New Zealand law on the sterilisation of intellectually disabled women and girls

Introduction

The right to refuse medical treatment upholds the right to autonomy over one's body. In turn, respecting autonomy upholds the moral duty to respect the views and decisions of others. If the goal of ethics is to do the right and decent thing; then respecting the autonomy of a person who will be affected by decisions is important. The fundamental right of everyone to refuse medical treatment as provided for in the New Zealand Bill of Rights Act 1990 (NZBORA) upholds the right to bodily integrity and autonomy but only applies to those who are considered competent to make the necessary decisions. People with intellectually disabilities are often deemed to be incompetent to consent to medical treatment because they are found to lack autonomy and as such others are required to make decisions on their behalf. When people lack the capacity to consent to medical treatment this represents a serious problem in biomedical ethics. However, the law regulates the sterilisation of people found to be incompetent that is, when they lack autonomy. Therefore the law must be seen to be doing what is right and decent. Intellectually disabled (ID) people may be sterilised, without their consent, under New Zealand (NZ) law and court authorisation is not always necessary. Involuntary sterilisation of people with capacity to consent or refuse consent to have medical treatment represents a violation of the respect-for-autonomy principle but under the law autonomy as such cannot be respected if it does not exist in a person, and thus for people with restricted or absent autonomy alternative moral considerations are essential when making decisions about...

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2 New Zealand Bill of Rights Act 1990 (NZBORA from here on in), s 11. This right is further embodied in the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (SR 1996/78) (Code of Rights from here on in), right 7.
6 X v Y [Mental Health: Sterilisation] above n 5 at [56]; Re X [1991] 2 NZLR 365 (HC) at 370. The former case involved an application for sterilisation of an intellectually disabled adult woman and the latter the same for a severely intellectually and physically disabled minor.
sterilisation.\(^7\) NZ enacted the Protection of Personal and Property Rights Act 1988 (PPPRA) to safeguard ID adults’ interests who “are not fully able to manage their own affairs”\(^8\). It is under that Act that the court hears applications for sterilisations of ID women. In the case of intellectually disabled minors the Care of Children Act 2004\(^9\) (COCA) provides that the child’s guardians (generally her parents) together with the appropriate medical professionals have the authority to decide which medical treatments the minor will receive and the High Court has observed that court authorisation in a case of sterilisation is not required.\(^10\) To gain insight into how these decisions are made by the court when they apply the law one must look at court judgments, to assess how such decisions are made. What follows is an enquiry and analysis of the law in NZ concerning the sterilisation of ID girls and women. The starting point will be to look at competence and capacity to consent to medical treatment since this must first be proven to lack to a degree that will allow the court to exercise its jurisdiction under PPPRA.

1. Competence and capacity to consent

Competence and to consent to medical treatment is a legal, moral,\(^11\) and bio-ethical\(^12\) subject. In most jurisdictions though only a court can decide if a person is incompetent and as such competence is a legal construct.\(^13\) A person may be competent to perform certain tasks but not others and therefore determination of competence must at all times be determined for the particular task or decision being considered\(^14\) that is, the assessment must be task specific. Capacities that will require a person to make competent decisions about health care include the capacity for understanding and communication, the capacity

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\(^7\) Douglas Diekema above n 1 at 23.

\(^8\) Protection of Personal and Property Rights Act 1988, (PPPRA from here on in), Long title.

\(^9\) Care of Children Act 2004, (COCA from here on in) s 36(1).

\(^10\) Re X above n 6 at 370.


for reasoning and deliberation and having an established set of values or notions of what is good. While assessment of capacity is usually consigned to the medical or mental health professionals and legislatures may decide on the level of incapacity required to find a person to be incompetent, the common law, laid down the test for capacity to consent to medical treatment in the English case of Re C (Adult: Refusal of Treatment). In that decision, Thorpe LJ stated that to establish capacity, one must prove that the individual can comprehend and retain treatment information, believe that information, and weigh it up on balance to arrive at a choice. The first assessments of competence in medical treatment situations however are made by medical practitioners who must judge whether a person is competent to give informed consent to a particular procedure. The expectation however is that incompetence is never assumed. The High Court set out guidelines for doctors to follow where they must decide on sterilisation and the prevention of menses. Relating to capacity these are:

- The intellectually disabled person’s level of functioning and development and whether there is any real likelihood that her capabilities will significantly increase in the future;
- The intellectually disabled person’s understanding of reproduction or conception;
- Whether the intellectually disabled person could care for a child?

PPRRA presumes that the subject person has the required competence and provides that the court’s jurisdiction to make personal orders relating to the ID adult will only apply if the adult “lacks, wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of any matter relating to his or her personal care and welfare;” To appoint a welfare guardian (WG) for an ID adult a higher test must be

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15 Buchanan and Brock above n 14 at 23 – 25.
16 Appelbaum and Grisso above n 13 at 348 – 349.
17 Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290.
18 Re C (Adult: Refusal of Treatment) above n 17 at 13.
20 Ibid.
21 Re X above n 6 at 376 – 377 as per Hillyer J.
22 PPRRA, s 5.
23 PPRRA, s 6(1).
met since it is considered an extreme intervention which may only be made if it can be shown that the ID person wholly lacks capacity in a specific area of her welfare and personal care. In cases of emergency and prevention of serious health damage, the WG may consent, without court authorisation, to medical procedures that will sterilise the ID patient.

PPPRA does not further define capacity or competence yet uses both terms throughout the Act without distinguishing between the two. In America these concepts are distinguished with ‘competence’ being specific and ‘capacity’ more general. In England, the terms are used interchangeably because generally determining capacity to make decisions in case of medical treatment is not what the law requires; competence is, albeit that capacity will go toward the court’s decision on competence. Academic commentator and former judge BD Inglis documented extrajudicially and in his judicial role held that competence and capacity are used as synonyms in NZ within the context of the PPPRA. Judge Boshier in BF v SF considered the two concepts not to be exchangeable and “competence” to be at a more subjective level whereas “capacity” in his opinion is a “distinct legal notion”. There have been occasions where the court and the medical professionals have been at odds in assessing capacity under PPPRA. Research has shown that many medical practitioners

24 Re L [2001] NZFLR 310 (DC) at para [36].
25 PPPRA, s 12 (2)(a); In the matter of G [1994] NZFLR 445 (FC) at pp 448-449. As will be discussed below, the courts have held though that in cases of proposed sterilisation of an adult that are not emergencies or therapeutic a court must authorise the procedure once it has been established that the patient lacks the required capacity. In making its decision the court relies on medical evidence.
29 In 1995 in that jurisdiction the Law Society and British Medical Association provided a joint definition of capacity for clinicians to follow which was similar to the definition established at common law. The Law Commission made recommendations for a ‘Mental Incapacity Act’. Following consultation, the UK Government issued proposals for law reform based on these recommendations and the Mental Capacity Bill was introduced by the House of Commons and eventually The Mental Capacity Act 2005 came into force in England and Wales in 2007 which basically codified the common law definition.
30 BD Inglis QC New Zealand Family Law in the 21st Century (Brokers, Wellington, 2007) at 723.
31 Re Tony (1990) 5 NZFLR 609 at 614.
32 BF v SF (1992) 9 FRNZ 231 (FC).
33 BF v SF above n 32 at 236.
34 HLS v BD [2005] NZFLR (FC) 795; Re H & H [Protection of personal and property rights] (1999) 18 FRNZ 297 (FC). The former case involved a mentally ill patient’s capacity to consent to medical treatment and the latter case the two subject persons’ capacity to manage property. Both cases were decided under PPPRA.
believe the assessment of competence to be primarily a medical question rather than the application of a legal rule; despite their knowledge of the relevant legal standard and that the determination of competence requires that the legal standard be applied. The court in turn relies on the expert evidence of health professionals when determining the ID person's competence/capacity. Despite clinicians in general and psychiatrists in particular having known the standard for legal competence they may apply it incorrectly which suggests that relying on expert medical opinion may establish preconceived notions and produce flawed results that undermine patient autonomy. In the medical profession the most commonly accepted definition is provided by Appelbaum and Grisso who set out four decision-making abilities necessary to determine competence namely: understanding, appreciation/realisation, reasoning, and the ability to communicate a choice. A shortcoming in any one of these abilities could potentially mean that the person's capacity to make decision is impaired. Appelbaum describes this understanding of capacity as indeed evolving from case law rather than from medical observation or experience. The NZ Family Court stated that to establish capacity in a case where a person has an intellectual disability it was:

... sufficient to show that the subject's capacity to understand the nature and to foresee the consequences of alternatives or options available for choice is so limited by intellectual disability or by mental illness or both that any choice between such alternatives or options which the subject may make cannot responsibly be recognised as effective.

