of the sterilisation operation and held that there was no clear and convincing proof that sterilisation was in Sarah's best interests. In short, that case has followed the approach of the majority of the judges in the *Marion's Case*[27] and applied the best interests test by considering the many factors deemed relevant to the determination of the best interests of Sarah.

4.3 Distinction between therapeutic and non-therapeutic sterilisation

Some cases have used the distinction between therapeutic and non-therapeutic procedure to determine if sterilisation procedure should be authorised. It was argued in these cases that sterilisation procedure should never be performed for "non-therapeutic" purpose as that may not be for the best interest of the patient.

One of the strongest advocates for the use of the distinction between therapeutic and non-therapeutic sterilisation is La Forest J in the Canadian case of *Re Eve*.[28] It was held

[25] See footnote 20 above
[26] (1994) FLC 92
[27] See footnote 20 above
[28] See footnote 9 above

in that case that sterilisation procedure should never be authorised for non-therapeutic purposes under the *parens patriae* jurisdiction. It was said that one could never safely determine that a non-therapeutic sterilisation was for the benefit of that person. The judgment did not set out clearly what amounts to non-therapeutic sterilisation. Prior to the decision of *Re Eve*,[29] the Court of Appeal of British Columbia ordered the performance of a hysterectomy on a seriously retarded child in *Re K and Public Trustee*.[30] The court in that case held that the operation was therapeutic, based on the child's phobic aversion to blood and the fear that her menstrual period would seriously affect her.[31] It is not clear if the judge in *Re Eve*[32] intended the word "therapeutic" to cover the circumstances of *Re K and Public Trustee*.[33]

The English case of *Re D (a minor) (wardship: sterilisation)*[34] adopted the distinction between therapeutic and non-therapeutic treatments and held that sterilisation could be performed on therapeutic ground without the need to obtain consent from anyone. Heilbron J granted an order to prevent the sterilisation of D in that case because it was, *inter alia*, not "medically indicated".[35] Therefore, it is argued that the conclusion that sterilisation should never be allowed for non-therapeutic purposes is a principle arising from the application of the best interests test, that any non-consensual sterilisation for non-therapeutic purposes could not be in the best interests of a person.

[29] See footnote 20 above
[30] (1985) 19 DLR (4th) 255, 63 BCLR 145, [1985] 4 WWR 724
[31] It was however stressed in this case that this case could not and must not be regarded as a precedent to be followed in cases involving sterilisation of mentally disordered persons for contraceptive purposes.
[32] See footnote 20 above
[33] See footnote 30 above
[34] See footnote 7 above
[35] [1976] Fam. 185, at 196F-G

However, the House of Lords in the case of *Re B (a minor) (wardship: sterilisation)*[36] regarded such distinction as totally meaningless, and, if meaningful, was irrelevant to the best interests test.

The later House of Lords' decision in *Re F (mental patient: sterilisation)*[37] did not expressly mention the distinction between therapeutic and non-therapeutic treatment, but all the judges there concurred that treatment for the purpose of preserving life or improving or preventing the deterioration of physical or mental health can be carried out without the consent of the patient. Lord Bridge and Lord Griffiths appeared to share the view that sterilisation for purely medical reasons can be performed without consent, hence indirectly acknowledging the distinction between therapeutic and non-therapeutic sterilisation.[38] Lord Bridge and Lord Goff said that treatment necessary to preserve the well-being of a patient could also be lawfully given without consent. It is nevertheless not clear what the word "well-being" connotes or if sterilisation for the purpose of preventing menstruation should be considered as a therapeutic procedure.

The distinction between therapeutic and non-therapeutic was also considered along with the best interests test in *Re E (a minor) (medical treatment)*[39] and *Re GF (medical treatment).*[40] Both cases were reported in 1991 and both cases labelled sterilisation for the purpose of preventing menstruation as a "therapeutic" procedure, and used that to distinguish such cases from the other sterilisation cases. The former case concerned a minor, while the latter case was about a 29-year-old adult. The facts and decisions of both cases were similar, and both cases were decided by Sir Stephen Brown P sitting in

[36] See footnote 15 above
[37] [1990] 2 AC 1, [1989] 2 All ER 545. See Paragraph 5.1.2 of Chapter 5 for the facts of this case.
[38] Lord Bridge said that those who administer "curative or prophylactic treatment" on incompetent or unconscious patients should be immune from liability in negligence notwithstanding the lack of consent, if they acted with due skill and care, judged by the standard in *Bolam* v *Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582.
[39] [1991] 2 FLR 585, [1992] Fam Law 15, 7 BMLR 117
[40] [1992] 1 FLR 293, 7 BMLR 135

the Family Division of the High Court. Both girls suffered from mental handicap and were cared for by their parents. It was proposed that the girls undergo hysterectomy operation because they suffered from serious menorrhagia, which means excessively heavy menstruation. The conditions of both girls could not be satisfactorily treated by hormones. Sir Stephen Brown P was of the view that the operation was in the best interests of the girls. However, the judge emphasised in both cases that the purpose of the proposed operation was not to achieve sterilisation. The hysterectomy operation was required for "therapeutic" reasons. Sterilisation was the inevitable and incidental result of hysterectomy. The judge held that the consent of court (in the case of a minor) or a declaration of the court as to its lawfulness (in the case of an adult) was not necessary for a proposed therapeutic operation which would have the incidental effect of sterilising a woman who cannot consent, where the operation was necessary to improve the health of the patient, or to prevent deterioration in her health.

These two cases had brought back the distinction between "therapeutic" and "non-therapeutic" purposes of sterilisation operation, which had been discredited by the House of Lords in *Re B (a minor) (wardship: sterilisation)*,[41] and subtly resurrected by the House of Lords in *Re F (mental patient: sterilisation).*[42] Nonetheless, it is submitted that both cases may have been too liberal in their interpretation of the word "therapeutic".

In Australia, the distinction between "therapeutic" and "non-therapeutic" was the first basis upon which the majority of the judges in the *Marion's Case*[43] decided that court should be involved in authorising sterilisation so as to ensure the best protection of the

[41] See footnote 15 above
[42] See footnote 37 above
[43] See footnote 20 above

interests of a child. However, the judges acknowledged that the dividing line between therapeutic and non-therapeutic sterilisation might be unclear.

This chapter illustrated how the courts had grappled with the various principles aimed at protecting the interest of the individual concerned as opposed to the general welfare of the state as a whole. The shift of paradigm may have been a slow process but the history of sterilising mentally disordered persons has certainly played a role in reminding the courts why the shift has been necessary. The judges in the earlier judgments appeared to have made more reference to the history of sterilising mentally disordered persons in their judgments. As acknowledged by La Forest J in *Re Eve*,[44] social history has clouded our vision. A commentator who considers the judgment of *Re Eve*[45] as being too conservative has described the decision of *Re Eve*[46] as an "overreaction to the abuses of the past".[47]

[44] See footnote 9 above
[45] See footnote 9 above
[46] See footnote 9 above
[47] Shone, Margaret A., "Mental Health – Sterilization of Mentally Retarded Persons – *Parens Patriae* Power: *Re Eve*" (1987) 66 *Canadian Bar Review* 635, at page 645

Chapter 5

The Scope of the Best Interests Test

As seen in Chapter 4, sterilisation can only be performed if it is in the best interests of the patient but it is not easy to work out how exactly the best interests should be determined. The question of "how" involves at least two questions: one is a jurisdictional question of "who" should decide, the other is the substantive question of "what" considerations should be taken into account. The answer provided by cases in various jurisdictions shows how important a role doctors play in the decision making process. It should be noted that although the focus of this thesis is on adults rather than minors, some cases on minor persons are also examined to illustrate the way courts have decided issues that are common to both adults and minors.

5.1 Who decides best interests?

5.1.1 Jurisdiction

Canada

The jurisdictional position in Canada was conclusively decided by the case of *Re Eve*,[1] which states that the court can use its *parens patriae* jurisdiction to authorise the performance of a surgical operation that is necessary to the health of an adult person who cannot care for himself or herself. Nevertheless, the *parens patriae* jurisdiction should never be used to authorise sterilisation for non-therapeutic purposes. In arriving at this conclusion, La Forest J emphasised that the exercise of the *parens patriae* jurisdiction was confined to doing what is necessary for the protection of the person for whose benefit it was exercised.

[1] (1986) 31 DLR (4th) 1, [1986] 2 SCR 388. See more discussions on this case in Chapter 4.

Australia

The jurisdictional position in Australia insofar as mentally disordered adults are concerned is largely governed by the respective state legislation.[2] For instance, sections 3 and 21 of the Adult Guardianship Act[3] (Australia) of the Northern Territory place such decision in the hands of the Local Court. Insofar as minors are concerned, cases were divided on the issue of mandatory court involvement prior to the *Marion's Case.*[4] Two first instance decisions, namely *Re a Teenager*[5] and *Attorney-General (Qld)* v *Parents ('In Re S'),*[6] held that parental consent was sufficient and approval of court was unnecessary.[7] Another two first instance decisions, namely *Re Jane* and *Re Elizabeth*,[8] held that court's consent was required as it was too dangerous to leave the decision in the hands of the parents and the medical profession.[9] The position in Australia now is the one laid down by the *Marion's Case*,[10] namely only a court can authorise sterilisation of a mentally disordered child.

New Zealand

New Zealand has a statute on sterilisation, namely the Contraception, Sterilisation and Abortion Act 1977 (New Zealand)[11]. By statute, parents of an intellectually handicapped child might give consent to such an operation, but doctors had to also satisfy themselves that the consent was for the benefit of the child.[12] Hillyer J in *Re X*[13] opined that to require parents to go before the court for determination in every case

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[2] See footnote 21 of Chapter 4
[3] No. 45 of 1988
[4] *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B. ('Marion's Case')* (1992) 175 CLR 218, 66 ALJR 300. See also Paragraph 4.2 of Chapter 4
[5] [1989] FLC 92-006
[6] (1989) 98 FLR 41
[7] In any event, *Re a Teenager* [1989] FLC 92-006 held that the parental right had to be exercised in accordance with the welfare principle and could be challenged, even overridden, if it was not so exercised.
[8] [1989] FLC 92-023, (1989) 13 Fam LR 47
[9] Both cases stated prevention of menstruation as the purpose of the sterilisation procedure.
[10] See footnote 4 above.
[11] Public Act: 1977 No. 112
[12] Section 34 of Contraception, Sterilisation and Abortion Act 1977 (Public Act: 1977 No. 112) (New Zealand)
[13] [1991] 2 NZLR 365. See also Chapter 6.

would place too great a burden on parents. It is against this backdrop that Hillyer J listed 17 factors to assist doctors in making their decisions.[14]

England

The jurisdictional position in England is different from that in Canada, Australia and the US. As stated by Lord Brandon in *Re F (mental patient: sterilisation)*,[15] unlike England, the *parens patriae* jurisdiction in respect of persons of unsound mind is still available to the courts in Canada, Australia and the US. As a result, the position in England prior to the coming into force of the Mental Capacity Act 2005 (UK)[16] in April 2007 remained that of the position laid down by the House of Lords in *Re F (mental patient: sterilisation)*.[17]

In *Re F (mental patient: sterilisation)*,[18] the House of Lords held that no court had jurisdiction to give or withhold consent to a sterilisation operation in the case of an adult as it would in wardship proceedings in the case of a minor. This was because the *parens patriae* jurisdiction of the Crown as related to person of unsound mind no longer existed. Besides, the jurisdiction under the Mental Health Act 1983 (UK)[19] was limited to making orders in relation to the property and analogous affairs of a mental patient and did not extend to consenting to medical or surgical treatment. The courts also did not have the jurisdiction to approve or disapprove an operation.[20] The courts however

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[14] See Chapter 6
[15] [1990] 2 AC 1, [1989] 2 All ER 545
[16] c. 9. The MCA applies to England and Wales and it aims to clarify the laws in relation to decision-making on behalf of mentally disordered adults. Section 2(5) of the MCA provides that the MCA applies to a person that is 16 or over. However, pursuant to Section 18(3), the powers in relation to property may be exercised in relation to a younger person who has disabilities which will cause the incapacity to last into adulthood: paragraph 24 of Explanatory Notes to MCA.
[17] See footnote 15 above
[18] See footnote 15 above
[19] c. 20
[20] However, at the Court of Appeal, all three judges, namely Lord Donaldson, Neill LJ and Butler-Sloss LJ, were of the view that seeking court declaration on the lawfulness of the procedure was not the appropriate procedure. Neill LJ remarked that declaration is not a satisfactory form of procedure because if the claim were unopposed, the proceedings would be open to the technical objections that declarations

had the jurisdiction to make declarations as part of the inherent jurisdiction. The House of Lords hence decided that the court could declare the lawfulness of such an operation on the ground that it was in the best interests of the patient. Although such declaration was not necessary to establish the lawfulness of the operation, the majority of the judges agreed that as a matter of good practice the court's jurisdiction should be invoked whenever such an operation was proposed.[21] Lord Brandon listed six special features of such an operation to justify why such practice is highly desirable. The first was the irreversibility of the operation. Secondly, the operation deprived a fundamental right of a woman and thirdly, such deprivation gave rise to important moral and emotional considerations. The fourth feature was the higher risk of a decision being decided wrongly without the involvement of court. Fifthly, in the absence of the involvement of court, there was a risk of the operation being carried out for improper reasons or with improper motives. Finally, involvement of the court in the decision to operate could protect the doctors from subsequent adverse criticisms or claims.

If the sterilisation is performed on therapeutic grounds, then according to *Re GF (medical treatment)*,[22] court declaration need not be made so long as two medical practitioners are satisfied that the operation is necessary for therapeutic purposes, is in the best interests of the patient and there is no practicable and less intrusive means of treating the condition.

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are not in the ordinary way made by consent nor where the defendant or respondent has asserted no contrary claim. They were of the view that approval of the court (under its inherent jurisdiction) should be obtained before operation of this kind was carried out.

[21] Lord Griffiths disagreed with other judges on this point. His Lordship was of the view that the law ought to be that approval of the court must be obtained before sterilisation of a woman incapable of giving consent could be carried out. On grounds of public interest, an operation to sterilise a woman incapable of giving consent either on grounds of age or mental incapacity was unlawful if performed without the consent of the High Court. Lord Goff disagreed with this proposition and said that if it became the invariable practice of the medical profession not to sterilise an adult woman incapacitated from giving consent unless a declaration that the proposed operation was lawful was first sought from the court, there would be hardly any practical difference between seeking the court's approval under the *parens patriae* jurisdiction and seeking a declaration as to the lawfulness of the operation.

[22] [1992] 1 FLR 293, 7 BMLR 135

The Practice Note issued by the Official Solicitor in 2006[23] took into account the development of case law in this area and stated that sterilisation for contraceptive purposes of a person who cannot consent is a category of treatment in which case-law has established that a court application should be made.[24]

The Practice Note however did not specify if sterilisation on purely medical grounds could be performed without the prior sanction of a judge. The Mental Capacity Act 2005 (UK)[25] has not materially altered the current position, as it specifies that court sanction is unnecessary so long as the principles set out in the Mental Capacity Act 2005 (UK)[26] are followed. The court however still retains the power to make declarations. In the event of difficulties in arriving at a decision, the matter can be referred to the new Court of Protection, which allows decision to be made by letter.

However, some confusion has arisen insofar as the jurisdictional position in England was concerned. In the case *Re S (medical treatment: adult sterilisation)*,[27] the judge stated that sterilisation should never be carried out on a woman incapable of giving her consent without the prior "approval" of the High Court. That case had confused the distinction between a declaration and an approval. The English court does not have the jurisdiction to give an approval in respect of adult persons of unsound mind.

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[23] *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity)* [2006] 2 FLR 373

[24] Paragraph 5(2) of *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity)* [2006] 2 FLR 373

[25] See footnote 16 above

[26] See footnote 16 above

[27] [1998] 1 FLR 944, [1998] Fam Law 325. See also Chapter 6.

Another confusion arose from the judgment of Thorpe LJ in *In re S (adult patient: sterilisation).*[28] In that case, Thorpe LJ referred to *Re F (mental patient: sterilisation)*[29] and held that there was no difference between a *parens patriae* jurisdiction and the inherent jurisdiction of the court, relief would thus be granted so long as the welfare of the patient required it. However, it is submitted that Thorpe LJ misunderstood the following statement of Lord Goff in *Re F (mental patient: sterilisation)*,[30] which was used as an antithesis to suggest that the *parens patriae* jurisdiction of the court should be different from the inherent jurisdiction of the court –

> "If, however, it became the invariable practice of the medical profession not to sterilise an adult woman who is incapacitated from giving her consent unless a declaration that the proposed course of action is lawful is first sought from the court, I can see little, if any, practical difference between seeking the court's approval under the *parens patriae* jurisdiction and seeking a declaration as to the lawfulness of the operation."[31]

In short, unlike the courts in Canada, Australia and the US, the courts in England cannot exercise the *parens patriae* jurisdiction in respect of persons of unsound mind. Following the coming into effect of the Mental Capacity Act 2005,[32] it is now clear that court's approval is not necessary before a mentally disordered adult can be sterilised, although the court still has the power to make a declaration on the lawfulness of any act.

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[28] [2001] Fam 15
[29] See footnote 15 above
[30] See footnote 15 above
[31] [1990] 2 AC 1, at page 83
[32] See footnote 16 above

5.1.2 Best interests test versus *Bolam* test

The fact that the English courts only have declaratory jurisdiction means that some other parties other than the courts have the primary right to decide on issues like this in England. It is apt at this juncture to examine further the decision of the House of Lords in the case of *Re F (mental patient: sterilisation)*.[33] As mentioned earlier, the House of Lords in that case held that no court had jurisdiction to give or withhold consent to a sterilisation operation of an adult.

Re F (mental patient: sterilisation)[34] concerned F, a 36-year-old woman suffering from an arrested or incomplete development of the mind. F's mother, on behalf of F, commenced the proceeding in 1988 to seek a declaration to the effect that to sterilise F would not amount to an unlawful act by reason of the absence of F's consent, or to seek court's consent under the *parens patriae* or inherent jurisdiction to sterilise F. The judge in the court of first instance granted the declaration. The Court of Appeal upheld the order. The Official Solicitor appealed to the House of Lords.

F's mental capacity was comparable to a child of four or five. Her verbal capacity was that of a two-year-old. There was no prospect of any improvement in F's mental capacity. She could not express her views verbally but could indicate her likes or dislikes. F was liable to become aggressive, but great progress had been made through occupational therapy. F had become less aggressive. The proposal to have F sterilised arose from a sexual relationship F had formed with another patient, P, since 1987. It was said that F would not be able to cope with pregnancy, labour, delivery or looking

[33] See footnote 15 above
[34] See footnote 15 above

after a child. The appeal was unanimously dismissed by all five judges of the House of Lords.[35]

Lord Brandon stated that the lawfulness of a doctor giving treatment to an adult incompetent to give consent depended on whether or not it was in the best interests of the patient concerned rather than any approval or sanction of the court. If doctors were to be required to decide if the treatment was in the best interests of adults incompetent to give consent, the test to be applied is the *Bolam* test.[36] If a stricter test were to be applied, then such adults would be deprived of the benefit of medical treatment competent adults would enjoy. Lord Goff shared the view of Lord Brandon in the application of best interests test, but made it clear that the legal justification for treatment without consent generally was the principle of necessity, not of emergency.[37] The permanent state of affairs of a mentally disordered person calls for a wider range of care than may be requisite in an emergency which arises from accidental injury. Lord Griffiths shared the view of Lord Brandon in the application of best interests test, while acknowledging that ultimately, public interest is the reason why mentally incompetent should be given treatment to which they lack the capacity to consent.[38]

Therefore, it would appear that the House of Lords in *Re F (mental patient: sterilisation)*[39] has left the definition of "best interest" to the doctors. In fact, the House

[35] Lord Bridge, Lord Brandon, Lord Griffiths, Lord Goff and Lord Jauncey
[36] See footnote 38 of Chapter 4 and the discussion below
[37] The principle was mentioned in passing by Lord Brandon in his judgment.
[38] This test was used by Neill LJ and Butter-Sloss LJ at the Court of Appeal. Neill LJ said that the question that should be asked was whether or not the operation was necessary and the proper safeguards were observed. Neill LJ defined "necessary" as "that which the general body of medical opinion in the particular speciality would consider to be in the best interests of the patient in order to maintain the health and to secure the well-being of the patient". This definition was adopted by Butter-Sloss LJ. Neill LJ also expressed disapproval of sterilisation performed for the convenience of caregivers. Butter-Sloss LJ remarked that sterilisation for eugenic or purely social reasons were "totally abhorrent and unacceptable".
[39] See footnote 15 above

of Lords' decision in *Re F (mental patient: sterilisation)*[40] is the first case that placed the best interests test alongside the *Bolam* test. The reason for doing so cannot be separated from the fact that the court in England does not have the jurisdiction to approve sterilisation of mentally disordered adults. As a result, the strict legal position is that in the absence of consent by the patient, only doctors could decide whether or not sterilisation is in the best interests of a mentally disordered adult.

Best interests of the patient or best interests of the doctors?

The *Bolam* test refers to the test laid down by the case of *Bolam* v *Friern Hospital Management Committee*[41] on the standard of care that should be exercised by a doctor when carrying out medical treatment. The test provides that a doctor is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of medical opinion skilled in that particular art.

The *Bolam* test may not appear to have any relevance to the best interests test. However, it is not uncommon for the courts to rely on medical opinion to arrive at a decision, as illustrated by the decision of the High Court in *T* v *T*,[42] where the question of best interests appeared to have been answered based on "medical evidence". This has been attributed to the vagueness of the best interests test, which allows the test to become "a means by which the medical profession fashion a decision-making process on paternalism and clinical need".[43]

[40] See footnote 15 above
[41] [1957] 2 All ER 118, [1957] 1 WLR 582
[42] [1988] Fam. 52, [1988] 1 All ER 613. See footnote 18 of Chapter 4 .
[43] Davies, Michael, *Textbook on Medical Law*, 2nd ed., (London: Blackstone Press, 1998), at page 153

The decision of the House of Lords to apply a test for negligence to a question of clinical practice has been criticised.[44] In any event, the approach was followed subsequently in the case of *Re W (mental patient) (sterilisation)*.[45] In *Re W (mental patient) (sterilisation)*,[46] the mother of W sought a declaration that an operation to sterilise W would be legal. W was a 20-year-old girl with severe learning difficulties and had a mental age of about seven. Hollis J granted the declaration. Hollis J relied on the views of Lord Jauncey in *Re F (mental patient: sterilisation)*[47] to come to the conclusion that all that was necessary was the presence of a responsible body of medical opinion skilled in the particular field of diagnosis and treatment in favour of sterilisation. The judge concluded that sterilisation was in W's best interests notwithstanding his acknowledgement that there was only a small risk of W becoming pregnant at that time. The judge said that the future is relevant when considering the best interests of the patient.

However, although the House of Lords in *Re F (mental patient: sterilisation)*[48] regarded the *Bolam* test as the applicable test for doctors in determining whether or not sterilisation is in the best interests of the mentally disordered adult, the House of Lords did not suggest that doctors therefore have absolute discretion in deciding the matter. The House of Lords not only did not rule out the relevance of factors such as the risk of pregnancy in the best interests test, Lord Goff expressly stated that the validity of expert opinions had to be weighed and judged by the court.

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[44] Mason, J.K. and R.A. McCall Smith, *Law and Medical Ethics*, 5th ed., (London, Edinburgh, Dublin: Butterworths, 1999), at page 104
[45] [1993] 1 FLR 381, [1993] Fam Law 208
[46] See footnote 45 above
[47] See footnote 15 above
[48] See footnote 15 above

In any event, *Re F (mental patient: sterilisation)*[49] has given the opportunity to the critics to doubt if the best interests test is still a test that is for the interest of the patient or if it has become a test to shield doctors from lawsuits. This was evident from the reluctance of the courts in other jurisdictions to follow similar approach. The Australian cases of *Re Jane*[50] and the *Marion's Case*[51] were concerned over the existence of "black sheep" in the medical profession who are not prepared to live up to the professional standards of ethics, as well as those who may form sincere but misguided views about the appropriate steps to be taken. Both the *Marion's Case*[52] and the New Zealand case of *Re X*[53] acknowledged that sterilisation is not just a medical issue and the decision should be made by a team of multidisciplinary people.

Clarifying the relationship between the best interests test and the Bolam test

It was against this backdrop that two English Court of Appeal cases, namely *Re A (medical treatment: male sterilisation)*[54] and *In re S (adult patient: sterilisation)*[55] took the opportunity to clarify the relationship between the best interests test and the *Bolam* test. The case of *Re A (medical treatment: male sterilisation)*[56] concerned a 28-year-old man with Down's syndrome. A had significant to severe impairment of intelligence, and he was sexually aware and active. The High Court judge refused the application for a declaration that it was in A's best interests to have vasectomy performed on him without his consent. The Court of Appeal dismissed the appeal on the ground that it was not in A's best interests to have him sterilised. Dame Elizabeth Butler-Sloss LJ decided in that case that the best interests test and the *Bolam* test are two separate duties.

