'Sterilisation' of Young Intellectually Disabled Women

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INTRODUCTION

In this article I will discuss the major legal and ethical issues surrounding the practice of 'sterilisation' of young intellectually disabled women. It is timely to do so now, the question having recently been before the High Court in *Secretary, Department of Health and Community Services* v *JWB and SMB* ('*Marion's* case'),[1] though the practice is by no means a new one.[2] After a discussion of the various judicial viewpoints in *Marion's* case I will suggest some considerations which appear to have escaped their Honours' attention in the case. In particular, I will attempt to construct a feminist position on the question, building on the argument that the practice of involuntary 'sterilisation' is informed by deeply sexist attitudes. To the extent that 'sterilisations' are performed on otherwise healthy but intellectually disabled women on the basis of anti-woman beliefs, I believe that the practice is an affront to all women,[3] and serious attention must be paid to the issue *from this viewpoint*, and not simply from the viewpoint of prevailing medical, legal or even 'community'[4] standards.

The issues tend to arise in cases concerning young women at the onset of puberty, which for most occurs in the early teens. Thus the cases have been

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1 (1992) 175 CLR 218.

2 The Family Law Council of Australia has recently issued a Discussion Paper canvassing many of the issues this article addresses: see Family Law Council, *Sterilisation and Other Medical Procedures on Children*, Discussion Paper (October 1993). Another notable development has been the decision of the High Court in *P* v *P* (1994) 120 ALR 545. There the High Court held that the power of the Family Court to authorise a 'sterilisation' operation extends to situations which would otherwise be covered by State law — in this case, the *Guardianship Act* 1987 (NSW). Thus, although the State Act purported to make such treatment an offence in the absence of consent by the Guardianship Board, the treatment could be carried out without the threat of a criminal sanction under the State Act, on the basis of consent by the Family Court.

3 I cannot make a claim like this without acknowledging the dangers of claiming to speak for 'all women'. The fact that women as a group are divided along socio-economic, racial and other lines results in some clear divergences in interests and outlooks within the group. However, this is one issue where in my opinion the interests of women as a group do converge; if anyone has a greater interest in seeing involuntary sterilisation regulated it is women who are disadvantaged by their race or social class. See C Rutherford, 'Reproductive Freedoms and African American Women' (1992) 4 *Yale Journal of Law & Feminism* 255, 274, and fns 90–92 infra and accompanying text. For this reason, I would argue that the women's movement *as a whole* should treat this issue as one of priority.

4 See *Marion's* case (1992) 175 CLR 218, 295 per Deane J. There is of course a serious danger that 'community' standards will be just as sexist as those of the medical or legal professions, or even more so. In my opinion, such standards are not exempt from feminist scrutiny simply because they find their base in a broader cross-section of society than do certain other types of standard.

dealt with according to the law applying to children, which is the position of parents as guardians and their authority to consent to medical treatment on behalf of their minor children as affected by the *Family Law Act* 1975 (Cth). But because it concerns the onset of puberty, the issues raised affect intellectually disabled women as women, and not as children. Thus, this article addresses the issues in terms of the position of women with intellectual disabilities, not the legal categorisation of those women as children. Once they turn 18, the legal framework of family law no longer applies, and in most states, the system of guardianship and administration boards comes into effect. Cases dealt with in this arena do not involve the complications which tend to arise from the position of children in the family structure, the parental role as guardians of their children who are able to consent to treatment on their behalf, and the potential for conflicts of interest between family carers and the women involved.

My practice of using inverted commas with the word 'sterilisation' should be commented on in the beginning. It is clear that in the majority of the cases on the 'sterilisation' of intellectually disabled women the end sought by those proposing the operation is not the prevention of reproduction but 'menstrual management' or, more accurately, suppression of menstruation. So much was made explicit in the application in *Marion's* case, where the procedure in respect of which an order was sought was a hysterectomy. If reproductive capacity were the only concern, surely a tubal ligation would suffice. Resort to hysterectomy makes it clear that the concern is menstruation and not reproduction. Thus the word 'sterilisation' in this context is something of a euphemism; I use it in inverted commas because it is slightly inaccurate and it obscures the real issue.

Certain considerations lead me to see the necessity for a feminist analysis of the issue of 'sterilisation'. The first is the fact that an operation which results in the removal of a person's reproductive capacity raises special issues above and beyond those involved in any other kind of operation. Since reproduction is an area where sexual 'difference' is particularly apparent, there may be particular interests that women have which risk being overlooked by a 'gender-neutral' analysis. Or, on the other hand, there is also a risk that sexual stereotypes might be introduced into the analysis — women might be assumed to have particular interests when in fact those interests are shared by men.

The other reason why a feminist analysis is necessary is the fact that 'sterilisation' raises questions of human rights and particularly of women's rights to control over their own bodies. The applicability of feminist analysis is by no means limited to areas of law which affect women *as women*, but in such areas feminism has a particular capacity to shed light. It is important to explain how the 'sterilisation' issue fits with all the other legal issues arising out of treatment of women's bodies; this I do below, but first it will be instructive to consider the decision in *Marion's* case, as an illustration of how the law responds to the issue.

MARION'S CASE

In *Marion's* case, the High Court decided by majority[5] that decisions relating to the 'sterilisation' of the intellectually disabled must be referred to a court of competent jurisdiction. The decision means that the parents or guardians of the individual concerned cannot consent on her behalf to procedures which deprive her of the ability to reproduce. Brennan, Deane and McHugh JJ in the High Court dissented, but all recognised that there were some cases where court permission should be sought.

In this section I will set out the factual and precedential background to the case, before proceeding to discuss the majority and minority decisions in the Family Court and the High Court.

Background

The case came to the High Court on appeal from an order of the Full Court of the Family Court of Australia,[6] where a majority[7] had held that while it was desirable that parents and doctors seek a court's authorisation before proceeding with such an operation, it was not *necessary* for them to do so for the operation to be legal.

Facts

'Marion', the young woman whose fate was at issue, was 14 years old when the High Court handed down its decision. At the time of the original application to the Family Court in respect of her proposed 'sterilisation' she was 12 and had commenced menstruating approximately two-and-one-half months before.[8] She suffered from 'mental retardation, severe deafness and epilepsy ... an ataxic gait and behavioural problems'.[9] The proposed treatment included a hysterectomy and an ovarienectomy. The latter procedure was expected to 'stabilise hormonal fluxes'.[10] The aim of the proposed hysterectomy was to avoid pregnancy and menstruation 'with its psychological and behavioural consequences'.[11] One must assume from the wording of the application[12] that these 'consequences' were those only of menstruation, not of pregnancy as well. The conclusion to be drawn from this is that pregnancy was considered undesirable for reasons other than its 'psychological and behavioural consequences'.

The applicants had pleaded that Marion 'is incapable of caring for herself physically and/or properly understanding the nature and implications of

[5] Mason CJ and Dawson, Toohey and Gaudron JJ.
[6] *Re Marion* (1990) 14 Fam LR 427.
[7] Strauss and McCall JJ; Nicholson CJ dissenting.
[8] See the facts as set out in the judgment of Nicholson CJ: (1990) 14 Fam LR 427, 428.
[9] (1992) 175 CLR 218, 229.
[10] Ibid.
[11] Ibid.
[12] See (1990) 14 Fam LR 427, 428.

sexuality, pregnancy and motherhood.'[13] However, it is nowhere spelt out why this necessarily leads to the conclusion that she would not enjoy or find any fulfilment in sexuality, pregnancy or motherhood.[14]

Marion's parents applied to the Family Court for an order authorising the performance of the hysterectomy and ovarienectomy, or alternatively a hysterectomy, on Marion, and a declaration that it was lawful for them (the parents) to consent on Marion's behalf to those procedures.

Precedents

There were four reported Australian cases on the issue, each decided by a single judge of the Family Court: *In Re Jane*,[15] *In Re Elizabeth*,[16] *In re a Teenager*[17] and *In re S.*[18] The latter two of these supported the applicant's case in so far as they held that there was no need for court involvement in the decision-making process. The other two stood for the opposite conclusion.[19] The Australian authority on the question of parental authority to consent was therefore equally divided. In all four cases, however, the conclusion was reached that the operation was in the child's best interests. This was in spite of the fact that none of the girls involved had yet commenced to menstruate. In all four cases there were two major reasons proffered for the proposed operation: the inappropriateness of pregnancy and potential trauma which would or could be caused by menstruation. On the main point eventually decided in *Marion's* case, the four judges were, as previously noted, evenly divided. The two earlier, and more substantial, decisions can be referred to in order to gain an insight into the reasons for the different conclusions.

