III. STERILIZATION

A. Introduction

Voluntary sterilization is an increasingly applied method of fertility control in the Commonwealth, as in the world at large, and may protect more women against pregnancy than any other method of contraception (see below). Despite a history of restrictive laws and, for instance, medical and religious attitudes, voluntary sterilization figures very prominently in many Commonwealth countries' practice of reproduction control, although in many others recourse to permanent surgical contraception is treated with caution by the population of reproductive age, the medical profession and the law.

An historical and socio-medical curiosity is the continuing disproprotionate respect paid to the observation made in a dissenting opinion in 1954 by Dennning L.J. (as he then was) on the propriety of purely contraceptive sterilization. The statement was expressly disapproved by the two other Court of Appeal judges in 1954, and it has not grown in legal significance in the last three decades, but it persists in lay perceptions of the law. In Bravery v. Bravery, [1954] 3 All E.R. 59 the issue was whether sterilization without spousal agreement constituted matrimonial cruelty. The Court held that on the facts of the case it did not, but Denning L.J. invoked perceived principles of criminal law, reflecting feudal objections to the maim of castration, to conclude that vasectomy, even when voluntary, was unlawful. Objection was taken to sterilization that would enable a man to be sexually active without risking financial and other responsibility for offspring. This was considered to open the way to licenciousness, personal degradation and injury to the public interest (see the quotation at Chapter I, A). The disagreement of the Court of Appeal's majority in 1954 should have shown that the case was legal authority for the reverse proposition to that addressed by Denning L.J., namely that purely contraceptive sterilization is lawful. Jurisdictions applying English Common law differently are anachronistic and fallacious. In Queensland, Australia, for instance, it has not been made clear that vasectomy is lawful by Common law principles.

Distinguishable from contraceptive sterilization is that performed for therapeutic reasons. When a woman's life or permanent health would be endangered by future pregnancy and delivery, for instance, sterilization is thereapeutic. Women may also be affected by diseases for which treatment is indicated such as hysterectomy which renders them incapable of childbearing. The latter treatment is only indirectly described as sterilization, however, since its primary purpose is to remove or prevent pathological conditions. Its effect of ending reproductive potential is secondary. It is similarly the case when a man

affected for instance with testicular cancer is operated upon. Removal of testicles renders him sterile, but that is an effect of the treatment, not its purpose. Because of its concern with reproduction law, this Report gives attention to sterilization effected for purposes of reproductive control, rather than as a secondary result of treatment directed to another purpose. More ambivalent is sterilization performed for the eugenic purpose of preventing transmission of harmful genetic characteristics to offspring. That will be considered here as primarily contraceptive, although courts may be willing to see it as analogous to therapeutic sterilization.

Rates of recourse to voluntary sterilization vary in the Commonwealth. It has been estimated (see J.A. Ross, S. Hong and D.H. Huber, Voluntary Sterilization: An International Fact Book, 1985, Table 2.1 at pp. 10-11) that, by 1982, 20.6 percent of couples used sterilization, amounting to over 24 million voluntarily sterilized people, predominantly women. This rate is comparable to that in other Commonwealth countries, such as Hong Kong, with a 1981 rate of 17.7 percent, Singapore with 22 percent by 1977, and Sri Lanka with 20.7 percent by 1982. In the United Kingdom the rate by 1976 was 13 percent, suggesting that by present time it would be more comparable to India's rate, as might Australia's rate, which by 1979 stood at 22.2 percent. Highest in the Commonwealth was Canada's rate by 1984 of 43.5 percent. In contrast, the rate by 1981 in Bangladesh was 4.8 percent, and in Malaysia was 5 percent. The Commonwealth Caribbean countries appeared to occupy an intermediate position, the 1979 rate in Jamaica being 9.8 percent and the rate in Barbados by 1981 being 14.7 percent. As non-surgical means of sterilization develop, and microsurgical means evolve, recourse to procedures may increase (see M. Klitsch, "Sterilization Without Surgery" 8 In't'l. Fam. Planning Perspectives 101).