[49] See footnote 15 above
[50] [1989] FLC 92-023, (1989) 13 Fam LR 47
[51] See footnote 4 above
[52] See footnote 4 above
[53] See footnote 13 above
[54] [2000] 1 FLR 549
[55] [2001] Fam 15
[56] See footnote 54 above

In the case of an application for approval of a sterilisation operation, the judge rather than the doctor had to decide what the best interests of the patient entail.

The Court of Appeal in *In re S (adult patient: sterilisation)*[57] also held that the best interests test extends beyond the considerations set out in the *Bolam* test. That case concerned one S, who was a 28-year-old girl with severe learning disability. S's mother sought a declaration that an operation of sterilisation could be lawfully performed. The sterilisation procedure proposed was laparoscopic subtotal hysterectomy. The Court of Appeal acknowledged the anomaly of how the *Bolam* case had become relevant in this type of cases but indicated that *Re F (mental patient: sterilisation)*[58] was really a case on jurisdiction rather than a review of best interests on the merits. In any event, since the Court of Appeal was bound by the House of Lords' decision, it was decided that the *Bolam* test should be applied at the outset to ensure that the treatment is recognised by a responsible body of medical opinion. This should then be followed by a consideration of the best interests of the patient on broader ethical, social, moral and welfare grounds.

Although the position in England has now been clarified by the two Court of Appeal decisions, it demonstrates the difficulty in applying the best interests test and the volatility of the test itself. The best interests test was supposed to safeguard the interest of the patient, yet it was almost turned into a test, at least in England, that could serve the interests of only the doctors.

The inability of the best interests test to withstand changing jurisdictional circumstances is not its only problem, as illustrated in paragraph 5.2 below, where the diverse factors

[57] See footnote 55 above
[58] See footnote 15 above

cases have taken into account when applying the test have made the test not only unpredictable, but again something only the doctors are fit to determine.

5.2 The web of factors which make up the best interests test

5.2.1 How many factors make up the best interests test?

The courts usually take into account more than one factor when deciding whether the sterilisation operation is in the best interests of a patient. However, most probably as a result of the lack of guidelines, the approaches adopted had not been consistent. There is a group of cases in which the best interests of the patient appeared to have been decided based on only three or fewer factors. Another group of cases have either recognised that many factors are relevant to the best interests test or attempted to identify all such factors.

Cases that fall into the first category include *Re M (a minor) (wardship: sterilization)*[59] and *Re P (a minor) (wardship: sterilization)*,[60] where the judges used the evidence on the high reversibility of tubal ligation to distinguish these cases from *Re B (a minor) (wardship: sterilisation)*[61] and order the performance of sterilisation.

The facts and decisions of both cases were similar. Both girls, J and T, were 17 years old when their cases were heard. The purpose of both cases was to obtain the leave of the High Court to carry out sterilisation of the girls by occlusion of the Fallopian tubes. Intellectually, both girls were around the age of six years old. However, unlike J, it was expressly stated in the facts that the intellectual development of T would never

[59] [1988] 2 FLR 497
[60] [1989] 1 FLR 182, [1989] Fam Law 102
[61] [1988] 1 AC 199, [1987] 2 All ER 206. See also Paragraph 4.2 of Chapter 4.

improve.[62] Both girls have a healthy sexual appetite, but would not be able to cope with pregnancy, abortion, childbirth or the consequences of their child being removed from them. All alternatives to sterilisation were considered unsuitable to them.

The judges in both cases granted the leave to sterilise the girls concerned as they were of the view that the risk of the girls becoming pregnant must be removed. Both cases placed special emphasis on the evidence given by the experts as to the reversibility of proposed operation. In the former case, Bush J referred to the evidence of a professor and a doctor, which stated that an operation that involves the placing of clamps on the Fallopian tubes could be successfully reversed in 50 to 70 percent of the cases. The judgment of Eastham J in *Re P (a minor) (wardship: sterilization)*[63] went a step further. The judge used the evidence of a 95 percent chance of successful reversal of the proposed sterilisation to suggest that sterilisation should no longer be viewed as a procedure which should be exercised only in the last resort.[64]

Re E (a minor) (medical treatment)[65] and *Re GF (medical treatment)*[66] also fall into the first category as the best interests test in those cases was satisfied due to the "therapeutic" nature of the operation.[67]

The decision of *Re X (adult sterilisation)*[68] also falls into this category. *Re X (adult sterilisation)*[69] concerned X, who was 31 years old at the time the judgment was

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[62] The judge in *Re M (a minor) (wardship: sterilization)* [1988] 2 FLR 497 made no mention of the prospect of improvement in the intellectual development of J.
[63] See footnote 60 above
[64] The suggestion was made in relation to the comment of Dillon LJ in *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206 that sterilisation should be exercised only in the last resort.
[65] [1991] 2 FLR 585, [1992] Fam Law 15, 7 BMLR 117. See also Paragraph 4.3 of Chapter 4.
[66] [1992] 1 FLR 293, 7 BMLR 135. See also Paragraph 4.3 of Chapter 4.
[67] The girls in these two cases suffered serious menorrhagia, which means excessively heavy menstruation. See Paragraph 4.3 of Chapter 4
[68] [1998] 2 FLR 1124, [1998] Fam Law 737

delivered. She had the symptoms of Down's syndrome. Her mental age was between four and six. That case listed only three factors that were deemed relevant to the best interests test, namely the degree of risk or likelihood of X becoming pregnant; the risk of physical or psychological harm to X if she became pregnant or gave birth to a child; and the availability of reversible or less invasive alternative to sterilisation. All three matters were answered based on the facts adduced. With regard to the first matter, the facts considered were X's fertility and her history of sexual behaviour. The facts relevant to the second matter included X's attitude towards bodily functions and her inability to look after a child. The third question was answered negatively notwithstanding the availability of a reversible alternative, as the judge was of the view that the irreversible nature of sterilisation was not material.

The second group of cases listed many factors that are relevant to the best interests test. In England, *Re D (a minor) (wardship: sterilisation)*[70] considered six factors,[71] while Lord Templeman listed seven types of expert evidence that should be adduced in *Re B (a minor) (wardship: sterilisation).*[72] Dame Elizabeth Butler-Sloss LJ held in *Re A (medical treatment: male sterilisation)*[73] that the best interests encompass medical, emotional and all other welfare issues. In that same case, Thorpe LJ suggested that judges should draw a balance sheet to weigh the benefits against the counterbalancing disadvantages. The first entry should be any factor or factors of actual benefit, while

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[69] See footnote 68 above

[70] [1976] Fam. 185, [1976] 1 All ER 326. See also Paragraph 4.1 of Chapter 4.

[71] D's mental and physical condition and attainments had improved; D's future prospects were as yet unpredictable; there was the likelihood that in later years D would be capable of giving valid or informed consent; D's opportunities for promiscuity were virtually non-existent, as her mother never left her side and she was never allowed out alone; there were two alternative methods of contraception which could be safely and satisfactorily used; and D's frustration and resentment of realising what had happened could be devastating.

[72] [1988] 1 AC 199, at 206 -

"…the reasons for the application, the history, conditions, circumstances and foreseeable future of the girl, the risks and consequences of pregnancy, the risks and consequences of sterilisation, the practicability of alternative precautions against pregnancy and any other relevant information."

[73] See footnote 54 above

the other sheet should contain counterbalancing disadvantages. If the account is in relatively significant credit, then the judge can conclude that the application is likely to advance the best interests of the patient. There should not be too much concentration on the evaluation of risks of happenings. This balancing exercise was applied subsequently by Cazalet J in *A National Health Trust* v *C (a patient by her friend the Official Solicitor).*[74]

The NHS Trust in the case *A National Health Trust* v *C (a patient by her friend the Official Solicitor)*[75] sought a declaration that an operation of sterilisation by occlusion of the Fallopian tubes may be lawfully performed upon C despite C's inability to consent to it. C was a 21-year-old girl suffering from Down's syndrome. Cazalet J undertook a balancing exercise by first listing the benefits and potential benefits of sterilisation, followed by a list of the disadvantages of sterilisation. There were seven items in the first list. They included the fact that sterilisation gave safer protection against conception than the contraceptive pill; the greater independence C could have after sterilisation; C not having to take a daily contraceptive pill under supervision; not having to worry that the effect of the pill being nullified through some unanticipated event; not being necessary for C's needs to be reviewed in the future; C not being concerned about the operation; and the reduced anxiety for C's mother and family. Two disadvantages of sterilisation were listed, namely the risks of the operation and the discomforts which might follow, as well as the problems C might have with her periods if she came off the pill. Cazalet J therefore concluded that it is physically, emotionally and for other reasons in C's best interests that the sterilisation should be performed on C.

[74] The case was heard in the Family Division on 8 February 2000.
[75] See footnote 74 above

The US court in *Re Hayes*[76] appeared to consider the ability of a person to care for a child as a relevant factor, and placed significant weight on the irreversibility of sterilisation procedure. The former factor was also emphasised in the subsequent case of *Re Grady*.[77] The majority of the judges of the Supreme Court of New Jersey in *Re Grady*[78] set out nine factors that should be considered when considering whether sterilisation was in the best interests of the incompetent person.[79]

In 1987, the legislature of the state of California incorporated the tests suggested by the court in *Re Hayes*[80] in section 1950 *et seq.* of the California Probate Code.[81] Section

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[76] (1980) 608 P.2d 635. See also Paragraph 4.2 of Chapter 4.
[77] (1981) 426 A.2d 467
[78] See footnote 77 above
[79] The nine factors are: -

(1) the possibility that the incompetent person could become pregnant;
(2) the possibility that she would experience trauma or psychological damage if she became pregnant, and conversely, the trauma or psychological damage from the sterilisation operation;
(3) the likelihood that she would voluntarily engage in sexual activity or be exposed to imposed sexual intercourse;
(4) her inability 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 in foreseeable future;
(6) the advisability of sterilisation at the time of application rather than in the future;
(7) her ability to care for a child and the possibility that she might, with a partner, care for a child;
(8) evidence that scientific or medical advances in the foreseeable future might make possible either improve her condition or alternative and less drastic sterilisation procedures; and
(9) a demonstration that those seeking the sterilisation are seeking it in good faith, and that their primary concern is the incompetent person's best interests rather than their own or the public's convenience.

[80] See footnote 76 above
[81] The section appeared to have also incorporated the factors set out in *Re Grady* (1981) 426 A.2d 467. However, Ramirez, P.J. in *Re Angela* (1999) 70 Cal App 4th 1410 considered only *Re Hayes* (1980) 608 P.2d 635 in his discussion the new sections. Section 1958 of that legislation provided that the court may authorise sterilisation only if all of the following eight factors were established beyond a reasonable doubt: -

(a) the person proposed to be sterilised was incapable of giving consent to sterilisation, and the incapacity was likely to be permanent;
(b) the person is fertile and capable of procreation;
(c) the person is capable of engaging in, and is likely to engage in sexual activity;
(d) either the person was permanently incapable of caring for a child even with training and assistance, or pregnancy or childbirth would pose risk to the life of the person and there were no other appropriate methods of contraception;
(e) all less invasive contraceptive methods including supervision were unworkable, inapplicable or medically contraindicated; isolation and segregation should not be considered as less invasive means of contraception;
(f) the proposed method of sterilisation entailed the least invasion of the body of the person;
(g) the current state of scientific and medical knowledge did not suggest either that a reversible sterilisation procedure or other less drastic contraceptive method would shortly be available, or that science was on the threshold of an advance in the treatment of the person's disability; and

1958 considered the ability to care for a child a factor as important as the risk pregnancy or childbirth could pose to the life of the person, and only one of the two factors needed to be proven.[82] Further, the section appeared to apply to irreversible sterilisation only as paragraph (g) suggested that authorisation should not be given if reversible sterilisation procedure was available.[83] It is therefore unclear what tests governed the authorisation of reversible sterilisation. More interestingly, paragraph (e) specified that "isolation and segregation" should not be considered less invasive means of contraception.[84]

The numerous conditions listed in the Californian law were used in the case of *Re Angela*[85] in 1999. Angela was a 20-year-old woman who was severely mentally retarded. Her parents applied for a court order authorising them to give consent for Angela's sterilisation. The proposed sterilisation surgery was laparoscopic bilateral tubal ligation. The Court of Appeal of California considered each of the eight factors listed in section 1958 and affirmed the decision of the probate court to approve the petition of Angela's parents. Apart from paragraph (c) of Section 1958,[86] the court did not have any difficulty proving all the factors. There was no evidence showing that Angela was sexually active as of the time of the hearing. In answering the question of the likelihood of Angela engaging in sexual activity in the future, the court relied on the evidence which suggested that Angela was "passive and compliant" and that she was highly likely to participate sexually if asked to do so. The court also considered the fact that Angela would be entering a program that had male participants and in which she would be less supervised. The court however did not consider the reversibility of

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(h) the person had not made a knowing objection to his or her sterilisation.

[82] See paragraph (d) in footnote 81 above

[83] See paragraph (g) in footnote 81 above

[84] See paragraph (e) in footnote 81 above

[85] (1999) 70 Cal App 4th 1410

[86] See paragraph (c) of footnote 81 above

laparoscopic bilateral tubal ligation. This is potentially a reversible operation and may fall outside the scope of section 1958.

5.2.2 Are all the factors equally important?

Besides the lack of clarity in how many factors constitute the best interests test, the nature of and the manner in which each of the factors can be determined has also brought into questions the weight each of these factors should be given in the decision-making process.

Likelihood of improvement of the condition that has incapacitated the ability of the patient to give consent

Whether or not there is a likelihood of improvement in the condition that incapacitated the ability of a mentally disordered person to give informed consent is a factor that has been mentioned in the majority of the cases on sterilisation. However, most cases have indicated the absence of this factor on the facts of the case,[87] and none of the cases have laid down any guideline on how this factor should be proved.

The case of *Re D (a minor) (wardship: sterilisation)*[88] found that D's mental and physical condition and attainments have improved. The decision against authorising sterilisation in that case was based partly on the fact that D might be able to consent later. However, the evidence of improvement in a person's mental and physical condition is insufficient to show that the patient might be able to consent later. In the

[87] *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206; *T v T and Another* [1988] Fam 52, [1988] 1 All ER 613; *Re F (mental patient: sterilisation)* [1990] 2 AC 1, [1989] 2 All ER 545; *Re HG (specific issue order: sterilisation)* 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403; *Re X (adult sterilisation)* [1998] 2 FLR 1124, [1998] Fam Law 737; *Re Z (medical treatment: hysterectomy)* [2000] 1 FLR 523, [2000] Fam Law 321; *Re SL (adult patient) (medical treatment)* [2000] 1 FLR 465, [2000] Fam Law 322

[88] See footnote 70 above

facts of *Re F (mental patient: sterilisation)*,[89] F had made "great progress" in her condition, yet it was said that she would never understand enough to give consent. The case of *Re HG (specific issue order: sterilisation)*[90] said that there was no hope of "radical" improvement, although it is uncertain what "radical" means.

The Canadian case of *Re Eve*[91] and the US cases such as *Re Hayes*[92] and *Re Grady*[93] have all expressly considered the likelihood of improvement in the incapacitating condition as an important factor for a decision on sterilisation. These cases have considered the likelihood alongside the foreseeability of scientific or medical advances. Therefore, besides evidence showing actual and foreseeable progress of the mentally handicapped person himself or herself, more macro factors such as the advancement of science and medicine also play a part in deciding whether or not this factor can be satisfied.

Notwithstanding that this factor directly relates to the capacity of a person to give consent, this factor is usually used to decide the substantive issue of whether or not sterilisation operation should be authorised,[94] rather than the issue of capacity itself. The Mental Capacity Act 2005 (UK)[95] also listed this factor as one of the components of the best interests test.[96]

The likelihood of improvement in the capacity to consent is not entirely a medical problem. Capacity to consent is an integral part of the principle of autonomy. Whether

[89] See footnote 15 above
[90] 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403. See Chapter 6 for facts of this case.
[91] See footnote 1 above
[92] See footnote 76 above
[93] See footnote 77 above
[94] See *Re D (a minor) (wardship: sterilisation)* [1976] Fam. 185, [1976] 1 All ER 326; *T* v *T and Another* [1988] Fam 52, [1988] 1 All ER 613; *Re Eve* (1986) 31 DLR (4th) 1, [1986] 2 SCR 388; *Re Hayes* (1980) 608 P. 2d 635; *Re Grady* (1981) 426 A. 2d 467; *Re Angela* (1999) 70 Cal App 4th 1410.
[95] See footnote 16 above
[96] Section 4(3) of the Mental Capacity Act 2005 (c. 9) (UK)

or not there is any likelihood of improvement should therefore be examined in the light of the question of capacity generally. The likelihood of personal progress and medical or scientific advancement should be judged by looking at how such development can improve the ability of the mentally disordered person to comprehend, retain and weigh each of the information relevant to the sterilisation procedure and to communicate his or her decision. It is therefore submitted that this factor forms an essential part of the principle of autonomy and must be examined carefully when deciding whether sterilisation of mentally disordered adults should be carried out in the absence of consent.

Risks related to pregnancy and childbirth

There is now no doubt that sterilisation cannot be carried out for the purpose of avoiding the risk of giving birth to a mentally disordered child. It is also clear that involuntary sterilisation can only be carried out if it is in the best interests of the patient and not any other person. Therefore, the risks the sterilisation is aimed at avoiding must amount to risks to the patient himself or herself.

The risks related to pregnancy and childbirth to the mentally disordered person are commonly used to justify the need for a sterilisation procedure. Pregnancy was described as "an unmitigated disaster" to the mentally disordered child in *Re B (a minor) (wardship: sterilisation).*[97] It was said that she would not be capable of easily supporting the inconveniences and pains of pregnancy, and the process of delivery would likely be traumatic to her and would cause her to panic. Cases such as *Re M (a minor) (wardship: sterilization)*, [98] *Re P (a minor) (wardship: sterilization)*,[99] *Re F*

[97] See footnote 61 above
[98] See footnote 59 above
[99] See footnote 60 above

(mental patient: sterilisation)[100] and the New Zealand case of *Re X*[101] had also stressed the inability of the mentally disordered person in those cases to cope with pregnancy and labour. *Re Z (medical treatment: hysterectomy)* [102] and *A National Health Trust* v *C (a patient by her friend the Official Solicitor)*[103] shared the view that pregnancy and delivery would be traumatic to the mentally disordered persons there, and the parents of the mentally disordered adult in *Re X (adult sterilisation)*[104] felt that pregnancy would be a "bewildering, frightening and damaging experience for her".

However, the Canadian case of *Re Eve*[105] did not think that giving birth would be necessarily more difficult for Eve than for any other women. Brennan J stated in the dissenting judgment of *Marion's Case*[106] that although others might see the pregnancy and motherhood of a mentally disordered girl as a tragedy, she, in her own world, might find in those events an enrichment of her life.

Less controversial are those cases that have shown that pregnancy and childbirth could harm the actual physical health of the patient. In *Re W (mental patient) (sterilisation)*,[107] it was believed that the patient's epilepsy would most likely worsen during pregnancy. The girl in the US case of *Re Angela*[108] might die from seizures if she were to become pregnant.

Therefore, care should be taken when weighing the risks related to pregnancy and childbirth. It should always be remembered that pregnancy and childbirth are not

[100] See footnote 15 above
[101] See footnote 13 above
[102] [2000] 1 FLR 523, [2000] Fam Law 321
[103] See footnote 74 above
[104] See footnote 68 above
[105] See footnote 1 above
[106] See footnote 4 above
[107] See footnote 45 above
[108] See footnote 85 above

necessarily more difficult an experience for the mentally disordered persons. In an extreme case such as those in *Re Angela*[109] where pregnancy will result in death, sterilisation may be justified on therapeutic ground if the likelihood of pregnancy is real.

Further, Brennan J in *Marion's Case*[110] stated that he did not see the risk of pregnancy as something that could be weighed alongside sterilisation. This is because pregnancy is a possibility, but sterilisation, once performed, is a certainty. Brennan J was of the view that if non-therapeutic sterilisation could be justified at all, it could be justified only by the need to avoid a tragedy that is imminent and certain.

The risk of pregnancy is therefore too remote a factor and should not be considered a factor in the best interests test.

Risks in respect of abortion or removal of child

Another type of risk mentioned in the sterilisation cases is the one related to abortion. It was suggested in *Re B (a minor) (wardship: sterilisation)*[111] that pregnancy would have to be terminated if B were to become pregnant, but since B menstruated irregularly, it would not be easy to detect or diagnose pregnancy in time for safe abortion. *Re Z (medical treatment: hysterectomy)*,[112] on the other hand, was concerned about the disastrous psychological and emotional fallout an abortion would bring to the mentally disordered person. It is submitted that abortion is traumatic to all individuals, regardless of the status of their mental health. It is hard to justify the performance of an invasive procedure (sterilisation) in order to prevent the impact of another possible invasive

[109] See footnote 85 above
[110] See footnote 4 above
[111] See footnote 61 above
[112] See footnote 102 above

procedure (abortion). Both are invasive procedures, with the latter just being a possibility and as such too remote.

Besides the trauma of pregnancy and delivery, many English cases have also taken into account the trauma associated with the eventual removal of the child from the mentally disordered parent and sent for adoption due to his or her inability to care and provide for the child. Such risk was mentioned in *Re M (a minor) (wardship: sterilization)*,[113] *Re P (a minor) (wardship: sterilization)*,[114] *Re Z (medical treatment: hysterectomy)*[115] and *A National Health Trust* v *C (a patient by her friend the Official Solicitor).*[116] The case of *A National Health Trust* v *C (a patient by her friend the Official Solicitor)* [117] stressed that the removal of baby could be frightening, deeply disturbing and extremely psychologically traumatic to the mentally disordered person in that case. However, it is submitted that this is a risk that can usually be averted by training and education.

Risk of menstrual periods

The risk brought about by excessive menstruation was the ground relied upon by *Re E (a minor) (medical treatment)* [118] and *Re GF (medical treatment).* [119] Painful menstruation and severe inability in coping with menstruation was used to support a sterilisation order in *Re Z (medical treatment: hysterectomy).*[120] Excessive menstruation should not be listed as a separate because it would have to be therapeutic in nature before it can be used to justify sterilisation and as such this factor is in fact part of the broader test of therapeutic and non-therapeutic sterilisation.

[113] See footnote 59 above
[114] See footnote 60 above
[115] See footnote 102 above
[116] See footnote 74 above
[117] See footnote 74 above
[118] See footnote 65 above
[119] See footnote 66 above
[120] See footnote 102 above

Risk of sexual assault

Arguably, many applications to the court for an order of sterilisation were in fact premised upon the worry that the mentally disordered person would be sexually assaulted. However, the issue was never put in perspective until the Australian case of *L and GM* v *MM*[121] and the English case of *Re LC (medical treatment: sterilisation).*[122] Both cases stated correctly and in no uncertain term that sterilisation could not protect one from the risk of sexual assault.

Foreseeability

Besides having to prove the substance of the risks sterilisation is aimed at avoiding, the foreseeability of the risks also has to be proved. The fertility of the patient as well as the likelihood of the patient engaging in sexual activity are relevant insofar as the risks related to pregnancy and childbirth are concerned. There appears to be some medical evidence showing that certain mentally disordered person, such as those suffering from the Down's syndrome, would have reduced fertility.[123] It has also been suggested that most of the mentally handicapped persons are incapable of having children as a physiological fact.[124] In any event, the US cases such as *Re Grady*[125] and *Re Angela*[126] illustrate the difficulty in proving fertility. While *Re Grady*[127] chose to say that there was a presumption of fertility, *Re Angela*[128] used a syllogism to answer the question, that is if the person was not fertile then the sterilisation would not take away something she had, and if she was fertile then it was necessary to consider further factors. It is submitted that such syllogism is unhelpful and renders the need to prove fertility totally

[121] (1994) FLC 92
[122] [1997] 2 FLR 258, [1997] Fam Law 604
[123] See the opinion of one expert in *A National Health Trust* v *C (a patient by her friend the Official Solicitor)* (8 February 2000) in this regard, which was however not accepted by the judge.
[124] Davies, Michael, see footnote 43 above, at page 301
[125] See footnote 77 above
[126] See footnote 85 above
[127] See footnote 77 above
[128] See footnote 85 above

redundant. The preferable approach would be to consider the fertility of the person for the sole purpose of deciding the necessity of sterilisation. If the person is not fertile, there is no reason why she should be made to go through such procedure when such procedure is not without risks. In any event, the question of fertility is part of the larger question of foreseeability. Foreseeability should not be seen as merely a factor in the best interest test but as an integral part of the decision-making process.

In *Re F (mental patient: sterilisation)*,[129] it was found that F had already formed a sexual relationship with another patient. However, the majority of the sterilisation cases involved persons who are not sexually active. Closely linked to the likelihood of the patient engaging in sexual activity is the level of supervision the patient is subjected to. In *Re D (a minor) (wardship: sterilisation)*,[130] the opportunity for D to engage in sexual activity was said to be virtually non-existent as her mother never left her side and she was never allowed out alone. In *Re LC (medical treatment: sterilisation)*[131] and *Re S (medical treatment: adult sterilisation)*,[132] the judges agreed that the high level of care the mentally disordered person was receiving at the time the application was made has taken away the risk of engaging in sexual conduct hence pregnancy and delivery. It is for the same reason that cases have also taken into account the desire of the carers to let the patient live a more independent life.[133] The irony of the situation was acknowledged by Johnson J in *Re S (medical treatment: adult sterilisation)*.[134] If a person is cared for and supervised by caring and responsible parents then the wish of the parents to have their child sterilised will be overridden, while a similar application, made by careless and irresponsible parents, would be granted.

