

Lecture Notes 2008-2009. Code: Med-04.01-v2C-01.09

Medical Law

Topic 4 (of 10):

Contraception and Sterilisation

Aim:

To provide an outline account of the law and ethics relating to contraception; to focus on the cases where damages have been awarded or withheld following a negligent sterilisation; and, finally, to review the cases on non-therapeutic sterilisation.

Objectives:

After careful study of this topic you should be able to:

1. Discuss the law and ethics relating to GPs giving contraceptive advice and/or treatment to minor females;
2. Explain the circumstances under which a claim for damages for the birth of a child following a failed sterilisation will be allowed and compare them with cases where the claim has been rejected;
3. Provide a comprehensive and comparative account of the non-consensual sterilisation cases from *Buck v Bell* (1927) to *Re F* (1989) and *In Re S* (2000).

Family Planning: An Ethical as well as a Legal Concern

The prevention or termination of pregnancy in a fertile female is as much a matter of ethics and social concern as it is of law; and various methods for limiting the size of families ('family planning'), including the Biblical reference to *coitus interruptus* (***Genesis 38.8-10***), have been recorded for over two thousand years. With regard to contraception, in particular, there appear to be at least three moral stand-points: that it is never permissible; that it is an acceptable way of spacing a family within marriage; and that contraception is a right for all regardless of age or status. Whatever one's moral views are, there is a relationship between law and morals that was expressed by ***Coleridge LCJ*** in *R v Instan* [1893] 1 QB 450 @ 453 where he said:

"It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation."

A controversial legal issue that arose from old case law was where the parties to a marriage supported different standpoints on family planning: i.e., where, (say) the woman had no immediate desire to start a family and insisted on contraceptive precautions, but the man believed that the use of pills and/or condoms was immoral. The marriage might not have been consummated but neither party could rely on wilful refusal of the other so as to seek an annulment: There would have to have been a resort to divorce law. (see *Baxter v Baxter* (1948)).

The current judicial attitude towards contraception has been summarised in *R (on the application of Smeaton) v Secretary of State for Health and Others* [2002] 2 FLR 146 (infra) where *Munby J* said that: ... ‘respect for the personal autonomy which our law has now come to recognise demands that the choice be left to the individual’.

(1) Contraception

Contraception advice and/or treatment for females over the age of majority is provided for under *s.5 NHS Act 1977*¹ so its legality is not in dispute. Indeed, *s.5(1)(b)* imposes a duty upon the Secretary of State:

To arrange, to such extent as he considers necessary to meet all reasonable requirements in England and Wales, for the giving of advice on contraception, the medical examination of persons seeking advice on contraception, the treatment of such persons and the supply of contraceptive substances and appliances.

However, under a GP’s contract with his health authority (HA) he is *not* required to provide contraceptive services, nor are patients required to consult their usual GP for such services. A GP *not* wishing to provide such services can either refer a patient to another GP or ask the patient to contact the HA and be supplied with the name of a GP who will supply such services. With reference to ‘the supply of contraceptive substances and appliances’, *Gillian Douglas*, (*Law Fertility and Reproduction* London: Sweet & Maxwell, 1991) has noted that:

All contraceptives supplied by clinics are free, including condoms. Those *prescribed* by GPs are also free of charge, emphasising the importance the state attaches to encouraging the use of contraception, since no other prescription items are free to adults who do not have special financial or other circumstances².

In *Gillick*, *Lord Frazer* observed that:

[The imposition of the duty on the Secretary of State in *s.5 NHS Act 1977*] and other provisions show that Parliament regarded ‘advice’ and ‘treatment’ on contraception and the supply of appliances for contraception as essentially medical matters. So they are, but they may also raise moral and social questions on which many people feel deeply, and in that respect they differ from ordinary medical advice and treatment.

However, *Kennedy & Grubb* appear to believe that, as a matter of law, there is no difference between contraceptive treatment and ‘ordinary medical treatment’ unless perhaps, the patient to be treated is a minor or mentally ill or mentally handicapped. Although the *Family Law Reform Act 1969* lowered the age of majority from 21 to 18, *s.8* of the same Act (FLRA 1969) permitted the *over 16s* consent to treatment. However, the Act does not say that the giving of contraceptive advice and/or treatment to girls under 16 years of age cannot be given: it is a matter of clinical judgement based on the doctor’s estimation of the girl’s capability of understanding the issues and on her apparent maturity.

¹ See now, *Schedule 1, NHS Act 2006*

² Clearly, this statement no longer applies to the NHS in Wales!

With regard to contraception, then, the principal legal issues relate to the establishment of a minor female's capacity to consent to treatment; and the giving of advice and/or treatment to that minor before she engages in sexual intercourse. That the legal issues cannot be separated from the moral perspectives were noted by *Mason & Laurie*³ who said:

“The problem is essentially that of deciding whether [the doctor] should do anything which might facilitate [the young girl] engaging in sexual activity. If his patient is, say, 14 or 15, he may well be of the view that it is too young an age for sexual intercourse. This disapproval is more likely to be based on the view that sexual activity at such an age may lead to emotional trauma and a risk of disease – including iatrogenic disease - rather than on social or moral grounds. On the other hand, refusal to prescribe contraceptives may ultimately be more damaging to the patient in that sexual activity, once embarked upon, is likely to be continued and may result in pregnancy - and giving birth to a child or abortion at such an age are likely to be severely disruptive of the patient's life.