Key legal issues of Commonwealth concern include how doctors are required to inform potential patients for sterilization of its risks and side-effects, whether involuntary sterilization can be undertaken upon mentally impaired persons for therapeutic, contraceptive or eugenic reasons, and whether legal minors are amenable to sterilization procedures upon the sole consent of their parents. A number of cases, particularly in England, have tackled the question of whether, following negligently conducted or explained sterilization resulting in pregnancy and childbirth, damages can successfully be claimed, and, if they can, what items of expense such damages may cover. The Commonwealth may in time generate a body of case law comparable in directiveness, although not necessarily in bulk or outcome, to that of the United States. A further area of concern is the role of spousal veto, where the position may be comparable to that prevailing regarding contraception in that, whatever legislation provides, husbands have veto power over their wives' choices when the reverse is not the case.

Chapter V below, which addresses responses to infertility, is affected by sterilization. If a woman's illness necessitates surgical removal of her uterus, her ovaries may remain functional. She may accordingly be able to avail herself of recovery of ova, their in vitro fertilization through her husband's sperm, and implantation of the resultant embryo in the uterus of a woman, such as a relative, willing to act as a surrogate mother. This scenario may be remote in many Commonwealth countries, due both to technological and legal barriers; it must be recognized, however, that when the barriers are the latter and not the former, they obstruct the woman's only opportunity to receive and rear the child of her family. If treatment of disease renders a woman infertile due to surgical or drug-related damage to her fallopian tubes, in vitro fertilization may be available to assist conception through her ovum and her husband's sperm, and implantation in her uterus of the resultant embryo for subsequent gestation and birth. In vitro fertilization will thus offer an artificial fallopian tube to relieve inferility, and permit the couple to have their own gestation and delivery as would a couple not suffering infertility.

B. The Law on Informed Consent to Sterilization

Commonwealth law on informed consent to medical care, relevant to the decision to accept a sterilization procedure and the choice of which means of sterilization to have, has recently shown a division of jurisprudential approach. The English House of Lords in Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital, [1985] 1 A.C. 871 declined to follow the lead given by the Supreme Court of Canada in Reibl v. Hughes (1980), 114 D.L.R. (3d) 1, which adopted a body of modern United States' case-law exemplified particularly in the cases of Canterbury v. Spence (1972), 464 F. 2d 772 and Cobbs v. Grant (1972), 104 Cal. Rptr. 505. The Canadian Court rejected existing precedents in favour of the modern United States' approach, but the House of Lords' retention of its earlier doctrines, expressed in particular in Bolam v. Friern Hospital Management Committeee, [1957] 2 All E.R. 118 (H.L.), now discloses a division between English and modern North American judicial approaches to the issue of informed consent to medical care.

Emphasis upon consent to medical care arises from the legal need to remove a defendant's liability for surgical or other medical battery or assault by showing that the patient gave consent, since consent negates battery and assault. To show that the plaintiff patient's compliance with medical care was not adequately voluntary, the practice evolved, principally in the United States, of arguing that to be of legal effect, consent has to be adequately informed. Hence, the doctrine of "informed consent" arose. In modern times, however, the doctor's duty to give information to a patient about prospective

treatment is considered to relate not to the law of assault and battery, but to negligence law. If treatment is given that has not been discussed with the patient, or which differs from or exceeds that to which consent was given, battery law is applicable. If the only treatment given is that to which the patient consented, but without having been given adequate information, the case for the plaintiff/patient will be considered to fall only under the law of negligence.

Although the expression "informed consent" can be anticipated to take root in Commonwealth legal literature, it may be hoped and urged that the concept be expressed instead as "informed decision-making" or "informed choice" (see Laskin, C.J.C. in Reibl v. Hughes at p.11). The expression "informed consent" incorrectly suggests that:

(1) the purpose of informing is to induce consent;

(2) that if consent is not given it is because the patient is not adequately informed; and

(3) that a refusal of consent does not have to be as well informed as a decision to accept treatment.

The purpose of informing is to serve a patient's self-determination and medical choice. Patients determine the goals of treatment, but frequently leave the means of achieving those goals to medical judgment. To know what goals are reasonably achievable, patients must be given information. Reciprocally, doctors must learn from patients what the patients consider to be important in their lives, including what physical, mental and, for instance, reproductive capacities they most value and wish to preserve if possible, and what capacities patients are willing to sacrifice in pursuit of goals of general health. Doctors need this information of patients' priorities in life in order to judge what medical options may be presented to patients as likely to serve their goals. Patients' reproductive intentions are clearly of major significance to their medical care.