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[129] See footnote 15 above
[130] See footnote 70 above
[131] See footnote 122 above
[132] See footnote 27 above
[133] *Re Z (medical treatment: hysterectomy)* [2000] 1 FLR 523, [2000] Fam Law 321; *A National Health Trust* v *C (a patient by her friend the Official Solicitor)* (8 February 2000)
[134] See footnote 27above

The risk must either be current or be expected in the foreseeable future. In the case of *Re W (mental patient) (sterilisation)*,[135] although the risk of W becoming pregnant at the time the application was made was small, it was held that the future is relevant so long as it is foreseeable. The judge did not think that a decision should be deferred until it is possibly too late. However, the judge in *Re S (medical treatment: adult sterilisation)*[136] stressed that the risk must be identifiable rather than speculative. Thorpe J had also commented in *Re A (medical treatment: male sterilisation)*[137] the fact that the lower court concentrated too much on the evaluation of risks of happenings, some of which were hypothetical. He went on to say that a risk was no more than a possibility of loss and should have no more emphasis in the exercise than the evaluation of the possibility of gain.

Therefore, insofar as the risks and consequences of not undergoing sterilisation are concerned, foreseeability appears to be the only important factor. The risks that can be used to justify the performance of sterilisation must be based on concrete proof of the danger the risks would pose to the mentally disordered person rather than mere speculation.

Availability of alternative method to avoid the risks and consequences of not carrying out sterilisation

Besides the distinction between therapeutic and non-therapeutic sterilisation, the case of *Re GF (medical treatment)*[138] had also added that there had to be no less intrusive means of treating the condition. The requirement of proving that there are no less

[135] See footnote 45 above
[136] See footnote 27 above
[137] See footnote 54 above
[138] See footnote 66 above

intrusive means than sterilisation is not unique to the case of *Re GF (medical treatment)*.[139] The case of *Re X (adult sterilisation)*[140] has also considered this factor an important part of the best interests test. The judge in *Re X (adult sterilisation)*[141] listed three relevant matters with regard to the best interest test, and the availability of reversible or less invasive alternative to sterilisation was one of them. Nevertheless, in that case, notwithstanding the availability of reversible alternative, the judge was of the view that the irreversible nature of sterilisation was immaterial since it was impossible to foresee a time when it could become in X's interests to conceive or bear a child.

The availability of alternative method to sterilisation was considered by almost all sterilisation cases studied in this thesis. Except for the case of *Re GF (medical treatment)*,[142] all such cases have considered this factor as part of the best interests test. Generally, sterilisation should not be ordered if less intrusive alternative method to avoid the same risks is available. This is in line with the concept that sterilisation should be considered a step of last resort, which means sterilisation should only be carried out when alternative and less invasive procedures have all failed.

However, there appears to be a difference between the English and the US cases in respect of the nature of the alternative methods considered. The English cases focused mainly on other conventional contraceptive methods such as the oral pills for birth control and the intra-uterine device. The earlier cases have focused on comparing oral contraceptives with sterilisation. Many cases found evidence to show that oral contraceptives were not suitable alternatives because it was impossible to ensure that the mentally disordered person would follow the regime, or because the oral contraceptives

[139] See footnote 66 above
[140] See footnote 68 above
[141] See footnote 68 above
[142] See footnote 66 above

would react with the other medication given for the purpose of treating other medical condition, such as epilepsy. In the case of *Re HG (specific issue order: sterilisation)*,[143] it was said that a see-saw or yo-yo effect would develop between oral contraceptives and the anti-epileptic drugs. The House of Lords in *Re B (a minor) (wardship: sterilisation)* [144] opined that the effectiveness of oral contraceptives is "entirely speculative". Later cases have also considered the intra-uterine device as an alternative to sterilisation. However, in cases such as *Re W (mental patient) (sterilisation)*,[145] *Re X (adult sterilisation)* [146] and *Re Z (medical treatment: hysterectomy)*, [147] intra-uterine device was ruled as an inappropriate alternative because of the risk of actinomyces infection, the risk of displacement, as well as the fact that three operations were needed to affix the device as opposed to one operation required for sterilisation. It was not until the Court of Appeal's decision in *In re S (adult patient: sterilisation)* [148] that intra-uterine device was regarded as a less invasive procedure that should be adopted first. If such measure fails, the applicants should then return to the court to seek a declaration in respect of a sterilisation surgery. The intra-uterine device is a more viable alternative to sterilisation because it can not only prevent pregnancy, but also reduce the amount of menstrual bleeding, and may therefore be suitable for cases where prevention of menstruation is one of the aims of sterilisation.

The US cases and legislation such as the California Probate Code also required the consideration of other contraceptive methods as possible alternative to sterilisation. In addition to that, they also saw supervision, education and training as forms of less

[143] See footnote 90 above
[144] See footnote 61 above
[145] See footnote 45 above
[146] See footnote 68 above
[147] See footnote 102 above
[148] See footnote 28 above

drastic contraception methods.[149] *Re Hayes*[150] saw much value in training retarded persons as it was thought that retarded persons were generally capable of learning and adhering to strict rules of social behaviour. Such approach is echoed by the Office of the Public Advocate in the state of Victoria in Australia, which requires documents to show that the following options have been tried on any mentally disordered person who is the subject of a proposed non-therapeutic sterilisation operation: -

- education about reproduction and health;
- training in protective behaviours;
- counselling for human relations;
- behaviour management (including menstrual management); and
- appropriate contraception methods of a less restrictive nature.

According to a report, a parenting group in Canada that provides free parenting program for persons with mild to moderate developmental disabilities has seen tremendous improvement in the parenting skills of such parents.[151]

It is therefore submitted that available alternatives to sterilisation should not be restricted to the conventional contraceptive methods but should be extended to supervision, training, education, counselling and behaviour management. Sterilisation should not be viewed as the easier option.[152] The role of supervision in removing the risk of pregnancy was already recognised in the English case of *Re LC (medical*

[149] See section 1958(e) of California Probate Code
[150] See footnote 76 above
[151] Rojas, Marcela, "Disabled taught parenting skills in Westchester Arc program", *The Journal News*, 25 January 2006, 2 February 2006 <http://www.thejournalnews.com/apps/pbcs.dll/article?AID=/20060125/NEWS02/601250315/1027/NEWS11>
[152] Freeman, M.D.A., "Sterilising the Mentally Handicapped", *Medicine, Ethics and the Law*, Ed., M.D.A. Freeman, (London: Stevens & Sons, 1988), at pages 69-70

treatment: sterilisation),[153] although it should be emphasised that supervision is not synonymous to isolation and segregation.

Physical risks of a sterilisation operation

Sterilisation should not be carried out if the risks and consequences of the operation outweigh the benefits the operation can bring. The risks a sterilisation operation pose to the physical health of a person have been outlined in Paragraph 2.1 of Chapter 2 of this thesis. According to the case of *Re S (medical treatment: adult sterilisation)*,[154] sterilisation carried a risk of fatality of 4 in 50,000 due to the general anaesthesia involved and there would be significant pain for a few hours after the operation. Nevertheless, the House of Lords in the case of *Re B (a minor) (wardship: sterilisation)*[155] considered sterilisation a simple and minor operation carrying a very small degree of risk. The case of *A National Health Trust* v *C (a patient by her friend the Official Solicitor)*[156] also considered sterilisation operation "a relatively minor one".

It should be remembered that the risk of sterilisation operation differs depending on the type of operation and the methods used to conduct the operation. For instance, in the US case of *Re Angela*,[157] it was stated that laparoscopic bilateral tubal ligation required general anaesthetic for approximately 30 minutes and would involve only tiny incisions. Although the physical risks of sterilisation operation should be considered when deciding whether or not the operation should be ordered, that does not mean that if the risks are relatively low then sterilisation should be ordered. Sterilisation is an invasive procedure, where risks are inevitable, and therefore utmost care should always be taken in ordering its performance.

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[153] See footnote 122 above
[154] See footnote 27 above
[155] See footnote 61 above
[156] See footnote 74 above
[157] See footnote 85 above

Emotional and psychological impact of a sterilisation procedure

The emotional and psychological impact of sterilisation was the focus of more discussion in sterilisation. *Re D (a minor) (wardship: sterilisation)*[158] foresaw the frustration and resentment that the patient would face if she realised what had been done to her. *Re F (mental patient: sterilisation)*[159] acknowledged that there were emotional considerations in a decision that concerns sterilisation. *Re Eve*[160] also considered the negative psychological impact of sterilisation. It has been highlighted in the report on sterilisation of the Law Reform Commission of Canada that "sterilised mentally retarded persons tend to perceive sterilisation as a symbol of reduced or degraded status"[161] and that sterilisation may reinforce existential anxieties. The sources of anxieties include low self-esteem, feelings of helplessness, need to avoid failure, loneliness, concern over body integrity and the threat of death.[162]

The findings of the Canadian report on this issue were quoted in *Re Eve*[163] as well in the *Marion's Case.*[164] Brennan J in his judgment in the *Marion's Case*[165] found it necessary to consider how sterilisation had disturbed the person's mind and how the operation has changed her self-perception. The US case of *Re Hayes*[166] also recognised that sterilisation could have long-lasting detrimental emotional effects on retarded person.

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[158] See footnote 70 above
[159] See footnote 15 above
[160] See footnote 1 above
[161] Law Reform Commission of Canada, *Sterilization – Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper 24), (Ottawa: Law Reform Commission of Canada, 1979), at page 50
[162] Roos, Philip, 'Psychological Impact of Sterilization on the Individual', *Law and Psychology Review*, 45(50), (1975), as quoted by Law Reform Commission of Canada, see footnote 161 above, at pages 50-51
[163] See footnote 1 above
[164] See footnote 4 above
[165] See footnote 4 above
[166] See footnote 76 above

Some cases have not considered the emotional consequences of sterilisation operation at all. One such instance is *Re X (adult sterilisation).*[167] It is submitted that the consequences of sterilisation could be particularly grave in that case because X had in fact indicated that she wanted to have babies. There is little doubt that she would be shattered upon realising that she could no longer have babies.

Risk of sexual assault after a sterilisation procedure

One other consequence of sterilisation was mentioned by *Re LC (medical treatment: sterilisation).*[168] One of the reasons sterilisation was applied for in that case was the fear that the girl would be sexually assaulted. Thorpe J indicated in that case that not only would sterilisation not remove the risk of sexual assault, it might in fact expose the girl to greater risk of sexual invasion as the potential perpetrator might feel less inhibited to perform the crime. There is also a possibility that the carers of the girl would become less concerned to protect the girl from sexual activity, hence exposing her to the risk of exploitation, sexually transmitted disease, or abuse.[169]

Reversibility of sterilisation

The irreversible nature of a sterilisation operation has been recognised by many cases, such as the Court of Appeal's decision in *Re F (mental patient: sterilisation)*[170] as well as the House of Lord's decision in the same case (where the prospects of reversing a tubal ligation operation was said to be substantially less than 50 per cent). The irreversible nature of a hysterectomy operation was considered a very serious factor in *In re S (adult patient: sterilisation)*[171] and *Re Eve*.[172]

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[167] See footnote 68 above
[168] See footnote 122 above
[169] Cica, Natasha, "Sterilising the Intellectual Disabled" (1993) 1 Med L Rev 186, at page 219
[170] Lord Donalson MR said that a sterilisation operation is irreversible and is of an emotive, sensitive and potentially controversial character.
[171] See footnote 27 above

The irreversibility of a sterilisation operation was used in *Re F (mental patient: sterilisation)*[173] to answer the question of why court should, as a matter of good practice, be involved in the decision to sterilise a mentally disordered adult. Arguably, the irreversibility of a sterilisation operation had also been used to justify the necessity to consider if there are available alternatives to sterilisation. The US case of *Re Hayes*[174] and the California Probate Code required proof that the current state of medical and scientific knowledge must not suggest that, *inter alia*, a reversible sterilisation procedure would be shortly available. However, as discussed in Paragraph 2.1 of Chapter 2, not all sterilisation procedures are irreversible. It would appear that if the proposed sterilisation itself is reversible, the California Probate Code would not be applicable.[175] Does that mean that a reversible sterilisation procedure is less of a sterilisation than a sterilisation operation that is irreversible? Is a reversible sterilisation operation necessarily less invasive than an irreversible sterilisation operation?

The case of *Re M (a minor) (wardship: sterilization)* and *Re P (a minor) (wardship: sterilization)* relied heavily on the existence of evidence which showed that the sterilisation operation was highly reversible. The operation proposed in both cases was tubal ligation. The former case relied on evidence which showed that 50 to 70 per cent of tubal ligation by the use of microsurgery could be successfully reversed. The latter case had evidence showing that clip sterilisation followed by subsequent micro-surgical anastomosis carried a 95 per cent chance of reversal, but the reversal operation was longer and involved larger surgical wound and longer stay in hospital. Nevertheless, the

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[172] See footnote 1 above
[173] See footnote 15 above
[174] See footnote 76 above
[175] It should however be noted that the US case of *Re Angela* (1999) 70 Cal App 4th 1410 applied the provisions in the California Probate Code despite the fact that the proposed operation in that case was tubal ligation, which is generally viewed as highly reversible. The court did not consider the reversibility of the operation.

judge in that case said that the fact that the operation was reversible meant that it is no longer a step of last resort. The emphasis the judge placed on the potential reversibility of the sterilisation has been described as "fallacious".[176]

The fact that an operation is reversible does not affect the magnitude of the operation and the risks involved in the operation. A reversible operation would cause as much psychological damage to the patient as a patient who underwent an irreversible operation. Any feeling of relief in knowing that the operation can be reversed would have been neutralised by the stress involved in undergoing another surgery, especially when an operation to reverse a sterilisation procedure is usually a more complex and serious surgery than the original sterilisation operation.[177] Further, the truth remains that more sterilisation operations are performed than the operations to reverse sterilisation. This could mean that the success rate of the reversal operation is likely to be smaller than the initial sterilisation procedure as it is less common.

It is therefore submitted that a reversible sterilisation operation is no less invasive than an irreversible sterilisation operation. As such, a reversible sterilisation method should never be considered a less intrusive alternative to an irreversible sterilisation operation. Irreversibility is generally irrelevant to the question except insofar as it affects the physical risks and consequences of the operation to the patient. In that connection, it should be reminded that using the irreversibility of an operation to consider the question of best interests is not the same as using the best interests test to dismiss the relevance of irreversibility. The latter was the approach adopted by *Re X (adult sterilisation)*[178]

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[176] Brazier, Margaret (2), "Sterilisation: Down the Slippery Slope?" (1990) 6 PN 25, at page 27
[177] See Eastham J's judgment in *Re P (a minor) (wardship: sterilization)* [1989] 1 FLR 182, [1989] Fam Law 102 and Brazier, Margaret (2), see footnote 176 above, at page 26
[178] See footnote 68 above

when it was held that since it was in X's best interests not to have children, the irreversible nature of the procedure was immaterial.

Conclusion

Most of the factors used by sterilisation cases for the purpose of determining best interests are in fact not sufficiently important for them to constitute an integral part of the best interests test. The best interests test remains at best an unstable test that can be applied in many different ways depending on the types of evidence adduced. As commented by the judge in *Re Eve*,[179] judges were generally ill-informed about the factors relevant to a wise decision in this difficult area, and however well presented a case might be, it could only partially inform. The best interests test was not sufficiently precise or workable in situations like this. Further, most of the factors considered are within the sole expertise of doctors. For instance, factors such as the risks related to pregnancy and childbirth, the risks in respect of abortion, the physical risks of operation and the reversibility of sterilisation are matters in which the expert opinions of doctors would have to be sought before any decision can be made. If they are all essential parts of the best interests test, then the best interests test will be akin to any other medical test, where only the doctors know best. Is the sterilisation of mentally disordered adults a medical problem or is it more of a social issue?

[179] See footnote 1 above

Chapter 6

Medicalisation of Social Problems

Chapter 5 examines the factors often considered in cases on sterilisation of mentally disordered persons, and most of the factors appear medical in nature. However, the decisions of the following two cases, namely *Re LC (medical treatment: sterilisation)*[1] and *Re S (medical treatment: adult sterilisation)*,[2] suggest that some of the "medical" factors are also social problems. In both cases, the judge refused to authorise sterilisation for the mentally disordered adults since both girls were receiving high level of care and supervision and they were protected from the risk of invasive sexual assault.

Re LC (medical treatment: sterilisation)[3] concerns L, a girl who was 21 years of age when the application was heard. L had severe learning difficulties and had an intellectual age of approximately three and a half years. L was indecently assaulted by a member of staff at a specialist residential home in 1990. She moved to another residential home in August 1992, which provided a higher level of supervision and care. However, L's mother was worried that L might be assaulted in the future and the assault might lead to conception. Thorpe J did not grant the order, because it was established that the present level of care and supervision L received was of such high quality that it would not be in L's best interests to impose upon her a surgical procedure which is not without risks and not without painful consequences.

Re S (medical treatment: adult sterilisation)[4] concerned S. S was 22 years old and her mental and emotional state was such that she was unable to look after herself. S's

[1] [1997] 2 FLR 258, [1997] Fam Law 604
[2] [1998] 1 FLR 944, [1998] Fam Law 325
[3] See footnote 1 above
[4] See footnote 2 above

parents were worried that at some time in the future, S might engage in sexual intercourse and become pregnant. Johnson J examined the situations in which S was away from her parents' supervision and concluded that the circumstances of S both now and in the foreseeable future were indistinguishable from those in *Re LC (medical treatment: sterilisation)*.[5] The judge therefore dismissed the application in the absence of any risk that can be called identifiable rather than speculative. In this regard, Johnson J emphasised that it is particularly important in this field of law that there should be identifiable consistency in the decisions that are made.

There could be a few "medical" justifications to sterilisation available in both cases above. For instance, the doctor who cared for L in *Re LC (Medical Treatment: Sterilisation)*[6] testified that there was no alternative to sterilisation procedure as the risks involved in the type of oral contraceptive most suitable for L were significantly greater than the risks involved in sterilisation procedure. However, the fact that both cases decided that the high level of care and supervision could reduce the risks to the extent of rendering sterilisation unnecessary shows that many problems can be solved using "social" rather than "medical" method.

It may be helpful to compare the above two cases with *Re HG (Specific Issue Order: Sterilisation)*[7] and *Re Z (medical treatment: hysterectomy)*[8] to see if the latter two cases could have been decided differently if the judges have considered the level of care the patients in these cases were receiving.

[5] See footnote 1 above
[6] See footnote 1 above
[7] 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403
[8] [2000] 1 FLR 523, [2000] Fam Law 321

The case of *Re HG (Specific Issue Order: Sterilisation)*[9] was about whether or not T should be sterilised. T was a girl who was just short of 18 when the matter went before the Family Division. She suffered from chromosomal deficiency. As a result, she was an infant in terms of her mental abilities. Those closest to T were worried about the risk of T being involved in sexual activity with hostile stranger and becoming pregnant. These caused much anxiety to T's carers. Further, it was suggested that T might become less heavily supervised in years to come. The judge concluded that sterilisation is in T's interest.

The courts were careful when considering the interest of the carers. Sterilisation for the purpose of alleviating the burden of the carers or the public had been tacitly disproved by *Re B (a minor) (wardship: sterilisation).*[10] Nevertheless, in the case of *Re HG (specific issue order: sterilisation),*[11] the judge took into account the "legitimate aspirations and anxieties of the parents and other carers" as part of what influences T's best interests. It was said that if anxiety could be removed from the carers of a child or young adult such as T, then there was an element at least in which that came into the equation as being in the interest of the child or young adult herself. It has been argued that although the interests of the patient have to be the predominant interests to be considered, other interests should also be taken into account. This is because individuals live as part of the society.[12]

The Family Division granted another declaration in relation to the sterilisation of a mentally disordered adult in *Re Z (medical treatment: hysterectomy).*[13] That case concerned Z. Z was a 19-year-old woman suffering from Down's syndrome. Her

[9] See footnote 7 above
[10] [1988] 1 AC 199, [1987] 2 All ER 206. See also Paragraph 4.2 of Chapter 4.
[11] See footnote 7 above
[12] Brazier, Margaret, *Medicine, Patients and the Law,* (London: Penguin, 1992), at page 109
[13] See footnote 8 above

mother was of the view that Z should undergo hysterectomy because firstly, Z's menstrual periods caused significant distress and disturbance to Z, and secondly, pregnancy would result in substantial trauma and psychological damage to her. The proposed hysterectomy operation was laparoscopic subtotal hysterectomy. Such procedure is similar to laparoscopic hysterectomy except that the cervix and the Fallopian tubes are conserved.

Bennett J held that complete cessation of Z's periods was in her best interests as Z had great difficulty coping with her hygiene as a result of her periods and her periods served no useful purpose at all. The judge was further of the view that Z should be completely protected from pregnancy because she was fertile and sexually aware, and the trauma of pregnancy, child birth and the inevitable removal of her baby would be a catastrophe for her. The judge considered the evidence of two of the four experts who were of the views that Z should have Mirena intra-uterine device[14] fitted rather than having to undergo laparoscopic subtotal hysterectomy. The judge however found that there was a small risk that the Mirena may become displaced. Although the risk was small, the consequences of the risk, namely conception, were something that should be eliminated altogether in Z's case. The judge was of the view that the risks attached to a hysterectomy were not so significant, considering that it could dramatically improve Z's quality of life and give her total protection from pregnancy.

Like *Re LC (medical treatment: sterilisation)*[15] and *Re S (medical treatment: adult sterilisation),*[16] both *Re HG (Specific Issue Order: Sterilisation)*[17] and *Re Z (medical*

[14] The Mirena device has to be inserted under anaesthetic and must be replaced after five years. It is a very effective method of contraception. However, the Mirena may fall out of position and nobody will notice it. The Mirena is very likely to reduce the duration and amount of menstrual bleeding.
[15] See footnote 1 above
[16] See footnote 2 above
[17] See footnote 7 above

treatment: hysterectomy)[18] applied the best interests test. The factual circumstances of the latter cases are not dissimilar to that of the former two cases. The main difference lies in the fact that supervision was not highlighted as a means of mitigating the risk of pregnancy in the latter cases. The carers in the latter cases did indicate that the patients might become less heavily supervised in the future, hence indirectly acknowledging supervision as an effective means of minimising the risks. It was also mentioned in *Re Z (medical treatment: hysterectomy)*[19] that Z had difficulty coping with her hygiene as a result of her menstruation. However, the judge did not consider the possibility of getting professional help to train Z on menstrual hygiene. It is clear from these two cases that the problems aimed to be solved through sterilisation are problems that can be effectively dealt with by the society. Had the judges considered the amount of supervision the patients in those cases were receiving, they could have come to the same conclusion as the judges in *Re LC (medical treatment: sterilisation)*[20] and *Re S (medical treatment: adult sterilisation).*[21] Medical procedures should be used to address medical issues rather than social problems, especially when the procedure is a sterilisation operation that will have permanent impact on a person's body. Even if the society has yet to develop a way to resolve these problems without resorting to medical means, that should not mean that the society should stop working towards a system that can effectively protect the welfare of mentally disordered persons. Sterilisation in these cases is not more than a convenient way of getting out of a social dilemma. Through "medicalisation" of social problems, the cases have found a way out of the social dilemma as it is easier to make "medical" decisions than "social" decisions.

[18] See footnote 8 above
[19] See footnote 8 above
[20] See footnote 1 above
[21] See footnote 2 above

Re HG (Specific Issue Order: Sterilisation) [22] and *Re Z (medical treatment: hysterectomy)*[23] are not the only cases that "medicalise" social problems. Many other English cases rely on large amount of expert evidence from medical doctors to support the performance of sterilisation procedure. That is no different in the New Zealand case of *Re X*[24] decided by Hillyer J in the High Court of New Zealand. X was a girl 15 years of age. She had a mental age of about three months. X was severely handicapped and had no control over her bodily function. The parents of X applied to the court for an order consenting to X undergoing a hysterectomy operation. Hillyer J granted the order after considering several factors, such as the difficulty in telling when X was in pain; how X would most certainly suffer the pain of menstruation; how X would fail to cope with motherhood, pregnancy, labour, menstrual periods or the hygienic aspects involved; how X's menstruation would be an additional burden to her carers; the fact that X's sister was slightly handicapped; the other types of contraception not being able to prevent menstruation absolutely. The judge stressed that the proposed operation was an amenorrheoa operation, namely an operation for the purpose of preventing menstruation, rather than for the purpose of sterilisation and relied on the Canadian case of *Re K and Public Trustee.*[25] In arriving at his decision, the judge emphasised the high possibility of X suffering menstrual pain and held that it was unfair to expose X to the suffering. Although some medical evidence was against the operation being performed before the first menstrual period commenced, the judge said that there was no real point in waiting upon weighing the risk of exposing X to a painful and possibly traumatic periods against the remote possibility that the operation would not be necessary. Hillyer J is more willing to order sterilisation for the purpose of preventing menstruation than for contraceptive purpose.

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[22] See footnote 7 above
[23] See footnote 8 above
[24] [1991] 2 NZLR 365
[25] (1985) 19 DLR (4th) 255, 63 BCLR 145, [1985] 4 WWR 724. See also Paragraph 4.3 of Chapter 4.