The decision of Nicholson CJ in *Jane's* case, that the operation is unlawful without court approval, is based on three major considerations: first, his Honour was concerned about the kinds of operations, beyond hysterectomy, to which parents could consent on behalf of their children if he held otherwise.[20] Second, his Honour was willing to give recognition to reproduction as a fundamental right, of which no-one should be easily deprived.[21] Third, his Honour expressed doubts that the medical profession could be relied on as a guardian of daughters' rights.[22] A related point was that there is the potential for parents, in deciding whether to consent, to be biased in favour of their own

[13] Ibid.
[14] See under the heading 'Inability to Understand Equals Inability to Enjoy?' infra.
[15] (1988) 12 Fam LR 662.
[16] (1989) 13 Fam LR 47.
[17] (1988) 13 Fam LR 85.
[18] (1989) 13 Fam LR 660.
[19] It is interesting to note that the two cases which gave greater protection to the intellectually disabled girl or woman were given a full name (Jane or Elizabeth). In the other two cases, the person the subject of the decision was de-personified, being referred to as simply 'S' or 'a teenager'.
[20] Clitoridectomy and forced organ donation were mentioned: (1988) 12 Fam LR 662, 685.
[21] Id 688–9.
[22] His Honour noted that the medical profession 'has members who are not prepared to live up to its professional standards of ethics and experience teaches that the identity of such medical practitioners becomes known to those who require their assistance': id 685.

interests at the expense of the daughter's.[23] In other words, Nicholson CJ recognised the potential for abuse of power by parents and medical practitioners if the decision is left up to them. His Honour expressly noted the conflict between the principle of paramountcy of the child's interests and any approach which takes into account the 'rights' of parents.[24]

By contrast, Cook J in the *Teenager's* case, which was decided only shortly before *Jane's* case, showed great faith in the nuclear family as a protector of children's rights and the rights of the disabled. However, a close reading of the judgment leads to the suggestion that his Honour was actually more concerned about the rights of parents and families per se rather than their role in protecting the disabled child.

The basis for the rights which his Honour was concerned to protect was found in s 43(b) of the *Family Law Act* 1975 (Cth), which requires the Family Court to give specific recognition to 'the need to give the widest possible protection and assistance to the family as the natural and fundamental group unit of society'.[25] This provision, it seems, justifies a Family Court judge in balancing the interests of one member of a family against those of the family as a whole, and most particularly of the parents. The apparent logical inconsistency of calling the child's interests paramount and proceeding to recognise as relevant some competing interests is not addressed.

Cook J also devoted a considerable amount of time to discussion of a Canadian case, *Re K; K* v *Public Trustee*,[26] which rejected the proposition that generalised rights of the disabled and of children generally and public policy are of any importance in deciding a case of this type.[27] It appears that the need to give careful consideration to the facts of each individual case excludes the possibility of taking into account generally accepted standards for the treatment of similarly placed people. *Re K* is also authority for the proposition that to the extent that the disabled are unaware of the significance of a matter, for example menstruation — or indeed of its existence, as was the case for all four of the girls here — they cannot derive any enjoyment from a right to involvement in that matter, and cannot miss the right if they are deprived of it. The right is meaningless to them, and therefore, it would seem, meaningless to the court.[28] Cook J noted in *Re K* 'a rather extraordinary similarity to the facts and issues of this present case'[29] and concluded that he did 'not consider it necessary to refer to any other authorities or cases upon which submissions were made',[30] commenting favourably upon its 'common sense and pragmatic approach to the problem'.[31] It must therefore be concluded that his Honour approved of the reasoning in the case, and that the *Teenager's* case is also

[23] Id 689.
[24] Id 686.
[25] *In re a Teenager* (1988) 13 Fam LR 85, 99. Cook J's interpretation of the provision was challenged by Simpson J in *In Re S* (1989) 13 Fam LR 660, 672.
[26] (1985) 4 WWR 724 (British Columbia Court of Appeal); see (1988) 13 Fam LR 85, 103–11.
[27] (1988) 13 Fam LR 85, 103.
[28] Id 104.
[29] (1988) 13 Fam LR 85, 104.
[30] Id 111.
[31] Id 112.

authority for the proposition that people who do not understand their rights do not have any rights.

Thus, since there is no effective right in the girl to be protected by a court of law, and since the very proceedings interfere in an offensive way with the rights of the parents, there was no warrant, in Cook J's opinion, for involving the court in 'sterilisation' decisions, let alone requiring such involvement as a matter of course.

In *Elizabeth's* case, Ross-Jones J followed Nicholson CJ, deciding that court approval should be sought where the purpose of the proposed operation is non-therapeutic and it would interfere with a basic human right, such as reproduction.[32] In *S's* case, Simpson J reached the opposite conclusion, holding that there was no warrant for the introduction of common law restrictions on the responsibilities and rights of guardians as set out in the *Family Law Act* 1975 (Cth).[33] His Honour also considered that the risks associated with the operation were minimal,[34] the child's uterus was of no benefit to her[35] and that parents of similarly situated children would not necessarily seek court approval even if such were held to be necessary.[36]

It should be noted that in all four of the Australian cases preceding *Marion's* case, even those which held that parents do not have the power to consent, it was ultimately decided that the operation was in the girl's best interests, in that it was preferable to the alternatives of pharmacological intervention and hygiene training programmes, and should go ahead.

The Judgments in the Family Court

In *Marion's* case Nicholson CJ held that it was not within a parent's powers to consent on behalf of a child to 'sterilisation'. If parents wish to have a child 'sterilised', they must seek the authorisation of the court.[37] In so holding, his Honour was being consistent with his earlier holding in *Re Jane*. The only exception his Honour was willing to recognise to this general proposition was the case of an emergency operation 'for the treatment of an illness and which, as a by-product, involves sterilisation'.[38] His Honour said:

> I am not prepared to accept a proposition that the common law leaves mentally retarded children in . . . an unprotected position, given its long history of protection of the rights of children in general, and of children under a disability in particular.[39]

His Honour also indicated a willingness to accept, if necessary (which it was not for the purposes of this decision), that certain substantive rights of intellectually disabled people set out in the *Declaration on the Rights of Mentally*

[32] (1989) 13 Fam LR 47, 62.
[33] (1989) 13 Fam LR 660, 671.
[34] Id 669.
[35] Id 669–70.
[36] Id 674.
[37] (1990) 14 Fam LR 427, 448.
[38] Ibid.
[39] Id 449.

Retarded Persons (1971) have been incorporated into Australian law through the *Human Rights and Equal Opportunity Act* 1986 (Cth).[40]

Strauss and McCall JJ, however, held that parents do have the power to consent to 'sterilisation' on behalf of a child. Thus recourse need not be had to a court before such an operation can be lawful. Their Honours also rejected the proposition that the *Declaration on the Rights of Mentally Retarded Persons* has been incorporated into Australian law.[41]

Their Honours thought that an operation could be lawfully consented to by parents if it was in the child's best interests. However, they gave no guidelines as to when the operation would and would not fit that description. Thus the matter still lies substantially within the discretion of parents and doctors. McCall J noted:

> I appreciate that this is an unsatisfactory state for the law to be in as it gives little comfort to the medical profession in deciding whether or not to act on parental consent. . . . A medical advisor should not be in a position of having to make his own subjective assessment of whether the consent by the parents has been given with reference to the correct legal principles.[42]

However, his Honour did not take the opportunity to relieve the medical profession of this burden by providing for compulsory court determinations of the legality of the operation. In his Honour's view this was a matter which should be cleared up by the legislature.[43]

The High Court's Decision

The Majority

Mason CJ and Dawson, Toohey and Gaudron JJ delivered a joint judgment in *Marion's* case, holding that a 'sterilisation' operation is illegal unless the Family Court's approval is first sought and given. Their Honours considered the fundamental principles of criminal and tort law relating to consent to medical treatment, but with the caveat that 'sterilisation implies more than medical, or surgical, treatment'.[44]

Marion was found to be incapable of consenting to treatment on her own behalf, so the Court had to address the question who *could* consent on her behalf. Generally speaking, a parent's authority to consent to treatment on behalf of a child is subject to the overriding requirement that the treatment be in the child's best interests.[45] It was accepted by all parties in the case that 'sterilisation' could be in a child's best interests; the fundamental question was who decides whether that is the case or not — the parents or the courts?

[40] Id 451–2.
[41] Id 461 per Strauss J, 473–4 per McCall J.
[42] Id 473.
[43] Ibid.
[44] (1992) 175 CLR 218, 232.
[45] Id 240.

The majority clearly saw 'sterilisation' as a special case, noting three factors militating in favour of treating 'sterilisation' in that way:

> First, the concept of a fundamental right to procreate; secondly, in some cases, a similarly fundamental right to bodily inviolability or its equivalent; thirdly, the gravity of the procedure and its ethical, social and personal consequences.[46]

Their Honours noted also that there is a 'significant risk of making the wrong decision'[47] because of 'the complexity of the question of consent',[48] the fact that 'the medical profession very often plays a central role in the decision' and 'it is hard to share the view . . . that absolute faith in the integrity of all medical practitioners is warranted',[49] and because of 'the independent and possibly conflicting (though legitimate) interests of the parents and other family members'.[50]

These reasons form the basis for the majority's decision that the court alone could consent on behalf of an intellectually disabled child to a 'sterilisation' (except that their Honours explicitly left open the question whether the common law recognises a fundamental right to procreate).[51] In their Honours' opinion, 'there is less likelihood of (intentional or unintentional) abuse of the rights of children if an application to a court is mandatory.'[52]

The majority also held that the Family Court has jurisdiction to make such decisions,[53] but not to extend the power of parents or guardians in relation to such decisions.[54]

Their Honours offered some guidance to judges who would be deciding such cases in future. The essential point of reference is the best interests of the child, with further definition being provided by a reference to the necessity that the child should be able 'to lead a life in keeping with . . . her needs and capacities.'[55] Thus, the convenience of 'sterilisation' as a contraceptive measure would not suffice. The best interests principle would also require that 'sterilisation' should be a step of last resort. In so far as the operation has the object of suppressing menstruation,[56] this means that less invasive procedures must have failed, or 'that it is certain that no other procedure or treatment will work.'[57] The majority anticipated that in most cases, the opinion of the Court would coincide with the wishes of the family.[58]

[46] Id 249.
[47] Id 250.
[48] Ibid.
[49] Id 251.
[50] Ibid.
[51] Id 254.
[52] Id 253.
[53] Id 254–8.
[54] Id 257–8.
[55] Id 260.
[56] Id 259.
[57] Ibid.
[58] Id 260.