Patients may decline treatment options of which they have been appropriately informed on rational grounds, but as competent, autonomous beings, patients are entitled to decline treatment options upon irrational, sentimental, emotional, religous, philosophical or other grounds. It does not follow that refusal of an advised medical option is due to lack of information, and doctors should not add to or emphasize adequate information already presented, or exaggerate benefits of treatment or risks of declining treatment, lest they may appear to be pressuring, unduly inducing or coercing a particular decision. The duty to inform appropriately applies, however, to decisions not only to have treatment, but also to delcine it; the counterpart of

"informed consent" is "informed dissent". When legal analysis centred upon battery and assault law, a decision not to touch the patient did not need consent, whereas a decision to touch clearly did. Now that analysis is based upon negligence law, however, a doctor may be liable whose negligent informing of a patient caused the patient to forego probably beneficial care, including sterilization where indicated.

Analysis discloses three levels at which information may be pitched, namely:

(i) the professional standard;
(ii) the subjective patient standard; and
(iii) the objective patient standard.

The Bolam approach representing the professional standard, which prevailed in Ontario and Canada generally before Reibl v. Hughes, requires the doctor in principle to give such information as would be given by an ordinary skilled doctor of the speciality or style of practice of the doctor in question, acting in accordance with the practice accepted at the time as proper by a responsible body of medical opinion. In Sidaway, the House of Lords applied the Bolam test, adding some fine tuning to the effect that the proposed treatment might involve substantial risk of grave consequences in which it might be found that, without regard to contrary medical opinion, a patient's right to decline is so obvious that no prudent doctor could fail to warn of the risk, except in emergency or other exceptional circumstance.

In Reibl v. Hughes, the Supreme Court of Canada, approving in principle the decision of the Ontario Court of Appeal, rejected the professionally-oriented approach, reasoning that when doctors have to decide what to say to patients, they should direct their attention not inwards to representative doctors, but outwards to representative plaintiffs. In adopting a patient-oriented approach, however, the Court rejected the subjective patient standard, because of the realities of litigation. The patients who sue are disappointed, often injured and perhaps embittered. They must show that the defendant doctors' failure to make disclosure caused them to accept the treatments they claim injured them. The Court considered that defendants should not be at the mercy of the "bitter hindsight" of patients, and that their defences should not be vulnerable to patients' answers to the question "Had you known then what you know now (namely, that the treatment will cause injury), would you have agreed to the treatment?" The Court favoured the so-called objective patient standard of disclosure, not only by elimination of alternative standards but also because of its positive merits.

The subjective patient standard is pitched at the prudent person in the patient's circumstances, and requires disclosure of such information as such a patient would consider material to the choice to accept or reject a proposed treatment. This would include the normal risks of relatively mild effects, and also low risks of exceptional or unusual effects of a serious nature. Since the patient is deemed to be reasonably intelligent, however, information of a general nature that ordinary people know is not required to disclosed, such as that no medical treatment is completely safe and that, for instance, a blood transfusion bears an irreducible minimum risk of causing injury, such as hepatitis, which no amount of care can prevent. A plaintiff who alleges that failure to give information caused the plaintiff to accept a treatment that caused injury, including injury that no amount of care could have prevented, must show not only that he or she would not have accepted the treatment if informed of the risk, but also that a prudent person in his or her circumstances would have refused the treatment.

In the context of sterilization, the Bolam test of disclosure requires doctors to identify and observe what their peers would do, whereas the Reibl v. Hughes test requires doctors to consider the position in life and preferred life styles of their patients, and to adjust this information to what they actually know or should know of the individual patients concerned. It has been held, for instance, that when a patient is conscientiously troubled by the proposal to have contraceptive sterilization because of her Roman Catholic faith, its risks of adverse effects must be explained with care since they may persuade her to decline the procedure; see the discussion in Videto v. Kennedy (1981), 125 D.L.R. (3d) 127 (Ont. C.A.).