The sterilisation order made in *Re X*[26] was for the purpose of protecting X from possibly traumatic periods. Even if we were to put aside the speculative nature of the risk given the fact that X had not begun her first menstruation period at that time, we cannot ignore the large amount of expert evidence from doctors relied upon by the judge in arriving at this decision. The problems are not entirely medical in nature. There is a possibility that X may be successfully trained to handle her periods.

The fact that the decision to sterilise was not merely a medical issue and there are social and psychological consequences to sterilisation was also acknowledged by the judges in the *Marion's Case*.[27] That was one of the reasons used in that case to justify mandatory court involvement. The judges said that the medical profession, like all professions, also had members who would act with impropriety. The judges also noted the fact that parents and other family members of the intellectually disabled person may have conflicting interests so there is a danger that the patient's interests may not be upheld if the decisions are left in the hands of the family members.

The inconsistent manner in which the courts in many jurisdictions have viewed the relevance of childcare also goes towards showing that sterilisation is very much a social matter. Although *Re B (a minor) (wardship: sterilisation)*[28] has impliedly disprove sterilisation on grounds of public policy and sterilisation for the convenience of carers, that same case used the inability of B to care for a child to deny B of her right to reproduce.[29] In the case of *Re X (adult sterilisation)*,[30] the judge considered the fact that

[26] See footnote 24 above
[27] *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B. ('Marion's Case')* (1992) 175 CLR 218, 66 ALJR 300. See also Paragraph 4.2 of Chapter 4.
[28] See footnote 10 above
[29] The House of Lords in that case said that the right of reproduction is irrelevant to B because of, *inter alia*, her inability to care for a child.

X could not bring up a child was relevant in ascertaining X's best interest, although it was also emphasised that that fact alone did not justify sterilisation.

The US cases such as *Re Hayes*[31] and *Re Grady*,[32] as well as legislation such as the California Probate Code have all considered the ability of the mentally disordered person to care for a child a relevant factor when considering if sterilisation should be authorised.

On the other hand, *Re Eve*[33] did not agree with the assumption that mentally disordered persons will not be fit parents. That judgment referred to the working paper of the Law Commission which referred to a study which showed that mentally incompetent parents showed as much fondness and concern for their children.[34] Most importantly, it was said that the difficulty faced by mentally disordered parents in coping with matters is a social problem and the problem is not limited to the mental incompetents.

Laws are made to solve social problems. There must therefore be a reason why the handling of sterilisation of mentally disordered persons has been particularly difficult. According to Brennan J in the *Marion's Case*,[35] the conundrum surrounding the issue of sterilisation is attributable to the lack of clear community consensus on the issue that the courts or the legislature can translate into law. Public opinion has shifted since the days when sterilisation was mandatory for mentally disordered person in countries like the

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[30] [1998] 2 FLR 1124, [1998] Fam Law 737. See also Paragraph 5.2.1 of Chapter 5.
[31] (1980) 608 P.2d 635. See also Paragraph 4.2 of Chapter 4.
[32] (1981) 426 A.2d 467. See also Paragraph 5.2.1 of Chapter 5.
[33] (1986) 31 DLR (4th) 1, [1986] 2 SCR 388. See more discussions on this case in Chapter 4.
[34] Law Reform Commission of Canada, *Sterilization – Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper 24), (Ottawa: Law Reform Commission of Canada, 1979), at page 33. However, it should be noted that the conclusion of the study referred to by the Working Paper was not that mentally handicapped persons could make good parents. Quite the contrary, the conclusion was that notwithstanding the fondness and concern for their children, the children still suffered from neglect and deprivation. The neglect stemmed from the inability to cope rather than from an unwillingness to provide the necessary care.
[35] See footnote 27 above

US and Canada. Today, there is little doubt that sterilisation on eugenic grounds is no longer acceptable.[36] Nevertheless, the history of sterilisation has not only kept all policy makers and judges in check, it has given rise to, arguably, the very cautious attitude demonstrated by the decision of cases such as *Re Eve*.[37]

However, sterilisations continued to be performed for other purposes. The popularity of the operation as a contraceptive among mentally healthy adults and the increasingly competitive way of life means that in most societies, there is little possibility of ever achieving a community consensus on the acceptability of sterilising mentally disordered adults. Indeed, the dissenting judges in *Re Hayes*[38] had indicated that sterilisation is too complex a public policy issue that only the legislature should decide.

Be that as it may, regardless of the forum for policy-making, it should be remembered that sterilisation is not just a medical problem and we must not pretend too great an objectivity when dealing with sterilisation. If medical intervention becomes the normal way of solving similar social problems, it would be no different from sterilisation on eugenic grounds, in that we let medicine do the job because the society does not want to take up the social responsibility of protecting and caring for the mentally disordered persons. In a way, that will amount to protecting the interests of the society rather than the interests of the patient, and thus run the danger of slipping back to the days where interests of the state prevailed.

[36] It should however be noted that Bush J in *Re M (a minor) (wardship: sterilization)* [1988] 2 FLR 497 appeared to have taken into account eugenics consideration when he said that there is a 50% chance that the Fragile X syndrome suffered by M would be passed to any child she might bear and that an abortion would have to be carried out if such disease is discovered in her foetus.
[37] See footnote 33 above
[38] See footnote 31 above

Chapter 7

The Inadequacies of Rights-Based Approach and the Best Interests Test

It is the aim of this chapter to show that the human rights argument and the best interests test have contributed to a development of law that does not always protect the interests of the individuals and why these principles should not be used as the guiding principles for lawmakers or decision makers insofar as sterilisation of mentally disordered adults is concerned.

7.1 The inherent instability of rights-based arguments

The protection of human rights may be regarded as the basis of the best interests test. Therefore, at least in theory, human rights should be able to satisfactorily safeguard the rights of the disordered adults even when the best interests test fails. However, that is not the case.

Many judgments in respect of the sterilisation of mentally disordered persons used the language of "fundamental rights" to support their decisions. At least seven forms of fundamental rights have been mentioned in these cases, namely: -

(1) Right of personal inviolability[1]

(2) Right to free procreative choice[2]

(3) Right to privacy, including the right to enjoy sexual relationship[3]

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[1] *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B. ('Marion's Case')* (1992) 175 CLR 218, 66 ALJR 300

[2] *Skinner* v *Oklahoma* (1942) 316 US 535; *Re Hayes* (1980) 608 P. 2d 635; *Re D (a minor) (wardship: sterilisation)* [1976] Fam. 185, [1976] 1 All ER 326; *Re F (mental patient: sterilisation)* [1990] 2 AC 1, [1989] 2 All ER 545; *Re Grady* (1979) 405 A. 2d 851; *Re Jane, Re Elizabeth* [1989] FLC 92-023, (1989) 13 Fam LR 47; *Vaughn* v *Ruoff* (2001) 253 F.3d 1124

[3] *Re Hayes* (1980) 608 P. 2d 635; *Re Grady* (1979) 405 A. 2d 851; *Re HG (specific issue order: sterilisation)* 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403; *Re X (adult sterilisation)* [1998] 2 FLR 1124, [1998] Fam Law 737

(4) Right to freedom of movement[4]

(5) Right to equality, especially in medical treatment[5]

(6) Right to protect family life[6]

(7) The protection of personal integrity and human dignity[7]

The first three rights have been used to either justify or deny the granting of a sterilisation order. The fourth and fifth items have only been used in the argument for the granting of sterilisation order and the remaining items are used for the refusal to grant such order.

Right to free procreative choice and its relationship with the right of personal inviolability

Right of free procreative choice is the right to choose whether or not to procreate. The right to procreate is sometimes referred to as the right to reproduce, while the right not to procreate is sometimes referred to as the right not to reproduce, or the right to contraception or sterilisation. The right to procreate can be found in Article 16 of the Universal Declaration of Human Rights[8] and Article 23 of the International Covenant on Civil and Political Rights,[9] where it was stated that men and women have the right to marry and to found a family.

Many cases stated that the right to procreate or reproduce is a fundamental right of human beings. For instance, *Skinner* v *Oklahoma* [10] considered marriage and

[4] *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206; *A National Health Trust* v *C (a patient by her friend the Official Solicitor)* (8 February 2000)
[5] *Re F (mental patient: sterilisation)* [1990] 2 AC 1, [1989] 2 All ER 545
[6] *Re a Teenager* [1989] FLC 92-006
[7] Brennan J's dissenting judgment in *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B. ('Marion's Case')* (1992) 175 CLR 218, 66 ALJR 300
[8] GA Res. 217 (III), UN GAOR, 3d Sess., Supp. (No. 13) at 71, UN Doc. A/810 (1948)
[9] Opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976)
[10] (1942) 316 US 535

procreation something that is fundamental to the very existence and survival of the human race. This view was shared by *Re Hayes*.[11] In England, Heilbron J in the case of *Re D (a minor) (wardship: sterilisation)*[12] said that sterilisation operation involves the deprivation of the right of a woman to reproduce. However, it should be remembered that Heilbron J made this statement when considering the jurisdictional issue of court's involvement rather than the question of best interests. In the case of *Re F (mental patient: sterilisation)*,[13] Lord Brandon had also used the fundamental right to reproduce to answer the question of why the court should, as a matter of good practice, be involved in the decision-making process. The right of procreation has also been used by critics to denounce the practice of compulsory sterilisation. It was said that the right to parenthood is a fundamental liberty and the right of procreation far outweighed the contribution of compulsory sterilisation to public welfare.[14]

Some cases, however, accepted the existence of the right to reproduce but dismissed it as something that has no value to the mentally disordered person in those cases. That was the case with *Re B (a minor) (wardship: sterilisation)*,[15] where it was said that the right to reproduce was of no value to B because B could not link intercourse to childbirth, could not understand pregnancy and delivery, could not form maternal instincts and could not care for a child. It has been suggested that unlike *Re D (a minor) (wardship: sterilisation)*[16] and *Re Eve*,[17] where there was an objective recognition of the right to reproduce, *Re B (a minor) (wardship: sterilisation)*[18] required subjective

[11] (1980) 608 P. 2d 635. See also Paragraph 4.2 of Chapter 4.
[12] [1976] Fam. 185, [1976] 1 All ER 326. See also Paragraph 4.1 of Chapter 4.
[13] [1990] 2 AC 1, [1989] 2 All ER 545. See also Paragraph 5.1.2 of Chapter 5.
[14] Mimi Kamariah, "Rights of Mentally Retarded Persons In Domestic Relations" [1980] 7 JMCL 201, at page 209
[15] [1988] 1 AC 199, [1987] 2 All ER 206. See also Paragraph 4.2 of Chapter 4.
[16] See footnote 12 above
[17] (1986) 31 DLR (4th) 1, [1986] 2 SCR 388. See more discussions on this case in Chapter 4.
[18] See footnote 15 above

knowledge of and appreciation of its existence.[19] The position of *Re B (a minor) (wardship: sterilisation)* [20] was followed by *Re S (medical treatment: adult sterilisation)*,[21] where it was said that the right to reproduce was of value only if it was accompanied by the ability to make a choice.

The issue of choice between the right to procreate and the right not to procreate was considered in *Re Grady*.[22] That case recognised that the right to procreate is a fundamental right, but at the same time acknowledged that an individual also had the right to sterilise oneself. It was said that the right to procreate and right to sterilise oneself are conflicting and as such the court had to make a choice in the event a mentally disordered person could not do so. The same deduction came to the opposite conclusion in the Canadian case of *Re Eve.*[23] The Canadian court said that the choice between two alleged constitutional rights, namely right to procreate and the right not to procreate, was one the courts could not safely exercise. The right to choose whether or not to reproduce also features in the Australian case of *Re Jane.*[24] In the US case of *Vaughn v Ruoff*,[25] it was stated that a personal decision relating to procreation or contraception is a protected liberty interest and all persons, including the mentally handicapped, have this liberty interest.

Once the focus is shifted to the question of choice, the issue turns into one of right to choose. The right to choose is essentially an integral part of the right to personal inviolability or the right to bodily integrity. It would therefore appear that there is no such right to free procreative choice that is independent of the right to personal

[19] Davies, Michael, *Textbook on Medical Law*, 2nd ed., (London: Blackstone Press, 1998), at page 301
[20] See footnote 15 above
[21] [1998] 1 FLR 944, [1998] Fam Law 325. See also Chapter 6.
[22] (1981) 426 A.2d 467
[23] See footnote 17 above
[24] [1989] FLC 92-023, (1989) 13 Fam LR 47
[25] (2001) 253 F.3d 1124

inviolability. Indeed, it has been argued that English law does not recognise the right to reproduce. English law only recognises the right to choose whether or not to reproduce and that was premised upon the principle of autonomy.[26] That was the view shared by the majority of the judges in the *Marion's Case*,[27] where the judges expressly doubted the existence in the common law a fundamental right to reproduce which was independent of the right to personal inviolability. The question posed by the judges was: if there is an absolute right to reproduce, is there a duty to bear children?[28] The judges went on to say that if the "right to reproduce" simply comprises a right not to be prevented from being biologically capable of reproducing, then that is a right to bodily integrity. The concept of the right to reproduce has also been questioned on the ground that the right to reproduce requires the co-operation of another person who is under no obligation to provide.[29] Further, absolute right to reproduce could also mean that everyone has the right of access to all means or technology of assisted reproduction such as surrogate motherhood by way of womb-leasing.[30]

Right to privacy and right to enjoy sexual relationship

The right to privacy was mentioned in two US cases, namely *Re Hayes*[31] and *Re Grady*.[32] Both cases shared the view that sterilisation touches upon the "right to privacy" of a person. The concept of right to privacy in the US is developed through

[26] Grubb, Andrew and David Pearl, "Sterilisation and the Courts" [1987] C.L.J. 439, at page 448
[27] *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B. ('Marion's Case')* (1992) 175 CLR 218, 66 ALJR 300. See also Paragraph 4.2 of Chapter 4.
[28] See also Brazier, Margaret, *Medicine, Patients and the Law,* (London: Penguin, 1992), at page 392
[29] Mason, J.K. and R.A. McCall Smith, *Law and Medical Ethics*, 5th ed., (London, Edinburgh, Dublin: Butterworths, 1999), at page 100
[30] See Mason, J.K. and R.A. McCall Smith, footnote 29 above and Robertson, John A., "Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth" (1983) 69 *Virginia Law Review* 405, at page 420 *et seq*.
[31] See footnote 11 above
[32] See footnote 22 above

case law and has been ruled as a constitutional right.[33] The term has been used to refer to the protection of the right to marital privacy, sexual privacy, abortion, etc.[34]

That is not to say that the right to privacy is a uniquely US concept. Article 12 of the Universal Declaration of Human Rights[35] and Article 17 of the International Covenant on Civil and Political Rights[36] protect a person from arbitrary interference with his privacy. Article 8 of the European Convention on Human Rights[37] also required member states to respect private life. Although the right to privacy in the US is traditionally used to protect a person from interference, the English cases of *Re HG (specific issue order: sterilisation)*[38] and *Re X (adult sterilisation)*[39] used the right to enjoy the pleasure of sexual relationship to support the decision to authorise the performance of sterilisation on a mentally disordered child. This is because in the absence of sterilisation, the prospect of pregnancy would require her carers to ensure that she does not engage in any sexual relationship. However, it should be reminded that there are risks associated with sexual activity, such as the risk of sexually transmitted disease and the risk of sexual exploitation.[40]

Right to freedom of movement and right to equal medical treatment

Two rights, namely the right to freedom of movement and the right to equal medical treatment, have been used to justify the order for sterilisation. The right to freedom of movement is guaranteed by Article 12 of the International Covenant on Civil and

[33] *Griswold* v *Connecticut* (1965) 381 U.S. 479
[34] See cases such as *Eisentadt* v *Baird* (1972) 405 U.S. 438; *Roe* v *Wade* (1973) 410 U.S. 113; *Lawrence* v *Texas* (2003) 539 US 558
[35] See footnote 8 above
[36] See footnote 9 above
[37] *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, CETS No.: 005 (entered into force 3 September 1953)
[38] 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403. See also Chapter 6.
[39] [1998] 2 FLR 1124, [1998] Fam Law 737. See also Paragraph 5.2.1 of Chapter 5.
[40] Cica, Natasha, "Sterilising the Intellectual Disabled" (1993) 1 Med L Rev 186, at page 218

Political Rights.[41] The right to equality is safeguarded by Article 2 of the Universal Declaration of Human Rights,[42] Article 1 of the Declaration of the Rights of the Mentally Retarded Persons[43] and Article 3 of the Declaration on the Rights of Disabled Persons.[44] Article 1 of the Declaration of the Rights of the Mentally Retarded Persons[45] provides that "mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings". Article 3 of the Declaration on the Rights of Disabled Persons[46] said that disabled persons have the same fundamental rights as their fellow citizens of the same age.[47]

Both the Declaration of the Rights of the Mentally Retarded Persons[48] and the Declaration on the Rights of Disabled Persons[49] also provided that mentally retarded persons and disabled persons have the right to medical treatment.[50]

The English case of *Re B (a minor) (wardship: sterilisation)*[51] placed much emphasis on the need to allow B the freedom of movement and such need was used to support a decision to sterilise since it was likely that B would be permitted to move about more freely under less supervision. Although that same case was of the view that the right to

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[41] See footnote 9 above
[42] See footnote 8 above
[43] GA Res. 2856 (XXVI), 26 UN GAOR Supp. (No. 29) at 93, UN Doc. A/8429 (1971)
[44] GA Res. 3447 (XXX), 30 UN GAOR Supp. (No. 34) at 88, UN Doc. A/10034 (1975)
[45] See footnote 43 above
[46] See footnote 44 above
[47] The Declaration on the Rights of Disabled Persons, see footnote 44 above, appears to apply to mentally disordered persons as well because Article 1 defines "disabled person" to mean "any person unable to ensure by himself or herself wholly or partly the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not, in his or her physical or *mental capabilities*." [emphasis added]
[48] See footnote 43 above
[49] See footnote 44 above
[50] Article 2 of the Declaration on the Rights of Mentally Retarded Persons, see footnote 43 above, provides that "mentally retarded person has a right to proper medical care and physical therapy". Article 6 of the Declaration on the Rights of Disabled Persons, see footnote 44 above, provides that "[d]isabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthetic appliances, to medical and social rehabilitation, aid, counselling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the process of their social integration or reintegration."
[51] See footnote 15 above

reproduce had no value to B, the freedom of movement appeared to be of value to B. Although the rights language was not used, it was mentioned several times in the judgment of *A National Health Trust* v *C (a patient by her friend the Official Solicitor)*[52] the desire to make the mentally disordered person in that case more independent, with less supervision.

Section 1(6) of the Mental Capacity Act 2005 (UK)[53] also took into account the right of freedom of movement when it stated that regard must be had to whether the purpose for which an act is needed can be effectively achieved in a way that is less restrictive of the person's freedom of action.

It would appear that the right to freedom of movement has also been the underlying basis of a provision in the California Probate Code.[54] In relation to the available alternatives to sterilisation, it was specified in the California Probate Code that supervision is a form of less invasive contraceptive method, but "isolation and segregation shall not be considered as less invasive means of contraception".[55] There is therefore a difference between supervision and isolation or segregation. Unlike the latter, it is unlikely that the former would infringe the right to freedom of movement.

The right to equal medical treatment has been used in the case of *Re F (mental patient: sterilisation)*[56] to justify sterilisation. The House of Lords in that case emphasised that mentally disordered person must not be deprived of the medical care available to mentally healthy person. Since mentally healthy adults are entitled to sterilise themselves, mentally disordered person should also be entitled to such right.

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[52] Unreported case on 8 February 2000. See also Paragraph 5.2.1 of Chapter 5.
[53] c. 9
[54] See section 1958(e) and Paragraph 5.2.1 of Chapter 5.
[55] See footnote 54 above
[56] See footnote 13 above

Right to protect family life

The right to protect family life can be found in Article 12 of the Universal Declaration of Human Rights[57] and Article 17 of the International Covenant on Civil and Political Rights,[58] which provide that no one shall be subjected to arbitrary interference with his family. The right to protect family life was used in the Australian case of *Re a Teenager*[59] to hold that parents should be the ones to decide whether or not sterilisation should be carried out on their children. It was held that in the intimate environment of family life, parents are given the unique opportunity to become aware of the special needs of their child. The court has no special expertise as against such experience and proximity.

However, in the case of *Re S (medical treatment: adult sterilisation)*,[60] the right to protect family life under Article 8 of the European Convention on Human Rights[61] was acknowledged but it was held that the concept had no application in that case because sterilisation in that case was not for the purpose of curing any medical malaise but for less tangible social reasons.

Personal integrity and human dignity

Article 5 of the Universal Declaration of Human Rights[62] and Article 7 of the International Covenant on Civil and Political Rights[63] provide that no one shall be subjected to cruel, inhuman or degrading punishment. Article 3 of the Declaration on

[57] See footnote 8 above
[58] See footnote 9 above
[59] [1989] FLC 92-006
[60] See footnote 21 above
[61] See footnote 37 above
[62] See footnote 8 above
[63] See footnote 9 above

the Rights of Disabled Persons[64] also provides that disabled persons have "the inherent right to respect for their human dignity".

Brennan J in the *Marion's Case*[65] considered involuntary sterilisation a serious invasion of personal integrity and a grave impairment of human dignity. As such, there had to be a compelling justification before sterilisation of an intellectually disabled person could be carried out.

Conclusion

The rights-based approach towards the question of sterilisation is problematic. The first problem is the one illustrated by the *Marion's Case*,[66] where the right to procreate or not to procreate is no different from the right of personal inviolability. Perhaps the right to procreate has been emphasised in an attempt to correct the mistakes of the past, resulting in a conservative approach that is not necessarily serving the interests of the weak.[67]

Further, it seems that there are always possibilities of using one type of right to cancel out the effect of another right. For instance, the right to reproduce can concede to the right to freedom of movement. The right to freedom of movement can in turn be dismissed by the right to respect private life.

More importantly, the way sterilisation cases had used fundamental rights to justify their decisions showed that most of the concepts are too fluid and imprecise. If

[64] See footnote 44 above
[65] See footnote 27 above
[66] See footnote 27 above
[67] Reilly, P.R., "Eugenic Sterilization in the United States", *Genetics and the Law III - National Symposium on Genetics and the Law*, Ed., Aubrey Milunsky and George J. Annas, (New York: Plenum Press, 1985), at page 243

protection of fundamental rights alone can be used to justify a decision on sterilisation, it would appear that the choice is abundant and one can find at least one human right concept for any type of decision. It is submitted that the rights-based approach does not promote certainty in law and is prone to misuse. Therefore, the concept of fundamental rights should not be used to justify any decision[68] unless the concept has been translated into sound legal principle with sufficient certainty in application. An example of legal principle derived from fundamental right is the law on consent for medical treatment, which is derived from the principle of personal inviolability. Brennan J's decision in the *Marion's Case*[69] is also an illustration of such transformation, where the conclusion that non-therapeutic involuntary sterilisation can never be authorised was derived from the need to protect personal integrity and human dignity.

7.2 The best interests test is not the best test

In most cases on sterilisation, the test for deciding whether or not sterilisation should be carried out is the best interests test, although it is rather impossible to work out from the case law of all these jurisdictions how exactly the test should be applied. The best interests test in relation to mentally disordered adults has been described as "profoundly, perhaps inevitably, vague"[70] and "indeterminate, speculative and value-laden".[71] This is perhaps because, as stated by Professor Ian Kennedy, the test is not really a test at all and is merely a conclusion of social policy.[72]

The main feature of the best interests test is that it has to be applied for the best interests of the patient himself or herself and not any other person. That appears to be the only

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[68] See Thomas, Ann, "For Her Own Good – A Reply" (1987) 84 *The Law Society's Gazette* 1196
[69] See footnote 27 above
[70] Davies, Michael, see footnote 19 above, at page 153
[71] Freeman, M.D.A., "Sterilising the Mentally Handicapped", *Medicine, Ethics and the Law*, Ed., M.D.A. Freeman, (London: Stevens & Sons, 1988), at page 67
[72] Kennedy, Ian, "Patients, doctors and human rights", *Human Rights for the 1990s*, Ed., Robert Blackburn and John Taylor, (London and New York: Mansell, 1991), at pages 90-91

feature of the test, as the word "best" is devoid of precise meaning and totally dependent on the circumstances. The test appears to allow decision-makers to merely state their conclusions.[73]

Brennan J, in his dissenting judgment for the *Marion's Case*,[74] said that the best interests approach offered no hierarchy of values which might guide the exercise of a discretionary power to authorise sterilisation and contain no general legal principle which might direct the difficult decisions to be made in this area. Brennan J however recognised that the law should not pretend too great a precision since this was a field where the law had not developed, where ethical principles remained controversial and where each case turned on its facts. Nevertheless, in the absence of legal rules or any hierarchy of values or guidelines, the best interests approach would depend upon the value system of the decision maker and create an "unexaminable discretion in the repository of power". Brennan J agreed with the views of Professor Ian Kennedy that –

> "…by transforming a complex moral and social question into a question of fact, the best interests approach leaves the court in the hands of experts who assemble a dossier of fact and opinion on matters which they deem relevant without reference to any check-list of legal requirements."[75]

Despite the lack of clear legal principles and hierarchy of values, most cases on sterilisation have used the best interests test to justify their decision. Some of these cases have decided the answer based on facts alone, some have left the decision to the doctors. However, more cases have attempted to develop a guideline by listing the factors that are relevant to the test.