“[Moreover], a decision to provide contraception to a minor poses a number of additional ethical and legal dilemmas for the doctor, including whether he can proceed without the consent of the parents, the nature and extent of his obligation of confidence to the minor, and whether he attracts any criminal liability as being party to an offence of sexual intercourse with a minor⁴.”

That a doctor is under a duty to provide a careful explanation of the nature and risks of contraceptive methods there is no doubt. The 6th edition of *Mason & McCall Smith*⁵ noted that:

Few long term contraceptive methods can ... be applied without some risk – and the risk may be serious. [The risks include] intravascular thrombosis ... menstrual disturbances; and a possible association between contraceptive therapy and an increased incidence of carcinoma of the breast or cervix is still debated.

[Note, however, that in 1999 the results of a study over the past 25 years of the health of females who have been regular users of the contraceptive pill disclosed no discernible health risk compared with those who have not been 'on the pill'. This contrasts with the estimated 300,000 women who stopped taking the pill following a government warning in the autumn of 1995 that certain brands could increase the risk of thrombosis: 'Pill scare brings more babies' (1996) *The Sunday Times*, August 25th. Contrast the evidence from Denmark, however, p5]

The leading case on contraceptive advice to minor females is:

Gillick v West Norfolk & Wisbech A.H.A. [1986] AC 112

Mrs Victoria Gillick objected to a 1981 DHSS circular which stated that in certain circumstances a doctor could prescribe contraceptive devices and treatment to a girl under 16 without knowledge or consent of her parents: i.e. (in effect) Mrs Gillick was contending that girls under the age of 16 did not have capacity to consent to contraceptive treatment. In the High Court she failed to get a declaration that the DHSS guidelines were unlawful;

³ *Mason & Laurie*, *Mason & McCall Smith's Law and Medical Ethics*, 7/e. Oxford: OUP, 2005, p126

⁴ He doesn't, when he acts for medical reasons: see s.73 *Sexual Offences Act 2003*.

⁵ *Law and Medical Ethics* (2002), p138.

she succeeded in gaining a unanimous decision in her favour in the Court of Appeal; but then failed by 3-2 to have this decision upheld by the House of Lords. Although ‘understanding’ formed the basis of the Lords decision, there was no clear rationale as to what constituted ‘understanding’. In essence, *Lord Frazer* accorded the medical profession a great deal of discretion in such circumstances; *Lord Scarman* put a far more stringent obligation on the doctor by noting that the doctor should not prescribe contraceptive treatment unless he is satisfied that the girl’s circumstances are such that he ought to proceed without parental knowledge and consent; while *Lord Templeman* said: ‘the effect of the consent of the infant depends on the nature of the treatment and the age and understanding of the infant.’

In particular, *Lord Frazer* specified five criteria with which the doctor must satisfy himself he has complied before he may regard the girl’s consent as effective, viz;

- (1) that the girl ... will understand his advice; (2) that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive treatment or advice her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.

N.B.: The *Sexual Offences Act 2003, s.73*, has made it clear that a doctor who prescribes contraceptive treatment to a minor of sufficient maturity and understanding does not commit a criminal offence:

s.73 Exceptions to aiding, abetting and counselling

- (1) A person is not guilty of aiding, abetting or counselling the commission against a child of an offence to which this section applies if he acts for the purpose of –
 - (a) protecting the child from sexually transmitted infection,
 - (b) protecting the physical safety of the child,
 - (c) preventing the child from becoming pregnant, or
 - (d) promoting the child’s emotional well-being by the giving of advice,

and not for the purpose of obtaining sexual gratification or for the purpose of causing or encouraging the activity constituting the offence or the child’s participation in it

The Immature Minor

With regard to an immature minor, i.e. a minor who a doctor doesn’t regard as having capacity to consent to treatment, there is conflicting academic opinion as to whether a doctor could or should inform the girl’s parents of her request for contraceptive advice and/or treatment. Three views are those expressed by Montgomery; Kennedy; and Grubb & Pearl. ‘No’ says *Montgomery*: if immature minors aren’t treated in confidence they won’t seek treatment at all. *Kennedy* is of the opinion that public policy requires that a doctor should exercise judgement in the best interests of the child, which may mean that the

doctor may disclose information to the parents. In contrast with Montgomery, *Grubb & Pearl* argue that a doctor may be under a duty to disclose.

Post-Coital Birth Control: Contraception or Abortion?

The ‘morning after’ pill prevents implantation of a fertilised egg. Accordingly, it is used as a contraceptive measure: it is not an abortifacient.

R (on the application of Smeaton) v Secretary of State for Health and Others [2002] 2 FLR 146

John Smeaton, on behalf of SPUC (Society for the Protection for the Unborn Child), sought to challenge the legality of the Prescription Only Medicines (Human Use) Amendment (No.3) Order, 2000, SI 2000/3231, which permitted the sale of the morning after pill without prescription. In essence, the claim was that the morning after pill was an abortifacient, not a contraceptive. The claimants argued that the meaning of ‘miscarriage’ in the Offences Against the Person Act 1861 included the prevention of implantation. If this was accepted, then post-coital contraception could amount to a criminal offence under ss.58 and 59 of the 1861 Act as, to be permissive (lawful) under the Abortion Act 1967 (as amended), any substance that caused miscarriage or abortion would require two doctors acting in good faith to certify that the requirements laid down in the 1967 Act were satisfied. If the morning after pill was ruled to be an abortifacient, then, in the absence of compliance with provisions of the 1967 Act, it could be a criminal offence for a pharmacist to supply the pill and for the woman to take it.