C. Sterilization and Retardation

It has been seen that the purpose of informing patients is to serve their right of self-determination. Not all persons have the capacity, however, to be legally autonomous. Legal minors may not (see below), although the Gillick case (see Chapter II, B, above) shows that minority age in itself does not bar legal capacity to give effective consent to confidential medical treatment. Similarly, mental retardation in itself is not a bar to autonomy. If mental age can be determined by some reliable, objectively verifiable or replicable measure, retarded persons may be considered by reference to their mental age rather than to their chronological age. So assessed, many may be found to be capable of autonomy. Since autonomy is the right to make decisions, it includes the choice to exercise judgment unwisely, and to have to bear the consequences. Young children should not be allowed to hurt themselves through inexperienced exercise of choice, because they lack foresight, hindsight and insight; they are accordingly protected by paternalism of their parents or other guardians. Adults should

not be treated paternalistically, however, and nor should mature minors. When retarded persons have the capacity of mature minors, they should be treated equally and be recognized to have some capacity for autonomy, with all of its positive and negative consequences.

Retarded persons are often divided into the four categories of the mildly, moderately, severely and profoundly retarded (see B.M. Dickens, "Retardation and Sterilization" (1982), 5 Int'l J. Law & Psychiatry 295). Mildly retarded persons may be comparable to legal minors, and, at the other end of the spectrum, profoundly retarded persons may be so incapacitated that they require assistance to cope with the regular discharge of their bladders and bowels. Accordingly, periodic menstruation is a difficulty for those responsible for their care rather than for them themselves. Sterilization by hysterectomy to obviate menstruation of this population, in order to ease caretakers' duties, would in itself be unlawful. Mentally incompetent persons are not liable to be subjected to major, highly invasive, irreversible non-therapeutic surgery solely for the advantage of others.

A distinction must be drawn in principle, although its clinical application requires particular clarity of diagnosis, between therapeutic and non-therapeutic (particularly contraceptive) sterilization. Therapeutic sterilization may be considered where pregnancy would be life-endangering or a serious risk to enduring health. This cannot affect males, and is not too common among females. Concerning retarded females, sterilization procedures may be proposed because they would be psychologically devastated by pregnancy, but procedures are more often proposed not to preclude pregnancy per se, but to end liability to menstruation among those unable to cope with it although they can otherwise care for themselves. They may be acutely distressed by blood (see Re K and Public Trustee (1985), 19 D.L.R. (4th) 255 (B.C.C.A.)) or be severely disoriented, at hygienic risk, and incapable of being trained to deal with each new month's experience. Hysterectomy may accordingly be proposed in order to end their liability to unmanageable severe distress. Its effect of rendering them sterile is secondary.

Eugenic sterilization is a middle ground between therapy which has a side-effect of causing sterility, and purely contraceptive sterilization. It is usual to find guarded legal tolerance of eugenic sterilization (see the Bravery case, A above) although its underlying presumption that the retarded peson's retardation is of genetic origin and likely to be transmitted had to be tested in each case. When retardation is due to a congenital but non-genetic condition, or to a birth trauma such as hypoxia or a post-natal incident, the presumption is false, and provides no legal basis for intervention on eugenic grounds.

Purely contraceptive sterilizations cannot in principle be authorized for retarded persons where these treatments would pre-empt reproductive decisions such persons have, or could develop or be trained to have, capacity to exercise for themselves. Where a mildly retarded person has or could reach capacity to marry, for instance, the decision on reproduction should legally be made within the marriage, although it may be subject to non-directive advice from outside persons.

Where capacity to exercise choice appears chronically lacking, a decision on the legality of consent to contraceptive sterilization by a third party depends on the prevailing view of sterilization. If it is seen as a procedure done primarily to the individual, it may appear unjustly paternalistic and oppressive. In the context of minors, such a view of sterilization has condemned it in forthright terms as a violation of human rights (see Heilbron J. in Re D. (a minor), [1976] 1 All E.R. 326 at p. 332, discussed below). It may be seen, however, as a procedure done primarily for the individual. It may be observed that contraceptive sterilization is widely practised among mentally competent persons for their perceived benefit, and that, as a matter of human rights to the equal benefit and protection of the law, it should not be unavailable to retarded persons. If they cannot avail themselves of it due to incompetence, others should be able to seek and approve it on their behalves.

This view should be treated with great caution. Courts have expressed strong reservations about the legality of competent adolescents consenting to non-therapeutic, irreversible surgical contraception, meaning sterilization (see Woolf J. in the Gillick case, [1984] 1 All E.R. 365 at p. 374). Further, the population of competent adults having recourse to contraceptive sterilization is often quite differently situated from retarded persons whose guardians seek their sterilization, in that they are older and have completed the building of families according to their preferred design. The claim to exercise rights on behalf of an unmarried adolescent with no children on analogy with those a competent woman aged, for instance, over thirty years with three or four children will exercise for herself may be specious, and require stronger libertarian justification than the principled claim itself provides.