The Minority

Brennan, Deane and McHugh JJ dissented. All three of these judges recognised that there were some cases where permission should be sought. For Brennan J, these were the cases where the proposed treatment was not 'therapeutic' in nature.[59] Deane J held that parents have the right to consent on behalf of the child to an operation whose capacity to enhance the welfare of the child is, by community standards, obvious; this could include non-therapeutic 'sterilisation' in some cases.[60] McHugh J sought to limit the categories of case where the parents could consent to the 'sterilisation' of the child, by reference to the welfare of the child, compelling circumstances justifying the treatment and the absence of conflict between the interests of the parent and those of the child.[61]

My main criticism of the minority judgments is that even though they did lay down guidelines for the making of decisions relating to the 'sterilisation' of the intellectually disabled, they directed those guidelines at the wrong people. It is simply unfair to expect the parents of an intellectually disabled child to understand what the minority judgments require of them. Even assuming that parents have ready access to the judgments, the time to read them carefully and the skills with which to understand them (which, it is submitted, probably would involve some legal training), they cannot be confident that they are deciding the way a judge would decide. Yet it is judges who, if anything goes wrong, will be evaluating the parents' actions. Even if the parents obtain legal advice to assist the decision whether to have their daughter 'sterilised', it will ultimately be they, not their lawyer, who bear the legal responsibility for the act. In these circumstances, it is better that judges themselves should bear the responsibility: that is, that they alone should have the legal authority to consent to this kind of operation.

There is nothing particularly new in this; even in a standard negligence case, a defendant's actions are evaluated by judges according to standards which have been laid down by judges in decided cases. There are, however, differences between negligence and the proposed 'sterilisation' of a young woman. First, negligence is something which typically happens as a result of a moment's inadvertence.[62] A 'sterilisation' involves a fair amount of advance planning, and therefore reflection over whether it is the best thing to do. In negligence, there is usually no opportunity to consult a lawyer, much less seek a court order, before acting. With 'sterilisation', there is such an opportunity and such an opportunity should be taken.

[59] Id 269 ff.
[60] Id 296–7.
[61] Id 320–2.
[62] The exception is the case of a corporate defendant which has committed negligence in the course of its business, particularly its corporate decision-making process. Such a defendant has ample opportunity to reflect before acting. Empirically, of course, the corporate tort defendant is the rule rather than the exception in the appellate courts, particularly given the modern trend towards statutory compensation schemes for motor vehicle injuries. It is this type of defendant, however, which is most likely to have the resources to ensure making a decision similar to that which a court would make. It can therefore be distinguished from the parents of a disabled girl.

THE PREFERABILITY OF THE MAJORITY'S DECISION

I have already indicated what I think is the major weakness of the minority's conclusion. It follows that in my opinion, the majority's decision is preferable for the reason that it reaches the opposite conclusion and hence the opposite practical result: that is, it takes the burden off non-lawyers of making what is in essence a legal decision, or at least a decision with important legal ramifications. In this section I will set out some further arguments in favour of the majority's decision. I disclaim, however, at the end of this Section, the proposition that a court is *the ideal* decision-maker in this regard.

The Role of the Medical Profession

Historically, judgments in this area have shown a marked tendency to defer to the judgment of medical practitioners.[63] This tendency is particularly marked when it is a question of deciding whether to rely on evidence of medical practitioners in preference to that of other health-care professionals.

The judgment of Simpson J in *S's* case is worthy of examination in this regard. His Honour repeatedly expresses satisfaction at the evidence of medical practitioners without seeing a need to reiterate their opinions, let alone discuss their foundation.[64] This attitude stands in sharp contrast to that which his Honour adopted towards other professionals, summarily dismissing the evidence of the Director of the centre where the girl had lived since she was six and who promised that 'the centre "is prepared to do whatever is needed to maintain an appropriate level of hygiene for S"',[65] and a program consultant employed by the Commonwealth Community Resource Unit who explained the difference between the 'utilitarian' approach of the medical profession and the 'least restrictive alternative' principle espoused by the behavioural sciences.[66]

Generally speaking, the 'least restrictive alternative' approach of other professionals, notably those involved in the day-to-day care of the girls, tends to lead them to oppose the operation and to advocate training programmes, pharmacological treatment, or at least waiting to see just how bad the prob-

[63] See J Blackwood, 'Sterilisation of the Intellectually Disabled: The Need for Legislative Reform' (1991) 5 *Australian Journal of Family Law* 138, 151–2; J Shaw, 'Sterilisation of Mentally Handicapped People: Judges Rule OK?' (1990) 53 MLR 91, 92.

[64] (1989) 13 Fam LR 660, 663–7; see also Blackwood, op cit (fn 63) 151–2 fn 80.
It might also be noted that in *Elizabeth's* case, Ross-Jones J stated that he was 'impressed' by the evidence of an obstetrician and gynaecologist who relied only on his own experience and a ten-year old report from Sweden for which he was unable to provide a reference: (1989) 13 Fam LR 47, 58. (This evidence, predictably, told in favour of the operation.) One need only imagine a lawyer before the court seeking to rely on some proposition, and citing only his or her own experience and an anonymous case or article, to appreciate the extraordinariness of this judicial reaction!
Cook J in the *Teenager's* case also showed a tendency to rely on medical evidence without rehearsing it: see, eg, (1988) 13 Fam LR 85, 94.

[65] (1989) 13 Fam LR 660, 663. His Honour's response to this promise was: 'I found his evidence somewhat theoretical and accordingly only of limited assistance': ibid.

[66] Id 664. ('In my view little of [her] evidence is of direct assistance in the resolution of the issues before me': ibid.)

lems become.[67] This stands in stark contrast with the utilitarian approach which medical practitioners tend to adopt, which is likely to lead them to support the performance of the operation. For as long as it is accepted that the girl will never bear children, her uterus is of no use to her and is therefore better removed.[68] It is therefore not surprising that all four judges in the pre-*Marion* Australian cases concluded that the operation was justified.

Deference to medical science, and to its 'knowledge', is by no means a new phenomenon; nor is it unique to Australia[69] or limited to this area of law.[70] There is not the space here to consider the possible cause or causes of this deference,[71] but what is clear is that this tendency on the part of judges causes them to shirk their responsibilities for deciding matters in a way that coincides with the best interests of the individual concerned. The results are particularly regrettable here because, by constructing the issue as a 'medical' one, they perpetuate the historical view of 'mental handicap as a disease and mentally handicapped people as "sick" and "unfortunate"'.[72] In most if not all cases, it will not be in the individual's best interest to be regarded in this way.

The decision of the majority displays a healthy scepticism towards the medical profession, and in particular towards the capacity of its members to deal with complex moral and human rights issues.[73] It might be objected that such a scepticism might be just as well directed towards courts, but it will be argued below that this is not the case.[74] One cannot have complete confidence in any person or body when it comes to this kind of decision, but it is argued that at least in court proceedings one can be fairly sure that all the issues will be raised and considered. As much cannot be said of the medical decision-making process.

[67] See *In re S* (1989) 13 Fam LR 660, 664, quoting the evidence of a psychologist:
> It is far less restrictive for contraceptive purposes for a female to take the contraceptive pill than to have a hysterectomy. It is far less restrictive for a female to be taught menstrual hygiene than to have a hysterectomy. It is far less restrictive for a female to be assisted in menstrual hygiene than to have a hysterectomy.

[68] An example of the medical profession's utilitarian approach is provided in the following paraphrase of a comment of one of the medical witnesses in *In Re S*: 'there is no point in the child going through the problems associated with menstruation if she is not ever to bear children': id 669.

[69] See Shaw, op cit (fn 63) 102 (in the UK, the only criteria on which to ascertain a patient's best interests appear to be found in a medical practitioner's clinical judgment).

[70] In *Mt Isa Mines* v *Pusey* (1970) 125 CLR 383, eg, Windeyer J noted that the law's recognition of 'nervous shock' as a compensable injury relied on developments in medical knowledge: id 395.

[71] Shaw suggests that it may be a form of inter-professional solidarity: Shaw, op cit (fn 63) 97. Another possibility is that it may be an unwillingness to be seen to make decisions with which someone is always bound to disagree, and disagree violently. One who felt this unwillingness would surely find reliance on the 'judgment' of some 'expert' an easy and convincing way of avoiding the undesired appearance.