Held:

Munby J did not accept SPUC’s case as to the meaning of the word “miscarriage” in 1861. Some of the leading and most authoritative medical works of the time strongly supported the idea that miscarriage becomes possible only after implantation. Accordingly, SPUC’s application was dismissed.

Munby J

I have made it clear that the court cannot concern itself with moral or religious issues. But that does not mean that I cannot blind myself to the social realities, which underlie this case, nor to the social implications were I to find in favour of SPUC ... On the logic of its own case, SPUC’s challenge, and the allegations of serious criminality *inter alia* by the woman concerned, are not simply to the morning after pill. They extend to *any* chemical or device which operates, or may operate, by impeding discouraging or preventing the natural process at any time after fertilisation has started, alternatively has completed. They extend to *any* drug or device which may operate in that way, even if it may also operate in a way which impedes, discourages or prevents the process of fertilisation. The medical profession and female members of the public have for years been operating on the basis that the use, prescription and supply of such chemicals and devices is legal and involves no potential criminality. The pill has been available since the 1960s and the morning after pill since the early 1980s. The position has remained unchallenged until sought to be reopened in these proceedings.

...

There would ... be something ... grievously wrong with our system ... if a judge in 2002 were to be compelled by a statute 141 years old to hold that what ... millions, of ordinary honest, decent, law abiding citizens have been doing day in day out for

so many years is and always has been criminal. I am glad to be spared so unattractive a duty ...

... in this as in other areas of medical ethics, respect for the personal autonomy which our law has now come to recognise demands that the choice be left to the individual.

The view that the ‘morning after pill’ and the I.U.D. are not unlawful was expressed by **Professor Glanville Williams** more than 20 years ago and echoed by the then **Attorney General** in 1983 who concluded that:

... the phrase “procure a miscarriage” cannot be construed to include the prevention of implantation. Whatever the state of medical knowledge in the 19th century, the ordinary use of the word “miscarriage” related to interference at a stage of pre-natal development later than implantation. [Thus, ‘the morning after’ pill] does not constitute a criminal offence within either sections 58 or 59 of the Offences Against the Person Act 1861.

Research and Policy on Contraception in other Jurisdictions

America

The American Food and Drug Administration (FDA) declared in February 1997 ‘that high doses of certain standard birth control pills are a safe and effective way to prevent pregnancy when used as ‘morning after’ pills following unprotected sex’: “FDA OKs Birth Control Pills for ‘Morning After’” (1997) Los Angeles Times, February 25th. The article acknowledged that the pills ‘have been used in Europe for years in this fashion. But pill manufacturers [in America] have been reluctant to promote or seek approval for emergency contraception because of political pressures and fear of litigation.’

China

The China News Service cited the 20.6 million births in China in 1995 ‘as evidence of success for the nation’s tough family planning policy’. The figure was 470,000 fewer than in 1994: (1996) The Times, April 2nd.

Denmark

Evidence reported in the BMJ in September 1999 indicated that the results of an analysis of all women aged between 15 and 49 who were admitted to hospital in Denmark for venous thrombo-embolism, or serious blood clots were that “The most modern type of contraceptive pill may increase the risk of blood clots by a sixth”, (1999) The Times, September 24th. Whereas The Times report stated that ‘the research ... will cast doubt on the Government’s recommendations on the Pill’s safety’, a spokesman for the Department of Health contended that: “Women have no need to change from their oral contraceptive based on the evidence published today”.

Finland

In 1999, **Kosunen et al** reported in the eBMJ that the results of a questionnaire directed at 22,000 14-17 year olds in Finland demonstrated that ‘emergency contraception has not become the contraceptive of choice among Finnish teenagers’. The researchers found that

between only 1.5%-3% of the girls did not know what emergency contraception was and that overall only 6% had used it.

Sweden

‘Taking the pill can reduce the risk of women having hip fractures in later life’ by 25%-44%, (1999) *The Times*, April 30th. The beneficial effects of oestrogen noted in the Swedish study also appeared to underpin the study in *The Netherlands* that suggested that “Taking the contraceptive pill may reduce the chances of contracting Alzheimer’s disease by up to a third” (1999) *The Times*, November 18th.

(2) Sterilisation

A ‘successful’ sterilisation terminates a patient’s ability to reproduce: it is a permanent form of contraception. Sterilisation of a male is known as a vasectomy – the legality of which has been challenged by *Lord Denning* (see infra). A vasectomy is, generally, a non-therapeutic procedure in relation to the man’s physical health. Sterilisation of a female, which can be achieved by way of a number of procedures, e.g., tubal ligation and hysterectomy, can take the form of therapeutic sterilisation, performed so as not to endanger a woman’s physical or mental health or non therapeutic sterilisation undertaken as a permanent method of birth control.

There appear to be two principal ethical objections to sterilisation:

(i) that sterilisation is generally regarded as an irreversible process (no guarantee of reversal) and an individual ‘may later undergo a change of mind and may wish to return to a position which is now irrevocably closed’. The individual may have succumbed to social or personal pressures and consequently has not given free and real consent.