The issue of the conditions under which retarded adults may be sterilized upon third parties' consent is pending decision in the Supreme Court of Canada, in the case In Re Eve. On appeal in Prince Edward Island, the court held by majority that the retarded woman could be sterilized on the decision of her parent (see (1981), 115 D.L.R. (3d) 283), but the dissenting judgment of McDonald J. conformed to an approach United States' courts have taken. This favours neither a simple prohibition upon contraceptive sterilization, nor simple

permission of a conclusive decision of a guardian, but addresses the range of questions the medical answers to which will determine the issue. The questions concern such matters as the retarded person's present and prospective capacity for autonomy including marriage, the likelihood and imminence of sexual intercourse, the availability of less invasive contraceptive alternatives, the effect upon the person's emotional health and morale of later learning of inability to have children and, for instance, the person's capacity to rear a child, with and without assistance. Further, the approach requires independent legal representation of the retarded person before an impartial decision-maker, and assurance that a guardian's proposal for sterilization is not affected by self-interest, but is addressed solely to the benefit of the retarded person. Within this limit, it may be determined that it is a benefit that the person will, if sterilized, be afforded a more liberated style of living, including, for instance, company of and private time with members of the other sex, as befits persons of similar age and disposition. Nevertheless, it is clearly oppresive that retarded persons can escape unduly circumscribed social environments, whether in their own homes or in institutions only by being submitted to non-therapeutic sterilizations. An independent decision-maker must be careful to ensure that a retarded person is not manipulated through a contrived and unfair "bargain".

D. Sterilization of Minors

As in the case of adults, care must be taken to distinguish sterilization per se from therapeutic treatment which may have the side-effect of rendering the subject incapable of procreation but which in itself is primarily directed to a health-preserving end. Further, the category of legal minors includes those who are retarded while under the age of majority or the age which legislation or statutory instruments make sufficient in itself to give autonomous medical decisions legal effect. The future procreative rights of minors must be no less protected than those of retarded adults, and the procreative capacity of minors is no more at the free disposal of their parents than is that of retarded persons at the free disposal of their guardians. Equally, however, the therapeutic needs of minors must be met according to objective data dependent upon medical predictions, and parents are bound to provide their children with necessaries of life, which include health care. Health options may be expected to be exercised so as to maximize retention of procreative capacity, but it must be sacrificed when essential as an unavoidable side-effect of other, urgently compelled treatment.

It is unlikely that a non-therapeutic sterilization would be proposed for a mentally normal adolescent, but the sub-division of contraceptive sterilization dealing with risks of genetic transmission of severely handicapping traits may be presented

as a legitimate eugenic claim to sterilization of a minor. It should be resisted in principle, however, because adults possess the right to risk dysgenic reproduction, and a minor's future right of adult choice should not be denied by a pre-emptive exercise of parental power. Even mentally impaired minors may grow to capacity to exercise choice, and any doubt regarding the development of such capacity must be resolved in their favour. A decision to sterilize for contraceptive or eugenic reasons should not be taken prematurely, lest it may foreclose basic human rights the individual will become capable of exercising in adulthood (see In Re D. (a minor), [1976] 1 All E.R. 326).

The mature minor doctrine, approved in the Gillick case, raises the question whether minors can give legally satisfactory sole consent to contraceptive sterilization. Judges have expressly denied this (see Woolf J. in Gillick, Chapter II, B, above) and it may be accepted, not necessarily axiomatically but with considerable ease, that the tests proposed in Gillick by Lord Fraser (Chapter II, B, above) are not satisfied by a legal minor requesting or otherwise purporting to consent to purely contraceptive sterilization.