[72] Id 103.

[73] (1992) 175 CLR 218, 251. See also *In Re Jane* (1988) 12 Fam LR 662, 685 per Nicholson CJ.

[74] See under the headings 'Deciding on Behalf of Another' and 'A Word Of Caution: Courts As Decision-Makers' infra.

Deciding on Behalf of Another

One of the fundamental sources of difficulty in cases like *Marion* is that they call for a decision as to who is the best person to make a decision on behalf of another, because that person is incapable of deciding for herself. If she could make the decision, it would be informed by the complex concatenation of rational and irrational considerations that come into play when we make decisions for ourselves. It is important to recognise that when we make decisions on behalf of another person, that same complex concatenation of considerations is bound to come into play. The reason this recognition is important is that we must identify, and try to distance ourselves from, our own personal biases when we are making a decision on behalf of someone else. This is the only way that we can hope to replicate the decision that the person would have made for herself.

Recognition of personal biases is difficult at the best of times. There are certain values that we hold so dear that it is simply too painful to recognise that others may have a different view. Much as we may wish to believe that our beliefs and values are based on deep reflection and rational, perhaps objective, but certainly unassailable considerations, we must accept when making an important decision on someone else's behalf that that person might see things completely differently.

When one person makes a decision that another should be 'sterilised', these tensions are made all the more difficult for the fact that, emotionally, reproduction is a highly charged field of human endeavour. It is thus very difficult to decide how attached or detached the decision-maker should be. There may be a tendency on the part of people who are not intimately involved in the life of the person the subject of the decision to become overawed by the emotional component of the decision, at the expense of attention to the practicalities of the person's day-to-day life. On the other hand, people who *are* intimately involved in the person's life, particularly those who have responsibility for her day-to-day care, risk submission to the temptation to give effect to their own interest in keeping that care as simple as possible, at the expense of human dignity for that individual. A decision must be made which strikes a balance between these two tendencies, and a decision-maker chosen who is in the best position to avoid these two temptations. If such a balance cannot be struck, or if there is a need to give preference to one temptation over another, there should be a legal presumption that the intellectually disabled stay intact, in keeping with the fundamental precepts of the common law.

Courts have at their disposal training in techniques of decision-making which are well-suited to ensuring the outcome which best serves the interests of the disabled woman. In particular, courts are accustomed to making decisions on the basis of whether some standard of proof has been reached. A cornerstone of common law decision-making is the presumption in favour of the status quo, the most famous example being the presumption of innocence. This type of decision-making has a built-in assumption that one cannot ever be confident of arriving at the truly 'correct' decision. Decisions made in this way, on the basis of an assumption of the preferability of bodily integrity,

have a much better chance of being made in the interests of the person whose body is in question. Medical decision-making, on the other hand, is premised on the assumption that one *can* ensure that one arrives at the correct decision, or the decision which will achieve the best possible medical outcome. This is because of the widespread view of medicine as a science, and of science as a privileged method for arriving at the truth.

Medical practitioners, moreover, are more likely than courts to take a narrow view of health and the needs of human beings. Scientific method leaves little room for empathic considerations, or for the recognition of dignity or the social ramifications of the mere knowledge that these procedures are carried out in these circumstances. Courts are accustomed to formulating principles on which to decide, which do take into account those types of considerations.

There is also the question of natural justice: that is, it is not guaranteed in informal decision-making processes that all sides of the story will be heard. At least in court proceedings the 'patient' is represented by counsel, and thus her interests will be raised.

Finally, in assessing the appropriateness of a decision-making body, it is important to consider the issue of bias. We have already seen that the family is likely to have divergent interests and be subject to the temptation to serve those interests rather than those of the 'patient'. In relation to medical practitioners, it must be noted that in these circumstances the effective relationship, both interpersonal and financial, is likely to be between practitioner and family, rather than practitioner and 'patient'. This situation must surely raise a temptation to put priority on the interests of the family, since it is only to them that the doctor is answerable in any real sense.

For the above reasons, it is clear that courts are in a better position than the alternative forum of parents and doctors to reach a satisfactory decision in respect of the sterilisation of a disabled person.

The Risk of Discrimination

'Sterilisation', when it is carried out otherwise than in the best interests of the girl or woman, amounts to a gendered harm. By this I mean that *those who suffer the harm suffer it on account of, or because of, their gender*; in other words, they would not suffer it if they were of the opposite gender.[75] Marion's parents would not have sought to 'sterilise' her if she had been a boy. The term gender refers to the *social meaning* of being the possessor of one or other set of sexual organs; thus, if Marion had been a boy, the organs which had the corresponding social meaning to her uterus and ovaries — the testes and scrotum — would not have been removed. Her sexuality and reproductive functions would not have been seen as things to be taken away 'in her own interests'.

It is my contention that the attitudes which underlie and inform proposals to 'sterilise' intellectually disabled women are likely to be, and in many cases

[75] On gender-specific injury, see R Graycar and J Morgan, *The Hidden Gender of Law* (1990) 272–6.

are, deeply sexist and offensive. Rules and procedures need to be developed to ensure that all traces of such attitudes are removed from decision-making in this area. This means, among other things, that the grounds for the decision must be clearly spelled-out and circumscribed.

Menstruation and Social Taboos

It has already been explained above that if a person proposes that a hysterectomy be performed upon another person, the first person's main concern must be menstrual management.[76] Consideration of the possible reasons why such a drastic response should be proposed leads to the conclusion that the perceived 'necessity' can result only from deeply sexist — indeed misogynist — views.

Why should a disabled woman be prevented from menstruating? The undesirable consequences of menstruation appear, by and large, to be assumed to be self-evident.[77] Mention was made in the cases, however, of associated pain, headaches and backaches,[78] of fear of blood[79] and of the adverse psychological consequences of scolding or disapproval attendant on accidental soiling.[80] Another possible problem was adverse reaction to the inaccessibility of the sexual organs (for masturbation) during menstruation.[81] It is to be presumed that menstruation is generally seen as adding to the responsibilities of carers. The additional care involved is perhaps also seen as an undesirable imposition on the girl. Once again, there are suggestions that inability to understand why it is happening to her would make a disabled girl unable to cope with menstruation in the same way that an able girl can.[82]

There are two possible, acceptable reasons why disabled women should not be allowed to menstruate, and they are not mutually exclusive: that the experience of bleeding is traumatic for intellectually disabled women in a way that it is not for other women, and that the maintenance of hygiene during an intellectually disabled woman's periods creates problems for her caregivers. It is important to ensure neither of these factors is influenced by the social and cultural taboos which attach to menstruation in our society and which should not be allowed to sway such decisions. It is to be hoped that future decisions in similar situations will pay strict attention to these issues and make a concerted effort to ascertain exactly which of these factors comes into play in the individual case, and to what extent.

[76] See the 'Introduction' supra.

[77] For a general discussion of projected consequences of menstruation, see *In Re Elizabeth* (1989) 13 Fam LR 47, 57–61.

[78] *In Re Jane* (1988) 12 Fam LR 662, 666; *In Re Elizabeth* (1989) 13 Fam LR 47, 58.

[79] *In Re Elizabeth* (1989) 13 Fam LR 47, 59; *In re a Teenager* (1989) 13 Fam LR 85, 87. However, as one of the witnesses in the latter case observed, 'many women dread blood tests and feel sick at the sight of accidental injury and blood but cope satisfactorily with menstruation': ibid. Although no such fear had been previously demonstrated in one of the cases, the court was persuaded by the suggestion — largely unfounded — that it might develop: *In re S* (1989) 13 Fam LR 660, 665.

[80] *In Re Jane* (1988) 12 Fam LR 662, 665 and 681.

[81] *In re S* (1989) 13 Fam LR 660, 664, 665–6, 668.

[82] *In re a Teenager* (1988) 13 Fam LR 85, 111 (discussing *Re K; K* v *Public Trustee* (1985) 4 WWR 724 (British Columbia)).

It is essential in cases of this kind that the motives of the family in seeking the 'sterilisation' be scrutinised. There are certain aspects of the decided cases which should have put the judges deciding them on notice that there was a danger of the girl's interests being subordinated to those of her parents: for example, when the operation is proposed before menstruation has even begun. It is clear in such cases that the procedure is being proposed at least partly for the convenience of the caregivers. However understandable the desire for this convenience may be, every endeavour should be made to ensure that such convenience is not accorded an undue amount of weight; ideally, it should not be a consideration at all. Courts should not allow a hysterectomy to proceed unless they are convinced that the individual concerned cannot be taught any degree of menstrual hygiene, and that other methods for the suppression of bleeding would be inappropriate. Ideally, birth control pills should be administered for a trial period prior to the application, and evidence led as to their effect on the individual.

The social taboos surrounding menstruation form a particularly weak justification for the performance of a hysterectomy on an impaired girl or woman. Reliance on those taboos raises the spectre of an assumption that a woman's body must be controlled simply because it is a woman's body.[83] If this assumption does underlie 'sterilisation' proposals, it places 'sterilisation' in the company of any number of other issues where women's bodies become the subject of legal deliberation, such as prostitution, pornography and street harassment.