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[73] Cica, Natasha, see footnote 40 above, at page 214
[74] See footnote 27 above
[75] Kennedy, Ian, see footnote 72 above

Carers' interest

Cases have differed on whether or not the interest of third parties, such as the carers of the mentally disordered person, is relevant to the best interests test. Cases frequently stress the need to ensure that it is the best interests of the patient rather than other persons. According to the *Marion's Case*,[76] in the event of conflict of interests between the interests of other family members and the patient's welfare, the court has to ensure that the patient's interests prevail. However, at least four cases on sterilisation have expressly considered third party interests as relevant to the best interests test. The first of such cases is *Re W (mental patient) (sterilisation)*,[77] which suggested that the worry of W's mother, who was also the carer, was relevant since if worry affected the mother, it was likely to affect her care of W. Another such case is *Re HG (specific issue order: sterilisation)*,[78] which held that the legitimate aspirations and anxieties of the parents and other carers influenced the best interests of the patient. The case of *A National Health Trust* v *C (a patient by her friend the Official Solicitor)*[79] also considered third party interests as relevant because it was said that the anxiety of the family could lead to a more restrained life than would otherwise be in the patient's best interests. The New Zealand case of *Re X*[80] considered carers' interest from the angle of quality of life. It was suggested in that case that the additional burden menstruation would bring, and the fact that there was another mentally handicapped child in that home as factors contributing to the reduced quality of life that could be given to X if time had to be spent on X. The Court of Appeal in *Re A (medical treatment: male sterilisation)*,[81] on

[76] See footnote 27 above
[77] [1993] 1 FLR 381, [1993] Fam Law 208. See also Paragraph 5.1.2 of Chapter 5.
[78] See footnote 38 above
[79] See footnote 52 above
[80] [1991] 2 NZLR 365. See also Chapter 6.
[81] [2000] 1 FLR 549. See also Paragraph 5.1.2 of Chapter 5.

the other hand, left open the question of whether third party interests should ever be considered in a case concerned with the best interests of a patient.

The four cases above introduced carers' interests into the equation of the best interests test by saying that these interests affect the patients themselves too. However, by recognising that a person's anxiety could lead to more restrained life, the court appeared to have approved and accepted the reasonableness of such reaction of the carers. It is submitted that more care should be exercised before any third party interest is allowed to be part of the best interests test. The general rule should be that the interest of any third party is never a part of the best interests test unless in the most exceptional circumstances, where the third party's interest directly affects the interest of the patient and that the third party is in no position to improve the circumstances.

Factors which have been taken into account

The factors which have been taken into account in ascertaining best interest can be broadly divided into the following three categories: -

(a) the risk and consequences of not carrying out the sterilisation;

(b) the risk and consequences of carrying out the sterilisation; and

(c) the availability of less intrusive alternative to sterilisation.

The factors that fall into the first category include matters such as the risks of pregnancy and giving birth, the risk of abortion and the emotional consequences if the child were to be sent for adoption. These risks must be foreseeable, and therefore factors such as the likelihood of the patient engaging in sexual activity, the fertility of the patient and the level of supervision the patient is receiving are all relevant.

The risks and consequences of carrying out the sterilisation refer to factors such as the duration of hospital stay and the pain and discomfort of the operation, the risk of the operation and the psychological damage of the operation.

The last category of factors relate to the availability of less intrusive alternative to sterilisation. This category is closely related to the first category, in that the alternative must be capable of avoiding the same risks sterilisation is targeting. This category of factors is significant for the purpose of showing that sterilisation is a step of last resort.[82]

Decisions based entirely on facts

There are cases that have decided the question of best interests based on facts alone. This is a problematic approach since facts do not suggest what ought to be done.[83] Further, the decision arrived at from the use of such approach would depend almost entirely on the types of information that are compiled by "experts" beforehand, in a manner that reflects their view.[84] Some other cases have decided the same question based on only three or fewer factors. These cases can be further divided into two groups, that is those cases where the three or fewer factors appeared to have caused a sterilisation operation to be ordered, and those where the inability to satisfy one factor was used to refuse a sterilisation procedure. It is submitted that the approach of the former group is not to be preferred. This is because it is not enough for some of the factors relevant to best interests be proven. All the factors must be proven, and the failure to prove the existence of even one factor is sufficient to negate "best".

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[82] See the majority judgment in the *Marion's Case*, see footnote 27 above.
[83] Kennedy & Grubb, *Medical Law*, 3rd ed., (London, Edinburgh, Dublin: Butterworths, 2000), at page 1166
[84] Kennedy, Ian, see footnote 72 above

That is not to say that all factors must be proven beyond a shadow of a doubt. The US case of *Re Angela*[85] suggested an approach called the "error cost analysis", where the potential harms that may occur during and following pregnancy are viewed in light of the probability that these harms will be realised. According to the error cost analysis, a court should select the option that subjects the least expected harm in the event the court's decision is incorrect. The analysis involves comparing the expected harms suffered by the individual in the event the court errs in its decision. In determining the expected harms, courts must consider not only the amount of harm that would be suffered but also the probability that such harm will be realised.[86] In the case of *Re Angela*,[87] the court had trouble finding clear and convincing evidence to show that Angela was likely to engage in sexual activity. However, the court applied the error cost analysis and held that since pregnancy would potentially bring about great harm to Angela and her foetus, the required showing of likelihood that Angela would engage in sexual activity is proportionately smaller.

Some of the cases have considered the fundamental rights or liberties of the patient when considering the best interests formula. For instance, the judge in *Re B (a minor) (wardship: sterilisation)*[88] considered it important that B should have more freedom of movement. The Canadian case of *Re Eve*[89] used the basic right of procreation to conclude that non-therapeutic sterilisation could never be in the best interests of the patient. The emphasis of the US case of *Re Hayes*[90] was on the right of privacy, which is a right safeguarded by the US Constitution. Nevertheless, it is uncertain if fundamental rights should be used as a factor to weigh alongside the other factors such

[85] (1999) 70 Cal App 4th 1410. See also Paragraph 5.2.1 of Chapter 5.
[86] Cleveland, "Sterilisation of the Mentally Disabled: Applying the Error Cost Analysis to the Best Interest Inequity" (1997) 86 Geo LJ 137, at page 145-146
[87] See footnote 85 above
[88] See footnote 15 above
[89] See footnote 17 above
[90] See footnote 11 above

as the risks and consequences of performing or not performing sterilisation, since the values on either side are not comparable.[91]

The later English cases on sterilisation have shifted the attention to choosing between the sterilisation and the various alternatives to sterilisation.[92] One of such cases is *In re S (adult patient: sterilisation)*.[93] In that case, the judge at the lower court held that both sterilisation and the alternative were lawful and left the decision on which of the two methods should be adopted to the mother of the girl and the doctors. The Court of Appeal allowed the appeal and held that a judge deciding the best interests of the patient had to make a choice between the available options and pick only the best.

A few other English cases found it necessary to introduce other principles in addition to the best interests test, such as the distinction of therapeutic and non-therapeutic and the fact that there had to be no less intrusive means of treating the condition. The requirement of proving that there are no less intrusive means than sterilisation is also considered an important component of the best interests test in the *Marion's Case*[94] and the two US cases of *Re Hayes*[95] and *Re Grady*.[96]

One of the most marked differences between the approaches of many English cases and the cases of other jurisdictions is that the English cases often determine the question of best interests purely on facts, providing hardly any guideline that future decision-makers can rely on, such as in the case of *Re B (a minor) (wardship: sterilisation)*.[97] On

[91] See Brennan J's judgment in the *Marion's Case*, see footnote 27 above. See also Paragraph 7.1 of the present Chapter.
[92] *Re Z (medical treatment: hysterectomy)* [2000] 1 FLR 523, [2000] Fam Law 321; *In re S (adult patient: sterilisation)* [2001] Fam 15
[93] [2001] Fam 15. See also Paragraph 5.1.2 of Chapter 5.
[94] See footnote 27 above
[95] See footnote 11 above
[96] See footnote 22 above
[97] See footnote 15 above

the other hand, there are cases such as the Canadian case of *Re Eve*[98] and Brennan J's dissenting judgment in the *Marion's Case*[99] where instead of relying solely on the best interests test, they appeared to have applied the best interests test to arrive at the principle that sterilisation for non-therapeutic purposes could never be carried out in the absence of the consent of the patient.

It has been suggested that the major difference between the English case of *Re B (a minor) (wardship: sterilisation)*[100] and the Canadian case of *Re Eve*[101] is that the former attempts to generalise on principles, while the latter is determined to particularise on the facts.[102] Ironically, while the Canadian academic writing has criticised the decision of *Re Eve* [103] as discriminatory, [104] in England the case has generally been viewed favourably in comparison with the "sterile logic of the House of Lords" in *Re B (a minor) (wardship: sterilisation).*[105]

Most cases, however, lie somewhere in between the two cases. One common characteristic shared by all these other cases is that they all attempted to consider the factors that were thought to be relevant to the best interests test. The difference between them, however, lies at the manner in which the different factors were considered. There are cases like *Re F (mental patient: sterilisation)*[106] that placed the decision in the hands of doctors, an approach followed subsequently by *Re W (mental patient)*

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[98] See footnote 17 above
[99] See footnote 27 above
[100] See footnote 15 above
[101] See footnote 17 above
[102] Mason, J.K. and R.A. McCall Smith, *Law and Medical Ethics*, 5th ed., (London, Edinburgh, Dublin: Butterworths, 1999), at page 100
[103] See footnote 17 above
[104] Robertson, Gerald, "Sterilization, Mental Disability, and re Eve: Affirmative Discrimination?", *Discrimination in the Law and the Administration of Justice*, Ed., WS Tarnopolsky et al., (Montreal: Les Editions Themis, Inc, 1993), at pages 452-453
[105] See footnote 15 above and Bainham, Andrew, "Handicapped Girls and Judicial Parents" (1987) 103 *The Law Quarterly Review* 334, at page 339
[106] See footnote 13 above

(sterilisation);[107] there are also cases which appeared to suggest that the best interests of the patient can be decided by looking at only three or fewer factors.[108] The Canadian case of *Re K and Public Trustee*[109] can be categorised alongside those English cases that have used very few factors to determine best interests, as the best interests test in that case was satisfied due mainly to the "therapeutic" nature of the operation.[110]

Besides England and Canada, the other jurisdictions have generally recognised that many factors are relevant to the best interests test. The majority of the judges in the Australian case of *Marion's*[111] recognised the need to develop guidelines so as to give further content to the best interests test. The New Zealand case of *Re X*[112] listed 17 factors for the purpose of assisting doctors in determining whether or not sterilisation operation should be carried out on mentally handicapped child, but it was the eight to nine factors listed by the US cases of *Re Hayes*[113] and *Re Grady*[114] that have found its way into the judgment of the Australian cases such as *Re Jane* and *P* v *P*.[115]

It is now clear that best interests encompass medical, social, emotional, ethical and all other welfare issues and are not limited to best medical interests.[116] However, it is also clear that the best interests test is not the best test judging from the large array of ways cases on sterilisation have used the test and the widely differing views on its desirability. Although many cases have recognised that all factors should be taken into account, it is rather impossible to satisfy oneself that all factors have indeed been considered. Further,

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[107] See footnote 77 above
[108] See page 119 above
[109] (1985) 19 DLR (4th) 255, 63 BCLR 145, [1985] 4 WWR 724. See also Paragraph 4.3 of Chapter 4.
[110] The girl in *Re K and Public Trustee*, see footnote 109 above, was said to have phobic aversion to blood.
[111] See footnote 27 above
[112] See footnote 80 above
[113] See footnote 11 above
[114] See footnote 22 above
[115] (1994) 19 Fam LR 1, (1994) 120 ALR 545
[116] *Re MB (medical treatment)* [1997] 2 FLR 426; *Re A (medical treatment: male sterilisation)* [2000] 1 FLR 549; *In re S (adult patient: sterilisation)* [2001] Fam 15

the more the factors are considered, the harder it is to determine how one should weigh the conflicting factors and interests when the weight and values of the factors are often not comparable. Most importantly, as shown in Chapters 5 and 6, the propensity of the best interests test to slip into a test that eventually protects the interests of doctors, carers and even the state makes one wonder how a "test" can fail to uphold its only feature, namely to protect the patient.

Therefore, it is submitted that the best interests test is similar to the human rights approach in that it should not be used, in isolation, to guide any decision on sterilisation, unless it comes in a form a solid legal principles that can offer sufficient certainty to decision makers. An example of a legal principle derived from the best interests test is the principle that non-therapeutic sterilisation can never be authorised in the absence of the patient's consent. Such principle is built on the premise that non-therapeutic sterilisation is not necessarily in a person's best interests. It allows one to decide whether or not sterilisation should be granted based on whether or not the operation is therapeutic in nature. Although the definitions of "therapeutic" and "non-therapeutic" are not without ambiguities, it is a more stable test as it keeps the power of the decision makers in check and reduces the risk of wrong decision due to incomplete consideration of facts.

7.3 Substituted judgment test

It is perhaps apt to also consider the "substituted judgment test" as it has been argued that the states in the US have used the substituted judgment test rather than the best interests test in determining whether or not sterilisation should be applied. According to La Forest J in the Canadian case of *Re Eve*,[117] five out of the nine states in the US that

[117] See footnote 17 above

have equitable jurisdiction to authorise non-consensual sterilisation exercise such power on the basis of the best interests test,[118] while the remaining states apply the substituted judgment test. According to *Re Eve*,[119] an example of that can be found in the decision of the Supreme Court of New Jersey in *Re Grady*.[120]

Substituted judgment test is generally understood as a test to determine what decision the mentally disordered person would make if she is reviewing her situation as a person competent to make decision. The main difference between the substituted judgment test and the best interests test lies at the fact that the former attempts to determine the actual interests and preferences of the mentally disordered person by allowing the court to consider a number of factors bearing directly upon the condition of the mentally disordered person, such as the values of the person, any religious beliefs held by the person, and her societal views as expressed by her family. This approach premised on the basis of protecting a person's moral dignity and right to free choice.

La Forest J in *Re Eve*[121] rejected the substituted judgment test and called it a "fiction", since what the mentally disordered person would do if she or he could make the choice was a matter of speculation. The test was also rejected by the *Marion's Case*.[122] In that case, it was said that semantically, the concept of a substituted consent is a legerdemain. The concept represented the very antithesis of consent for instead of protecting the dignity of the person, it authorises the administration of medical treatment to such person irrespective of consent.

[118] The five states are Alaska, Indiana, New Hampshire, Pennsylvania and Wisconsin.
[119] See footnote 17 above
[120] See footnote 22 above
[121] See footnote 17 above
[122] See footnote 27 above

Besides the rejection by the Canadian and Australian cases, the English cases also do not appear to favour the substituted judgment test. The case of *Airedale NHS Trust* v *Bland*[123] considered the substituted judgment test, at least in relation to a patient who had never been capable of expressing preferences, a fictitious construct. Paragraph 28 of the Explanatory Note to the Mental Capacity Act 2005 (UK)[124] expressly stated that the test is best interests and best interests test is not a test of substituted judgment. According to the Explanatory Note, the difference between the best interests test and the substituted judgment test is that the former is an objective test while the latter is subjective. Notwithstanding that, section 4(6) of the Mental Capacity Act 2005 (UK)[125] itself expressly provides that the person making a determination of best interests must consider –

> "(a) the person's past and present wishes and feelings…,
>
> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
>
> (c) the other factors that he would be likely to consider if he were able to do so."

It is submitted that the distinction between the best interests test and the substituted judgment test is at best semantic. The US case of *Re Grady*[126] is as much a case on the application of the best interests test as any other English and Australian case, perhaps even more so. To suggest that the best interests test is an objective test fails to recognise that due to the lack of legal principles guiding the application of the test, there is not much objectivity in its application. Further, the fact that the substituted judgment test takes into account the values and beliefs of a person if he or she had been competent is not more subjective and speculative than the best interests test taking into account the

[123] [1993] 1 All ER 821
[124] See footnote 53 above
[125] See footnote 53 above
[126] See footnote 22 above

"possible" risks the mentally disordered person would face if sterilisation is not carried out. What matters is not the name of the test used to decide if a person should be sterilised, but the actual constituents of the test and the way the test is used to arrive at a decision. It has been suggested that subjective issues such as respect for dignity and religious culture should be considered as much as objective standards, and to do so is to extend the principle of autonomy to "its full logical expression".[127] In a society like Malaysia where family value features prominently in the daily life of her people, it is important to not overlook the cultural and religious values and beliefs of a person when deciding important question such as this.

[127] Davies, Michael, see footnote 19 above, at page 154

Chapter 8

Principle of Autonomy and the Dichotomy between Therapeutic and Non-Therapeutic Sterilisation

In the past three chapters the development of the law in the area of sterilisation of mentally disordered persons and the relevance of the best interests test and the rights-based approach were examined. In this chapter, two other principles which are often quoted and used in cases on sterilisation and which can provide sufficient legal certainties to ensure that the interests of the adult patient himself or herself are upheld at all times are discussed. The two principles are the principle of autonomy and the principle that non-therapeutic sterilisation cannot be performed without the consent of the patient.

8.1 Principle of autonomy

The following statement of Cardozo J in *Schloendorff* v *Society of New York Hospital*[1] is often quoted with regard to the principle of autonomy –

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault…"[2]

The principle of autonomy, sometimes referred to as the principle of self-determination, gives every person the right to determine what should be done with his own body. This principle is the reason consent qualifies as an exception to the inviolability of a person's body. It is also because of this principle that the basis upon which a person exercises his autonomy is not open for scrutiny. This position was stated clearly by Lord

[1] (1914) 105 N.E. 92
[2] See footnote 1 above, at page 93

Templeman in *Sidaway* v *Board of Governors of the Benthlem Royal Hospital and the Maudsley Hospital*[3] –

> "If the doctor making a balanced judgement advises the patient to submit to the operation, the patient is entitled to reject that advice for reasons which are rational, or irrational, or for no reason."[4]

The principle of autonomy has become such a pivotal feature of medical law that in *Airedale NHS Trust* v *Bland*,[5] Lord Goff, after approving the principles laid down by the two cases above, acknowledged the following –

> "To this extent, the principle of sanctity of human life must yield to the principle of self-determination…, and, for present purposes perhaps more important, the doctor's duty to act in the best interests of his patient must likewise be qualified."[6]

In the US, the principle of autonomy has been interpreted as a "constitutionally protected liberty interest" in the 14th Amendment of the Constitution.[7]

It is thus easy to see why it is necessary to consider the role the principle of autonomy should play in sterilisation cases. The principle of autonomy is an established principle of law that is the backbone of the laws on consent in medical law. There is no doubt that under normal circumstances, no sterilisation procedure should be performed on a mentally healthy adult unless he or she has consented to it. Every adult is assumed to have the capacity to make his or her own decisions unless it is proven otherwise. There

[3] [1985] A.C. 871
[4] See footnote 3 above, at page 904
[5] [1993] 1 All ER 821
[6] See footnote 5 above, at page 866
[7] See Section 1 of Amendment XIV to the United States Constitution and *Cruzan* v *Director, Missouri Department of Health* (1990) 497 U.S. 261

is no reason to presume that a mentally disordered adult necessarily lacks the ability to consent to sterilisation procedure. Mental condition is an illness one suffers. One does not become less of an adult simply because, for instance, one suffers from diabetes. The only difference between mental illness and other forms of medical condition is that mental illness happens to affect a few matters that are, incidentally, commonly used to define adulthood. There are, however, many different types of mental condition, with varying degree of incapacity. It has been said that people with mild to moderate mental retardation are capable of understanding a lot of matters so long as the explanation is given properly and clearly by persons who understand them.[8] Just as medical law refuses to use "status" test to decide capacity to consent, the "status" of a person as a mentally disordered person should not be used to decide if he or she has the capacity to consent. There should be an individualistic test, giving priority to the autonomy of a person.

Mentally incompetent persons may have the capacity to make decision. There is a rebuttable presumption that an adult has capacity for all purposes.[9] Evidence should therefore be adduced to show the lack of such capacity before any decision could be made for them. The majority of the judges in the Australian case of *Marion's*[10] also acknowledged that there was nothing inherent in mental handicap that would prevent a person from providing competent consent to a sterilisation. The judges also recognised that there were varying kinds and consequences of intellectual disability and that it was unfortunate they were surrounded by misconceptions which often involve an underestimation of a person's ability. Such misconception was perhaps the reason

[8] Goldhar, Jeff, "The Sterilization of Women with an Intellectual Disability" (1991) 10 *University of Tasmania Law Review* 157, at page 188

[9] Paragraph 11 of *Practice Note (Official Solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity)* [2006] 2 FLR 373

[10] *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B. ('Marion's Case')* (1992) 175 CLR 218, 66 ALJR 300. See also Paragraph 4.2 of Chapter 4.

behind Heilbron J's expression of surprise when the mother and D's psychiatrist attempted to seek D's consent to sterilisation in *Re D (a minor) (wardship: sterilisation).*[11]

The Mental Capacity Act 2005 (UK)[12] in the UK incorporates the principle of autonomy in the very first section. Subsections (2), (3) and (4) of Section 1 read as follows: -

> "(2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision."

The next question becomes what is the pre-requisite of consent and how one should decide whether or not a mentally disordered adult has the capacity to consent to sterilisation procedure. As shown below, the case law on sterilisation in various jurisdictions has not provided a comprehensive answer to this question. This is perhaps due to the use of "child analogies" in sterilisation cases since these cases often described the mental condition of a patient in terms of his or her "mental age".[13]

How cases on sterilisation treat the issue of capacity to consent

<u>England</u>

In England, the question of the capacity of a mentally disordered adult to consent to a sterilisation procedure was first considered in the case *Re D (a minor) (wardship:*

[11] [1976] Fam. 185, [1976] 1 All ER 326. See also Paragraph 4.1 of Chapter 4.
[12] c. 9
[13] Brazier, Margaret, *Medicine, Patients and the Law,* (London: Penguin, 1992), at page 100 and Lee, Robert and Derek Morgan, "Sterilisation and Mental Handicap: Sapping the Strength of the State?" (1988) 15 *Journal of Law and Society* 229, at page 238

sterilisation).[14] With regards to the question of D's consent, Heilbron J was of the view that D could not possibly have given an informed consent and was surprised that D's paediatrician requested D's mother to seek D's consent to the operation and that they thought such a discussion was fit to be carried out. Heilbron J however noted the fact that there was the likelihood that D would be able to make her own choice when she grew older. It is nevertheless unclear from the judgment how the judge arrived at the conclusion that D did not have the capacity to consent and that D might be able to make that decision later.

Subsequent cases on sterilisation of mentally disordered persons in England also failed to shed light on the components of a valid consent for a sterilisation procedure. Most of the cases established the lack of capacity to consent to sterilisation as a matter of fact.[15]

That was also the approach adopted in the leading case on sterilisation of mentally disordered adults in England, namely the decision of the House of Lords in the case of *Re F (mental patient: sterilisation).*[16] With regards to F's ability to consent, it was stated as a fact that F could not and could never be mentally competent to appreciate the issues involved and to give consent to sterilisation or indeed any medical treatment. This fact was not contested by any of the parties.

In any event, it is possible to identify some of the factors that have probably influenced the minds of the judges on this question from the way the facts were laid down in some cases. The two decisions of the Family Division of the High Court in 1992, namely *Re*

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[14] See footnote 11 above

[15] *Re B (a minor) (wardship: sterilisation)* [1988] 1 AC 199, [1987] 2 All ER 206; *T* v *T and Another* [1988] Fam 52, [1988] 1 All ER 613; *Re F (mental patient: sterilisation)* [1990] 2 AC 1, [1989] 2 All ER 545; *Re HG (specific issue order: sterilisation)* 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403; *Re Z (medical treatment: hysterectomy)* [2000] 1 FLR 523, [2000] Fam Law 321; *Re SL (adult patient) (medical treatment)* [2000] 1 FLR 465, [2000] Fam Law 322

[16] [1990] 2 AC 1, [1989] 2 All ER 545. See also Paragraph 5.1.2 of Chapter 5.

W (mental patient) (sterilisation)[17] and *Re HG (Specific Issue Order: Sterilisation)*,[18] appeared to suggest that a person would have to understand the connection between sexual intercourse, pregnancy, childbirth and contraception or sterilisation before he or she can decide whether or not to consent to sterilisation. In *Re W (mental patient) (sterilisation)*,[19] it was stated in the facts of the case that W could not understand contraception, sterilisation, or the connection between sexual intercourse, pregnancy and childbirth.

The judge in *Re HG (Specific Issue Order: Sterilisation)*[20] noted that T had limited capacity. T had no knowledge of sexual matters, no concept of pregnancy, marriage, contraception, childbirth, child-rearing, and that she would never achieve such understanding. That case appeared to be the only case which included the concept of marriage in the long list of matters required to be understood.