Most recently the NZ High Court observed that the factors that will determine whether a person has capacity under PPPRA are the ability to: communicate choice, understand relevant information, appreciate the situation and its consequences, and manipulate

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39 Paul S Appelbaum “Ought we to require emotional capacity as part of decisional competence” (1998) 8(4) KIEJ 377 at 378.
41 X v Y [Mental Health: Sterilisation] above at para [51]. In that case the High Court cited Re FT (District Court, Auckland, PPPR 68/94, 11 January 1995, Judge Boshier) with approval.
information. This is indeed in sync with the definition provided by Appelbaum and Grisso as based on the evolving case law. Capacity/competence for adults under PPPRA is therefore established based on the test as it evolved from case law and is decided by the court but based largely on the evidence provided by medical experts. Bray\(^{42}\) correctly proposes that PPPRA requires a functional approach by the court when determining capacity that is, to establish the degree of the intellectually disabled person’s capacity to make decisions or to communicate.

The notion of informed consent evolved from the law and moral philosophy while the legal doctrine of informed consent to treatment evolved largely through case law.\(^{43}\) Section 2 of the Health and Disability Commissioner Act 1994 defines informed consent as meaning that, in relation to a health care procedure, such consent is freely given by the consumer; or where applicable, by any person who is entitled to consent on the consumer’s behalf and that the consent is obtained in accordance with the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996 (Code of Rights) requirements.\(^{44}\) Accordingly the consent given must be “real” and not be spoilt by lack of relevant information — including alternatives — and the material risks of the proposed procedure.\(^{45}\) To give or to refuse consent fundamentally involves some capacity to understand what the medical treatment will involve but this alone is not sufficient and the person must also have the ability to “process” the information provided as well as come to a decision.\(^{46}\) Parallel to the legal requirement of informed consent to medical treatment is the presumption that the patient has the capacity to make the decision.\(^{47}\) The High Court stated that reproduction clearly involves choices as to whether, when, and with whom to have children and that an informed decision requires some understanding of conception and the consequences in terms of pregnancy, birth, and child rearing.\(^{48}\)

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\(^{43}\) See generally Ruth R. Faden and TL Beauchamp above n 11.

\(^{44}\) Code of Rights, Right 5 and 6.

\(^{45}\) The rights respectively set out the right to information and requirement of informed consent.

\(^{46}\) X v Y [Mental Health: Sterilisation] above n 5 at para [51].

\(^{47}\) See e.g. generally MJ Gunn, JG Wong and others above n 28.

\(^{48}\) X v Y [Mental Health: Sterilisation] above n 5 at para [72].
On the moral status of ID individuals, it is argued that they are viewed as having a lower moral status than people who are ontologically independent and autonomous.\textsuperscript{49} This is because, based on the liberal individualistic view of the "self", to be a legitimate or true "self" is to be independent as well as autonomous and whereas disability is considered in dependent terms the integrity of the ID person's "self" is threatened.\textsuperscript{50} Since ID persons are perceived to have less or even no independence and autonomy they are viewed as having lower moral status; as not being 'true' selves. By law a person's competence will necessarily have implications for whether she is allowed to decide what type of medical treatment, if any, is received.

PPPRA first embodies the principle of competence and everyone (to whom PPPRA applies) is first presumed competent to make decisions and manage their own affairs unless the criteria establishing lack of capacity are satisfied.\textsuperscript{51} The onus is on the applicant for the court's authorisation of a proposed action on behalf of the ID adult to satisfy the court that the subject person is impaired to a degree that must justify intervention by the court.\textsuperscript{52} The Code of Rights too presumes that every consumer of health and disability services is competent to make an informed choice and to give informed consent unless there are reasonable grounds for believing otherwise.\textsuperscript{53}

Finally, the PPPRA provides that a person in respect of whom the application is made for the exercise of the court's jurisdiction should not be deemed to lack capacity on the grounds that the person is making or is intending to make an imprudent decision.\textsuperscript{54} Imprudence is measured against the standard of "any decision that a person exercising ordinary prudence would not have made or would not make given the same circumstances".\textsuperscript{55} Arguably, this can be seen as a subjective and values based standard.

\textsuperscript{50} Ibid.
\textsuperscript{51} PPPRA, s 5
\textsuperscript{52} \textit{B v DR} [1994] NZFLR 898 (FC) at 899.
\textsuperscript{53} Code of Rights, Right 7(2).
\textsuperscript{54} PPPRA, s 6(3).
\textsuperscript{55} Ibid.
Children below the age of 16 do not themselves have the capacity to consent or refuse consent to medical treatment but are protected by the Contraception, Sterilisation, and Abortion Act 1977 (CSA) from involuntary sterilisation. This apparently does not apply to ID minors or to 16 and 17 year old ID young people whose parents/guardians “might well be able to give a legally effective consent” to sterilisations. The views of the parents/guardians will be taken into account by the health care provider; however it is ultimately the provider’s responsibility to form an independent decision about the child’s competence. Once the ID person turns 18 the PPPRA applies and establishing capacity/competence falls under the court’s jurisdiction. Hillyer J in Re X placed significant responsibility on doctors to ensure that informed consent is given in cases of sterilisation of an ID child and that the operation is done for the benefit of the child. This means that medical practitioners are greatly responsible for thoroughly assessing the child or young person’s capacity and wishes. During a New Zealand parliamentary debate in 2004 on the Care of Children Bill a member of parliament in her argument stated that “[t]he fact is that sterilisation of young disabled girls is occurring in this country on non-medical grounds without their informed consent.” She stated that the reasons are multiple and include families being concerned and unsure how to manage issues that arise when such a girl starts her period. What follows is an analysis of the rights of ID girls and women and how such rights are protected in the context of sterilisation decisions.

57 Tompkins J concluded that the right to refuse or consent to medical treatment did not exist for minors and based his decision on the legal age (16) to give effective consent or refusal of consent to medical treatment, with no regard for Gillick v West Norfolk Area Health Authority [1986] 1 AC 112 (UKHL) which led to increasing minor autonomy.
58 Contraception, Sterilisation, and Abortion Act 1977, s 7.
59 Ibid; Re X above n 6.
60 PDG Skegg “Capacity to Consent to Treatment” in PDG Skegg and R Paterson (eds) Medical Law in New Zealand (Brokers Ltd, Wellington, 2006) 171 at 196.
61 Sue Johnson Rebecca Keenan and Robert FB Perry “Consent Issues: Children, Consumers with a Mental Illness or Intellectual Disability” in Rebecca Keenan and Louisa Clery above n 19 at 140.
62 Re X above n 6.
64 Ibid.
65 Metiria Turei (4 November 2004) 621 NZPD 16627.
66 Metiria Turei above n 64.
2. Rights of persons with intellectual disability in the context of sterilisation

Under international human rights law, individuals have the right to be recognised as persons before the law\(^{66}\) and the right to equality before the law, including people with disabilities.\(^{67}\) The most recent relevant legal step taken by the NZ government was to ratify the United Nations Convention on the Rights of Persons with Disabilities (CRPD) on 26 September 2008. The first principle of CRPD is “[r]espect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons”.\(^{68}\) The purpose of CRPD is to “promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity”.\(^{69}\) (Own emphasis). CRPD adopts the social model of disability.\(^{70}\) That model of disability, developed in the 1980s, emphasises that people with disabilities are disempowered not due to their impairments, but rather by the barriers that face them and which flow from societal attitudes and restrictions on persons with disabilities.\(^{71}\) The medical model of intellectual disability focuses on the impairment, the medical diagnosis, individual deficits, and the need for a cure through for example medical services\(^{72}\) and the way in which the abnormality causes some degree of disability or functional limitations.\(^{73}\)

Non-discrimination is one of the eight principles of CRPD as is respect for human dignity\(^{74}\) and paragraph 1 of article 4 obligates states parties to implement measures to ensure that all of the rights of CRPD are bestowed on persons with disabilities. Article 5 declares that states parties to CRPD recognise that all people are equal before the law and

\(^{66}\) Universal Declaration of Human Rights, article 6; International Covenant on Civil and Political Rights (ICCPR from here on in), article 16.

\(^{67}\) ICCPR article 26.

\(^{68}\) Convention on the Rights of Persons with Disability (CRPD from here on in), article 3(a).

\(^{69}\) CRPD, article 1


\(^{71}\) Andreas Dimopoulos Issues in Human Rights Protection of Intellectually Disabled Persons (Ashgate, Farnham, 2010) at 19 – 25.