(ii) *Mason & Laurie* note that: ‘The objection of the Catholic Church is more direct. In Catholic teaching, sterilisation is a mutilation of the body which leads to the deprivation of a natural function and is, therefore, to be rejected’⁶. Sterilisation can only be accepted if it is carried out for therapeutic purposes – that is, where it is necessary for the physical health of the patient.

As recently as 1954, *Lord Denning* was of the opinion that a man could not give a valid consent to a vasectomy. In *Bravery v Bravery* he said:

Take a case where a sterilisation operation is done so as to enable a man to have the pleasure of sexual intercourse without shouldering the responsibilities attached to it. The operation is plainly injurious to the public interest. It is degrading to the man himself. It is injurious to his wife and any other woman whom he may marry, to say nothing of the way it opens to licentiousness, and unlike other contraceptives, it allows no room for a change of mind on either side. It is illegal, even though the man consents to it ...

⁶ *Mason & Laurie*, *Mason & McCall Smith’s Law and Medical Ethics*, 7/e. Oxford: OUP, 2005, p130

[*Lord Denning* regarded contraceptive sterilisation as being equivalent to maim in the criminal law. Consequently, it would also be a criminal battery as ‘the operation is plainly injurious to the public interest’. As noted on p1, this no longer represents the law (and, probably, it never did): - see now *The Queen (on the application of SPUC) v. Secretary of State for Health* [2002] 2 FLR 146].

Sterilisation Requires [as a minimum] Real Consent

Consent of the autonomous patient must be obtained if a charge of battery is to be avoided, i.e. sterilisation cannot automatically be performed concurrently with some other gynaecological operation to which the patient has been consented. A doctor cannot merely go ahead and act ‘in her best interests’ without her agreement. That is, in the absence of an emergency, the defence of necessity will not be applicable:

Devi v W.Midlands A.H.A. (1990)

Here a married woman, a mother of four children, went into hospital for a minor gynaecological operation. During the course of the operation the surgeon sterilised her when he discovered her womb was ruptured. The operation wasn’t immediately necessary and, furthermore, Mrs Devi’s religion didn’t allow sterilisation or contraception.

Held: Mrs Devi’s inability to conceive again coupled with the neurosis caused by what had been done to her was to be compensated for by an award of damages totalling £6,750.

Devi’s case is factually similar to the earlier Canadian case of:

Murray v McMurchy (1949)

A doctor discovered during a Caesarean section that P’s uterus would have made it hazardous for her to go through another pregnancy and, although there was no pressing need for it, he sterilised her by tying her fallopian tubes.

Held: It would not have been unreasonable in the circumstances to postpone the sterilisation until after consent had been obtained in spite of the convenience of doing it on the spot.

A doctor who has obtained the patient’s consent to the operation may still be liable in negligence if he fails to discuss properly with the patient the implications of the operation in a manner consistent with good medical practice:

Wells v Surrey A.H.A. (1978)

A 35 year old Roman Catholic was about to undergo a Caesarean section for the birth of her second child when she signed a consent form. During the course of the operation she was sterilised.

HELD: Although she had in fact consented to such additional surgery as was necessary and she understood the physical implications, she was inadequately counselled as to the mental anguish she would suffer as a result of the sterilisation: getting her consent as she was being wheeled into the operating theatre fell below acceptable medical practice; it was negligent.

Imposing Liability for failed sterilisation

Liability will not be imposed unless it can be established that the failure to achieve sterility was due to medical negligence in the performance of the operation, or negligence in imparting the requisite quantum of information, or to breach of contract, rather than to the

inherent possibility that conception might still occur after the attempt purely as a result of the vagaries of nature.

Gold v Haringey Health Authority [1998] QB 481

In 1979, when Mrs G was pregnant and in hospital awaiting birth of her third child, she and her husband were discussing his having a vasectomy. However, a consultant at the hospital suggested that Mrs G be sterilised. This was agreed and was undertaken the day after Mrs G gave birth to a daughter. No mention was made of a sterilisation failure rate of up to six per thousand when carried out immediately after childbirth. The operation did not succeed and Mrs G gave birth to a fourth child three years later. She alleged negligence both in performance of the operation and in non-disclosure of the failure rate contending, on the latter point, that knowledge of this would have been a deciding factor in Mr G being vasectomised.

HELD: Mrs G failed in her claims. With regard to the non-disclosure of the failure rate, it was established that in 1979 a substantial body of doctors would *not* have given any warning as to the failure of female sterilisation, the defendants were not liable.

Eyre v Measday [1986] 1 All ER 488

In 1978, P, a 35 year old woman, was a private patient of M, a gynaecological surgeon, and she contracted with him to have a laparoscopic sterilisation. This was performed competently, but M did not inform P that there was a chance of between two and six per thousand of her becoming pregnant again. P did conceive, and gave birth to a healthy boy. She sued M for breach of contract.

HELD: The contract was for a laparoscopic sterilisation: it was not a guarantee of absolute sterility.