Taking the first example, why is prostitution, one of the few ways in which an unskilled woman can earn a reasonable income in this society, traditionally legally suspect and socially stigmatised? In the case of women prostitutes, who in recent times at least have been in a significant majority, the stigma arises from the fact that it involves a woman owning and exploiting her own body;[84] yet 'ownership' and exploitation of her body by a man was considered to be quite acceptable. This explains the historical belief, which was accepted as law in Australia until very recently, that a man could not rape his wife.[85] Legally inhibiting prostitution is a way of controlling women's use of their

[83] It is interesting to note that a recent survey of women in the Hunter Valley (NSW) found that 'demographic variables of parent's country of birth, educational level and employment status predicted recent hysterectomies'. In other words, less empowered women were more likely to have undergone elective hysterectomies: see M J Schofield, et al, 'Prevalence and Characteristics in a Community Survey' (1991) 31 *Australian and New Zealand Journal of Obstetrics and Gynaecology* 153. This would tend to support the thesis that the medical establishment (perhaps unwittingly) uses hysterectomy as a means of controlling women.

[84] In the case of male prostitutes, it is because it generally involves homosexuality; women have not historically been in the habit of paying for sexual gratification.

[85] But see now *R* v *L* (1991) 103 ALR 577. See also *Crimes Act* 1900 (NSW), s 61T; *Criminal Code Act* 1899 (Qld), s 347; *Criminal Law Consolidation Act* 1935 (SA), s 73; *Criminal Code Act* 1924 (Tas), s 185(1); *Crimes Act* 1958 (Vic), ss 40 and 62; *Criminal Code Act* 1917 (WA), s 325 (repealed by Act No 74 of 1985).

bodies; exempting men from prosecution for rape of their wives was[86] a way of ensuring that the majority of women in society do not have any legal right to control the use of their bodies by others. The second example, pornography, is a method by which large numbers of men who have never even met a certain woman can have access to graphic images of — and thus control — her body. It is objected to, if at all, on the basis of its effect on consumers and society at large (obscenity) and not on the basis of the role it plays in the degradation of the woman involved (and, it could be argued, of all women).[87] It is taken for granted that women's bodies should be used and appropriated — controlled — in this way; the only question is how far the results should be distributed. The final example is street harassment of women.[88] This amounts to a form of control over women and their bodies in that the desire to avoid such harassment frequently dictates women's movements in public places.[89] The typical legal response to this observation would be 'Well, that's just too bad, there's nothing we can do'. On the contrary, however, there is plenty the law could do — it simply wouldn't dream of doing it because that would abrogate the 'rights' of harassers to control their space and the women in it.

To return, then, to the 'sterilisation' of the intellectually disabled: it is noteworthy that all of the decided Australian cases on the issue related to proposed operations on girls or women. In order to see the pervasive potential for gender bias in such cases, we can consider the likely reaction to an analogous situation involving an intellectually disabled boy or man. Clearly there is no direct male analogy to menstruation, but I suggest that for these purposes a rough analogy can be provided by masturbation. This is slightly clouded by the fact that masturbation by either sex is an expression of the individual's sexuality. However, in the case of men masturbation is also a visible manifestation of the individual's reproductive capacity. If proposals are routinely made to perform hysterectomies upon intellectually disabled girls because of the inconvenience and taboos associated with menstruation, we need to ask what the reaction would be to a proposal of castration for an intellectually impaired boy because of a habit of masturbating in public. Such a proposal would, of course, rightly or wrongly, be considered as preposterous. Of course it would be difficult, if not impossible, to make out a legal case of gender discrimination against the doctors and particularly the family involved, but that is not the point. The point is that we may surmise from the way these situations are handled that the taboos which attach to menstruation do not

[86] I use the past tense here because of the decision in *R* v *L* (1991) 103 ALR 577, but should point out that there is at least one judge in Australia who still believes that in his jurisdiction, a man is justified in using violence to 'persuade' his wife to consent to sex with him. This is Mr Justice Bollen, of the Supreme Court of South Australia, whose direction to the jury in a rape-in-marriage case has become somewhat notorious through media exposure and public discussion in the first half of 1993: see B A Hocking, 'The Presumption not in Keeping with *Any* Times: Judicial Re-Appraisal of Justice Bollen's Comments Concerning Marital Rape' (1993) 1 *Australian Feminist Law Journal* 152.

[87] See S Rozanski, 'Obscenity: Common Law and the Abuse of Women' (1991) 13 *Adel LR* 163.

[88] See generally C G Bowman, 'Street Harassment and the Informal Ghettoization of Women' (1993) 106 *Harv LR* 517.

[89] The title of Bowman's article is instructive in this regard: ibid.

attach to male sexual and reproductive functions. We must ask why that difference exists, and whether it should be perpetuated at the expense of a woman's reproductive capacity.

There can be no doubt about the proposition that attitudes to men and women in this situation diverge. The question then becomes: should the innocent impaired woman be subjected to a painful operation, and deprived of her capacity to reproduce — which may in fact be her sole claim to 'normality' — because of society's sexual bigotry? The further question must be asked: to the extent that the 'sterilisation' is claimed to be justified on the basis of social taboos, just who is being protected? The woman, who may be blissfully ignorant of such taboos, or the family?

Courts are enjoined by legislation[90] and by the common law to make this kind of decision in accordance with the best interests of the child. It is certainly arguable that a child's best interests are not served by measures which are carried out in the name of social institutions which she cannot understand — which, indeed, many highly intelligent women cannot understand. Judges should be especially vigilant, therefore, against confusing the interests of the family, or some perceived societal interests, with those of the child.

Eugenics

Although, as explained above, the real issue in these cases is menstruation and not reproduction as such, it must still be noted that a result (and arguably the most serious one) of the operation will be inability to reproduce. Furthermore, the very word 'sterilisation' (as opposed to, say, de-sexualisation) raises the rhetoric of reproduction. Therefore the issue of loss of reproductive capacity must be addressed squarely by the courts.

The majority in *Marion's* case did advert to the unfortunate history in many Western countries of sterilising women for the purpose of 'improving' the human race.[91] In the USA, women deemed to be unfit to reproduce have included African-Americans and native Americans, as well as those considered to be, in the terms of the time, 'mentally deficient'.[92] The way that these practices have placed the intellectually disabled in the same category as other disempowered and socially disadvantaged groups (that is, the category of people who should be deprived of reproductive capacity for the good of society) puts in relief the power discrepancies between them and the rest of society.

It also puts in relief the danger that unfairly discriminatory beliefs and stereotypes can shape people's attitude to sterilisation of members of certain groups. Members of the empowered group may think that they are doing

[90] See, eg, *Family Law Act* 1975 (Cth), s 64D.

[91] (1992) 175 CLR 218, 246–7. The most notorious declaration of the philosophy of eugenics was by Justice Oliver Wendell Holmes in the US: 'It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.... Three generations of imbeciles are enough': *Buck* v *Bell* 274 US 200, 207 (1927).

[92] See generally A Y Davis, *Women, Race and Class* (1982) 213 ff.

socially disadvantaged people a favour by 'freeing' them from the economic burdens of parenthood. However, children can be in themselves a source of support (be it emotional or financial) and thus a source of power for members of a disempowered group. Particularly in the case of indigenous populations, whose numbers have been decimated by colonisation, the importance of maintaining the highest population levels possible is another source of anxiety to reproduce, and hence to retain reproductive capacity.[93] On the other hand, of course, sterilisation is a very effective tool for colonisers in achieving genocidal aims.

Considered in this context, the position of intellectually disabled women may be seen in a different light. It may be very much in such a woman's interests to reproduce, even if she is unable to care for the child, and even if she is incapable of forming a 'normal' parent-child relationship with it. Although the same concern about maintaining population levels does not apply, there are clear parallels with regard to the consideration of financial support, and quite possibly emotional support as well.

The prospect of a severely intellectually disabled woman becoming a parent is likely in this society to raise arguments of economic efficiency: the tasks which mothers usually perform *gratis* for their children will not be done, and so someone must be paid to perform them, thus increasing drastically the financial cost of childrearing. Financial resources must be channelled into paying for childrearing work, the necessity of which can be avoided completely by a simple operation. To this argument it might be retorted that increases in financial cost do not amount to decreases in economic efficiency. Indeed, the current practice of channelling women into the unpaid work of childrearing and housekeeping irrespective of the contribution which they could otherwise be making to the workforce is arguably the most egregious inefficiency, by comparison with which any other inefficiency pales to insignificance.

Since it is clear that public institutions are unlikely to make funds available to pay for childrearing tasks which disabled mothers, unlike 'normal' mothers, are unable to perform for free, the burden is likely to fall on the woman's family to perform those tasks. The argument that it is unfair to place on the disabled woman's carers the burden of looking after grandchildren is attractive at first blush, but much less convincing when it is taken into account that those grandchildren will ultimately be an asset to the whole family, grandparents included. Of course the raising of a baby is a substantial task and not one to be undertaken lightly, especially by people who already have the burden of caring for a disabled adult. However, if a disabled woman has a child, one of the greatest worries facing her parents — what will happen to her after I am gone? — would be taken away to some extent, if not completely.