\(^{74}\) CRPD, articles 3(b) and (a).
are therefore equally entitled to its protection and benefits which is subsequently repeated in article 12. In terms of rights, it must be noted that CRPD does not create any new rights for people with disabilities that were not provided for in other human rights instruments but it seeks to advance the achievement by people with disabilities of those existing human rights. In NZ, under the doctrine of parliamentary sovereignty, domestic legislation overrides any international instruments that have been ratified and international legal instruments only become binding when incorporated by statute into the domestic law albeit that they can be referred to as extrinsic aids when the court interpret statutes. Therefore to understand the rights of ID people it is necessary to turn to the existing human rights instruments in NZ and to assess the discrepancies, if any, between these instruments and the ratified CRPD.

Section 11 of NZBORA guarantees “everyone” the right to refuse medical treatment and thereby recognises the right to dignity, bodily integrity, and autonomy. When the High Court had to decide what “everyone” means, it was interpreted to mean those who are “competent to consent”. That fundamental right, as it has been interpreted, may not apply to people with intellectual disabilities and for them equality before the law as espoused by CRPD – does then not generally exist. It remains to be seen how the court in future may refer to CRPD – as an extrinsic aid to statutory interpretation. It is of course up to parliament to override this judicial precedent by way of statutory enactment since that remains the highest form of law in NZ and as such can reverse precedents set by the judiciary. Section 21 of the Human Rights Act 1993 provides that the prohibited grounds of discrimination include disability and specifies intellectual disability as inclusive. This is further affirmed by s 19 of NZBORA which provides that “[e]veryone has the right to freedom from discrimination on the grounds of discrimination in the Human Rights Act 1993”. At first glance this could be the resolution that people who experience intellectually

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75 Ron McCallum above n 71.
77 Ibid.
78 NZBORA, s 11.
80 McDowell and Webb above n 77 at 127.
81 Human Rights Act 1993 (HRA from here on in), s 21, subsection (1)(b).
82 HRA section 21 subsection (1)(b)(iv).
disability may rely on, if it were not for section 5 of NZBORA which provides that the rights and freedoms contained in NZBORA may be subject to "such reasonable limits prescribed by law" and if such limits can be "demonstrably justified" in a "free and democratic society". Parliament, as the supreme law making body in New Zealand had decided not to prohibit sterilisation of ID adults under PPPRA, nor of ID minors under COCA. However, the courts have held that in cases of such adults, court sanction is not required in cases of medical necessity.83 Also as will be discussed, decisions to sterilise an ID woman are justified by the "welfare and best interests" standard – that is to grant or decline the application based on what is deemed to be in the best interests of the ID woman.

PPPRA was enacted to provide for the care and protection (guardianship) of adults84 who lack competence to make decisions on their own behalf. The High Court held that s 11 of NZBORA does not preclude the court from making an order for sterilisation under the PPPRA if it is based on the welfare principle.85 Under PPPRA a WG may apply to the court for directions relating to the exercise of her/his powers and the court may give such directions as it thinks fit.86

The Code of Rights gives patients the ability to enforce the rights contained in that Code. The right to refuse treatment under s 11 NZBORA is repeated in unqualified terms in the Code of Rights87 and where persons are regarded as not competent to consent or refuse consent to medical treatment, they still retain their other rights in the Code of Rights which includes the right to receive information suitable for the person's level of competence, provided to her in a manner that enables her to understand it, and the right to give informed consent to the extent appropriate to her level of competence.88 Importantly, the Code of Rights again enshrines the right not to be discriminated against 89 with discrimination defined as "discrimination that is unlawful by virtue of Part 2 the Human

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83 See 3.1 below.
84 PPPRA will not apply if the person is under 18 and has never been married or in a civil union, or is 16 or older and has never lived in a de facto relationship: s 6(2).
85 X v Y [Mental Health: Sterilisation] above n 5 at para [74] – [75].
86 PPPRA, s 18(6).
87 Code of Rights, Right 6(7).
88 Code of Rights, Right 7(3).
89 Code of Rights, Right 2.
Rights Act 1993". Finally the Code of Rights, like section 11 NZBORA, also applies to everyone – with of course the qualification that they are consumers of health and/or disability services. However, because the Code of Rights (a regulation) is subject to legislation and common (case) law, the qualification of “everyone” by the High Court prevails. Miller J in the High Court case X v Y [Mental Health: Sterilisation] stated that sterilisation is “a special case” and referred to Canadian and Australian cases in saying that “[t]here will be cases in which a person subject to the [PPPRA] cannot make an informed choice, yet may suffer psychologically from the loss of reproductive capacity ...” His Honour acknowledged that “[t]here is evidence that disabled people may see sterilisation as a symbol of reduced or degraded status but then went on to say: ... in some cases there may be clear proof that the person whose position the court is considering is not capable of any meaningful decision or understanding. To base a decision on a right that is meaningless to a woman in that position may be to inflict suffering on her due to pregnancy and childbirth, and hardship on others who must live with the consequences of the Court’s decision.

Miller J in his judgement also cited Lord Hailsham from an English case of 17 years earlier as follows:

To talk of the basic right to reproduce of an individual who is not capable of knowing the causal connection between intercourse and childbirth, the nature of pregnancy, what is involved in delivery, unable to form maternal instincts or to care for a child appears to be me [sic] wholly to part company with reality.

In relation to ID children’s right to be protected from involuntary, non-therapeutic sterilisation the Member of Parliament, during the parliamentary debate (mentioned above) on the Care of Children Bill, stated that:

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91 Code of Rights, Schedule 1(1).
92 Code of Rights, Right 7(1).
93 X v Y [Mental Health: Sterilisation] above n 5 at para [73].
94 Ibid.
95 Re Eve [1986] 2 SCR 388; (1986) 31 DLR (4th) 1 (SCC) at pp 428, 429; p 30 per La Forest J.
96 Secretary, Department of Health & Community Services v JWB & SMB (Marion’s case) (1992) 175 CLR 218 at p 261; pp 413, 414 per Brennan J.
97 X v Y [Mental Health: Sterilisation] above n 5 at para [73].
98 Ibid.
99 Ibid.
100 Re B (a Minor) (Wardship: Sterilisation) [1987] 2 WLR 1213; [1987] 2 All ER 206 at p 1216; p 213.
101 X v Y [Mental Health: Sterilisation] above n 5 at para [69].
102 Metiria Turei above n 64.
[T]here is no way that we in this country would allow the non-medical sterilisation of non-disabled children, yet we do at this time allow non-medical sterilisation of disabled children. In fact, that is a discriminatory process, and it cannot be justified.

In her argument the Member urged for a section to be added to the bill that will protect under aged ID women from involuntary and non-therapeutic sterilisations. Such a section was never added to the bill. When COCA replaced the Guardianship Act 1968, the responsibility of medical practitioners was provided for in section 36(1)(h) which states that health professionals must be satisfied that a particular procedure is for the young patient’s benefit. Parental consent to medical treatment was re-enacted and provided for under s 36(3) of COCA. In light of New Zealand’s ratification of CRPD but that the domestic law of NZ overrides the principles that that Convention represents, it may therefore be assumed to be “demonstrably justified” in New Zealand’s “free and democratic society” that a protective section geared at preserving ID children’s right to bodily integrity, was thought to be unnecessary. Sterilisation goes to the heart of ID children’s human rights. The absence of express protection or protective measures – other than parent’s consent and that of the relevant medical practitioner(s) – in the legislation in the context of involuntary sterilisation is of concern.

3. Who decides?

3.1 The Courts

Under NZ law the High Court has not lost its parens patriae power in relation to adults unable to look after themselves or their property as is the case in England from where the parens patriae principle originates. In that jurisdiction court approval must be sought in cases of proposed sterilisations of both adult and juvenile mentally incompetent persons

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103 Ibid.
104 NZBORA, s 5.
105 Ibid.
106 I Kennedy above n 12.
107 This is a very old prerogative jurisdiction of the Crown – which was conferred on the courts – under which the Crown had the power and duty to protect the persons and property of those who are unable to look after themselves.
unless the operation is for therapeutic medical purposes entirely.\textsuperscript{109} In NZ pursuant to s 17 of the Judicature Act 1908, the High Court may, “in effect consent or refuse consent on behalf of adults who lack the capacity to decide for themselves”.\textsuperscript{110} Section 114 of PPPRA states that “nothing in this Act limits the general jurisdiction accorded the High Court by section 17 of the Judicature Act “or otherwise”.\textsuperscript{111} It has been stated that the Family Court has “in the majority of situations effectively replaced the inherent parens patriae jurisdiction of the High Court”\textsuperscript{112} in relation to personal orders made under PPPRA however this is doubtful.\textsuperscript{113} Rather, the Family Court’s jurisdiction has been expanded for it to make personal orders, including for medical treatment,\textsuperscript{114} under PPPRA and as such it will be the court of first instance under the Act. Since PPPRA came into effect such treatment has indeed been authorised by the Family Court. The court may make an order for sterilisation pursuant to the powers bestowed on it by section 10, PPPRA once the presumption of competence has been rebutted. The court is instructed that one if its primary objectives is to decide whether the proposed medical intervention is the least restrictive on the subject person.\textsuperscript{115} That is then how PPPRA instructs the court to uphold the right to bodily integrity of ID adults\textsuperscript{116} that is guaranteed under NZBORA to everybody else who is competent.\textsuperscript{117}

In the case of ID women special requirements restrict – but do not prohibit – surrogate consent by a WG and protect women from involuntary and non-consensual

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\textsuperscript{109} Ibid. This is called the declaratory jurisdiction of the court and replaced the parens patriae jurisdiction in England which was abolished in 1959. Declaratory jurisdiction of the court was established in \textit{Re F: (Mental Patient; Sterilisation)} [1990] 2 AC 1.