Besides *Re HG (Specific Issue Order: Sterilisation)*,[21] the case of *A National Health Trust* v *C (a patient by her friend the Official Solicitor)*[22] also appeared to consider the understanding of the concept of child-rearing relevant. C's incapacity to consent was listed as one of the areas of common agreement. It was listed in the facts of that case that C (21-year-old) did not understand sexual intercourse and its relation to pregnancy and C could not appreciate the purpose of contraceptive pills and sterilisation operation. It was also mentioned that C also had no realistic grasp of what the requirements of a baby or child care could be.

[17] [1993] 1 FLR 381, [1993] Fam Law 208. See also Paragraph 5.1.2 of Chapter 5.
[18] 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403. See also Chapter 6.
[19] See footnote 17 above
[20] See footnote 18 above
[21] See footnote 17 above
[22] Unreported case on 8 February 2000. See also Paragraph 5.2.1 of Chapter 5.

There were times the mentally disordered person had indicated that he or she wished to have babies or did not want to undergo sterilisation. These wishes had however been dismissed in at least two English cases, namely *Re X (adult sterilisation)*[23] and *Re A (medical treatment: male sterilisation)*.[24]

Holman J in *Re X (adult sterilisation)*[25] first considered the question of whether or not X had, or might in the future have, the capacity to make an informed decision about sterilisation. The judge accepted the report of the consultant psychiatrist and arrived at the conclusion that X did not have and would never have such capacity. The consultant psychiatrist mentioned that X's inability to link cause and effect made it impossible for her to understand the need for contraception. However, the judge mentioned later in the judgment the fact that X could make a connection between sex and having babies, and that when asked, she had said that she would like to have babies. The judge acknowledged that this fact would appear to render performance of sterilisation on X a gross infringement of her right to bodily integrity and her right to reproduce. Yet the judge decided that X was unable to make any sensible and informed decision for herself and that X's feeling of having a baby was "subjective". The judge went on to say that such feeling was objectively contrary to her best interests.

The case of *Re X (adult sterilisation)*[26] appears to go against the well-established principle of autonomy in *Sidaway* v *Board of Governors of the Benthlem Royal Hospital and the Maudsley Hospital*.[27] The *Sidaway* case stated that the consent of a competent adult had to be upheld even if it was given on grounds that were irrational in the eyes of

[23] [1998] 2 FLR 1124, [1998] Fam Law 737 See also Paragraph 5.2.1 of Chapter 5.
[24] [2000] 1 FLR 549. See also Paragraph 5.1.2 of Chapter 5.
[25] See footnote 23 above
[26] See footnote 23 above
[27] See footnote 3 above

most people.[28] X indicated that she would like to have babies, yet the judge was of the view that such feeling was insensible and subjective. If the basis of such conclusion is X's lack of capacity to consent, the judge did not explain why the ability of X to make the connection between sex and having babies, which was exceptional among patients in cases of this nature, makes no difference. However, the judge appeared to have based his conclusion on the best interests test when he said that X's desire to have babies was contrary to her best interest. If X was a competent adult, whether or not her feeling is rational or in her best interest is irrelevant. This is well established by the *Sidaway* case.[29] X's autonomy is the issue here, not the best interests test. If X lacked the capacity to consent to such an operation, then that alone should be the reason for overriding her desire to have babies. The premise of the principle of autonomy is that the patient has the right to decide what is the best for them, whereas the best interests test was meant to help persons other than the patient to make decisions when the patient could not do so. Using the best interests test in the way Holman J did in *Re X (adult sterilisation)*[30] could thus erode of the principle of autonomy.

The case of *Re A (medical treatment: male sterilisation)*[31] went through similar deduction process although the outcome of the case was markedly different. It was stated in the facts of the case that A had indicated no when asked about an operation. However, Dame Elizabeth Butler-Sloss remarked that that was not an informed decision since he could not understand the reason for the operation. It was unclear how that conclusion was made, although the trial judge did find that A had no understanding of the link between sexual intercourse and pregnancy.

[28] See footnote 4 above
[29] See footnote 3 above
[30] See footnote 23 above
[31] See footnote 24 above

In short, it would appear from the above cases that although it remains uncertain what the components of a valid consent for a sterilisation procedure are, it is likely that a person would not be considered as being able to consent to sterilisation unless he or she understands –

(a) the connection between sexual intercourse, pregnancy and childbirth;[32]

(b) the concept of contraception or sterilisation, or the purpose of the sterilisation operation;[33]

(c) the concept of marriage;[34] and/or

(d) the concept of child-rearing.[35]

That is not to say that no attempt at defining the components of a valid consent has been made. One such attempt can be found in the Mental Capacity Act 2005 (UK).[36] The Mental Capacity Act 2005 (UK)[37] covers all decisions made on behalf of people who lack capacity, whether they relate to day-to-day matters or represent life-changing events,[38] except for any decision for treatment of mental disorder. The decision for treatment of mental disorder is currently covered by the Mental Health Act 1983 (UK).[39] It would appear that the decision to sterilise a mentally disordered adults, whether on therapeutic or non-therapeutic ground, would fall within the ambit of the

[32] *Re W (mental patient) (sterilisation)* [1993] 1 FLR 381, [1993] Fam Law 208; *Re HG (specific issue order: sterilisation)* 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403; *Re X (adult sterilisation)* [1998] 2 FLR 1124, [1998] Fam Law 737; *Re A (medical treatment: male sterilisation)* [2000] 1 FLR 549; *A National Health Trust* v *C (a patient by her friend the Official Solicitor)* (8 February 2000); *Re X* [1991] 2 NZLR 365

[33] *Re W (mental patient) (sterilisation)* [1993] 1 FLR 381, [1993] Fam Law 208; *Re HG (specific issue order: sterilisation)* 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403; *Re A (medical treatment: male sterilisation)* [2000] 1 FLR 549; *A National Health Trust* v *C (a patient by her friend the Official Solicitor)* (8 February 2000)

[34] *Re HG (specific issue order: sterilisation)* 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403

[35] *Re HG (specific issue order: sterilisation)* 16 BMLR 50, [1993] 1 FLR 587, [1993] Fam Law 403; *A National Health Trust* v *C (a patient by her friend the Official Solicitor)* (8 February 2000)

[36] See footnote 12 above

[37] See footnote 12 above

[38] Department for Constitutional Affairs, *Mental Capacity Act: Code of Practice*, 13 September 2007 <http://www.guardianship.gov.uk/downloads/Code_of_Practice_-_Web.pdf>, at paragraph 1.8

[39] c. 72

Mental Capacity Act 2005 (UK).[40] The rules set out in the Mental Capacity Act 2005 (UK)[41] apply to everyone working with and/or caring for adults who lack capacity, including relatives, professionals and other carers.[42]

Section 2(1) of the Mental Capacity Act 2005 (UK)[43] states that a person lacks capacity in relation to a matter –

> "if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."

Section 3(1) of the Mental Capacity Act 2005 (UK)[44] provides that a person is unable to make a decision for himself if he is unable –

> (a) to understand the information relevant to the decision,
> (b) to retain that information,
> (c) to use or weigh that information as part of the process of making the decision, or
> (d) to communicate his decision (whether by talking, using sign language or ay other means).

Sections 2(1) and 3(1) have been described as the "two-stage test of capacity" by the Code of Practice of the Mental Capacity Act 2005.[45] Section 3(1) is irrelevant if it

[40] See footnote 12 above
[41] See footnote 12 above
[42] Department for Constitutional Affairs, see footnote 38 above, at paragraph 1.10
[43] See footnote 12 above
[44] See footnote 12 above
[45] See footnote 38 above.

cannot be proven under section 2(1) that there is an impairment of or disturbance in the functioning of the person's mind or brain. The four items listed in the section 3(1) are disjunctive rather than conjunctive. Therefore, one can be said to lack the capacity to make decision for himself or herself so long as one of the above items can be proven. Section 3(2) of the Mental Capacity Act 2005 (UK)[46] explained that with regards to item (a) of section 3(1), a person who is able to understand an explanation given to him in a way that is appropriate to his circumstances should not be regarded as unable to understand the information. Section 3(3) clarified that a person who is able to retain the information for a short period only should still be regarded as able to make the decision. This would mean that a patient suffering from schizophrenia could make a decision when he was not delusive, notwithstanding that he would not remember the decision when he fell into a state of hallucination again. Section 4(4) explained that information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision. It however remains unclear how Section 3 of the Mental Capacity Act 2005 (UK)[47] should be applied to a sterilisation operation.

Canada

The court in *Re Eve*[48] did not set out the components of a valid consent to sterilisation, although the judge did take into account the possibility that Eve could be free from the incapacity she suffered as a result of advances of science.

Australia

None of the judgments in the *Marion's Case*[49] touched on what constitutes a valid consent to sterilisation. However, the majority of the judges, when stating that the

[46] See footnote 12 above
[47] See footnote 12 above
[48] (1986) 31 DLR (4th) 1, [1986] 2 SCR 388. See more discussions on this case in Chapter 4.

consequences of a wrong decision in sterilisation were very grave, attributed this to the fact that historically and at present time, those attempting to determine the capacity of an intellectually disabled child to consent to an operation of sterilisation were often affected by commonly held misconceptions about such person's ability to give consent.

McHugh J, in his dissenting judgment, considered that the possibility that the child would in the future acquire the capacity and maturity to decide whether or not she should be sterilised one of the three factors parents should take into account when deciding whether or not sterilisation could be authorised.[50]

New Zealand

The inability of the girl in the New Zealand case of *Re X*[51] to consent to sterilisation was presumed and not much was said about her capacity to consent. Later, the High Court had the opportunity to consider the sterilisation of a 29-year-old mentally disabled girl in the case of *R* v *R*.[52] That case was of particular significance as it expressly laid down four factors for the purpose of determining whether a person has capacity to make the relevant decision. The four factors are: the ability to communicate choice, the understanding of relevant information, the appreciation of the situation and its consequences, and the manipulation of information.[53]

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[49] See footnote 10 above
[50] The other two factors that could justify the sterilisation are: if the circumstances were so compelling that the welfare of the child justified the procedure, and in giving their consent the parents did not have any conflict of interest with the child's interest.
[51] [1991] 2 NZLR 365 See also Chapter 6.
[52] [2004] NZFLR 797
[53] See footnote 52 above, at paragraphs 50-51

US

Cases in the US have attempted to formulate guidelines for the purpose of determining whether or not sterilisation should be carried out. In the case of *Re Hayes*,[54] the first step was to find that the individual was incapable of making decision about sterilisation and was unlikely to develop such capacity in the foreseeable future. It is only when this step is satisfied that the other factors would be considered. In the subsequent case of *Re Grady*,[55] it was also stated that it is only where an incompetent person lacks the mental capacity to choose among procreation, sterilisation and other methods of contraception, that the court should exercise that right on behalf of the incompetent to reflect the person's best interest. *Re Grady*[56] stressed that the trial judge had to find that the person lacks capacity to make a decision about sterilisation and that the incapacity was not likely to change in the foreseeable future.

The legislature of the state of California incorporated some of the principles in *Re Hayes*[57] in section 1950 *et seq.* of the California Probate Code in 1987.[58] Section 1951 of the California Probate Code defined "consent to sterilisation" as "making a voluntary decision to undergo sterilisation after being fully informed about, and after fully understanding the nature and consequences of, sterilisation". The word "voluntary" was defined as "performed while competent to make the decision, and as a matter of free choice and will and not in response to coercion, duress, or undue influence"; while the phrase "fully understanding the nature and consequences of sterilisation" includes the understanding of all the following: -

[54] (1980) 608 P.2d 635. See also Paragraph 4.2 of Chapter 4.
[55] (1981) 426 A.2d 467
[56] See footnote 55 above
[57] See footnote 54 above
[58] See also Paragraph 5.2.1 of Chapter 5 for more discussion on the California Probate Code.

(a) that the person is free to withhold or withdraw consent to the procedure at any time before the sterilisation;

(b) available alternative methods of family planning and birth control;

(c) that the sterilisation procedure is considered to be irreversible;

(d) the specific sterilisation procedure to be performed;

(e) the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anaesthetic to be used;

(f) the benefits or advantages that may be expected as a result of the sterilisation;

(g) the approximate length of the hospital stay; and

(h) the approximate length of time for recovery.

The California Probate Code is however too specific, especially in specifying that the sterilisation procedure is irreversible. This makes it unclear if the legislation is at all applicable to many sterilisation procedures that are now considered reversible, such as tubal ligation. For instance in the 1999 case of *Re Angela*,[59] the proposed sterilisation surgery on Angela was laparoscopic bilateral tubal ligation. This is not an irreversible operation and it is doubtful if Section 1951 of the California Probate Code is applicable in that case.

Components of a valid consent

Although some legislative instruments, such as the Mental Capacity Act 2005 (UK)[60] and the California Probate Code, have attempted to list the components of valid consent, they have no direct application to Malaysia. It is thus necessary for the purpose of this thesis to consider the common law on consent generally to ascertain which approach should be used insofar as sterilisation procedure is concerned.

[59] (1999) 70 Cal App 4th 1410. See also Paragraph 5.2.1 of Chapter 5.
[60] See footnote 12 above

There are two aspects to any discussion on consent. One is external and the other is internal. The capacity of a person to consent is an internal matter affected by nothing other than the mental state of the patient himself. Sometimes, consent is given as a result of coercion or force of third party. This is as a result of external influence and such consent is involuntary and thus invalid.

In relation to the requirement that consent must be voluntary, it has been said that a consent given as a condition of release from an institution may not be voluntary.[61] To ensure that sterilisation is voluntary, there should be some substantive and procedural protection. There needs to be an inquiry into the possibility of coercion by way of outside influences, personal circumstances, present emotional state and mental condition; in other words, to find out if the operation is truly desired and truly voluntary.[62] This is also consistent with section 1951 of the California Probate Code, which defined the word "voluntary" as "performed while competent to make the decision, and as a matter of free choice and will and not in response to coercion, duress, or undue influence". There should also be clear procedural safeguards, as recommended in the Brock Committee Report. This is because in the circumstances of confinement involving the mentally disordered persons, many *de facto* involuntary consent to sterilisation would be able to pass off as genuine consent. This is particularly so where reduction in detention period, parole or discharge is to be the result of the submission to sterilisation.[63]

[61] Goldhar, Jeff, see footnote 8 above, at page 159
[62] Mimi Kamariah, "Rights of Mentally Retarded Persons In Domestic Relations" [1980] 7 JMCL 201, at page 212
[63] 1934 Cmd 4485, at 37-8, as quoted by Meyers, David W., "Compulsory Sterilisation and Castration", *Medical Law and Ethics*, Ed., Sheila McLean, (Ashgate: Dartmouth, 2002), at page 280

How capacity to consent should be determined

More complicated is the issue of how the capacity to consent should be determined. Perhaps a good case to begin with is the English Court of Appeal case of *Re T.*[64] That case concerned a woman who refused to consent to a blood transfusion after speaking to her mother, who was a Jehovah's witness. It was held in that case that the doctors were justified in disregarding her instructions because she had not been fit to make a genuine decision due to her medical condition and that she had been subjected to the undue influence of her mother, which vitiated her decision to refuse blood transfusion. Lord Donaldson in that case stated clearly that English courts do not accept the "transatlantic concept of informed consent" and that all that is required is that the patient should know "in broad terms the nature and effect of the procedure" to which consent or refusal was given. The duty of a doctor to give patient full information is separate from consent and as such the failure to give such information does not vitiate a consent or a refusal. That case also reaffirmed the rebuttable presumption of capacity in respect of an adult. The views expressed in the case of *Re T*[65] were shared by the House of Lords in *Airedale NHS Trust v Bland*.[66]

The judge in the case of *Re T*[67] was of the view that all that is required of the persons who gives a valid consent is that he or she must know "in broad terms" the nature and effect of the procedure. Applying such standard to the case of a sterilisation operation, it seems sufficient that the patient understands that the operation involves surgical procedure and that the effect of the operation is that he or she will no longer be able to have babies. It has been suggested by Margaret Brazier in a 1990 article that all the patient needs to understand is that "she will be put to sleep while a doctor operates on

[64] [1992] 4 All ER 649
[65] See footnote 64 above
[66] See footnote 5 above
[67] See footnote 64 above

her tummy to ensure that she is never able to have babies".[68] Nevertheless, it is submitted that making the whole process sounds so simple does not necessarily make the patient less inclined to agree to sterilisation. Quite the contrary, an explanation as simple as that may encourage the patient to consent to the operation, especially to a patient who has yet to develop any maternal instinct.

In any event, many cases in England appeared to have suggested that in order to consent to sterilisation, the patient needs to understand a bit more, such as the connection between sexual intercourse, pregnancy and childbirth.[69] The stringent requirements of the California Probate Code in the US, on the other hand, can be distinguished since the concept of "informed consent" is alive in the US. It would appear that the concept of informed consent is also relevant to Australia. It has been said that to ensure that consent is informed, a doctor in Australia should explain in detail the full implications of the operation, such as its reversibility, the psychological consequences, its advantages, risks, dangers, possible side effects, chances of success and the consequences of performing, or not performing, the procedure, the alternatives available, as well as that there may be circumstances in the future when the patient wants children.[70]

However, the position in England is not straightforward. Not long after *Re T*[71] was decided, the Family Division of the High Court had the opportunity to consider whether a 68-year-old schizophrenic man had the capacity to refuse medical treatment in *Re C (adult: refusal of medical treatment).*[72] The court in that case exercised its inherent jurisdiction and ruled by way of injunction or declaration that C was capable of refusing

[68] Brazier, Margaret (2), "Sterilisation: Down the Slippery Slope?" (1990) 6 PN 25, at page 26
[69] See page 133 above
[70] Goldhar, Jeff, see footnote 8 above, at pages 159, 160
[71] See footnote 64 above
[72] [1994] 1 All ER 819

to medical treatment. Thorpe J rejected the minimal competence test, that is the test that the capacity to refuse treatment is no higher than the capacity to contract and that the capacity to understand in broad terms the nature and effect of the proposed treatment is sufficient. Instead, Thorpe J was of the view that the question is whether it had been established that C's capacity was so reduced by his chronic mental illness that he did not sufficiently understand the nature, purpose and effects of the proffered amputation. There were three stages in the decision-making process, namely firstly, comprehending and retaining treatment information; secondly, believing it; and finally, weighing it in the balance to arrive at choice.

The test proposed by Thorpe J in *Re C*[73] was applied in subsequent cases such as *Tameside and Flossop Acute Services Trust* v *CH*,[74] *Rochdale Healthcare (NHS) Trust* v *C*[75] and *Re L.*[76] In 1997, the Court of Appeal in *Re MB (Medical Treatment)*[77] approved the method suggested by Thorpe J in *Re C.*[78] That case concerned MB. MB agreed to have a Caesarean section when she was 40 weeks pregnant since a vaginal delivery would pose a serious risk of death or brain damage to the baby. However, she panicked at the last moment during the attempts to carry out the operation because of her needle phobia and she withdrew her consent. The Court of Appeal held that it was unlawful for the consultant gynaecologist to operate on MB. In relation to the question on capacity to decide, Butler-Sloss LJ held, *inter alia*, that a person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when: -

[73] See footnote 72 above
[74] [1996] 1 FLR 762
[75] (unreported) 3 July 1996
[76] (unreported) 5 December 1996
[77] [1997] 2 FLR 426
[78] See footnote 72 above

- the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question; and
- the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.

The English court has traditionally rejected the concept of "informed consent" and given the principle of medical paternalism a stronger hold.[79] Notwithstanding that, *Re C*[80] and *Re MB (Medical Treatment)*[81] appeared to have brought England closer to the concept of "informed consent" in the US and Australia, although these cases have not clarify the nature of the information in which a patient must comprehend, retain and weigh. An analogy can been drawn from the House of Lords' decision on whether or not a minor girl could make decision to practise sex and contraception in *Gillick* v *West Norfolk & Wisbech AHA*.[82] Lord Templeman held in that case that a girl who could make decision to practise sex and contraception must not only have knowledge of the facts of life, the dangers of pregnancy and disease, but also an understanding of the emotional and other consequences to her family, her male partner and herself.

Conclusion

Notwithstanding that many cases on sterilisation did not expressly place the principle of autonomy at a pivotal position, the principle of autonomy should have been used as the first test in all sterilisation cases. This is because save for cases on failed sterilisation, cases on sterilisation are essentially cases on consent, which mean cases where court

[79] See the decisions of Lord Diplock, Lord Bridge, Lord Keith of Keinkel and Lord Templeman in *Sidaway v Board of Governors of the Benthlem Royal Hospital and the Maudsley Hospital* [1985] AC 871
[80] See footnote 72 above
[81] See footnote 77 above
[82] [1986] AC112, [1985]3 All ER 402

intervention has been sought due to the lack of consent. The law of consent in medical law is in existence because of the principle of autonomy. There is therefore no reason why the principle of autonomy, especially the wealth of case law on capacity to consent, should not be given the place it deserves in sterilisation cases. It is a certain and stable principle that can be effectively used as the first guard against any possibility of allowing the interests of the society or the state reign supreme. The principle of autonomy protects the autonomy of an adult patient, and mentally disordered adults should not be deprived of its protection just because of their illness.

Further, recognising the important role the general law on capacity to consent should play in sterilisation cases can also allow sterilisation cases to develop alongside the general law on capacity. For instance, following the decisions of the English courts in *Re C*[83] and *Re MB (Medical Treatment)*,[84] a mentally disordered adult may be expected to gain more understanding of a sterilisation procedure before he or she can be considered as having the capacity to consent to it.

8.2 Therapeutic versus non-therapeutic sterilisation

The distinction between therapeutic and non-therapeutic sterilisation has generated a lot of discussion in the sterilisation cases, especially while deliberating the point of jurisdiction. It has been said that this shows that there is an important difference between a person's "best medical interests" and "best social interests".[85] The way the distinction has been discussed in cases also shows that it is somewhat impossible to separate jurisdictional issue from the substantive law and vice versa.

[83] See footnote 72 above
[84] See footnote 77 above
[85] Cica, Natasha, "Sterilising the Intellectual Disabled" (1993) 1 Med L Rev 186, at page 195

There are at least three lines of cases in this regard. The first line of cases recognised the distinction between therapeutic and non-therapeutic sterilisation and used the distinction to suggest that whereas the decision to sterilise on therapeutic ground can be decided by the doctors alone, no decision to sterilise on non-therapeutic ground should be decided without the involvement of court. Cases such as *Re D (a minor) (wardship: sterilisation)*,[86] *Re E (a minor) (medical treatment)*,[87] *Re GF (medical treatment)*[88] and the majority judgment in the *Marion's Case*[89] fall into this category. Arguably, this also represents the view shared by the House of Lords in *Re F (mental patient: sterilisation).*[90]

Another line of cases had also recognised the distinction between therapeutic and non-therapeutic sterilisation and that the decision to carry out therapeutic sterilisation can be made by doctors. However, this line of cases did not think that non-therapeutic sterilisation could ever be carried out, and that not even the court had the power to authorise the performance of such operation. This is the position taken by the Canadian case of *Re Eve*[91] and followed by Brennan J in his judgment in the *Marion's Case*.[92]

In *Re Eve*,[93] it was held that neither courts nor parents could ever consent to a non-therapeutic sterilisation, although the exact ambit of "non-therapeutic" sterilisation remains vague. The dissenting judgment of Brennan J in the *Marion's Case*[94] differed from that of the majority in that he agreed with the Canadian decision of *Re Eve*[95] that neither parents or guardians or courts possessed any power under the general law to

[86] See footnote 11 above
[87] [1991] 2 FLR 585, [1992] Fam Law 15, 7 BMLR 117. See also Paragraph 4.3 of Chapter 4.
[88] [1992] 1 FLR 293, 7 BMLR 135. See also Paragraph 4.3 of Chapter 4.
[89] See footnote 10 above
[90] See footnote 16 above
[91] See footnote 48 above
[92] See footnote 10 above
[93] See footnote 48 above
[94] See footnote 10 above
[95] See footnote 48 above

authorise the non-therapeutic sterilisation of intellectually disabled children. In arriving at this conclusion, Brennan J first considered that the protection of human dignity was the value underlying the principle of inviolability of a person's body, and that the right to physical integrity was a condition of human dignity. Involuntary sterilisation was a serious invasion of personal integrity and a grave impairment of human dignity. Therefore, sterilisation of an intellectually disabled child required justification of a compelling kind. An obvious justification was when the proposed treatment was therapeutic. Brennan J was of the view unlike the best interests approach, the test of therapeutic medical treatment recognised the importance of personal integrity and of the maintenance and enhancement of natural attributes to the welfare of the child. The best interests approach was useful only to the extent of ensuring that the first and paramount consideration was the interests of the child, not the parents. Brennan J went on to say that non-therapeutic sterilisation could only be justified if such purposes possessed some higher value than the preservation of the patient's physical integrity and he was unable to postulate a case where it would be justifiable to sterilise a person for non-therapeutic purposes. He was of the view that balancing between the risk of invasion of physical integrity and the risk of future tragedy that could diminish quality of life could not be carried out, as the values on either side of the balance were not comparable. A rule had to give priority to the right to physical integrity and the human dignity it protected.[96]

The case of *Re B (a minor) (wardship: sterilisation)*[97] is the representative for the final line of cases. This line of cases considered the distinction between therapeutic and non-therapeutic sterilisation totally meaningless, and if meaningful, irrelevant to the best

[96] The dissenting judgment of Deane J stated that the decision of *Re X*, see footnote 51 above, by the High Court of New Zealand showed clearly that surgery for other than conventional medical purposes could be obviously in the interests of the child that parents could lawfully make the decision after due inquiry and adequate consideration.