E. Sterilization Failure

Since all techniques of sterilization (and contraception) of the sexually active have an irreducible minimum risk of failure, it does not follow that subsequent pregnancy is necessarily proof of negligence. It must be remembered, however, that failing to give appropriate information to a patient regarding risks of failure associated with different types of sterilization procedures may in itself constitute actionable negligence. Similarly, failing to conduct a proper post-vasectomy test or to warn the patient of the time after the procedure during which he may still release sperm in intercourse may give rise to a successful claim if pregnancy occurs. A particular difficulty is that, while sterilization should be approached as if it were irreversible, patient selection of means may be influenced by the possibility of reversibility. Reversibility is more achievable, perhaps by microsurgery, where intrusiveness of the procedure is less. Merely severing the fallopian tubes is less intrusive, for instance, than removal of a relatively lengthy section. The difficulty is that the greater the chance of reversibility, the greater the chance of spontaneous recanalization or other effect which restores the patient's fertility. The patient's interests in reversibility and in finality of the procedures conflict, and a patient may require sound counselling to set these interests at the balance of risk to benefit preferred by the patient.

(i) Contract Law

Although post-sterilization procedure conception may not be due to negligence, it will be successfully actionable if the surgeon involved gave an undertaking of a "safe" or sterile outcome. The plaintiff may sue not for inherent negligence in the selection, conduct or post-operative monitoring of the procedure, but for breach of contract. While negligence law centres upon reasonable person tests, contract law does not. Persons may contractually bind themselves to achieve impossible or unreasonably expectable results, and be contractually liable when they fail. This occurred at trial in the English vasectomy case of Thake v. Maurice, [1984] 1 All E.R. 513 (Q.B.D.), although on appeal the Court of Appeal found liability not in contract law per se but for negligent informing of the patient about the vasectomy operation in question ([1986] 1 All E.R. 497).

At Common law, a medical practitioner is not deemed to guarantee the effectiveness of any procedure or treatment undertaken, but, by express words or conduct, a doctor may warrant that a certain outcome will be achieved, such as sterility. Such a warranty forms part of any contract made with the doctor. Under a national health service in which a doctor is paid a fixed sum by the service per capita of the patients empanelled, no contract may exist between doctor and patient for services rendered. Under a public health insurance plan where doctors receive payments on a fee-for-service basis, a contract between doctor and patient does exist even though a third party, the health insurance plan, pays the contract price, usually agreed between representatives of doctors and a govenment officer such as a health minister. In either case, services may be sought by patients outside the health insurance scheme, such as by private insurance or personal payment. Whether a contract exists with the patient in such a case will be legally determined by reference to the doctor's basis of payment.

In Thake v. Maurice, the trial judge found that the doctor had warranted the success of the sterilization treatment. There is a difference between undertaking "to render the patient sterile", which imports a guarantee of effectiveness, and undertaking "to perform a vasectomy", which is understood to bear an unavoidable risk of failure. The doctor in the case was found at trial to have undertaken the former, and was according held liable for failure to render the patient sterile. On appeal, the Court of Appeal reversed this finding, on the ground that a reasonable person would not have taken the doctor to give a guarantee of absolute sterility, but upheld a second basis of liability for negligence in the doctor's failure to warn the patient that he might post-operatively remain or become fertile. In the absence of such warning, the patient's wife did not suspect her pregnancy early enough to be able to

terminate it safely, and accordingly gave birth to an unplanned sixth child.

(ii) Tort Law

Failure to warn a patient of the risks of failure of a sterilization procedure due not to negligence in its performance but to its irreducible uncetainty of outcome can constitute professional negligence, or negligence in fact. Whether this is also negligence in law, however, as found by the Court of Appeal in Thake v. Maurice, depends upon legal doctrine. Classically, there are four elements to legal negligence:

(i) A duty of care;

(ii) Breach of the duty of care;

(iii) Damage; and

(iv) Causation, that is that the damage is not merely subsequent to but actually caused by the breach of duty care.

In sterilization cases, item (i) is rarely contested, since it is normally clear that the attending doctor owes the patient a duty of care. This is both to perform the procedure according to the professional standard of care, and to give the patient appropriate information relevant to choice of means and uncertainty of outcome. A duty of care may be less clear, however, when a mentally incompetent person is treated (see C, above); a duty exists to treat the patient carefully, but the informing duty may be owed, contractually or otherwise, to others.