\textsuperscript{110} PDG Skegg above n 59 at 185 – 186. In \textit{Re W} [1994] 3 NZLR 600 (HC) at p 604, Neazor J confirmed that the High Court continued to have the powers inherent to the section 17.

\textsuperscript{111} Judicature Act 1908, section 17 provides:

The Court shall also have within New Zealand all the jurisdiction and control over the persons and estates of ... mentally disordered persons, and persons of unsound mind, ... as the Lord Chancellor of England, or any Judge or Judges of Her Majesty’s High Court of Justice or of Her Majesty’s Court of Appeal, so far as the same may be applicable to the circumstances of New Zealand, has or have in England under the Sign-manual of Her Majesty or otherwise.

\textsuperscript{112} BD Inglis \textit{New Zealand Family Law in the 21\textsuperscript{st} Century} (Brookers, Wellington, 2007) at 739.

\textsuperscript{113} See PDG Skegg above n 59 and Judicature Act, s 17 above n 111; PPPRA s 114; Inglis above n 112 at p 740, n 82.

\textsuperscript{114} PPPRA, s 10(1)(f).

\textsuperscript{115} PPPRA, s 8(1); \textit{X v Y (Mental Health; Sterilisation)} above n 5 at para [62]; \textit{Re H} [1993] NZFLR 225 (FC) at p 234.

\textsuperscript{116} \textit{X v Y (Mental Health; Sterilisation)} above n 5 at para [75].

\textsuperscript{117} NZBORA, s 11; \textit{Re S} above n 80.
sterilisations. This restriction includes that court authorisation must be sought before the operation may proceed except where the sterilisation is performed for medical purposes entirely such as in an emergency or to prevent serious health damage to the patient (therapeutic sterilisation). The restriction is not expressed by PPPRA or other legislation but appears to have been imposed by the court. CSA does not compel special consent requirements where adults lack capacity to consent to a sterilisation. Of note is the NZ Law Commission having reported that under the PPPRA “statutory coercive powers restrict mentally disadvantaged people”. Inglis asserts that in a case of an ID adult:

Typically the Court’s authorisation is imperatively required, whether or not an existing order [as to the consenting powers of the WG] may appear to authorise the proposed action, where what is proposed involves a serious, fundamental and irreversible intrusion into the protected person’s personal ... rights without the consent ... of that person and where those who wish the action to be carried out and those who are to carry it out require the specific protection of an order of the Court [is sought].

Accordingly the protection thus provided by court sanction is threefold: to protect the person who wants the procedure carried out; to protect the medical practitioner who performs the procedure and to protect the disabled person from bodily invasion without court sanction. It is not clear what Inglis means by “typically”. The court has found that only medically necessary sterilisations (therapeutic sterilisations) will not require court authorisation. In Re G [PPPR: hysterectomy] that involved an application for the court to authorise a hysterectomy to be performed on an ID woman, the court stated:

... it is clear that irreversible surgical intervention of this kind cannot lawfully be carried out on a patient whose intellectual incapacity prevents her from giving informed consent to it, except in a truly life-threatening situation of emergency ... unless the Court’s approval is given.

That has been confirmed by the High Court. Therefore only emergency procedures or procedures to prevent serious health damage that will amount to sterilisation in the case of

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120 Nicola Peart above n 118 at 479.
121 New Zealand Law Commission Protections some Disadvantaged People may need (NZLC R80, 2002) at 6 – 13.
122 BD Inglis New Zealand Family Law in the 21st Century (Brokers Ltd, Wellington, 2007) at 739.
123 (1993) 10 FRNZ 541(FC) at 542 per Judge Inglis.
124 X v Y (Mental Health: Sterilisation) above n 5 at para [56]. Miller J elsewhere in that judgment however left open the question of whether a welfare guardian may be given the power to give surrogate consent to sterilisation. This will be discussed under “Welfare Guardians and Parents” below.
an adult may proceed without court sanction. Accordingly all other proposed sterilisations of an ID person must be decided by a court. "Typically" must then refer to non-therapeutic sterilisations that is, they are not done as medical emergencies nor to prevent serious health damage. In other words, non-therapeutic sterilisations "typically" require court sanction. "Typically" however does not signify a definite rule or standard and leaves some room for doubt as to when such a procedure must be court authorised.

In NZ court authorisation is not a requirement for the sterilisation of an ID minor. This will be discussed in more detail below under 1.2 and 1.3.

3.2 Welfare Guardians and Parents

There is no doctrine in common law whereby a spouse or next of kin can give effective consent to the treatment of an adult where the treatment requires the patient's consent. Statute law in NZ provides for proxy consent by a WG which allows for a spouse or next of kin, or someone else, to give or refuse consent to medical treatment of an adult who lacks capacity to do so. Consent may not be refused when the proposed treatment is standard medical life saving treatment or for the prevention of serious health damage to the patient that is, the treatment is therapeutic. There is some debate over whether therapeutic sterilisations, in cases where females lack decisional capacity, also include hysterectomies for the purpose of preventing, or eliminating, menses. Medical practitioners and the High Court have classified sterilisation for the prevention of the onset of menses in a case of a severely physically and intellectually disabled minor as therapeutic sterilisation because she and her carers would find it difficult to cope with this additional burden. The 15 year old minor in that case had the intellectually capacity of a three month old infant and found it very difficult to cope with any form of pain. Typically, in the United Kingdom and Australia where court sanction for sterilisation procedures of both minors and adults are legally required, applications – mostly brought by the parent(s) of the ID woman/girl – were for patients to undergo hysterectomies due to perceived

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125 COCA, s 36(3) provides for parental consent to medical treatment; Re X above n 6 at 373.
126 PDG Skegg above n 59 at 180 – 181.
127 PPPRA, s 12.
128 PPPRA, s 18(1)(c)
129 Re X above n 6.
complications and severe discomfort when these women had their period, thereby eliminating menses. Elkins, in 1988, showed that by addressing parents' concerns and needs on issues such as sexuality, menstruation, and sexual behaviour of ID persons, the requests for and incidence of sterilisation were significantly reduced. Research in other countries indicates that the prevalence of sterilisation procedures is considerably higher amongst ID women compared to the general population. The realities in this regard in NZ should be explored. Should it be that such procedures are in fact medical necessities and as such are more frequently needed among women and girls with intellectually disability, it is worthwhile to also note that blanket prohibition of such procedures without court sanction and with the inevitable delays and costs that such a requirement will cause, may be unjust. This will delay and may restrict ID women from receiving medical care and treatment available to the wider female population should the latter be faced with the same physical complications.

The NZ High Court has set out guidelines for medical practitioners to follow in cases where the proposed sterilisation is to eliminate or prevent complications due to menses. These are discussed below at 3.3.

Pursuant to section 12(2) PPPRA a WG may be appointed "in relation to such aspect or aspects of the personal care and welfare" of the incapacitated adult "as the Court specifies in the order". Matters relating to healthcare are evidently encapsulated by "personal care and welfare". For the appointment of a WG the adult must wholly lack capacity which is a higher standard than when the court makes personal orders in relation to the disabled adult. The District Court stated that "orders for the appointment of a WG are more

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131 Examples of reported English cases: Re E (A Minor) (Medical Treatment) [1991] 2 FLR 585; Re GF (Medical Treatment) [1992] 1 FLR 293; Re Z (Medical Treatment: hysterectomy) [2000] 1 FLR 523; Re S (Adult Patient: Sterilisation) [2001] Fam 15 (CA).


135 PDG Skegg above n 59 at 181.

136 PPPRA, s 12.
intrusive than personal orders [made by the court]. This is because the scope of powers of a WG is wider than when the court is called upon to make a personal order since the latter will usually relate to only a specific aspect in the life of the disabled person. The Family Court must however specify the scope of the welfare guardian’s powers and the WG may only act according to the order made in that regard.