Also, it should not necessarily be assumed that no help in the raising of the grandchild will be forthcoming from the grandchild's father. There is no doubt that this will be true in many more cases than it should, but that does not mean that it will be true always, or even in the majority of cases.

[93] Id 218.

Inability to Understand Equals Inability to Enjoy?

Beyond the risk of 'sterilisation' decisions being informed by attitudes which unfairly discriminate against disabled women, there is also a more generalised risk of discrimination against the intellectually disabled, in the form of the assumption that such people have less capacity for enjoyment than do others. At several points in the various judgments, for example, mention is made of the fact that some intellectually disabled people are generally believed to be incapable of understanding sexuality and reproduction.[94] The observation is relied upon, it seems, to support the conclusion that 'sterilisation' is justified. It is argued that here, discriminatory attitudes are at work.

An example of the presumption of a nexus between understanding and enjoyment can be seen in the assumption, generally found in cases on this topic, that the only intercourse the girl would ever have would be non-consensual. It seems that those who make this kind of argument believe that we cannot enjoy or desire that which we do not understand.[95]

In the four pre-*Marion* cases, the most common arguments supporting the inappropriateness of pregnancy were the girl's inability to understand the connection between intercourse and reproduction, and her projected inability to understand or cope with the pain and trauma of childbirth.[96] Yet reproduction-related bodily functions and dysfunctions are surely no different from others in this regard — that is, if the girl cannot understand one she cannot understand the others. For example, can she understand constipation? Or, for that matter, excretion? Presumably not — yet we do not hear of many proposals to remove the relevant organs of the disabled on this basis. We do not even hear any suggestions that lack of understanding makes other bodily functions more traumatic than they would otherwise be — the kind of claim which is fairly common in relation to reproductive functions. There is clearly more at stake than compassion for the disabled in the claim that lack of understanding justifies surgical intervention.

There are two reasons why the proposition that lack of understanding justifies 'sterilisation' is quite troubling. First, a brief survey of modern Western popular culture shows that society *in general* has difficulty in understanding sexuality, relationships and family life. These themes can fairly be described as obsessions of modern Western society, and huge amounts of time, energy

[94] This proposition was specifically pleaded in relation to Marion: see (1990) 14 Fam LR 427, 428.

[95] Little attention was paid to the idea that close care and supervision would be just as good a contraceptive, in such a case, as a hysterectomy. Put differently, hysterectomy is no safeguard against sexual abuse and, as was pointed out in one of the cases, it might even invite abuse by a man who knew that the girl could not fall pregnant and therefore he was less likely to be 'caught out': *In Re Elizabeth* (1989) 13 Fam LR 47, 60. On the other hand, the need for close supervision in order to prevent pregnancy could be seen as an unnecessary imposition on the girl's freedom: *In Re Jane* (1988) 12 Fam LR 662, 666; *In re a Teenager* (1988) 13 Fam LR 85, 102.

[96] Because of this presumed inability to cope with childbirth, doctors have said that a caesarian section delivery would be indicated, but would raise problems because the girl might try to open the wound such surgery would leave: *In Re Jane* (1988) 12 Fam LR 662, 678. The same concern does not appear to apply to the wound which would be left by a hysterectomy operation.

and money go into endeavours to analyse, understand and comment upon them.[97] This is particularly so in the case of romantic and sexual relationships, but a large amount is said about family relationships as well. It is simply patronising and offensive to say that a person's understanding of relationships is defective by reason of an intellectual disability. It is entirely possible that the disabled have better prospects than we do of understanding relationships; many of our problems may be caused by a tendency to over-intellectualise. The intellectually able might take the plank from their own eye before removing the sawdust from the eye of the disabled.

The second reason is a corollary of the first: notwithstanding our imperfect understanding of romantic and family relationships, we continue to gain enjoyment and fulfilment from them. We also gain a considerable amount of pain and torment from them, from time to time (or more often, if we are unlucky), but we continue to engage in them. We tend to see them as fundamental to our humanity, and the enjoyment we gain may well be to some extent *because of* our lack of understanding, rather than in spite of it. As noted above, our ability to enjoy relationships does not derive from our intellect. It is therefore wrong to deprive intellectually disabled people of this enjoyment on the basis of defective understanding, even if such does exist. The question is one of enjoyment and fulfilment, and it is entirely possible that these can be achieved even in the absence of perfect understanding.

A similar issue arises in relation to the assumption by some judges that the intellectually disabled, being unable to 'understand' the processes of reproduction and so on, will make bad parents.[98] Our attitudes to parenthood, and to motherhood in particular, must be carefully scrutinised lest we find that they unfairly compound the disadvantages to which disabled women are subject. The concept of the 'good mother' is no stranger to the law; even today it still appears that women's efficacy and worth as mothers are judged on their ability to fit into some demeaning stereotype of female behaviour.[99] Holding a disabled woman to such a standard not only smacks of even more unreality but is even more unfair. It is certainly arguable that the main qualification for parenting is emotional resources, and our laws and attitudes should reflect this.

[97] A Freeman and E Mensch, 'The Public-Private Distinction in American Law and Life' (1987) 36 *Buffalo LR* 237, 253, citing M Foucault, *The History of Sexuality* (1978).

[98] See *In re A Teenager* (1988) 13 Fam LR 85, 102 per Cook J. Judges are not the only ones who make this assumption; commentators have been known to as well: see F Bates, 'Sterilisation of the Apparently Incapable: Emergency or Epidemic?' (1989) 14 *Australian Child and Family Welfare* 12, 14.

[99] See generally Graycar and Morgan, op cit (fn 75) ch 10 ('Losing Children: Motherhood on Trial'). Perhaps the most egregious example of legal construction of motherhood in a way that coincides with general social stereotypes about women is the way that women's sexual activities have been treated as relevant to custody disputes.

Bias in the Reconstruction of Another's Wishes

A study of 'right to die' cases in the United States of America[100] suggests that there is a danger of gender bias in cases where one person is legally empowered to make an important medical decision for another. If this danger does exist, handicapped girls and women who are at risk of 'sterilisation' face sex discrimination on two levels. The study analysed 22 cases where a judge was called on to decide whether a brain-dead patient should be removed from a life-support system. These cases are another clear example where one person is called on to make a decision on behalf of another.

It was found that in cases where the patient was male, judges tended to pay much more attention to statements he had made when alive, or to make an active attempt to reconstruct his wishes. Female patients were less likely to be taken seriously in this way, statements they had made being likely to be dismissed as emotional and irrational, and therefore unhelpful in reaching the correct decision in the case. Thus female patients' cases tended to be decided on the basis of 'objective' criteria, rather than the patient's 'subjective' wishes.

If this kind of bias is likely to come through when judges make 'sterilisation' decisions on behalf of those who are legally unable to decide for themselves, this is clearly a matter of concern. The issues are slightly different in 'sterilisation' cases, as there is unlikely to have been a time when the (prospective) patient was able to express a legally cognisable wish. The most we could extrapolate from an analogy with the right to die cases is that, on the assumption that people want to avoid painful surgery and maintain their bodily functions intact, this constructive wish is more likely to be ignored in the case of girls than in the case of boys.

However, there are other ways of avoiding gender bias in judges; indeed, one does not really need legislation or a constitutional guarantee to conclude that disparate treatment of similarly placed men and women is improper for a judge. The same cannot be said of doctors and especially of parents, who would otherwise be making the decision. Since these are generally thought to be actors in the 'private' sphere, it is difficult to apply to them standards of behaviour like non-discrimination, which are generally thought of as public in character.[101] Thus, the possibility of decisions relating to the 'sterilisation' of girls being made without reference to any constructive desire of hers is another reason to leave the decision in the hands of the courts rather than in those of the child's carers.

[100] S H Miles and A August, 'Courts, Gender and "The Right to Die"' (1990) 18 *Law, Medicine and Health Care* 85.

[101] For example, s 35 of the *Sex Discrimination Act* 1984 (Cth) exempts providers of positions involving the residential care of children from the application of the provisions which render sex discrimination unlawful, on the basis that such positions have a private dimension which is not shared by, eg, day-care centres. Other exemptions which are telling in this regard are those found in s 36 (charities), s 37 (religious bodies), s 38 (educational institutions established for religious purposes) and s 39 (voluntary bodies). All of these seem to have some dimension which sets them apart from the public, mercantile world which is generally seen as the key concern of equal opportunity.

A Word of Caution: Courts as Decision-Makers

For the above reasons, I argue that among the alternatives that have been mooted, courts are in the best position to make the decision with the requisite degree of objectivity. First, and most obviously, courts are not directly interested in the outcome of the individual case, and are therefore preferable decision-makers to families. Second, courts are accustomed to the task of safeguarding people's rights in a way that families and medical practitioners are not, and are accustomed to adopting procedures and decisional methodologies which are better geared than those of the medical practitioners to observing the interests of the party who is primarily affected. Third, having the decision-making process in the hands of the courts maximises the probability that gender bias and bias against the disabled will be reduced or eliminated.