Whether there is breach of duty is measured, with regard to performance of the procedure, by standards of a competent doctor or specialist, as the case of the defendant may be, in the circumstances. The duty of disclosure is measured, however, according to prevailing legal doctrine on informed consent (see B above). A duty may exist to disclose not only uncertainty of the method of sterilization proposed and accepted, but also of alternative methods available. In the South Australia case of F. v. R. (1983), 33 SASR 189 the patient claimed that, had she been informed of the risk of recanalization in tubal ligation, she would have insisted upon a more radical treatment which would have considerably reduced the risk of post-operative fertility. The patient failed on her claim of wrongful nondisclosure because the Supreme Court of South Australia found that a more radical sterilization procedure (for instance bilateral salpingectomy) was not good medical practice (at p. 195). Applying the professional standard of disclosure of information embodied in Bolam and later confirmed in the House of Lords in Sidaway (see B above), the Court ruled that the doctor was not

in breach of the duty of disclosure, since a competent doctor would not have informed her of such an alternative.

Where disclosure must relate not to the conduct of other doctors but to needs of patients, as in Canada undeer the principle in Reibl v. Hughes (see B above), a different result may follow. In the British Columbia case of Dendaas v. Yackel (1980), 109 D.L.R. (3d) 455, a doctor was held liable for not disclosing an alternative means of sterilization which the patient might have selected; the case may be consistent with F. v. R., however, because the more successful alternative procedure was professionally acceptable. The Canadian approach is nevertheless likely to follow United States' jurisprudence in holding that choice of treatment must be governed by the patient's priorities and risk-to-benefit assessment, and not merely by the doctor's preferred choice of options. Failure to inform according to the patient's informational needs will constitute breach of the duty of care.

The issue of damages is addressed below, but a significant point of principle is whether birth of a child can in law be a species of compensable injury. It may be considered instinctively or aesthetically offensive to regard a human being's birth as a legal damage, and courts have expressed distaste at the concept (see e.g. Doiron v. Orr (1978), 86 D.L.R. (3d) 719 (Ont. S.C.)). Nevertheless, it may be equally distasteful and contrary to good policy to hold that medical or other negligence in fact is legally protected or cured provided that it results in birth of a child. A distinction may be considered between birth of a healthy child and birth of a handicapped child, but this may be objectionable in stereotyping handicapped children as a damage to their parents, and in opening the way to discrimination against them. It may be claimed, however, that the child itself is not the damage, but that birth is a damaging event. The Quebec Superior Court awarded damages on birth of a healthy child following negligently conducted sterilization in Cataford v. Moreau (1978), 114 D.L.R. (3d) 585, and the English Court of Appeal in Emeh v. Kensington and Chelsea and Westminister Area Health Authority, [1984] 3 All E.R. 1044 held that there was no inconsistency with public policy to award damages for birth of a healthy child.

The causation issue concerns whether sterilization failure was due to the doctor's improper conduct of the procedure itself, or due to its inherent risk of spontaneous failure, which is resolved by medical evidence and the legal burden of proof. Alternatively, causation may depend on whether the doctor's misinformation of the patient as to options caused the patient to select a method which failed due to either negligent or spontaneous causes. This involves the legally required standard of disclosure (see B above) and whether the patient can show that, if more information would have been

given, a different choice would have been made which would have prevented the injury that resulted. Inadequate information as to risk of failure of the procedure may also deny an opportunity to seek abortion on pregnancy. The plaintiff must then show that abortion could and would have been obtained. This concerns causation not just of the injury but of the extent of damage.

(iii) Damages

Accepting that birth of a child through negligence in sterilization is actionable, an initial issue is the duty to mitigate the damage. On the principle that wrongdoers take their victims as they find them, they cannot complain if victims prove to be people to whom abortion or adoption is unacceptable; defendants cannot require injured plaintiffs to mitigate damages by abortion of fetuses or adoption of children resulting from their negligence (see Emeh, at p. 1053). In Thake v. Maurice (see above) the abortion issues was treated as one on which the plaintiff bore the onus of proof; here, as in Emeh, the Court of Appeal accepted the plaintiff's contention that, due to the pregnancy being disclosed at a relatively advanced stage, it was not reasonable to expect abortion to mitigate damage, even though there was no conscientious objection to abortion per se. If the issue is whether the refusal of abortion breaks the chain of causation which links the defendant's breach of duty of care to the plaintiff's damage, the plaintiff understandably bears the burden of proof on the issues. If the matter is treated, however, only as an unreasonable failure to mitigate damage, the defendant must address this when liability is established and the court considers the level of compensation. In Selvanayagam v. University of West Indies, [1983] 1 All E.R. 824, the Privy Council stated otherwise, but this seems inconsistent with the overwhelming weight of authority (see W.V. Horton Rogers, "Legal implications of ineffective sterilization" (1985), 5 Legal Studies 296 at p. 300, n. 26).