Inglis observes that some of the PPPRA provisions can at first glance be read as assigning “virtually a free hand” to the WG in managing the disabled person’s affairs and care, provided the guardian does this with the best interests and welfare of the disabled person as primary consideration. However he explains that this does not amount to the court “merely ... setting a framework and leaving the welfare guardian with a free hand to get on with the job in his or her own way”. The court must be satisfied that the proposed appointee agrees to the appointment, is capable of undertaking the duties, is likely to get along well with the person concerned, and will act according to the best interests of the incapacitated person. If the decisions or actions of a WG are within the constraints of a court order, they cannot be challenged on the basis that they do not accord with the wishes of the person on behalf of whom the guardian is acting, thus the decisions of the WG are to be treated as though made by the ID person herself. Consent thus given by a WG to medical procedures that fall within the scope of the welfare guardian’s powers and as determined by the court, will be valid consent not to be questioned. Note that this is not absolute because PPPRA also provides that the affected adult, or any other person with leave of the court, may apply for a review of decisions made by a WG. At the inception of PPPRA it was observed that whether involuntary sterilisation for non-therapeutic

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136 Re L [2001] NZFLR 310 (DC) at para [36].
137 PPPRA, ss 5, 6, 10(1)(k), 12, 18, 19, and 22.
138 BD Inglis above n _ at 746.
139 Ibid.
140 PPPRA, s 12(5)(a)-(e).
141 PPPRA, s 19.
142 PPPRA, s 19(1).
143 PPPRA, s 19(2).
144 PPPRA, s 89.
reasons should be included in medical treatment that the WG may consent to must be seriously questioned.\textsuperscript{145} Atkin\textsuperscript{146} commented:

It is hard to see how compatible the principles [that court must adhere to] of least restrictive intervention and encouragement [of the ID person to develop her capacity]\textsuperscript{147} are with a soft rule that allows guardians to make one of the most intrusive decisions of all.

Specific medical treatments are expressly excluded from the scope of consent to treatment by a WG under PPPRA\textsuperscript{148} however consent to sterilisation is not one of them. This notwithstanding, the courts have interpreted the powers of consent to medical treatment by the WG to exclude sterilisation of a non-therapeutic kind.\textsuperscript{149} Therefore in the case of \textit{Re G [PPPR: Hysterectomy]}\textsuperscript{150} the Family Court included in its order that the WG will have the authority to consent to an effective sterilisation since the facts of that case indicated that a hysterectomy was a medical necessity albeit that sterilisation was a side-effect of the operation but not the purpose. Miller J in the High Court appeal case of \textit{X v Y [Mental Health: Sterilisation]} cited\textsuperscript{151} from a speech by the Minister of Justice on the second reading in Parliament of the Protection of Personal and Property Rights Bill on 18 February 1988 where the Minister said:

Some submissions were concerned that a welfare guardian was not prohibited from deciding the question of sterilisation. However, it must be noted that a welfare guardian has only the powers that a court confers on him or her. There may be some cases - perhaps not very common - in which a family court would think it right that the decision on sterilisation could be made by a welfare guardian who is in close contact with the person, and who knows the circumstances of the person's daily life.

Note however that the Minister did not provide examples but had left this matter open to the court’s discretion. His Honour also noted that sterilisation does not require the court’s

\textsuperscript{146} Ibid.
\textsuperscript{147} PPPRA, s 8.
\textsuperscript{148} PPPRA, s 18(1)(c)-(f). These are refusal of consent to standard medical life saving or prevention of serious health damage treatment; consent to electro-convulsive treatment; consent to treatment that will destroy any part of the brain or brain function for the purpose of altering behaviour; and consent to the disabled person partaking in any medical experiment that is not for the purpose of saving the person's life or preventing serious health damage.
\textsuperscript{149} \textit{Re G [PPPR: Hysterectomy]} (1993) 10 FRNZ 541(HC) at 542; \textit{Re H [1993] NZFLR (FC) 225 at 241}; \textit{X v Y [Mental Health: Sterilisation]} above n 5 at para [56].
\textsuperscript{150} \textit{Re G [PPPR: Hysterectomy]} above n 147.
\textsuperscript{151} \textit{X v Y [Mental Health: Sterilisation]} above n 5 at para [54].
approval when the procedure is medically imperative\textsuperscript{152} in which case the WG, if one has been appointed, may \textit{not} withhold consent pursuant to s 18 (1)(c) PPPRA.

According to Atkin the underlying philosophy of PPPRA is to a large degree summed up by section 4 of the Act, which provides that persons with uncertain capacity are to be treated no differently from others in the community \textit{unless} the legislative path has been properly followed,\textsuperscript{153} for example the court appointment of a WG with specific powers to consent to medical treatment as determined by the court. PPPRA however makes it clear that the appointment of a WG must be a last resort\textsuperscript{154} and according to one legal practitioner who works in the field of disability, many ID people who live in support facilities do not have a WG:

\begin{quote}
In many cases where medical treatment is considered necessary by the medical professionals but for one reason or another the subject persons are unable ... to see the necessity for the proposed treatment resort has to be made to the Court for an order under section 10 (1)(f) [of the PPPRA].\textsuperscript{155}
\end{quote}

That statement could arguably be taken as evidence that a WG cannot regularly be called upon to consent to sterilisations of ID women because none had been appointed, bearing in mind that the statement only refers to those who live in support facilities.

The Code of Rights also stipulates that the "consumer" of health care includes a person entitled to give consent on behalf of that consumer\textsuperscript{156} that is, usually where the consumer is not competent to do so.\textsuperscript{157} The Code of Rights therefore provides the WG with the same rights as that of the patient. In accordance with Rights 5 and 6, Code of Rights, consumers have the right to efficient communication and full information, which must be communicated in a way that enables the consumer to understand the information and come

\begin{footnotes}
\item[152] X v Y [Mental Health; Sterilisation] above n 5 at para [56].
\item[153] WR Atkin, "Adult Guardianship Reforms – Reflections on the New Zealand model" (1997) 20(1) JLJP 77 at 81. Section 4 provides:
\begin{quote}
\textbf{Legal capacity of persons subject to orders under this Act}
Except as provided by or under this Act or any other enactment, the rights, privileges, powers, capacities, duties, and liabilities of any person subject to an order under this Act, whether in a personal, official, representative, or fiduciary capacity, shall, for all the purposes of the law of New Zealand (whether substantive, procedural, evidential or otherwise), be the same as those of any other person.
\end{quote}
\item[154] PPPRA, s 12(2)(b).
\item[155] Alan J Gluestein cited in \textit{Protections some disadvantaged people may need} (NZLC R80, 2002) at 15.
\item[156] Code of Rights, clause 4.
\item[157] Code of Rights, right 7.
\end{footnotes}
to a decision. The test “appears to be”\textsuperscript{158} whether the consumer understands the information that is or has been related to them. Right 5 requires the mode of communication to “enable” understanding and doctors are required to make possible understanding, “but cannot be expected to guarantee ... understanding, and the law makes no such requirement”\textsuperscript{159}. The High Court confirmed the test for informed consent to be whether the practitioner provided sufficient information to enable the consumer to make a decision in an appropriately informed way and not whether the practitioner had ensured that the patient/consumer understood the information that was provided\textsuperscript{160}. Pursuant to the Code of Rights this will include the WG. Therefore in the case of ID adults and where the court sees fit, the power of the WG may include consent to medical treatment however in cases of proposed sterilisation procedures that are deemed to be standard medical or life saving treatments the WG may give valid consent, indeed may not withhold consent, and court sanction for the procedure is not required.

Parents (guardians) may validly consent to a sterilisation operation on behalf of their ID child\textsuperscript{161}. A leading NZ policy consultant, Robert Ludbrook, agrees but uses more tentative language by explaining the law as follows: “[a] guardian would appear to have the power to consent to the sterilisation of a child whose capacity is impaired by an intellectual handicap...”\textsuperscript{162} (own emphasis). He refers to s 7 of CSA which prohibits parental consent to sterilisation of a minor who lacks capacity only because of her age. Parental consent however will be sufficient if the minor’s lack of capacity is an element of mental disability, provided the sterilisation is in the best interests of the young person as well as the least severe intervention possible\textsuperscript{163}. The High Court has stated\textsuperscript{164} as follows:

The real point that appears from the [legislation] is that it is specifically provided ... that consent may be given by the guardian to any medical procedure if consent is necessary. Of course where a child is under the age of 16 or is intellectually handicapped, such a consent is necessary. (Own emphasis).


\textsuperscript{160} Hamman v Director of Proceedings 12/3/09, Wild J, HC Auckland CIV-2007-404-3732 at paras [61]-[63].