On the other hand, it is important to recognise the shortcomings of courts as institutions for making this kind of decision. As part of my concern is to reduce or eliminate a harm whose gender-specificity makes it offensive to women in general, I must recognise quite frankly that it is widely recognised that courts themselves are not havens of non-sexist enlightenment. I am in effect assuming that courts can and will 'correct' for the sexist attitudes that exist in society at large, and this may be hopelessly naive.

On this I would like to make three observations: first, I do still hold that even if courts do not recognise the gender implications of the 'sterilisation' issue, they are equipped to reach fair decisions, albeit most likely on the basis of harmful stereotypes as I discussed above. A fair conclusion cannot be guaranteed in all cases, but disabled women do improve their odds in this way.

Second, this is exactly the kind of issue which should be addressed in gender sensitivity education programmes for judges.[102] If such programmes are offered and well-run, hopefully in a few years the odds will be even better, and decisions will be made on relevant criteria.

Third, nothing I have said is intended to suggest that courts are the only bodies which are equipped to make a fair and independent assessment of the situation of a disabled person. It is certainly arguable that where available guardianship boards or similar specialist tribunals should be making these decisions.[103] The main thrust of my argument should be understood to be that

[102] Such programmes are widespread in North America, and there are moves afoot to introduce them in various Australian jurisdictions: see D Malcolm, 'Women and the Law: Judicial Education on Gender Equality' (1993) 1 *Australian Feminist Law Journal* 139.

[103] Such tribunals do, in fact, exercise jurisdiction in the various States to make sterilisation decisions in relation to adult women. Informal inquiries by the author reveal that these bodies are actively involved in the development of guidelines to deal with such cases, and on the whole desire to keep their decision-making uniform with that at the federal level in respect of minors. It also appears that only a small number of cases arise within this jurisdiction: telephone conversations with Imelda Dodds, Public Guardian of Western Australia and Carolyn Richardson of the Guardianship Board of South Australia, June 1994. It is to be hoped that the forthcoming report of the Family Law Council (see reference to the Discussion Paper in fn 2 supra) will contribute to the formulation of guidelines for all bodies making these decisions.

courts are *better* bodies to make this kind of decision than the families and medical practitioners who, but for the decision in *Re Marion*, would have the final say. I should not be understood as arguing that courts are the *best* bodies. There are any number of reasons to say that courts are not ideal: the cost and delay involved in litigation and the formality and alienating nature of court proceedings are but a few examples. Any system which eliminates these aspects of proceedings must of course be welcomed.

Another basis on which it could be, and has been, claimed that courts are inappropriate decision-makers in this field is that judges lack the requisite knowledge to form opinions. In the leading Canadian case, *Re Eve*, La Forest J said:

> Judges are generally ill-informed about many of the factors relevant to a wise decision in this difficult area. They generally know little of mental illness, of techniques of contraception or their efficacy. And however well presented a case may be, it can only partially inform.[104]

I would respectfully beg to differ with this statement — not that judges are not well-informed on techniques of contraception and so on, but that detailed knowledge of the kind described is a necessary prerequisite for wise decision-making in this area. This is precisely the kind of matter on which expert evidence can inform a judge sufficiently to enable the application of legal principles and moral and ethical precepts to the decision. It is, moreover, those principles and precepts that should form the basis of the test. Medical evidence does not, and cannot, help to formulate the test.

THE NEED FOR GUIDELINES

The main problem of the majority's judgment in *Marion's* case is that it does not pay sufficient attention to the question of the criteria by which courts should decide future 'sterilisation' cases. In particular, the judgment is noteworthy for its apparent lack of concern for the particular facts of this case, and its failure to explore fully the broader context in which 'sterilisation' debates are carried out. Given that one of the virtues of the majority's decision is that it places responsibility for making the decision on a more appropriate decision maker, it is disappointing that the majority did not take the process one step further and articulate the criteria by which the decision should be made. In this section I elaborate my reasons for thinking that criteria are necessary, and make some suggestions as to what those criteria should be.

The Facts of the Individual Case

The majority in *Marion's* case pay very little attention to the facts of the case, nor do they make any suggestions as to how they think the case should ultimately be resolved. Failure to pay attention to the context of their decisions leads judges to appear to be assuming that all cases are the same. If it were

[104] (1986) 31 DLR (4th) 1, 32.

recognised that all cases are not the same, surely the majority would have attempted to give some guidance for those who will be reviewing applications in the future.

For example, nowhere in any of the judgments in the High Court or the Full Court of the Family Court does it become apparent what, if any, behavioural problems had proved to associate themselves with menstruation in Marion's situation. Indeed, at the time of the original application she cannot have been through more than three monthly periods — hardly sufficient time for any pattern to set in. The first three periods are, moreover, likely to be traumatic even for the most intellectually capable of girls.[105] Nor is there any explanation of the 'hormonal fluxes', if any, to which Marion had been subject, much less whether they had proved to cause problems for Marion or her caregiver or whether they were likely to settle down.

The High Court should have expressed an opinion on the fact that the application was made at such an early stage. Ideally, that opinion would have expressed disapproval. It should have signalled to future courts that early applications such as this need to be scrutinised carefully, so as to avoid the possibility of 'sterilisation' being carried out as a matter of course, rather than as the result of a process of reflection and weighing of competing considerations by the carers. It should also have signalled the need for cogent evidence about what menstruation does to the young woman in question, and held that generalised evidence of the effects of menstruation upon similarly placed young women should never be seen as a substitute.

The Broader Context of the Decision

Just as the judgments in *Marion's* case paid insufficient attention to the specific context of the case, so they paid insufficient attention to the broader context in which the issue arises. As discussed above, 'sterilisation' decisions are made in a social and historical context. The social context is one where the rights and interests of the weak and disempowered are routinely subjugated to the imperatives of economic efficiency and other anti-humanist goals. The historical context is one where the weak and disempowered have been systematically deprived of reproductive capacity on the grounds of a presumption of 'unfitness' — that is, they have been blamed and punished for society's failure to provide for them.

This broader context needs to be considered by decision makers, because there is a grave risk that the attitudes and beliefs which have contributed to its shaping are seeping into individual decisions and compromising the justice and equity of those decisions.

The motives of the applicants should be scrutinised for suggestions that they seek to avoid embarrassment arising out of the contravention of menstrual taboos. Such taboos, being sexist and offensive to women generally,

[105] The point was also made by two of the witnesses in *In re a Teenager* (1988) 13 Fam LR 85, 93 that 'mistakes ... in menstrual management ... occur readily in girls without disabilities'. This seriously weakens any argument about the social acceptability of 'accidents' of disabled women.

have no place in decision-making about the bodily integrity of an innocent disabled woman who has no say in how society regards her sexual and reproductive functions. Similarly, courts should be wary lest 'sterilisation' be proposed on the basis that women's bodies must be, should be, or even *can* be, controlled by others. They should bear in mind that it is very rarely that one hears a proposal to castrate — the male equivalent of a hysterectomy — a disabled man or boy because of problems arising out of his sexuality. This is not to argue that the problems with involuntary sterilisation of the disabled would fall away if we saw more castrations. It is simply to point out that there is more at stake here than treatment of disabled 'persons'.

The motives of the applicants should also be scrutinised for indications of the patronising and offensive assumption that impaired women should not reproduce, either on the basis of some eugenic imperative or on the basis that they are unfit mothers. Cogent evidence should be led of the likelihood of any offspring being impaired; even if such evidence is supplied, courts should be wary of falling into the belief that the simple fact of impairment obliterates the right to exist. Evidence should also be sought as to the individual woman's abilities, particularly her emotional capacity, relating to her potential as a mother. Courts should not assume that any impaired woman would have nothing to offer her child. Finally, courts should not allow sterilising procedures to be carried out unless they are satisfied that other methods of birth control would be inappropriate in the individual case.

Family Rights and Obligations

Another source of attitudes which might infect the decision-making process is the ideology of the family.[106] It has already been argued that the usual reaction to the prospect of increased family 'burdens' arising out of reproduction by a disabled member is possibly misguided. That is, the child of a disabled person may be an asset to the family. This observation serves to point up the shakiness of the foundation on which some at least of our thinking about families is based.

Concern for the 'rights' of parents, or the family, is a clear theme running throughout the four pre-*Marion* Australian cases. The judgment of Cook J in the *Teenager's* case provides the clearest example of this. In the course of the judgment, his Honour remarks several times that he was disappointed that the Human Rights Commission had concentrated in its submissions on the rights of children, and of the intellectually disabled, to the exclusion of the rights of parents.[107] Indeed, the courts at times seem positively protective of the right of parents not only to order affairs within their families to suit their

[106] See generally K A Petersen, 'Reproductive Rights: The Family and the State' (1991) 12 *Australian Journal of Marriage and Family* 92.

[107] (1988) 13 Fam LR 85, 98, 99, 112, 124. His Honour supplied this lack, spending a good deal of time discussing *Gillick* v *West Norfolk and Wisbech Area Health Authority* [1986] 1 FLR (UK) 224; [1985] 3 All ER 402, an English authority on parents' rights to be consulted about contraceptive treatment or advice provided to their daughters: (1988) 13 Fam LR 85, 113–16. His Honour also discussed at some length the constitutional protection of family privacy in the United States: id 116–17.

judgment or convenience, but simply to exercise the authority of decision-making within the family for its own sake.[108] Although all four judges in all four cases agreed that the overriding and paramount concern was the welfare and interests of the child,[109] persistent references to the effect of the decision on parents and other family members tend to suggest that what was in fact going on was a balancing of competing interests.