[97] [1988] 1 AC 199, [1987] 2 All ER 206. See also Paragraph 4.2 of Chapter 4.

interests test. *T* v *T and Another*,[98] *Re HG (Specific Issue Order: Sterilisation)*[99] and Deane J's judgment in the *Marion's Case*[100] followed this approach.

The distinction between therapeutic and non-therapeutic is valid

It is perhaps incorrect to say that the distinction between therapeutic and non-therapeutic sterilisation plays no role at all in sterilisation cases. This is because sterilisation cases concern the question of consent and doctors plays a significant part in issues governing consent to medical treatment. It is beyond doubt that doctors are the ones who could dispense with the consent requirement during emergency, where the treatment is necessary to safeguard the life and health of the patient. The fact that the necessary medical treatment involves sterilisation does not take away the right and duty of the doctors to perform such operation under those circumstances. The distinction between the therapeutic and non-therapeutic nature of the treatment is therefore relevant since it is clear that, at least during emergency, doctors could only justify the absence of consent to treatment on therapeutic grounds.

Further, it has been said that the distinction between therapeutic and non-therapeutic is in fact well known to medicine, medical law and medical ethics. For example, insofar as the research on human subjects is concerned, a different regime of rules regulates therapeutic and non-therapeutic research. The basis of the distinction between the two is the familiar concept of intention, which means an intervention is therapeutic if therapy is intended.[101]

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[98] [1988] Fam. 52, [1988] 1 All ER 613. See footnote 18 of Chapter 4.
[99] See footnote 18 above
[100] See footnote 10 above
[101] Kennedy, Ian, "Patients, doctors and human rights", *Human Rights for the 1990s*, Ed., Robert Blackburn and John Taylor, (London and New York: Mansell, 1991), at page 102

There was no wholesale rejection of the distinction between therapeutic and non-therapeutic sterilisation in *Re F (mental patient: sterilisation).*[102] The House of Lords in that case suggested that the basis for treatment without consent is the principle of necessity rather than emergency. The judges shared the view that treatment for the purpose of preserving life or improving or preventing the deterioration of physical or mental health could be carried out without consent of the patient, thus indirectly acknowledging the relevance of the distinction between therapeutic and non-therapeutic sterilisation.

The effect of recognising the distinction between therapeutic and non-therapeutic sterilisation is a far-reaching one, since it determines who get to make the decision. There is little doubt that doctors should be the ones who could make decision if the operation is "therapeutic" in nature. The authorities are divided as to whether or not non-therapeutic sterilisations can ever be lawfully carried out and if the answer is positive, whose decision that should be. It is submitted that *Re Eve*[103] is correct in saying that judges were generally ill-informed about the factors relevant to a wise decision in this regard and the decision is one for the legislature rather than the judiciary. However, by abstaining from proceeding without her consent, the judge in *Re Eve*[104] has in effect "legislated" against treatment without consent.[105] It has been argued in Canada that the approach of *Re Eve* [106] can be justified on the basis of "affirmative discrimination", which means in order to ameliorate the conditions of a disadvantaged group, it is justifiable to discriminate against some members of the group itself.[107]

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[102] See footnote 16 above
[103] See footnote 48 above
[104] See footnote 48 above
[105] See the discussion of *Re F (mental patient: sterilisation)* [1990] 2 AC 1, [1989] 2 All ER 545 in *Airedale NHS Trust* v *Bland* [1993] 1 All ER 821, at page 890
[106] See footnote 48 above
[107] Robertson, Gerald, "Sterilization, Mental Disability, and re Eve: Affirmative Discrimination?", *Discrimination in the Law and the Administration of Justice*, Ed., WS Tarnopolsky et al., (Montreal: Les Editions Themis, Inc, 1993), at pages 450, 455-456

However, such affirmative discrimination may be justified in Canada given its history on compulsory eugenic sterilisation, but many countries, such as Malaysia, are not burdened by the baggage of such history.

Definitions of therapeutic and non-therapeutic sterilisation

Given the far-reaching effect of the distinction between therapeutic and non-therapeutic sterilisation, it is important to define the word "therapeutic". *Re Eve*[108] may not be very instructive in this regard as it has been argued that the term "non-therapeutic" used in that case actually meant operation for the benefit of persons other than the patient herself.[109] The Australian case of *Re Jane*[110] defined therapeutic treatment to mean treatment of some malfunction or disease. Brennan J attempted a more detailed definition in the *Marion's Case*,[111] where therapeutic treatment is defined as a treatment –

> "…administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder, provided the treatment is appropriate for and proportionate to the purpose for which it is administered."[112]

According to Brennan J, non-therapeutic medical treatment is a –

> "treatment which is inappropriate or disproportionate having regard to the cosmetic deformity, pathological condition or psychiatric disorder for which the

[108] See footnote 48 above.
[109] Norrie, Kenneth McK., "Sterilisation of the Mentally Disabled in English and Canadian Law" (1989) 38 *International and Comparative Law Quarterly* 387, at page 390
[110] [1989] FLC 92-023, (1989) 13 Fam LR 47
[111] See footnote 10 above
[112] 175 CLR 218, at page 269

treatment is administered and of treatment which is administered chiefly for other purposes."[113]

Brennan J said that proportionality and purpose are the legal factors which determine the therapeutic nature of medical treatment. Proportionality is determined as a question of medical fact. Purpose is ascertained by reference to all the circumstances but especially to the physical or mental condition which the treatment is appropriate to affect.

It is submitted the definition of therapeutic treatment provided by Brennan J is useful. Nevertheless, it has also been acknowledged time and again that the line between therapeutic and non-therapeutic treatment is difficult to draw.[114] For instance, cases such as *Re E (a minor) (medical treatment)*[115] and *Re GF (medical treatment)*[116] considered sterilisation procedure for the purpose of preventing menstruation therapeutic in nature, as both the girls suffered from excessively heavy menstrual bleeding. The distinction between therapeutic and non-therapeutic treatment has also led Wall J to see heavy menstruation as an indication of the therapeutic nature of the sterilisation procedure in *Re SL (adult patient) (medical treatment).*[117] Wall J's decision was overturned by the Court of Appeal as the judges there found no evidence of "excessively heavy" menstrual bleeding. That case shows how thin the distinction between therapeutic and non-therapeutic can be.

[113] See footnote 112 above
[114] See the majority judgment in the *Marion's Case*, footnote 10 above.
[115] See footnote 87 above
[116] See footnote 88 above
[117] [2000] 1 FLR 465, [2000] Fam Law 322

Since sterilisation of a girl who suffered phobic aversion to blood in the Canadian case of *Re K and Public Trustee*[118] could be justified on the ground that it was therapeutic, it is not unlikely that someone may find the girl in *Re Z (medical treatment: hysterectomy)*,[119] who was rather distressed by her inability to handle the hygiene aspect of menstruation, is also in need of "therapeutic" sterilisation. It has also been said that the distinction allows the playing of the word game, where social interest such as the need for the patient to integrate into the community can be described as a psychology benefit. The term "medicalises" the process and makes it in the patient's best medical interest and hence therapeutic.[120] As a result of the difficulty in distinguishing the two, it has been suggested that by the Royal Australian College of Obstetricians and Gynaecologists that court approval can only be dispense with in life-threatening circumstances.[121]

It has thus been suggested that a procedure should only be described as therapeutic if performed to alleviate or prevent a recognised clinical condition. Excessively heavy or painful periods (rather than mere heavy or painful), or a psychiatric or psychological condition caused by menstruation (rather than mere distress or embarrassment) are examples of recognised clinical condition. Sterilisation for mere hygienic purposes is not therapeutic.[122]

Some commentators went a step further and viewed the facts of *Re B (a minor) (wardship: sterilisation)*[123] as indicating that the proposed operation there was really a therapeutic procedure. This is because there was evidence to show that B had the

[118] (1985) 19 DLR (4th) 255, 63 BCLR 145, [1985] 4 WWR 724. See also Paragraph 4.3 of Chapter 4.
[119] [2000] 1 FLR 523, [2000] Fam Law 321. See also Chapter 6.
[120] Cica, Natasha, see footnote 85 above, at page 198
[121] The Law Reform Commission of Western Australia, *Report on Consent to Sterilisation of Minors*, (Project No 77 Part II), (Perth: The Law Reform Commission of Western Australia, 1994), at page 61
[122] Cica, Natasha, see footnote 85 above, at page 198
[123] See footnote 97 above

tendency to open up post-operative scar, she would therefore not be able to go through a Caesarian section if she were to become pregnant.[124] It is submitted that the determination of therapeutic should be restricted to one level of eventuality, namely the consequence of not carrying out the sterilisation operation itself (for example, life threatened by tumour in the uterus), rather than the consequence (picking wounds) of the consequence of not carrying out sterilisation operation (becoming pregnant). In other words, the clinically recognised condition must already be present or is virtually certain to arise in near future.

Therefore, the approach proposed by Thorpe LJ in *In re S (adult patient: sterilisation)*[125] should be followed. Thorpe LJ considered the test set out by Sir Stephen Brown P in *Re GF (medical treatment)*[126] a test expressed in broad terms, and any interpretation and application should incline towards the strict and avoid the liberal. As such, it was suggested that if a particular case lies anywhere near the boundary line, it should be referred to the court by way of an application for a declaration of its lawfulness.

That, it is submitted, is a preferred approach given that it is easy to confuse social factors with medical factors. As shown in Chapters 6 and 7, the best interests test has the propensity of turning into a test that protects the interest of doctors and other carers. If that were to become the norm, it will become akin to sterilisation on eugenic grounds. A principle that provides that non-therapeutic sterilisation cannot be carried out under normal circumstances greatly reduces the subjectivity inherent in the best interests test. Such principle creates a stand on the issue, instead of leaving it to the decision-maker to decide what "best" means.

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[124] Grubb, Andrew and David Pearl, "Sterilisation and the Courts" [1987] C.L.J. 439, at pages 442-445
[125] [2001] Fam 15. See also Paragraph 5.1.2 of Chapter 5.
[126] See footnote 88 above

Nevertheless, to ensure that this principle is not dependent on the value system of the decision-maker, it is important that the terms "therapeutic" and "non-therapeutic" are capable of being defined with sufficient clarity. Just because a problem can be solved by medical means does not make it therapeutic. The dichotomy between therapeutic and non-therapeutic sterilisation can only be effectively used to safeguard the interest of the mentally disordered person if the word "therapeutic" is not given a broad interpretation. Whenever a circumstance ceases to sit comfortably in the realm of "therapeutic" sterilisation, the presumption should be that it is non-therapeutic hence the sterilisation must not be carried out unless the court is satisfied that it is in fact therapeutic in nature.

Chapter 9

Guiding Principles for Malaysia

As seen in Chapter 3, it would appear that the role of consent to sterilisation operation in the criminal law of Malaysia depends to a certain extent on whether or not sterilisation amounts to "grievous hurt".[1] However, statute and case law specific on sterilisation remains a blank slate in Malaysia. The precise approach Malaysia should take when faced with the question of sterilisation is far from clear, especially since there is no known community consensus on these issues yet. Further, the yet-to-be-in-force Mental Health Act 2001[2] does not address the issue of consent to general medical treatment of mentally disordered person.

Pending the enactment of any statutory direction or the guidance of Malaysian courts on this matter, a guiding principle should be developed for Malaysia so that it can be followed by any person with the responsibility of deciding the question of whether or not a mentally disordered adult should be sterilised.

Much can be learned from the way the laws of other jurisdictions have handled the issue. As illustrated in the earlier chapters, the best interests test is not the best test and if left to operate in a vacuum, it can potentially turn into a test that protects the interests of doctors, carers or the society rather than the patient himself or herself. The focus of this chapter is to propose a workable set of principles that can be used to determine what the best interests of a mentally disordered adult are insofar as sterilisation is concerned in the light of the laws in Malaysia. The principles are firstly, the principle of autonomy

[1] See Paragraph 3.1 of Chapter 3
[2] Act 615. See Paragraph 3.2 of Chapter 3.

and secondly, the principle that non-therapeutic sterilisation should not be carried out in the absence of the patient's consent.

9.1 The development in Malaysia

As highlighted in Chapter 1, unlike other medical procedures, sterilisation of mentally disordered person is rarely performed out of necessity or emergency, as the physical health of the person will not be in danger without such procedure. The cases on best interests test relating to other procedures or circumstances are therefore less relevant to this thesis. That is not to say that the existing case law in Malaysia should not be looked into, as several landmark decisions on consent and autonomy, as seen in Paragraph 9.1.2 below, are important to the way we view the principle of autonomy.

Before that, it is necessary to consider if there is any jurisdictional issue in Malaysia since who decides is as important as how it is decided.[3]

9.1.1 Jurisdiction

It is clear from the English case of *Re F (mental patient: sterilisation)*[4] that the English courts' *parens patriae* jurisdiction related to adult persons of unsound mind no longer exists. The courts in Canada, however, have such jurisdiction over mentally disordered adults. The question is therefore: do Malaysian courts have such jurisdiction?

The *parens patriae* jurisdiction is an ancient prerogative jurisdiction of the Crown going back to as early as the 13th century. "*Parens patriae"* is a Latin term which means "parent of his country" and *parens patriae* jurisdiction refers to the power and duty of the Crown to protect the persons and property of those who are unable to do so for

[3] See Chapter 5
[4] [1990] 2 AC 1, [1989] 2 All ER 545. See also Paragraph 5.1.2 of Chapter 5.

themselves. The persons protected by this jurisdiction include both minors and persons of unsound mind.

According to the judgment of the Federal Court in *Mahabir Prasad* v *Mahabir Prasad*,[5] the courts in Malaysia have jurisdiction to hear a custody case regarding infants under "an inherent jurisdiction which is derived from the Crown's prerogative powers as *parens patriae*".[6]

It is thus clear that the courts in Malaysia have *parens patriae* jurisdiction over infants. What about mentally disordered adults? Pursuant to Section 3 of the Civil Law Act 1956,[7] the common law of England and the rules of equity as administered in England on 7 April 1956 are to be applied by the court in West Malaysia.[8] The *parens patriae* jurisdiction in England was in existence long before 7 April 1956. It therefore becomes necessary to examine when the events that rendered the loss of the *parens patriae* jurisdiction in England over adult persons of unsound mind happened.

According to the judgment of Lord Brandon in *Re F (mental patient: sterilisation)*,[9] the *parens patriae* jurisdiction over persons of unsound minds ceased to exist in England as a result of two events, namely the coming into force of the Mental Health Act 1959 (UK)[10] and the revocation by Warrant under the Sign Manual of the last Warrant. Both these events took place on 1 November 1960. Therefore, as at 7 April 1956, the *parens patriae* jurisdiction over persons of unsound mind still existed in England. It would follow that Malaysian courts have *parens patriae* jurisdiction over mentally disordered

[5] [1981] 2 MLJ 326
[6] See footnote 5 above at 326
[7] Act 67
[8] The date relevant for Sabah is 1 December 1951, while the date for Sarawak is 12 December 1949.
[9] See footnote 4 above
[10] c. 72

person, and the need to consider if any jurisdiction existed under the mental health legislation or the rules of the court thus does not arise.

Insofar as whether or not the family members of a mentally disordered person can make decisions on his or her behalf, the provision of the yet-to-be-in-force Mental Health Act 2001[11] seems to suggest that consent to medical treatment can be given by a "relative" and the word "relative" is given a broad definition in the Mental Health Act 2001.[12] Unfortunately, the Mental Health Act 2001[13] does not provide any guideline on how such decision should be made and, as seen in Paragraph 3.2 of Chapter 3, it is unlikely that the Mental Health Act 2001[14] applies to sterilisation operation.

In short, the courts in Malaysia most probably have jurisdiction over mentally disordered adults. Therefore, the *Bolam* test[15] should not be relevant to the determination of whether or not sterilisation should be ordered in the absence of consent. This is further strengthened by the recent decision of *Foo Fio Na* v *Dr Soo Fook Mun and Hospital Assunta*[16] where the Federal Court of Malaysia rejected the applicability of the *Bolam* test in medical negligence, and preferred instead the approach of the Australian case of *Rogers* v *Whitaker.*[17] In *Rogers* v *Whitaker,*[18] the High Court of Australia stated that: -

> "…while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after

[11] See footnote 2 above
[12] See footnote 2 above
[13] See footnote 2 above
[14] See footnote 2 above
[15] See *Bolam* v *Friern Hospital Management Committee* [1957] 2 All ER 118, [1957] 1 WLR 582, *Re F (mental patient: sterilisation)* [1990] 2 AC 1, [1989] 2 All ER 545 and Paragraph 5.1.2 of Chapter 5.
[16] [2007] 1 MLJ 593. See also Paragraph 9.1.2 below.
[17] (1992) 175 CLR 479
[18] See footnote 17 above

giving weight to the paramount consideration that a person is entitled to make his own decisions about his life."[19]

That shows that regardless of where the jurisdiction lies and what the standard of care is, the overriding principle remains the same, namely the principle of autonomy. The impact of the decision of *Foo Fio Na* v *Dr Soo Fook Mun and Hospital Assunta*[20] on the principle of autonomy in Malaysia is discussed further in Paragraph 9.1.2 below.

9.1.2 Principle of autonomy in Malaysia

There is no doubt that the principle of autonomy is also applicable to Malaysia. From the angle of criminal law, several provisions in the Penal Code[21] have provided that an act done with consent is an exception to many offences listed therein.[22] Besides, section 77 of the Mental Health Act 2001 [23] has also provided that before surgery, electroconvulsive therapy or clinical trials are carried on a mentally disordered person, the consent of the patient himself must first be obtained if he is capable of giving consent.[24] More importantly, many cases on medical law in Malaysia have clearly shown that the principle of autonomy is alive in Malaysia.

Capacity to consent

In Malaysia, section 90(b) of the Penal Code[25] provides that a consent must be given by a person who can understand the nature and consequence of that to which he gives his consent.[26]

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[19] See footnote 17 above, at 484
[20] See footnote 16 above
[21] Act 574 Rev. 1997
[22] See Paragraph 3.1 of Chapter 3 above
[23] See footnote 2 above
[24] See Paragraph 3.2 of Chapter 3 above
[25] See footnote 21 above
[26] See Paragraph 3.1 of Chapter 3 above

The need for a consent to be voluntary and for the patient to have the capacity to give consent has also been recognised in the same section 90 of the Penal Code,[27] where it was provided that a consent is not a consent if it is given under fear of injury or under a misconception of fact.[28]

Section 77(5) of the Mental Health Act 2001[29] provides that a mentally disordered person who is capable of giving consent must understand five matters, namely the condition for which the treatment is proposed; the nature and purpose of the treatment; the risks involved in undergoing the treatment; the risks involved in not undergoing the treatment; and whether or not his ability to consent is affected by his condition.[30]

Since section 77(5) of the Mental Health Act 2001[31] most likely does not apply to sterilisation procedure and the Penal Code[32] is not specific to sterilisation cases, case law in Malaysia should be looked into to see if any guidance can be obtained on how exactly one should decide if a mentally disordered adult has the capacity to consent to a sterilisation procedure.

The principle of autonomy in *Sidaway* v *Board of Governors of the Benthlem Royal Hospital and the Maudsley Hospital*[33] has been followed by several cases in Malaysia. One such case is the case of *Liew Sin Kiong* v *Dr Sharon DM Paulraj.*[34] In that case, a doctor was sued by the plaintiff for negligence pertaining to the operation of his right eye. The plaintiff lost his right eye to post-operative infection. One of the allegations by the plaintiff was that the doctor failed to explain the possible complications and risk

[27] See footnote 21 above
[28] See Paragraph 3.1 of Chapter 3 above
[29] See footnote 2 above
[30] See Paragraph 3.2 of Chapter 3 above
[31] See footnote 2 above
[32] See footnote 21 above
[33] [1985] A.C. 871
[34] [1996] 5 MLJ 193

of blindness associated with the operation to the plaintiff. Ian Chin J in that case referred to *Sidaway* v *Board of Governors of the Benthlem Royal Hospital and the Maudsley Hospital*[35] and said that –

> "It is common ground that there is in law a duty on a doctor to warn the patient of any material risk in undergoing or foregoing surgery or treatment."[36]

That case was not about what risks are material for disclosure, but rather whether the doctor explained to the plaintiff the risk of infection. The judge found, on the facts of that case, that the doctor had explained the risk of infection to the plaintiff.

Insofar as the substantive negligence claim is concerned, the judge in *Liew Sin Kiong* v *Dr Sharon DM Paulraj*[37] used the test set out in *Bolam* v *Friern Hospital Management Committee*[38] and held that the doctor is not liable for negligence because what the doctor did was "in accordance with accepted practice".[39]

However, the *Bolam* test was not always followed. The Australian case of *Rogers* v *Whitaker*[40] refused to follow the *Bolam* test and said that it is for the courts to adjudicate on the appropriate standard of care that should be observed by a person with special skill. The first Malaysian case that endorsed the *Rogers* v *Whitaker* test is *Kamalam a/p Raman & Ors* v *Eastern Plantation Agency (Johore) Sdn Bhd Ulu Tiram Estate, Ulu Tiram, Johore & Anor*.[41] Richard Talalla J in that case expressly endorsed the *Rogers* v *Whitaker* approach and refused to be bound by the *Bolam* test.

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[35] See footnote 33 above
[36] See footnote 34 above, at page 203
[37] See footnote 34 above
[38] [1957] 2 All ER 118, [1957] 1 WLR 582
[39] See footnote 34 above, at page 227
[40] See footnote 17 above
[41] [1996] 4 MLJ 674. That case concerned a hypertension man who died after several examinations by a doctor.

The *Rogers* v *Whitaker* test was applied again later in the case of *Tan Ah Kau* v *The Government of Malaysia*.[42] In that case, the plaintiff was advised to undergo an operation for the removal of a cancerous growth. As a result of the operation, the plaintiff suffered damage to his spinal cord and was paralysed waist downwards. The plaintiff contended that no one had told him the risk of the operation, and the contents of the consent forms were not explained to him. Low Hop Bing J in that case referred to the case of *Rogers* v *Whitaker*[43] and held that –

> "…where the risk of paralysis was very real… it is absolutely essential for the attending surgeon… to warn the patient of the foreseeable risk".[44]

The confusion surrounding the application of the *Bolam* test and the *Rogers* v *Whitaker* test was finally put to rest following the decision of the Federal Court in *Foo Fio Na* v *Dr Soo Fook Mun and Hospital Assunta.*[45] The plaintiff in that case was involved in an accident. As the result of several failed operations on her, the plaintiff became paralysed. The plaintiff succeeded at the High Court in proving that her paralysis was caused by the first operation and that the defendant and the defendant's employing hospital were liable for negligence. The defendants' appeal to the Court of Appeal was successful. The plaintiff subsequently appealed to the Federal Court to determine the following question of law: Whether the *Bolam* test in the area of medical negligence should apply in relation to all aspects of medical negligence.

The Federal Court allowed the appeal and held that the *Rogers* v *Whitaker* test is more appropriate and viable than the *Bolam* test. Siti Norma Yaakob FCJ said that the *Bolam*

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[42] [1997] 2 CLJ Supp 168
[43] See footnote 17 above
[44] See footnote 42 above, at page 187
[45] See footnote 16 above

test has no relevance to the duty and standard of care of a doctor insofar as informing the patient of inherent and material risks of the proposed treatment is concerned –

> "The practitioner is duty bound by law to inform his patient who is capable of understanding and appreciating such information of the risks involved in any proposed treatment so as to enable the patient to make an election of whether to proceed with the proposed treatment with knowledge of the risks involved or decline to be subjected to such treatment."[46]

It is clear from the series of Malaysian cases ending with *Foo Fio Na* v *Dr Soo Fook Mun and Hospital Assunta*[47] that the principle of autonomy is very much alive in Malaysia and in order for patient to provide consent, doctor has to disclose risks involved in the proposed treatment. The court, in deciding on the standard of care a doctor should exercise in fulfilling the duty to disclose risks, should follow the *Rogers* v *Whitaker* test, not the *Bolam* test. Nevertheless, in the context of this thesis, the question of standard of care of a doctor is less relevant because it comes into play only if the capacity of the mentally disordered adult to consent has been established and if there is a dispute over the standard of disclosure of risks to such adult.

Although the important decision in *Foo Fio Na* v *Dr Soo Fook Mun and Hospital Assunta*[48] has changed Malaysian law on the standard of care required of a medical practitioner in the provision of advice and information prior to a proposed invasive procedure, this angle of the decision is not relevant in the context of this thesis. The focus of this thesis is not on the standard of care a medical practitioner should exercise when disclosing to patients the risks of sterilisation procedure. Rather, the focus is on whether sterilisation procedure should at all be performed without the consent of a

[46] See footnote 16 above, at paragraph 36
[47] See footnote 16 above
[48] See footnote 16 above

mentally disordered adult, and what decision-makers should take into consideration when answering such question. It is against this backdrop that consent is examined, because a mentally disordered adult cannot be presumed to be incapable of consenting to a sterilisation procedure. In order for a decision-maker to ascertain whether or not the mentally disordered adult possesses the ability to consent to a sterilisation procedure, it is necessary to find out how capacity to consent should be ascertained, in other words what information an adult should be able to process before a person can be considered as having the capacity to consent to a sterilisation procedure. The component of capacity to consent to one treatment necessarily differs from another, and it is particularly so in the case of sterilisation of mentally disordered adults.[49] Therefore, the absence of case law on sterilisation in Malaysia necessitates the examination of the sterilisation cases in other jurisdiction so as to ascertain the types of information a mentally disordered adult is required to comprehend before he or she can be considered as possessing the capacity to consent to a sterilisation procedure.[50]

9.1.3 The dichotomy between therapeutic and non-therapeutic sterilisation in Malaysia

In Chapter 8 the distinction between therapeutic and non-therapeutic sterilisation is argued to be valid and that non-therapeutic sterilisation should not be performed without the consent of the patient.