\textsuperscript{161} COCA s 36(3); Re X [1991] 2 NZLR 365 (HC).

\textsuperscript{162} R Ludbrook “A child’s right to consent to or refuse medical treatment” (2007) 11(2) Childrenz Issues 37 at 38.

\textsuperscript{163} Nicola Peart above n 117 at 478 – 479.

\textsuperscript{164} Re X above n 6 at p 373.
Therefore the ID minor is in the same consent-dependent category as the child below the age of 16 years, that is only the consent of the parent(s) is needed — in addition to the doctors’ agreement — for a sterilisation to proceed bearing in mind however that consent by parents to a sterilisation of child who lacks capacity due to age alone is specifically prohibited by statute.\textsuperscript{165} Such children’s right to bodily integrity in this context is therefore protected but not so for children with intellectual disability.

Hillyer J in the High Court case of Re X\textsuperscript{166} expressed his view in cases of ID minors as follows:

\begin{quote}
... that every case should come before the Court for determination, would in my view place far too great a burden on parents on whom many burdens are already imposed ... Such a burden should not automatically fall on any parent of a child where there is consensus that an operation to prevent menstruation [hysterectomy] would be in that child’s best interests.
\end{quote}

That case was decided in 1990 and remains the most authoritative reported NZ judgment on effectively sterilising an ID minor. The absence of further relevant reported court cases can either be an indication that such procedures do not happen or, more likely, that they happen but without court authorisation. Inglis asserts that “it is generally accepted that the Court’s sanction should always be obtained” for sterilisations of minors.\textsuperscript{167} However the High Court decision of Re X does not support this view.

That a young person of 16 years or older is able to provide or refuse consent to medical procedures as if of “full age”\textsuperscript{168} seems irrelevant to the ID young person who lacks the requisite capacity to consent to medical treatment due to her disability. Skegg states that\textsuperscript{169}:

\begin{quote}
There may be circumstances where a 16 or 17 year old is incapable of giving consent ... as a result of disability... In such a situation, a guardian may be able to give a legally effective consent or, if there is no guardian present in New Zealand, or a guardian cannot be found with reasonable diligence, consent may be given by a District Court Judge or by the chief executive of Ministry of Social Development: s 36(3) [COCA]
\end{quote}

The ID young person of 16 and 17 years who is found to be unable to give or withhold consent is therefore apparently in the same legal category as minors generally as far as consent is concerned i.e. that their parents/guardians may give valid consent on their

\textsuperscript{165} CSA, s 7.
\textsuperscript{166} [1991] 2 NZLR 365 (HC).
\textsuperscript{167} BD Inglis above n ___ at 480.
\textsuperscript{168} COCA, s 36(1).
\textsuperscript{169} PDG Skegg above n 59 at 196.
behalf. However if there is doubt the parens patriae jurisdiction of the High Court may be resorted to as in the case of Re X[170] or, more likely, the jurisdiction of the Family Court.

3.3 Medical practitioners
To understand the legal position of medical practitioners in cases of proposed sterilisation heavy reliance on the judgment of Re X (above) is required. After Hillyer J in the High Court observed that parental consent to the sterilisation of an ID child will suffice without court sanction, His Honour went on to say[171]:

[Parental consent is not the] end of the matter because even if consent is given, it is still necessary for a doctor to carry out that operation. Doctors will appreciate that they have an obligation to ensure that the operation they are carrying out is a proper one, and that the consent given is a proper consent.

It would seem therefore, that the medical profession must satisfy itself that the informed consent of the parents is given, and that the consent is for the benefit of the child. If they fail to do so, they could be liable under civil law or to medical disciplinary proceedings, or possibly even to criminal charges.

In reliance on extensive research done on court decisions in other jurisdictions by counsel in that case, His Honour proceeded to set out the following non-binding guidelines[172] for medical practitioners to follow when they have to decide on whether to sterilise an ID woman:[173]

- Is there a real likelihood that the intellectually handicapped person could conceive a child? [...]
- Will the individual ever be in a situation where sexual intercourse either voluntary or imposed can occur? [...]
- What is the possibility of trauma, psychological damage, or serious medical problems as a result of pregnancy? [...]
- Are there less drastic means of contraception which are practical and acceptably safe, having regard to the individual's circumstances? [...]
- Should the sterilisation take place now or would it be more appropriate to take place some time in the future? [...]
- Looking at the ID woman's circumstances should the right to reproduce be upheld at the expense of the right to be protected and be relieved from the consequences of other medical alternatives, pregnancy and childbirth? [...]

[170] [1991] 2 NZLR 365 (HC).
[171] Re X above n 6 at 373.
[172] The guidelines Hillyer J set out relating to establishing capacity were pointed out under “1. Competence and capacity to consent” above.
In relation to a procedure that will sterilise but is done for the management of menstruation, His Honour provided the following guidelines to be considered in addition to the ones above\textsuperscript{174}:

- Is the intellectually handicapped person menstruating or likely to menstruate in the future? This is clearly a factor, although not specifically referred to in the cases [that counsel relied on].
- What is the possibility of pain, trauma, psychological damage or medical problems resulting from menstruation? \[\ldots\]
- Will menstruation cause unacceptable behavioural or menstrual management problems for the person and/or her primary caregivers? \[\ldots\]
- What effect would the menstruation have on the intellectually handicapped person's important relationships? \[\ldots\]
- Is there a less drastic method of menstrual management which is practicable and acceptably safe having regard to the individual's circumstances?
- Does the intellectually handicapped person have an understanding of her bodily functions and an understanding of her female identity? \[\ldots\]
- Looking at the intellectually handicapped person's circumstances should the right to retain menstrual function as a part of a complete human female identity be upheld at the expense of the person's right to be protected and relieved from the consequences of menstruation? \[\ldots\]
- Should the menstrual management procedure take place now or would it be more appropriate to take place some time in the future? \[\ldots\]

That case involved the sterilisation (albeit that it was not the primary objective of the operation) by way of a hysterectomy of a severely intellectually and physically disabled child but it appears to be that the decision applies in all cases of sterilisation of ID minors and indeed, according to the guidelines above, to adult ID women also. His Honour further stated that despite the possibility that a doctor may not act ethically in reaching a decision in these cases, it is unjustified to impose on all parents the obligation to seek authorisation to guard against such possibility.\textsuperscript{175} His Honour pointed out that because such a procedure is a major one, a number of professionals will necessarily be involved, and therefore the operation will require additional approval from other medical professionals as well as their cooperation.\textsuperscript{176}

Eight years subsequent to that judgment a publication by the Ministry of Health (providing information for medical practitioners regarding children's consent to medical treatment) comments that Hillyer J has placed considerable responsibility on doctors to ensure that in

\textsuperscript{174} Re X above n 6 at 377 – 378.
\textsuperscript{175} Re X above n 6 at 375.
\textsuperscript{176} Ibid.
sterilisation cases, the operation is performed for the child’s benefit.\textsuperscript{177} The publication further advises that parents do not have the authority to give surrogate consent once their children reach adulthood (the age of 18) and that then, PPPRA requires court authorisation.\textsuperscript{178} The courts however, as discussed above, have stated that emergencies and cases involving prevention of serious health damage to the patient are exempt from this requirement. Of significance is that the Ministry in that publication further states that “less protection appears to be given to children with disabilities than to adults, despite their vulnerability”\textsuperscript{179} and that great responsibility is placed on doctors to “assess the risks and to examine the motivation of the person seeking the sterilisation”.\textsuperscript{180} How doctors perceive and exercise this responsibility and whether they deem the guidance for making these decisions to be sufficiently clear must be explored as well as the frequency with which they have to make such decisions.

Doctors are of course also ethically and professionally bound by their profession’s practice guidelines. In a “Consensus Statement”\textsuperscript{181} on the \textit{Royal Australian and New Zealand College of Obstetricians and Gynaecologists} (RANZCOG) website RANZCOG endorses an approach – for both adults and minors – similar to New Zealand’s PPPRA in that the least restrictive intervention possible must be sought in the management of women’s menstrual problems and further that action taken must be in the best interests of the patient. The Statement also provides that “destructive surgery”\textsuperscript{182} such as a hysterectomy is rarely required to manage menstrual problems in young girls. Issues to be considered when making assessments on menstrual management of ID women include, amongst others, the woman’s ability to manage sanitary care, her behaviour issues around the time of menstruation, her mobility, and physical ability to cope with the practicalities of menstrual care.\textsuperscript{183} These appear to be in line with the medical model of intellectual disability and not

\textsuperscript{178} Ibid.
\textsuperscript{179} Ministry of Health above n \underline{177} at 21.
\textsuperscript{180} Ibid.
\textsuperscript{181} The Australian Society of Paediatric and Adolescent Gynaecology (TASPAG) Working Party “Consensus Statement: Menstrual and Contraceptive Management in Women with an Intellectual Disability” (endorsed by RANZCOG, February 2003) <ranzcoh@ranzcoh.edu.au>
\textsuperscript{182} Ibid.
\textsuperscript{183} Ibid.
in line with CRPD that follows the social model. In another publication on the RANZCOG website specifically geared toward sterilisation of ID women it is also stated that the least restrictive intervention must be sought by practitioners.\textsuperscript{184}

A publication by the Medical Council of New Zealand states:\textsuperscript{185}

Occasionally, when people are unable to consent or refuse to consent to treatment, a legal opinion should be sought whether to seek authority from the ... Court. Such cases may include:

[...]