Nowhere is it frankly acknowledged that the parents' interests may diverge from those of the child; as a rule, the courts seem to operate on an assumption that all parents are 'wise and caring' (though perhaps the very use of that epithet implies recognition that some parents are not) and therefore by definition cannot have divergent interests. However, it is from time to time impliedly accepted in the cases that some matters which may be of concern to parents are neither here nor there for the child, in any direct sense. Where this acknowledgement is made, however, the argument generally proffered is that anything which increases the stress placed upon the parents will affect the level of care which they are able to give the daughter.[110] Occasionally the suggestion is made that placing undue strain on the parents will lead the child to be placed in an institution, the assumption apparently being that this is *ipso facto* undesirable.[111] Thus arguments supporting parents' rights and convenience are introduced in the guise of arguments about the welfare of the child.

It is often assumed, in discourse about the 'sterilisation' of the intellectually disabled, that parents know their child best and that this somehow puts them in a position to make the best decisions about her.[112] It is also often assumed that parents invariably will make decisions in the best interests of their children — that the family is, by virtue of being a family and for no other reason, automatically a haven of caring and non-exploitation. One need only point to

[108] *In re A Teenager* (1988) 13 Fam LR 85, 112–13, 119, 124; *In re S* (1989) 13 Fam LR 660, 662. (But cf the comments of Nicholson CJ in *In Re Jane* (1988) 12 Fam LR 662, 678 (discussing the judgment of La Forest J in *Re Eve* (1986) 31 DLR (4th) 1): 'His Honour, correctly in my view, discounted the purpose of relieving the mother of Eve of anxiety or difficulty'.)

The same protectiveness of parents can be seen in the medical profession: 'Dr McGuckin's impatience over what he sees as the unwarranted intrusion of the court and bureaucracy into the right of the parents . . . is evident from his report': *In re S* (1989) 13 Fam LR 660, 666. It is perhaps worth noting that Dr McGuckin was the doctor whom the parents had arranged to perform the operation. See also *In Re Elizabeth* (1989) 13 Fam LR 47, 57.

[109] *In Re Jane* (1988) 12 Fam LR 662, 686; *In Re Elizabeth* (1989) 13 Fam LR 47, 56; *In re a Teenager* (1988) 13 Fam LR 85, 112, 123; *In re S* (1989) 13 Fam LR 660, 670–1.

[110] *In Re Jane* (1988) 12 Fam LR 662, 681; *In re a Teenager* (1988) 13 Fam LR 85, 126, 129–30.

[111] *In Re Jane* (1988) 12 Fam LR 662, 681; *In re a Teenager* (1988) 13 Fam LR 85, 119. It is therefore interesting to note that in *S's* case it was the institution that opposed the operation proposed by the parents. Also, it might be noted that the mother of 'Elizabeth' took her daughter *out* of the Rudolf Steiner school where she had been residing as a result of a disagreement with the principal about the proposed 'sterilisation': *In Re Elizabeth* (1989) 13 Fam LR 47, 50.

On the assumption that institutionalisation is undesirable, see text accompanying fn 113 infra.

[112] See *In re a Teenager* (1988) 13 Fam LR 85, 111, 113, 114, 120, 125, 130.

the incidence of neglect and physical, sexual and emotional abuse of children in the family to expose this as the myth that it is.[113]

Thus, when we hear judges and commentators talking in terms of family rights of privacy,[114] we must be very careful indeed not to swallow such concepts whole. Such ideas invariably derive from the historical common law position (which, no doubt, reflected views widely held amongst the community that the common law served and represented) that men had dominion over their families — that a man's home is his castle — and that the home and the family are exempt from public scrutiny because of the necessity of preserving this sphere of power for individual men. The historical basis of the concept of family privacy, therefore, must make the concept itself suspect — or at least certainly not sacrosanct — in modern times.

Another assumption that we see, which probably derives from the same place as the assumption that parents will act in the best interests of their children, is that disabled children are better off at home than in an institution.[115] The enhanced likelihood of a disabled girl being kept at home if she has a hysterectomy has in fact been used as an argument in favour of the operation. Once again, it might be noted that it is possible to think of several interventions which would make a disabled person easier to care for at home which are not proposed in the routine way that female 'sterilisation' is. Many of a carer's tasks arise out of the disabled person's bodily functions, yet no-one, surely, would seriously suggest that for this reason it is in her best interests to remove the relevant organs. This is not to discount the interests of the carers, nor the effect that their situation and attitude are bound to have on the level of care the disabled person receives. The point is that somehow the womb, the female organ, is seen as dispensable in a way that other organs are not. This would tend to suggest that the real motivation behind proposals is something other than lightening the load of the carers, if other measures which would have the same effect are not routinely contemplated.

Furthermore, it is by no means self-evident that all disabled children are better off at home than in an institution. Surely it depends on the kind of home and the kind of institution which are in issue. The assumption that home is preferable is based on the unwarranted premise that all family homes are happy places. It may be painful for mainstream Australian society to accept that this notion is unwarranted, and downright wrong in many cases,

[113] In 1990–91, finalised investigations of child abuse and neglect reports accounted for 9.3 children per 1000 throughout Australia. Of the 49 721 reported and investigated cases, 46 769 were finalised and 20 868 were found substantiated. A further 3043 resulted in findings of 'child at risk'. In the substantiated cases of sexual abuse, 75% of victims were female; the gender distribution in categories of neglect, physical abuse and emotional abuse was roughly even. Parents (including step-parents, de facto parents, foster parents and guardians) accounted for 65% of perpetrators in substantiated cases. Siblings and other relatives constituted 6% of perpetrators: see G Angus and K Wilkinson, *Child Abuse and Neglect in Australia 1990–91*, Australian Institute of Health and Welfare Child Welfare Series No 2 (1993).

[114] See *In re a Teenager* (1988) 13 Fam LR 85, 108 per Cook J; Bates, op cit (fn 98) 14.

[115] *In Re Jane* (1988) 12 Fam LR 662, 681 per Nicholson CJ, and discussed by Bates, op cit (fn 98) 15. See also *In Re Elizabeth* (1989) 13 Fam LR 47, 63; *In re A Teenager* (1988) 13 Fam LR 85, 119. The proposition gains some support from the *Declaration on the Rights of Mentally Retarded Persons* (1971), art 4.

but that pain pales to insignificance beside that which might be inflicted upon an innocent person by an operation to deprive her of one of her bodily functions.

Courts which are to be making this kind of decision in the future should be alerted to the dangers of what might otherwise seem like 'natural' assumptions about the welfare of the intellectually disabled. They should be directed in no uncertain terms of the need for constant vigilance to ensure that the interests of the prospective patient are really being served, and it should be pointed out to them that the whole reason for entrusting the decision to them is the prospect that those interests will otherwise be overlooked.

CONCLUSION

Although it would have been preferable for the majority in *Re Marion* to spell out some guidelines for decision-making in the area of 'sterilisation' of the intellectually disabled, the decision is to be applauded for its recognition that the courts have an important role to play in this sensitive area. The approach of the majority is clearly preferable to that of the minority, which is to impose criteria to decide when a person other than a court can consent on the woman's behalf, but to leave it up to that same person to decide whether the criteria have been met. The interests of families of disabled women do not coincide with those of the women; indeed, as shown above, they are likely to be directly counterposed. There is far too great a risk of doctors' opinions being based on convenience, financial considerations and assumptions about a woman's capabilities to allow those opinions to be decisive of the issue. There needs to be some independent decision-maker who is truly in a position to give effect to the interests of the child. The majority's decision at least ensures that much.[116] Whether the kinds of factors discussed above will in fact be taken into account remains, of course, to be seen.

Wherever such matters are being discussed, it is important that feminists should add their voices. Not only is involuntary 'sterilisation' an issue of great importance to women of ethnic and racial minorities, it is a debate which, touching on matters which lie at the core of being a woman in this society, risks being conducted in such a way as to obscure women's interests.

Involuntary 'sterilisation' calls for an approach which recognises the gender-specificity of the harm that it inflicts (that is, people want to 'sterilise' girls and women, but not boys and men). In a world where men's interests are taken for granted — indeed, rarely if ever raised at all — and women's interests are the subject of litigation, it should be a fairly simple matter for courts to conclude that what motivates at least some 'sterilisation' proposals is not concern for the patient but sexist attitudes and assumptions. Once this conclusion is reached, there is ample basis for a rule that 'sterilisation' decisions

[116] As Shaw points out, 'recourse to the courts . . . is the only available avenue to an independent consideration of the situation of the mentally handicapped person by someone outside the medical, psychiatric and educational professions': op cit (fn 63) 102.

must be made by the courts rather than by families and medical practitioners. One need not resort to the notion of generalised rights to reproduction. One need simply recognise that the interests of disabled girls and women in such uncontroversial things as bodily integrity are likely to be ignored if the courts do not step in.