Section 4 of the Mental Capacity Act 2005 (UK)[51] considers, *inter alia*, the beliefs of the person relevant when considering if an act is in his or her best interest. Since the

[49] See Chapter 1.
[50] See Paragraph 9.2.1 below
[51] c. 9. See also Paragraph 8.1 of Chapter 8

majority of the population in Malaysia professes Islam, the way sterilisation is viewed in Islam might be relevant in the determination of guidelines for Malaysian patients.[52]

Religious rulings on sterilisation

As discussed in Paragraph 3.4 of Chapter 3, sterilisation of a person who professes Islam in Malaysia is prohibited by *fatwa*. However, a *fatwa* is merely an opinion and is not a legally binding code of law. Therefore, unless and until the *fatwa* is adopted by domestic law, no legal consequences could arise from failure to adhere to the *fatwa*.

In Islam, pregnancy is traditionally viewed as the will of God, which could neither be pursued nor prevented. However, with the advent of science and technology, the religious communities have been faced with the question of whether human beings have the right to regulate or reject pregnancy. Some *ulamas* are pro-contraception, while the others anti-contraception. The *ulamas* of Saudi Arabia are against contraception, while the Indonesian *ulamas* generally allow family planning (*tanzhìm al-nasl)* as promoted by the Indonesian government.[53]

Nevertheless, the fact that the *ulamas* in Indonesia allowed contraception does not mean that sterilisation is also allowed. Temporarily preventing pregnancy is not the same as permanently stopping the natural process of reproduction. Although the *fatwa* issued by the Malaysian National Fatwa Council expressly prohibits sterilisation,[54] the same *fatwa* appears to permit family planning for individual when the reasons for doing so are

[52] The legal status of any intended prohibition is however unclear. This is because it does not fall within the jurisdiction of the Syariah courts. Pursuant to item 4 of List I (Federal List) in the Ninth Schedule of the Federal Constitution of Malaysia, civil and criminal law and procedure and the administration of justice are Federal matters except for Islamic personal law relating to marriage, divorce, guardianship, maintenance, adoption, legitimacy, family law, gifts or succession, testate and intestate.
[53] Masdar F. Mas'udi, *Islam & Women's Reproductive Rights*, (Kuala Lumpur: Sisters in Islam, 2002), at page 65
[54] See Paragraph 3.4 of Chapter 3.

acceptable. Another *fatwa* has also declared that the Norplant System of contraception is generally permissible.[55]

The rationale for the prohibition on sterilisation is believed to stem from the Prophet himself. According to Sahîh al-Bukhârî –

> 'Abd Allah relates: "We were on a campaign with the Prophet (peace be upon him) and were destitute, so we asked if we could have ourselves castrated. The Prophet (peace be upon him) prohibited them from this. Then he permitted us to get married with a dowry of a single garment."'[56]

In any event, it is clear that sterilisation can be carried out if it is necessary for the preservation of life as one of the cardinal principles of Islamic law is the absolute protection of life.[57] The Islamic law also follows the rule which provides that all dangers must be avoided. Therefore, although sterilisation is prohibited by the religion, it could be performed under the emergency conditions.

It is submitted that under the teachings of Islam, sterilisation could not be conducted even when the patient consents to it. The only exception to this rule is when the life of the person would be endangered unless the operation is carried out. Therefore, insofar as sterilisation of mentally disordered person is concerned, the issue of consent is irrelevant under Islam and there would be no circumstances in which non-therapeutic sterilisation can be endorsed. Since the only time it would be allowed if when the health of the patient requires it, the operation would have to be entirely therapeutic. In short, non-therapeutic sterilisation is absolutely prohibited by Islam.

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[55] See Paragraph 3.4 of Chapter 3
[56] Volume 7, Book 62, Number 9
[57] "Whoever kills a person, unless it be for manslaughter or for mischief in the land, it is as though he had killed all men. And whoever saves a life, it is as though he had saved the lives of all men." (Al-Ma'idah [5]:32)

However, since Islam's prohibition of sterilisation does not appear to have legal status in Malaysia, a potential issue is whether non-therapeutic sterilisation may still be legally performed when the patient consents to it?

9.2 Guiding principles for Malaysia

For the purpose of determining whether or not sterilisation of mentally disordered adult should be performed in Malaysia, it is submitted that a set of guiding principles consisting two principles, namely the principle of autonomy, and the principle that non-therapeutic sterilisation should not be carried out in the absence of the patient's consent, should be adopted. The mechanisms of the guiding principles are set out below.

9.2.1 The first principle: principle of autonomy

As discussed in Paragraph 9.1.2 above, it is necessary to consider the position of the sterilisation cases in other jurisdictions in order to ascertain the types of information a mentally disordered adult is required to understand before he or she can be considered as having the capacity to consent to a sterilisation procedure. A summary of the relevant sterilisation cases in this regard is set out below.[58]

Having discussed the approaches adopted in England, Canada, Australia, New Zealand and the US, it appears that only England, New Zealand and the US have attempted to use a principled approach in determining whether or not a person has the capacity to consent to sterilisation.

[58] See also Paragraph 8.1 of Chapter 8 for more detailed discussions.

The New Zealand case of *R* v *R*[59] held that a person has the capacity to make a decision if he or she is able to communicate choice, understand the relevant information, appreciate the situation and its consequences, as well as manipulate the information. These four factors overlap to a large extent with the English definition of lack of capacity in the Mental Capacity Act 2005 (UK).[60] However, the definition in the Mental Capacity Act 2005 (UK)[61] is not specific to sterilisation procedure and unlike the New Zealand case, the Mental Capacity Act 2005 (UK)[62] is meant to address the persons with mental disability and hence adopts a two-stage test.[63] The second stage overlaps with the New Zealand test.[64]

The US has developed principles specific to sterilisation in Section 1951 of the California Probate Code.[65] Section 1951 of the California Probate Code[66] provides that there are two elements to "consent to sterilisation", namely it must be voluntary and there must be a full understanding of the nature and consequences of sterilisation. This approach differs from that of England and New Zealand in that the ability to communicate a decision is not stressed. On the other hand, unlike the US, neither England nor New Zealand has emphasised on the need for consent to be voluntary.[67]

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[59] [2004] NZFLR 797
[60] See footnote 51 above
[61] See footnote 51 above
[62] See footnote 51 above
[63] The first stage can be found in Section 2(1) of the Mental Capacity Act 2005 (UK), see footnote 51 above, which states that a person lacks capacity in relation to a matter –
"if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain."
[64] Section 3(1) of the Mental Capacity Act 2005 (UK), see footnote 51 above, provides that a person is unable to make a decision for himself if he is unable –

(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or ay other means).

[65] See Paragraph 8.1 of Chapter 8
[66] See footnote 65 above
[67] The word "voluntary" in Section 1951 of the California Probate Code was defined as "performed while competent to make the decision, and as a matter of free choice and will and not in response to coercion, duress, or undue influence". See also Paragraph 8.1 of Chapter 8.

Unlike the Mental Capacity Act 2005 (UK),[68] the California Probate Code in the US deals with consent to a sterilisation procedure specifically. It lists the exact information a person giving consent must fully understand. Insofar as England is concerned, the information that is relevant for this purpose can only be inferred from the way the facts in many cases have been set out. Section 4(4) of the Mental Capacity Act 2005 (UK)[69] merely explains generally that information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision. However, the California Probate Code runs the risk of being overly specific when listing that one of the information a person giving consent to sterilisation must fully understand is that "the sterilisation procedure is considered to be irreversible".[70] As seen in Paragraph 2.1 of Chapter 2, not all sterilisation procedures are irreversible.[71]

The US approach to the question of capacity to consent is unique in that two cases, *Re Hayes*[72] and *Re Grady*,[73] considered the question as the first step that should be taken when considering whether or not sterilisation should be performed. It is only when it can be satisfied that the patient lacks the capacity to consent that the other questions will become relevant.

In any event, it is generally well established in England, Canada, Australia, New Zealand and the US that the fact that a person was legally incompetent for some purposes did not mean that he or she necessarily lacks the capacity to make a decision

[68] See footnote 51 above
[69] See footnote 51 above
[70] See Chapter 8 above
[71] See also Paragraph 8.1 of Chapter 8
[72] (1980) 608 P.2d 635. See also Paragraph 4.2 of Chapter 4, and Paragraph 8.1 of Chapter 8.
[73] (1981) 426 A.2d 467. See also Paragraph 8.1 of Chapter 8.

about sterilisation. The English case of *Re D (a minor) (wardship: sterilisation)*,[74] the Canadian case of *Re Eve*[75] and the dissenting judgment in the Australian case of *Marion's*[76] have all stated that the patients in those cases may be able to consent in the future.

However, later cases on sterilisation such as *Re Z*[77] and *Re A*[78] seemed to have adopted the requirement of informed consent. The judge in *Re Z*[79] held that the girl had no mental capacity to decide sterilisation matter because it is unlikely that she "would be able to grasp the essentials which would be a pre-requisite of informed consent". In *Re A*,[80] the consultant psychiatrist dismissed A's indication of "no" to the operation on the basis that that was not informed since A could not understand the reason for the operation.

The Mental Capacity Act 2005 (UK)[81] provides that a person is unable to make a decision for himself if he is unable to understand the information relevant to the decision, to retain that information, to use or weigh that information as part of the process of making the decision, or to communicate his decision (whether by talking, using sign language or any other means).

[74] [1976] Fam. 185, [1976] 1 All ER 326. See also Paragraph 4.1 of Chapter 4.
[75] (1986) 31 DLR (4th) 1, [1986] 2 SCR 388. See more discussions on this case in Chapter 4.
[76] *Secretary, Department of Health and Community Services* v *J.W.B. and S.M.B. ('Marion's Case')* (1992) 175 CLR 218, 66 ALJR 300. See also Paragraph 4.2 of Chapter 4.
[77] [2000] 1 FLR 523, [2000] Fam Law 321. See also Chapter 6.
[78] [2000] 1 FLR 549. See also Paragraph 5.1.2 of Chapter 5.
[79] See footnote 77 above
[80] See footnote 78 above
[81] See footnote 51 above

Based on the position in Malaysia,[82] sterilisation cases in England, the general development of the law on consent in England, the *Gillick's case*[83] and the provisions of the Mental Capacity Act 2005 (UK),[84] it is submitted that for the purpose of determining whether or not a person has the capacity to decide if sterilisation procedure should be performed, it is no longer sufficient for a person to know in broad terms the nature and effect of the procedure. The person would have to understand that a decision on options is required.[85] As such, the person would have to be able to comprehend, retain and weigh information such as the consequences of having or not having the treatment; the connection between sexual intercourse, pregnancy and childbirth; the purpose of the sterilisation operation. It should be remembered that the English case of *Sidaway v Board of Governors of the Benthlem Royal Hospital and the Maudsley Hospital*,[86] which rejected the so-called "transatlantic" concept of informed consent, was a medical negligence case where the issue was whether the doctor has disclosed sufficient information to the patient rather than whether the patient has understood it. Malaysia has followed the approach in *Sidaway*,[87] but again, the issue was not whether the patient understands the information. It has been said that in order for the doctrine of informed consent to truly promote individual autonomy, the courts should also explore the concepts of communication and patient comprehension.[88]

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[82] See Paragraph 9.1.2 above
[83] [1986] AC112, [1985]3 All ER 402. See also Paragraph 8.1 of Chapter 8.
[84] See footnote 51 above
[85] Heginbotham, Christopher, "Sterilizing people with mental handicaps", *Legal Issues in Human Reproduction*, Ed., Sheila McLean, (Aldershot: Gower, 1989)
[86] See footnote 33 above
[87] See *Liew Sin Kiong* v *Dr Sharon DM Paulraj*, and footnote 34 above
[88] Puteri Nemie Jahn Kassim and Mohamad Akram Shair Mohammad, "The Doctrine of Informed Consent in the United States, England, Australia and Malaysia: A Comparative Case Analysis", *Issues in Medical Law and Ethics*, Ed., Puteri Nemie Jahn Kassim and Abu Haniffa Mohamed Abdullah, (Kuala Lumpur: Law Centre, Ahmad Ibrahim Kulliyyah of Laws, International Islamic University Malaysia, 2003)

It is submitted that insofar as the level of patient's comprehension of the information disclosed is concerned, the position of England is very similar to the US and Australia, at least insofar as the sterilisation cases are concerned. Incidentally, such approach also coincides with the Malaysian position on treatment for mental condition in section 77(5) of the Mental Health Act 2001,[89] where a person capable of giving consent is required to understand five matters. In short, it would appear that a mentally disordered person would have to demonstrate the ability to comprehend, retain and weigh a wide range of information relevant to sterilisation procedure before the person can be regarded as having the capacity to make any decision on sterilisation. The types of "relevant information" are –

- the nature and purpose of sterilisation procedure;
- the reason sterilisation is proposed;
- the consequences of not undergoing sterilisation (such as having babies);
- the consequences of undergoing sterilisation (such as pain and hospitalisation); and
- the available alternative methods.

It should however be remembered that the decision is entirely the patient's. Although all practicable measures should be taken to help a person to make and communicate a decision,[90] the decision must be the patient's independent decision and the fact that the decision is irrational and generally seen as not in his best interests has no relevance to the question of capacity at all.

Therefore, a person is said to possess the capacity to make a decision on sterilisation if he is able to –

[89] See footnote 2 above
[90] Sections 1(3) and 3(2) of the Mental Capacity Act 2005 (UK), see footnote 51 above, and Section 1958 of California Probate Code

(1) comprehend and retain the "relevant information";

(2) weigh the "relevant information" in the balance so as to arrive at a decision; and

(3) communicate his decision (whether by talking, using sign language and any other means).

Reasonable measures should be taken to help the person to communicate the decision and the failure of the person to communicate orally should not be assumed as an inability to communicate.

If the person has the capacity to consent to a sterilisation procedure, his or her decision would have to be followed regardless of the grounds and rationality of the decision, as long as it is given voluntarily. If the person has no capacity to consent to a sterilisation operation, the decision-maker would have to first determine the likelihood of improvement of the condition that has incapacitated the ability of the person to give consent. If there is a high possibility of improvement of the condition that has incapacitated the ability of the person to give consent, then the decision should be deferred until such time the person has the capacity. If the possibility of improvement is not high, then the test becomes whether or not the sterilisation procedure is for therapeutic or non-therapeutic purpose.

9.2.2 The second principle: the dichotomy between therapeutic and non-therapeutic sterilisation

As concluded in Chapter 8, the workability of the principle that non-therapeutic sterilisation must not be performed without the consent of the patient is highly dependent on the definitions of the terms "therapeutic" and "non-therapeutic".

Based on the position in Malaysia[91] and the general development of the law in relation to sterilisation of mentally disordered persons, it is submitted that the application of the principle that "non-therapeutic sterilisation must not be performed without the consent of the patient" should involve a two-stage deduction process. The first stage is to ensure that the risks the procedure is aimed at preventing is certain to arise. In other words, the risks must not be too remote. For instance, if there is malign tumour in the uterus, it is certain that the girl will die if the procedure is not carried out. Such risk is foreseeable. However, if the sterilisation is carried out to prevent the eventuality of the girl picking the wounds of her Caesarian section after she gets pregnant and deliver the baby, notwithstanding that the consequences of wound picking could be life-threatening, that eventuality should be considered remote.

After identifying the foreseeable risks, the decision maker, be it the courts or other parties, should move on to the second stage where it should be examined if a sterilisation carried out to avoid the foreseeable risks would qualify as a "therapeutic" sterilisation. This is where the definitions of the words "therapeutic" and "non-therapeutic" become crucial.

[91] See Paragraph 9.1.3 above

Brennan J in the *Marion's Case*[92] defined the term "therapeutic sterilisation" to mean a sterilisation administered for the chief purpose of preventing, removing or ameliorating a cosmetic deformity, a pathological condition or a psychiatric disorder, provided sterilisation is appropriate for and proportionate to the purpose for which it is administered. The legal factors which determine the therapeutic nature of sterilisation are proportionality and purpose. The former is determined as a question of medical fact, while the latter is ascertained by reference to all the circumstances but especially to the physical or mental condition which sterilisation is appropriate to affect. Advice from appropriately qualified medical experts should be sought in this regard.

It is submitted that the definitions given by Brennan J appear to be highly dependent on the views of the medical experts. If the principle that prohibits involuntary non-therapeutic sterilisation is to be used as one of the only two guiding principles for sterilisation of mentally disordered adults, it is imperative that the principle should be less technical in nature. If doctors are the ones determining if a procedure is therapeutic or not, even though judges are the ultimate adjudicator, the effect is that the *Bolam* test may be reintroduced and so once again, reintroduce a narrowly interpreted perspective of what exactly ought to be the best way to proceed with decision-making.

Since the basis for distinguishing therapeutic from non-therapeutic sterilisation is to avoid confusing medical factors with social factors, it is submitted that the best way to distinguish "therapeutic" from "non-therapeutic" is to define "non-therapeutic" using its "social" characteristic. A procedure would be considered "non-therapeutic" if it is carried out for social purpose. Whether or not it is for social purpose depends on the risk or problem aims to be solved or reduced by the procedure. If the risk or problem

[92] See footnote 76 above

can be solved or reduced by "social" means, then the procedure would be regarded as a "non-therapeutic" procedure. All procedures that are aimed at reducing or eliminating risk that can only be solved medically would be considered "therapeutic" in nature.

The word "social" here means what the society, including the state, carers, trainers and psychiatrists, should do in an ideal situation. This should be distinguished from the availability of alternatives. Whether or not the "social" means of handling the risk is available to the patient should not be relevant to the consideration. The consideration should be hypothetical, so that the question asked is "would an ideal society sterilise this person?". The fact that the state or the parents refuse or omit to deliver a higher standard of care towards the protection of the welfare of the mentally disordered adults does not mean that the state can proceed with these less-than-ideal methods. The state in particular and the society in general have the responsibility to protect its people and if the society collectively fails to do so, that is no reason why the patient should be made to go through painful procedure.

Examples

In a typical situation where the parents of a mentally disordered adult seeks to have the patient sterilised for fear of pregnancy, the first stage is to ask what risk sterilisation hopes to eliminate. If the risks sought to be avoided include the trauma of childbirth in the event of pregnancy, then the first question to ask is whether or not the risks are likely to arise. If the girl is stringently supervised, then the likelihood of pregnancy is low hence the risks of childbirth would be too remote. If the girl is not fertile, the risk of pregnancy would also be low. In the event the risk is high, the next question would then be "is this a therapeutic procedure?", "would an ideal society sterilise this person?".

For example, if it is possible to train and educate the girl to handle the trauma of childbirth, then the procedure would not be considered therapeutic in nature.

Another instance is where sterilisation is sought because the girl is unable to cope with menstruation. The first stage is to ask if it is certain that the girl will menstruate. If the girl will most certainly menstruate, then we have to ask if it is possible to solve the problem using social means. If the girl is capable of being trained to handle her menstruation, then that sterilisation will not be considered "therapeutic" in nature. If the girl suffers from phobic aversion to blood and she would faint upon any sight of blood, then it is more likely that sterilisation under those circumstances will be considered "therapeutic" in nature.

Chapter 10

Conclusion

It is unlikely that anyone would be deliberately reckless to a mentally disordered person when making a decision on whether or not such person should be sterilised. Most decisions are made out of genuine concern for the welfare of the mentally disordered person. However, as illustrated in this thesis, making a decision concerning sterilisation requires much more than mere compassion. The issues are complex and impinge on some of the most important values of human life, such as the right to self-determination and the right to found a family.

Sterilisation is a form of invasive procedure that is not without risks. Many sterilisation cases have attempted to weigh the risks of sterilisation against the risks of not performing sterilisation, although they are not always comparable. Law is oftentimes expected to reflect the views of the majority of the people in the relevant jurisdiction although a majority view on this moral and ethical issue is not necessarily exhaustive or determinative. It is thus submitted that we should take a philosophical approach and look into the history of sterilising mentally disordered persons, as history would provide us with the opportunity to see what the general consensus has been in this complex area of sterilisation of mentally disordered persons. It is clear that the practice of sterilising mentally disordered persons on eugenic grounds can no longer be tolerated. This is shown in the approaches of the earlier cases on sterilisation where the human rights of the patient are emphasised time and again to remind all that we must be extra vigilant when considering this issue because it involves the deprivation of a person's right to reproduce and found a family.

The subsequent trend of the development of case law on sterilisation became somewhat problematic as the law appeared to be protecting the interests of doctors more than that of the patient herself. This is partly because the fluid nature of the rights-based approach is unable to provide certainty to the law. Another major reason lies in the fact that the best interests test is not at all times a useful test. It leaves much in the hands of the decision-maker on how the test is to be applied. Doctors became the custodian of the matter in England when the English courts discovered that they do not have jurisdiction over mentally disordered adults. The *Bolam* test became the test for deciding whether or not a mentally disordered adult should be sterilised. It naturally followed that factors considered in determining the best interests of the patient became more "medical" in nature, resulting in a less than holistic approach suited to patients' needs.

Although the medical angle is relevant, it has been argued above that the sterilisation of a mentally disordered person is not entirely a medical issue. It is as much a social problem as a medical problem. To use medical means to solve a social problem is almost similar to sterilising mentally disordered persons to help save the state's cost to care for them. The general consensus obtained in the wake of the Second World War was that sterilisation of mentally disordered persons for the interests of the state is not acceptable and it is important that we zealously guard against any attempt that may bring us down the slippery slope.

It is for that reason that it is submitted that the best interests test might be meaningless without clear legal principles. The legal principles that can provide sufficient legal certainty in this regard are the principle of autonomy and the principle that non-therapeutic sterilisation cannot be carried out without the consent of the patient. The

first principle is a well-established principle in medical law that seeks to uphold the right of self-determination of the patient. The second principle is somewhat controversial in that many cases on sterilisation dismissed the relevance of the distinction between therapeutic and non-therapeutic sterilisation. Nevertheless, this principle is the only principle that can have the effect of separating the medical factors from the social factors. As mentioned earlier, the separation between the medical factors and the social factors is most important as the failure to do so may bring us dangerously close to the days where sterilisation is performed on large scale in the name of protecting the society.

It is therefore proposed in this thesis that Malaysia should use both the principle of autonomy and the principle that non-therapeutic sterilisation should not be carried out without the consent of the patient as the guiding principles when deciding whether or not a mentally disordered adult should be sterilised in Malaysia. The principle of autonomy, being a well-established principle of medical law, is recognised in Malaysia.[1] The principle of caution or restraint in cases of non-therapeutic sterilisation also coincides with the existing religious *fatwas* in Malaysia.

The first step would be to apply the principle of autonomy by determining whether or not the mentally disordered adults have the capacity to consent to the sterilisation procedure. A person would be considered as having the capacity to make a decision if he is able to comprehend and retain the "relevant information"; weigh the "relevant information" in the balance; and communicate his decision. Insofar as sterilisation is concerned, "relevant information" includes the nature and purpose of sterilisation; the

[1] See the Federal Court decision in *Foo Fio Na* v *Dr Soo Fook Mun and Hospital Assunta* [2007] 1 MLJ 593 and Paragraph 9.1.2 of Chapter 9.

consequences of not undergoing sterilisation; the consequences of undergoing sterilisation; and the available alternative methods.

If the person has the capacity to consent to a sterilisation procedure, then his decision would have to be followed regardless of the grounds and rationale of the decision. If the person does not have the capacity to consent, then the next step of examination would have to be taken.

This next step involves determining whether or not the sterilisation is therapeutic or non-therapeutic in nature. This step can be further divided into two stages. The first stage is an elimination process, where remote risks are not taken into consideration. It should not matter at this stage whether the risk is medical (therapeutic) or non-medical (non-therapeutic) in nature. The second stage involves examining the foreseeable risks identified at the first stage and ensuring that these risks are indeed medical (therapeutic) in nature. If the risk aimed to be prevented or reduced by sterilisation would not provide any medical improvement to the patient's condition but the underlying reasoning is to, for example, prevent the patient from being exposed to social evils, the ensuing sterilisation would be non-therapeutic.

This two-step test for Malaysia is forwarded as an adequate set of test as it consists of legal principles that can be used without compromising the ability of the law to accommodate different circumstances in each case. The various "medical" factors remain relevant, so long as they are not too remote. It is imperative that each of the different factors is also examined from the social angle so that only the reasons which are medical in nature qualify as therapeutic procedures. In the event of doubts on the therapeutic nature of the proposed sterilisation, a court order should be sought where it

is hoped that an equitable and fair balancing of the conflicting interests will be made in the interests of the incompetent patient.

(45,287 words)

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