(c) sterilisation of a patient who is unable to consent but for whom the family and other carers, supported by medical opinion, request the operation to enhance the quality of life of the patient and prevent deterioration in his or her physical or mental health;

From this statement it would appear that doctors are urged by the Council to rely on court decisions to decide what the correct procedure is while Hillyer J in turn — and providing guidelines — observed that doctors themselves should make the right decisions about the correct procedure to follow when contemplating the sterilisation of an ID woman. According to Ludbrook, despite the statutory provision in CSA that (by omission) allows parental consent to sterilisation of an ID child, “doctors are inclined to seek approval from a court before acting on the consent of parents ...”\textsuperscript{186} If this is the reality then those court decisions are unreported which makes it difficult to assess and follow how and if the courts are reaching such decisions. The statements by the Medical Council and by Ludbrook above further appear to indicate that doctors do not consider themselves to have the authority to decide on such procedures as observed by Hillyer J.

Medical practitioners are able to object to performing a sterilisation on conscience grounds however they must then refer the patient to a practitioner who is willing to perform the procedure.\textsuperscript{187} Enquiries must always be made as to whether a WG has been appointed and if not, and the person is found to be incompetent to consent, Right 7(4) of the Code of Rights states that the practitioner may provide treatment without consent, yet the Code does not specify that this must only be in emergencies or serious health risk situations. It must be assumed, based on case law, that in the case of a proposed ID adult sterilisation, this will only apply in emergency and critical situations because the Code of Rights is

\textsuperscript{184} RANZCOG “Sterilisation procedures for women with intellectual disabilities” (March 2010) <http://www.ranzcog.edu.au/>


\textsuperscript{186} R Ludbrook above n ____ at 38.

\textsuperscript{187} Health Practitioners Competence Assurance Act 2003, s 174; Nicola Peart above n ____ at 477.
subject to other legislation and common law. In addition clause 5 of the Code provides that nothing in the Code will prevent a health services provider to act in accordance with other legislation that authorises such action. Case law involving adults compels court authorisation for non-therapeutic sterilisation of adults as has been discussed. However, section 7 of CSA and case law authorises parental consent for sterilisation in the case of an ID minor with no express requirement of it being for therapeutic reasons only.

Under PPPRA the medical practitioner him/herself may also apply for a court order to proceed with an operation not consented to if the patient is an adult, in which case the court is bound by the Act’s obligation to decide if the intervention is the least restrictive. In Re J the Family Court expressed the obvious reality though that the court cannot make decisions without hearing the evidence of medical professionals. Medical attitude towards or against the wishes of a person with intellectual disability may largely be driven by the practitioner’s personal ethical consideration and also by the legal context. That ID women may be sterilised as minors without court authorisation may explain the limited number of reported judgments on sterilisations of ID adult women. Of course it is possible that such procedures are only performed as medical emergencies/necessities, therefore not requiring court sanction. Data should however be readily obtainable since CSA compels report submissions by medical practitioners to the Director General of Health on every sterilisation performed in NZ including the reasons for the operation and the age of the patient but excluding detail that may identify the patient. However to ascertain if and to understand how the courts come to decisions on sterilisations more reported judgments are needed as a matter of public interest.

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188 Right 7(1)
189 PPPRA, s 7(d).
190 PPPRA, s 8(1).
191 [1993] NZFLR 225 (FC) at 241.
193 CSA, s 8.
4. The Best interests/Welfare Test

The term “best interests” is used ten times in PPPRA\textsuperscript{194} but the Act does not set out guidelines as to how the best interests of a person must be established, nor does it define what best interests mean. The “best interests” test is also called the welfare principle\textsuperscript{195} and as such “welfare and best interests” are often referred to together as one concept. The \textit{Butterworths New Zealand Law Dictionary} defines “welfare” as “[a] state of well being; having one’s needs satisfied”\textsuperscript{196} which arguably can be rather different from “best interests”. The primary objectives to be followed by the court under PPPRA do not include consideration of welfare and the best interests of the subject person.\textsuperscript{197} The objectives are for the court to decide if the proposed intervention is the least restrictive in the life of the ID person and to encourage the person to develop her capacity to the fullest extent possible.\textsuperscript{198} When the WG exercises his/her powers though he/she must first and foremost act in the welfare and best interests of the subject person\textsuperscript{199} but pursuing the least restrictive intervention possible is not expressed. Judge Inglis confirmed that when the court must make a decision about medical treatment in respect of an ID person under PPPRA the principle of least restrictive intervention will apply, but when the court grants the WG the power to consent to a therapeutic hysterectomy, the welfare and best interests of the disabled person must be of first concern for the WG.\textsuperscript{200} Initially the Family Court indeed held that under PPPRA the test to be satisfied by the court for authorising medical treatment of a person unable to consent was not what was in the welfare and best interests of the person, but rather an enquiry into the level of incapability and then determining what the least restrictive intervention possible in the circumstances would be.\textsuperscript{201} However, later the High Court stated in \textit{In the Matter of A}\textsuperscript{202} that:

The Legislature would have expected the purpose and intention of the legislation to be given effect without recourse to an over-refined consideration of why the Legislature may have

\textsuperscript{194} PPPRA, ss 12(5)(b), 18(3), 30(1)(c), 31(5)(b), 32(3)(b), 33(4)(b), 36(1), 97A(2), 98A(2) and 105(1)(a).
\textsuperscript{195} BD Inglis \textit{New Zealand Family Law in the 21st Century} (Brokers, Wellington, 2007) at 726.
\textsuperscript{197} PPPRA, s 8. The objectives under PPPRA are to decide if the proposed procedure is the least restrictive intervention possible and to encourage the ID person to develop his/her capacity to fullest extent possible.
\textsuperscript{198} PPPRA, s 8.
\textsuperscript{199} PPPRA, s 18(3).
\textsuperscript{200} Re G [PPPRA: Hysterectomy] (1993) 10 FRNZ (FC) 541.
\textsuperscript{201} Re S (Shock Treatment) [1992] NZFLR 208 (FC) at 213.
\textsuperscript{202} [1996] NZFLR 359 (HC) at 372.
thought it wise to use the words "welfare and best interests" in one place but not in another. It is quite apparent that the Act is concerned with the welfare and best interests of the persons in respect of whom applications are brought to the Family Court.

The court went on to describe the Family Court's role under PPPRA\(^\text{203}\) as

... the bulwark of the protection of the individuals in respect of whom applications are made. The Legislature has entrusted it to achieve the objectives stated in s 8 and, by necessary implication, the welfare and best interests of the persons the subject of applications to it.

Most recently Miller J in the High Court stated that "... the statute presumes that the welfare of a person who is subject to [PPPRA] is actually best served if intervention is directed to [the section 8] objectives"\(^\text{204}\). That case was heard on appeal by the High Court after Judge Fraser in the Family Court\(^\text{205}\) found that "X", a pregnant 29 year old woman with intellectual disability lacked the capacity to care for a child or to understand what the task entails and granted the application by her WG for an abortion and sterilisation. His Honour saw this as being the least restrictive intervention and in her best interests. Miller J in the High Court granted the appeal against the Family Court's decision and ordered the Family Court to rehear the case in light of new evidence provided and then to decide if abortion and sterilisation were the least restrictive interventions. The Family Court subsequently found that ordering an abortion was not possible anymore due to the term of the pregnancy at that stage and upon hearing the new evidence found that sterilisation was indeed not the least restrictive intervention\(^\text{206}\). The ID woman in that case had at times resisted help and had often been uncooperative. She lacked money managing skills, trusted people easily, and had poor personal hygiene management. As Miller J stated; the Family Court judge had the benefit of hearing the woman's evidence first hand and forming an opinion as to her capacity. She herself gave evidence in the earlier case and acknowledged her pregnancy, clearly expressed her wish to have more children\(^\text{207}\) and stated that her pregnancy was "a dream come true".\(^\text{208}\) She also understood in part the correlation between taking contraceptives and its prevention of pregnancy.\(^\text{209}\)