Damages for a Failed Sterilisation

In *Udale v Bloomsbury A.H.A.* (1983) although damages were awarded for pain and suffering and for the loss of earnings, an award in respect of bringing up a child born after a failed sterilisation was rejected on the basis ‘that the coming of a child into the world is an occasion for rejoicing’. However, this policy decision was rejected in *Emeh v Kensington and Chelsea and Westminster A.H.A.* (1983), *in respect of a child who suffered from congenital abnormalities*, and an award for damages for the cost of rearing the child was made. Furthermore, it was held that Mrs Emeh’s failure to have an abortion on discovering that she was pregnant again did not constitute a *novus actus interveniens*. This policy was further extended in *Thake v Maurice* and in *Benarr’s case to include the cost of rearing healthy children*:

Thake v Maurice [1985] 2 WLR 337

A claim for damages was made in respect of the birth of a healthy child following a negligent vasectomy. The claim included the baby’s layette (£717) and the upkeep of the child to the age of 17 (£5960).

HELD: (Court of Appeal) The surgeon was negligent in not warning Mr T of the possibility of natural reversal of vasectomy. When the surgeon had said the operation was ‘irreversible’ he should have specified that this meant ‘not reversible by surgery’ and not let Mr T believe it meant ‘absolute sterility’.

The cost of *privately educating a child* were awarded as part of the damages won in *Benarr v Kettering Health Authority* (1988) and ten years later in *Crouchman v. Burke* (1998).

It was claimed that the outcome of the *Benarr* and *Thake* cases ‘illustrated that in England, damages for the upbringing of a child were greater the more affluent and ambitious were the parents,’ per **Lord Gill**, *McFarlane v Tayside Health Board*, Scots Law Report, (1996) *The Times*, November 11th. [N.B.: This law report summarises the position in Scots Law as at 1996. It also includes a review of English and American law at that time].

[Contrast *Pickett’s* case, (1999) *The Times*, February 19th, *infra*; and *McFarlane’s* case, *infra*]

In *Pickett’s* case, (1999) *The Times*, February 19th, a claim for damages for a second ‘late-failure’ vasectomy was dismissed despite Judge John Altman finding that St James’ University Hospital in Leeds had breached its duty by not warning the couple of possible failure of the second vasectomy. The couple had been told of a 3000-1 risk of a failure of the first vasectomy but received no warning in respect of the second vasectomy. Daughters had been born after both vasectomies. However, the judge decided that the couple had taken a gamble and had lost. That is:

“The reality is they knew of the risks. It was a human decision that, in effect, it couldn’t happen to them twice. There was a negligent act, but I also find that negligent act made no difference whatsoever to their state of mind.”

Moreover, in the **House of Lords** decision in *McFarlane’s* case, (1999) *The Times*, November 26th, a £100,000 claim against Tayside Health Board for the rearing of an unplanned child following a vasectomy was dismissed because, according to **Lord Millet**:

“... the law must take the birth of a normal, healthy baby to be a blessing, not a detriment. [The birth] brings joy and sorrow, blessing and responsibility. The advantages and disadvantages are inseparable. ... Nature herself does not permit parents to enjoy the advantages and dispense with the disadvantages.

“In other contexts the law adopts the same principle. It insists that he who takes the benefit must accept the burden.”

Lord Slynn focused on the claim being concerned with liability for economic loss. It was not just a question of quantification of damages but one of liability: of the extent of the duty of care which was owed to the parents. He referred to the neighbourhood or proximity test and, following *Caparo v Dickman* (1990), asked if it would be fair, just and reasonable for the law to impose the duty? He answered in the negative.

However, the principle of claiming damages for ‘wrongful birth’ of a *disabled* child following the performance of a negligent sterilisation remains unaffected. Indeed, damages of £1.3 million were awarded to a woman who bore a severely disabled son she conceived seven months after undergoing a negligent sterilisation in December 1987: *Mrs Taylor’s* case, (1999) *The Times*, November 26th.

It is not surprising that damages were awarded in Mrs Taylor’s case given that in *McFarlane*, **Lord Steyn** had opined that:

In the case of an unwanted child, who was born seriously disabled, the rule may have to be different.

Indeed, in *Parkinson v St James and Seacroft University Hospital NHS Trust* [2002] QB 266, the Court of Appeal upheld the first instance decision that, following a negligent sterilisation, the costs of the special needs of raising a child born with a serious behavioural disorder could be recovered. Recovery of damages would be contingent on the disability being 'significant' and *Hale LJ* referred to *Part III* of the *Children Act 1989* and said that:

A child is disabled if he is blind, deaf or dumb or suffers from mental disorder of any kind or is substantially and permanently handicapped by illness, injury or congenital deformity or such other disability as may be prescribed.

Moreover, the Court of Appeal had stressed that for damages to be awarded, the child's disability had to be a foreseeable consequence of the defendant's negligence. The question, then, of whether damages could be awarded for a child born prematurely, apparently healthy, but who then developed meningitis complicated by brain abscesses, arose in:

Groom v Selby (2001) 64 BMLR 47

Here, *Hale LJ* had no doubt about specifying the source of the disability: she reiterated what she and *Brooke LJ* had agreed in *Parkinson*, viz;

It must be genetic or arise from the processes of intra-uterine development and birth. That was what the doctor negligently failed to prevent [in this case]. [The baby's] meningitis was 'bad luck' in the sense that many newborn babies do not succumb to such infections. But it arose from the process of her birth during which she was exposed to the bacterium in question.