\(^{204}\) X v Y [Mental Health: Sterilisation] above n 5 at para [62].
\(^{205}\) Y v X [Mental Health: Sterilisation] 23 FRNZ 493 (FC).
\(^{206}\) R v R (No 2) [2004] NZFLR 817.
\(^{207}\) Y v X [Mental Health: Sterilisation] above n 5 at para [23].
\(^{208}\) Y v X [Mental Health: Sterilisation] above n 5 at para [22].
\(^{209}\) Y v X [Mental Health: Sterilisation] above n 5 at para [24].
pregnant she had managed to give up smoking, drinking and taking illicit drugs.\textsuperscript{210} If nothing else this shows that “X” has some ability to act responsibly, has some will power and significant self control. That “X” clearly would require dedicated and long term support in caring for a child and managing her affairs sufficiently is evident. That such support is not readily and continuously available was raised in the second Family Court hearing with funding being a major problem.\textsuperscript{211} Exploring and analysing social welfare policies and the extent of public support for people with disabilities, particularly in “X’s” situation, is beyond the scope of this paper. However that it was raised as a concern in that case indicates that it may in part influence how far reaching and invasive decisions are made by those with power about ID women’s rights to bodily integrity, their human dignity and indeed their best interests. It is submitted that given “X’s” level of capacity and her own expressed choices the initial order to have her sterilised was not made in consideration of one of the primary objectives to be followed by the court, i.e. to “enable or encourage that person to exercise and develop such capacity as he or she has to the greatest extent possible.”\textsuperscript{212} Nonetheless, the Family Court’s first decision was successfully appealed and the outcome was that the pregnancy was to continue to full term (note though that only because of the term of the pregnancy by then) and that “X” would not be sterilised but had to undergo a procedure to have a Mirena IUD inserted. Had it not been for the objective of deciding if the proposed treatment is the least restrictive intervention possible under section 8 of PPPRA, “X” may have lost her appeal not to be sterilised. Yet, “X’s” case raises urgent concerns as to how the Family Court reached its decision at first instance and how other decisions may have been reached, if any, that are unreported. Ominously, Judge Fraser ends his decision on the proposed sterilisation of “X” as follows:\textsuperscript{213}

It clearly needs to be spelled out to [X] that in the event of her failing to cooperate with this order [to have a Mirena IUD inserted], that she runs the risk of the Court determining that the only and least restrictive option available is sterilisation.

\textsuperscript{210} R v R (No 2) above n 206 at para [12].
\textsuperscript{211} R v R (No 2) above n 206 at para [14].
\textsuperscript{212} PPPRA, s 8(b).
\textsuperscript{213} R v R (No 2) above n 206 at para [93].
Further to the “best interests and welfare” principle under PPPRA, Miller J on hearing the appeal went on to say that the welfare principle “lies at the heart of the Family Court’s jurisdiction under ... the [PPPRA]”\(^{214}\) but that the court must first determine the ID person’s capacity to give informed consent before it can exercise its jurisdiction and then if it is found that the court does have jurisdiction due to lack of capacity of the ID person, to decide whether sterilisation is in the welfare and best interests of the person.\(^{215}\) Therefore, despite commentators at the inception of PPPRA pointing out that the best interests test “plays a far less prominent role”\(^{216}\) in the Act, both the High Court\(^{217}\) and the Family Court\(^{218}\) have held it to be of central importance when applying the PPPRA.

Commentators have also argued that determining the best interests of patients in receiving medical treatment without their consent is in effect delegated to the medical profession.\(^{219}\) Nonetheless, the actual decision to grant an application for medical treatment of an incompetent adult must be made by the judiciary. As Butler-Sloss P stated:\(^{220}\)

> In any event, in the case of an application for approval of a sterilisation operation, it is the judge, not the doctor, who makes the decision that it is in the best interests of the patient that the operation be performed ...

On how the judge should decide the best interests of a person with intellectual disability Thorpe LJ\(^{221}\) suggested a balance sheet approach of benefits and “non-benefits”,\(^{222}\) including potential gains and losses and then in the end deciding on balance what will be in the best interests of the person. However, techniques such as risk-benefit analysis are not solely empirical and value-free since it involves moral assessments and as such need constraints by principles of justice.\(^{223}\) The considerations that a judge will take into

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\(^{214}\) *X v Y [Mental Health: Sterilisation]* above n 5 at para [72].

\(^{215}\) Ibid.


\(^{217}\) *In the matter of A* [1996] NZFLR 359 (HC) at 372; *X v Y [Mental Health: Sterilisation]* above n 5 at para [72].

\(^{218}\) *Re H* [1993] NZFLR 225 (FC) at 234.


\(^{220}\) *Re A (medical treatment: male sterilisation)* [2000] 1 FLR 549 (UK) at 8.

\(^{221}\) *Re A (medical treatment: male sterilisation)* above n 220 at 13.

\(^{222}\) Ibid.

account and how she/he applies the best interests standard may be dependent on the specific judge and may therefore also be different from those of the WG or indeed from those of the disabled person’s legal representative. The difficulty has been acknowledged by Miller \textsuperscript{224} where he stated:

As the cases illustrate clearly, the welfare principle is capable of being viewed from a range of perspectives. It is susceptible to prevailing social norms and the personal values of the decision-maker. It is not an objective test and its workability depends on informed fact-finding and the wise exercise of discretion.

The High Court therefore considered the principal objectives of the court under PPPRA a “surer guide to the exercise of the decision-maker’s discretion than is a general appeal to the welfare principle”.\textsuperscript{225} The Family Court has also held that achieving the PPPRA’s objectives and the best interests of the relevant person can involve balancing different rights.\textsuperscript{226} Ethics researchers have noted that in ethical theory, philosophies have centered on competent persons’ rights and as grounded in utility or autonomy rather than on choices for persons who are incompetent.\textsuperscript{227} Legal commentators have also opined that the application of the legal test of best interests in favour of non-therapeutic sterilisation is dependent upon the understanding of intellectual disability from the perspective of the medical model of intellectual disability.\textsuperscript{228}

Therefore under PPPRA and in accordance with case law the standard and legal test applicable is twofold. Where the court grants the WG the power to consent to a therapeutic sterilisation the WG must act with the welfare and best interests of the ID woman in mind. The court however, in making a decision, must decide whether the proposed sterilisation is the least restrictive intervention possible and by so doing will uphold the ID woman’s welfare and best interests. That the best interests standard is subjective, values dependent, and uncertain, is a matter for parliament and the legislature to address. In light of the ratification of CRPD the time to do so may have arrived. NZ judges have relied heavily on

\textsuperscript{224} X v Y (Mental Health: Sterilisation) above n 5 at para [63].
\textsuperscript{225} Ibid.
\textsuperscript{226} Nesbit v S 29/8/08, Judge Burns, FC Auckland FAM-2008-004-2320 at para 20 – 21.
\textsuperscript{227} Allen Buchanan and Dan Brock Deciding for others: the ethics of surrogate decision making (Cambridge University Press, Cambridge (UK) 1989) at 3.
\textsuperscript{228} See generally Linda Steele “Making sense of the Family Court’s decisions on the non-therapeutic sterilisation of girls with intellectual disability” (2008) 22 AJFL at 1; K Keywood “Sterilising the Woman with Learning Difficulties – In Her Best Interests?” in J Bridgman and S Millins (eds) Law and Body Politics: Regulating the Female Body (Aldershot, Dartmouth, 1995) at 130.
English case law in deciding cases on sterilisation of women with ID, but in the words of one commentator:  

English law, ... has none the less exerted uninhibited paternalism towards persons with intellectually disability through the application of the best interests test by the judiciary. The common law has allowed many a non-consensual sterilisation to take place by blindly following unchallenged medical evidence presented in court.

Conclusion

Enforceable guidelines that govern particular conduct – such as the law laid down by the legislature and as interpreted by the judiciary in case law – is public policy. The ethics of public policy must progress from cases in which there are philosophical social disagreements and uncertainties and less ideal procedures to follow in resolving such disagreements. The law on the sterilisation of ID persons, as can be judged from academic commentators' and practitioners' tentative comments, is unclear and needs to be clarified. Cases decided by the courts must allow transparency by being reported with necessarily protective measures as to the protection of the identities of the parties. In light of CRPD and New Zealand’s international obligations under the convention, this may allow for wider debate and analysis of the approach, ethics, and values upon which these sensitive and invasive decisions are made. Where there is confusion, it must be addressed by the legal system. To allow uncertainty or worse, lack of protection where it can be given to those most vulnerable in our society, cannot be demonstrably justified in a free and democratic society.

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231 Ibid.