Very controversially, in *Rees v Darlington Memorial Hospital NHS Trust* (2003) where it was a *disabled parent* who gave birth to a healthy child, the House of Lords applied *McFarlane* (i.e., in essence, no award of damages) but subjected it to a 'gloss': a 'conventional sum', "not a nominal, let alone a derisory, award" (per *Lord Bingham*) of £15,000 was awarded and added to 'the award for the pregnancy and birth'.

Lord Nicholls agreed that: "An award of some amount should be made", but in not dissenting "from the sum of £15,000 suggested by ... Lord Bingham" he acknowledged that: "The amount of such an award will inevitably have an arbitrary character".

(**N.B.:** You should read *Rees v. Darlington* and be able to discuss the appropriateness, or otherwise, of the policy decision in deciding the case)

Sterilisation of Females With Learning Disabilities

[N.B.: The proposed sterilisation of an adult female with a learning disability must now be read in conjunction with provisions of the Mental Capacity Act 2005]

In *Law, Fertility and Reproduction*, **Douglas** notes that:

“At the turn of the century, a new impetus for birth control emerged in the spread of eugenic theory, loosely based on Darwin’s theory of evolution. It was argued that the human stock could be improved if ‘better’ people had children, and less superior specimens did not. This view was adopted particularly in the United States where it was used to sanction the often involuntary sterilisation of those deemed mentally defective, on the ground that this deficiency would be passed on to offspring.”

This view achieved great notoriety in 1927 when **Holmes J** expressed the view in *Buck v Bell* that:

“It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind ... Three generations of imbeciles are enough.”

Not surprisingly then, non-consensual sterilisation is described by **Mason & McCall Smith** (6/e) as capable of raising “a minefield of powerful objections”. They go on to note that:

“... despite some inevitable inconsistencies, a consensus is evolving in favour of non-consensual sterilisation given very specific criteria of justification. ...The immediate problem in all such cases is to strike a balance between the individual’s right to bodily integrity and the right to choose an operation which, in the case of the mentally handicapped, may carry with it greater freedom of access to community life and relationships. To make such a choice in surrogate fashion, however, is to invoke a ‘*substituted judgement*’ test. The great majority of courts have recognised the near impossibility of doing this in the face of congenital mental illness and have, accordingly, opted for a ‘*best interests*’ test which is also central to the welfare principle on which the English wardship jurisdiction is founded.”

Pre-1993, the criteria the Courts took into account before authorising non-consensual sterilisation were stated in the American case of *Re Hayes* (1980) and included:

- (i) confirmation that the subject is incapable of forming a judgement;
- (ii) the subject is physically capable of procreation;
- (iii) the subject is likely to / engage in / is engaging in sexual activity;
- (iv) confirmation that there is no reasonable alternative to sterilisation.

(From 1993, English law was provided for in: *Practice Note (Sterilisation: Minors and Mental Health Patients)* [1993] 3 All ER 222; see now: *Practice Note (Official solicitor: Declaratory Proceedings: Medical and Welfare Decisions for Adults who Lack Capacity)* [2001] 2 FCR 158).

A contentious issue raised by non-consensual sterilisation is whether it involves the deprivation of the basic human right to reproduce. This issue was raised in *Re D* (1976) and has been the subject of diametrically opposed opinions in later cases.

Re D [1976] 1 All ER 326

D was an 11 year old girl suffering from Sotos syndrome. Sotos syndrome may include some or all of the following: accelerated growth during infancy, epilepsy, generalised clumsiness, an unusual facial appearance, behaviour problems including certain aggressive tendencies, and some impairment of mental function which could result in dull intelligence or possibly more serious mental retardation. D's mother, who was described by the judge as 'an excellent, caring and devoted mother' had requested that D be sterilised because she (the mother) recalled that in the past she lived near a family who had the misfortune to have three mentally retarded children, and their plight and their troubled lives had deeply affected her. D's mother was very worried that D might be seduced and possibly give birth to a baby, which might be abnormal. She had always believed that D would not, or should not, marry and in any event would not be capable of bringing up a child. However, the social and behavioural reasons put forward by the consultant paediatrician for performing the sterilisation were seriously challenged by an experienced educational psychologist.

Held: *Heilbron J* cited with approval *Lord Eldon's* dicta in *Wellesley's* case (1827) that: '*It has always been the principle of this Court, not to risk the incurring of damage to children which it cannot repair, but rather to prevent the damage being done.*' *Heilbron J* continued by noting that:

"A review of the whole of the evidence leads me to the conclusion that in a case of a child of 11 years of age, where the evidence shows that her mental and physical condition and attainments have already improved, and where her future prospects are as yet unpredictable, where the evidence also shows that she is unable as yet to understand and appreciate the implications of this operation and could not give valid or informed consent, that the likelihood is that in later years she will be able to make her own choice, where, I believe, the frustration and resentment of realising (as she would one day) what happened could be devastating, an operation of this nature is, in my view, contra-indicated".

Accordingly, D remained a ward of Court because the operation was neither medically indicated nor necessary, and it would not be in D's best interest for it to be performed.

Re Eve (1986) (Decision of the Supreme Court of Canada)

Eve, who was 24 years old, attended a school for retarded adults. 'She was attracted and attractive to men and Mrs E feared she might quite possibly and innocently become pregnant'. Mrs E was a widow approaching 60 years of age. She decided Eve should be sterilised. It was said in Court that Eve would have 'no concept of the idea of marriage, or indeed, the consequential relationship between, intercourse, pregnancy and birth'.

Held: *La Forest J*, who also approved *Lord Eldon's* dicta in *Wellesley's* case, said:

"The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can *never* safely be determined that such a procedure is for the benefit of that person.

Accordingly, the procedure should *never* be authorised for non-therapeutic purposes under *parens patriae* jurisdiction.”

In *Re B* (1987), **Lord Hailsham** found La Forest J’s conclusion ‘totally unconvincing and in startling contradiction to the welfare principle’.

Re B [1988] AC 199

Jeanette was a 17 year old girl with a mental age of five or six. Although she was described as mentally handicapped and epileptic she was exhibiting the normal sexual drive and inclinations for someone of her age. However, it was said that she would not be able to cope with birth or care for a child.

Held: The House of Lords approved the application for sterilisation. The ‘basic human right’ of reproduction argument was rejected. **Lord Hailsham** said: “To talk of the ‘basic right’ to reproduce of an individual who, is not capable of knowing the causal connection between intercourse and childbirth, the nature of pregnancy, what is involved in delivery, unable to form maternal instincts or to care for a child appears ... wholly to part company with reality.”

Re M (A Minor) (Wardship: Sterilisation) [1988] 2 FLR 497

M was a 17 year old girl with a mental age of five or six. Two factors were cited as ‘evidence’ with regard to the sterilisation proposed for her, viz; that with the improvements in tubal surgery there was a 50 to 75% chance of successfully reversing sterilisation should M’s condition ever improve; and that there was a 50% chance that any child born to M might suffer from some degree of mental retardation.

Held: The sterilisation was approved. **Bush J** said that the eugenic considerations (that any baby might be born with a degree of mental handicap) were irrelevant – but, (according to **Brazier**) he did appear to take into account evidence that if M should become pregnant, an abortion on the ground of foetal handicap might be recommended.

Re P (A Minor) (Wardship: Sterilisation) [1989] 1 FLR 182

P was a 17 year old girl with a mental age of 6 and the communication skills of an average 6-year-old. As she was of normal and attractive appearance, not only did her mother think she was vulnerable to seduction [apparently she had already had sexual intercourse which she described as ‘painful’], but that if she became pregnant and understood what was happening she might refuse an abortion. It would be better to sterilise her than risk the trauma of separating her from her child at birth.

Held: Allowing the sterilisation, **Eastham J** based his decision on, *inter alia*, **Professor Robert Winston’s** evidence that reversal of female sterilisation carried out by clips on the Fallopian Tubes now has a 95% success rate!

Brazier compares this 95% success rate with “ ... 50to 75% [being] considered a good success rate by most competent gynaecologists. [And, she asks:] Can the possibility, even probability, of successful reversal justify no longer treating sterilisation as the ‘last resort’ but rather as a convenient method of contraception? ...”

Sterilisation as a ‘ast resort’ did not appear to be the basis of the decision in **Re HG** (*specific issue order: sterilisation*) [1993] 1 FLR 587 where the deputy judge authorising

the sterilisation of an epileptic teenager who also suffered from an unspecified chromosomal abnormality said:

“ ... a sufficiently overwhelming case has been established to justify interference with the fundamental right of a woman to bear a child. [Accordingly] it would be cruel to expose [her] to an unacceptable risk of pregnancy and that that should be obviated by sterilisation in her interests”.

However, “A clear distinction is to be made between an operation to be performed for a genuine therapeutic reason and one to achieve sterilisation”, per *Sir Stephen Brown P*, *In re E (a Minor) (medical treatment)* [1991] 2 FLR 585 where he *Held*: that parents were able to give a valid consent to the proposed hysterectomy to be performed on their 17 year old mentally handicapped daughter. The operation would be carried out for ‘a genuine therapeutic reason’ and the incidental result of sterilisation did not invalidate the consent. Yet this decision appeared wholly to ignore *Lord Hailsham’s* opinion in *Re B* that ‘[the] distinction ... between ‘therapeutic’ and ‘non-therapeutic’ purposes of this operation ... [is] irrelevant ...’.

Perhaps the President had thought that he had, at least, partially readdressed this confusion when, in *Re GF* [1992] 1 FLR 293, he gave doctors far clearer guidance as to when they could sterilise a female with learning difficulties – whether in wardship (as in *Re E*) or as an adult (as in *Re GF*), viz; two doctors would have to agree on three issues: first, the operation was necessary for therapeutic reasons; secondly, that the operation was in the best interests of the patient; and third, there was no practicable less intrusive treatment available. Where the three issues were agreed on, a declaration of lawfulness was not necessary.

The controversies surrounding sterilisations of incompetent females are no longer confined to minors, however: in *T v T* (1988) an application was made to sterilise a pregnant adult incompetent at the same time as she was to have an abortion, and a precedent set in that case was followed in *Re F* (1989); and in Scots law, in: *L v I’s Curator ad litem* (1996) *The Times*, March 19th.

[N.B.: Remember that the proposed sterilisation of an adult female with a learning disability must now be read in conjunction with provisions of the Mental Capacity Act 2005]

T v T [1988] Fam 52

Held: *Wood J* permitted sterilisation on ‘the demands of good medical practice’. He had rejected the defence of ‘necessity’ on account of its ill-defined limits (though what is more specific about ‘good medical practice’ is problematical!). The fact that the *parens patriae* jurisdiction had been abolished by the Mental Health Act of 1959 (now 1983) without being replaced meant that no one could authorise or prevent a non-consensual sterilisation of an adult. Accordingly, *Wood J* acknowledged that if (say) the medical profession sought an anticipatory declaration of the lawfulness of the procedure in pursuit of the demands of good medical practice, then the Courts could approve such a request.

In 1989, the case of *Re F* attracted much criticism, both on the way to the House of Lords and after the opinions of their Lordships were delivered. Notwithstanding the criticisms,

Re F became the leading case on the legal basis for administering non-consensual medical treatment.

Re F [1990] 2 AC 1

F, a 36 year old woman had been a voluntary in-patient in a mental hospital for more than 20 years. It was said that she had the verbal capacity of a child of two and the mental capacity of a child of four or five. F had formed a sexual relationship with a male patient and it was said that it would have been 'disastrous for her to conceive a child'. The psychiatric evidence to reinforce this assertion was that F would not understand the meaning of pregnancy, labour or delivery, and would be unable to care for a baby if she had one. Sterilisation was recommended as other forms of contraception were rejected for various reasons. With regard to the procedure, wardship did not apply as F was over the age of 18: there was no equivalent jurisdiction by which the court could exercise a power to consent on behalf of an incompetent adult. Nor was there jurisdiction under Part VII of the MHA 1983, 'Property and Affairs of Persons Under Disability' as the provisions were limited to business matters, legal transactions and other dealings of a similar kind.

Held: The House of Lords sanctioned the sterilisation and said that it *could be* justified by the principle of *necessity* if it was in the patient's *best interests*. **Lord Brandon** said that treatment would be in the best interests of a patient '... if, but only if, it is carried out in order to either to save [her life] or to ensure improvement or prevent deterioration in [her] physical or mental health'. **Jones** says: 'This statement of the patient's best interests is startling in its breadth. The patient's 'best interests' are to be based on the *Bolam* test. (**Jones** continues by noting that: '... applying *Bolam* to the defence of necessity means that there may well be more than one view, or indeed several views, as to what is the best interests of the patient and, accordingly, as to what course of conduct in relation to incompetent patients is justified in law, and *none* of these competing bodies of responsible bodies of medical opinion can be challenged in the courts. *This is medical paternalism run amok*').

That the procedure by way of declaration was appropriate and satisfactory in relation to incompetent adults was confirmed in Re F and general guidelines for seeking such declarations were explained in Re C The Times, February 13th 1990.

However, for a recent very controversial case in which a declaration for a 29-year-old woman with severe learning difficulties to be sterilised was *not* granted by the Court of Appeal, see: In re S (Adult Patient: Sterilisation) [2001] Fam 15. {Note the (declining) influence of the *Bolam* standard: 'that the *Bolam* test [remains] relevant to the judgment of the adult patient's best interests when a dispute arises as to the advisability of *medical treatment*' per **Thorpe LJ**; **but** given that there can be only one '*best interest*' – an interest that will be decided on more than just medical grounds – e.g., ethical, social and welfare grounds – this must be determined as an essential prerequisite by the doctor(s) or the court prior to the 'second stage' of administering treatment to the incompetent. The *Bolam* test has no role to play in this second, determinative, stage of establishing the lawfulness of the treatment.}

References

Brazier, *Sterilisation: down the slippery slope?* [1990] PN 25.

Douglas, *Law Fertility and Reproduction* London: Sweet & Maxwell, 1991, pp56-61.

Freeman, *Sterilising the Mentally Handicapped*, in *Medicine, Ethics and the Law* ed MDA Freeman, Stevens, 1988.

Jones, *Justifying Medical Treatment Without Consent*, [1989] PN 178.

Mason & Laurie, *Mason & McCall Smith's Law and Medical Ethics*. Oxford: OUP, 7/e 2005, Chs 5 & 6.

Shaw, *Sterilisation of Mentally Handicapped People: Judges Rule OK?* (1990) 53 MLR 91.

Mental Capacity Act 2005

Further Reading

Austria 'sterilises mentally handicapped women' (1997) *The Times*, August 28th

When sterilisation is the right answer (1997) *Sunday Telegraph*, September 14th

Workshop Questions

1. Critically evaluate the contribution to contemporary medical law of the House of Lords decision in *Re F* [1990] 2 AC 1.

2. Jennifer, aged 13, and Emily, aged 35, live in a home for the mentally retarded and are patients of Dr Tel Tales. Dr Tales has informed Jennifer's parents that she is 18 weeks pregnant and that an abortion and sterilisation would be appropriate. Jennifer's parents agree.

Dr Tales has also informed Emily's parents that, in view of Emily's growing interest in the opposite sex, it would be convenient for all concerned if she were to be sterilised. Emily's parents agree.

Dr Tales has now sought your advice as to whether he may perform these operations without incurring legal liability. Advise him.

3. Doctors have proposed that a non-consensual sterilisation is appropriate for Mary, a 23-year-old incompetent female. They are unsure of the law, however, and have asked you to advise them. Critically evaluate the factors that would determine whether the operation can be performed lawfully.