Parents' actions for sterilization or contraceptive failure are often described as wrongful conception or wrongful birth actions (contrast the child's action for wrongful life, below). Most courts accepting the action in principle are willing to award damages for inconvenience and pain and suffering in pregnancy, confinement and delivery and for lost income, costs of maternity clothes, preparing a nursery and similar out-of-pocket expenses. They also may allow recovery of medical costs of the negligent sterilization or contraceptive advice and/or treatment. More contentious is whether they will award damages for the prospective costs of rearing the child until termination of parents' legal responsibility provide children with necessaries of life.

In Cataford v. Moreau (above), the Quebec Superior Court awarded a sum to cover such expenses, although calculated at a

very modest level (see R.P. Kouri, case comment at (1979), 57 Can. Bar Rev. 89); in contrast, the contemporaneous Ontario case of Doiron v. Orr (above) observed, obiter, that such an award would be highly offensive to principle and dysfunctional in practice, because of harm to a child from knowing that it was unwanted and was being supported from outside its family. The South Australian Supreme Court in R. v. F. (above) similarly rejected a claim for care of the child born of failed sterilization, while awarding damages for pain and suffering in wrongful pregnancy. This shows how courts may balance the costs of pregnancy against the benefit (often call the "blessing") of having a child; the benefit of a healthy child may exceed that of a sickly or handicapped child whose health is a source of anxiety (see Emeh, above).

A balancing approach was applied to damages in Udale v. Bloomsbury Area Health Authority, [1982] 2 All E.R. 522, where liability for failed sterilization was admitted. The High Court judge weighed heavily the mother's love for and joy in the child, and found it to at least balance the inconvenience and financial disadvantage she had suffered. The Court also expressed the opinion, however, that damages should not be awardable as a matter of principle lest unloving parents may receive damage awards when loving parents would not. This appears to be an unnecessary formulation of a normative rule when it is more appropriate to address each case upon its merits, in a pragmatic fashion. The judge similarly observed that it is a long-standing cultural assumption that birth of a child is a blessing and an occasion for rejoicing (see at p. 531). Again, this is a matter better addressed pragmatically. A number of Commonwealth Courts have implemented the observation of a 1971 Michigan judgment on contraceptive error resulting in birth, equally applicable to sterilization error, that:

> "Contraceptives are used to prevent the birth of healthy children. To say that for reasons of public policy contraceptive failure can result in no damage as a matter of law ignores the fact that tens of millions of persons use contraceptives daily to avoid the very result which the defendant would have us say is always a benefit, never a detriment. Those tens of millions of persons, by their conduct, express the sense of the community." (Troppi v. Scarf (1971), 187 N.W. 2d 511 (Mich. C.A.))

On their understanding of their community, based on the empirical data of sterilization and contraceptive practice, courts may assess damages for injuries caused by childbirth. In the later Emeh case, the English Court of Appeal saw the matter of damages differently from the court in Udale. The child in Emeh had abnormalities, which may distinguish the case from Udale, but the Court of Appeal appeared to disapprove the Udale

expression of public policy opposed to awards of damages for wrongful birth following negligent failure of contraception or sterilization.

(iv) Wrongful Life

The difficulty Commonwealth courts have found before accepting the contention that birth of a child, for instance through negligent sterilization, can be a species of legal damage to the parents offers some guidance to how they might respond in principle to the claim that the child itself is also legally injured by such birth. A claim of this nature is increasingly called a "wrongful life" claim, but the name arose less by way of explanation than as a parody of the wrongful death action, which Common law courts also rejected. When statutes of the mid-nineteenth century afforded a deceased person's estate the means to sue for the injury causing death, the "wrongful death" action was created. This was invoked to deride the subsequent claim that a plaintiff's very life could be a source of legal injury.

Modern commentators go further, to distinguish the wrongful life action from the "dissatisfied life" action, in which a child seeks damages not simply for having been born but for having been born illegitimate or otherwise socially (as opposed to physically or mentally) disadvantaged. In the United States, the first case to allow a claim for wrongful life was a Californian case of 1980 (Curlender v. Bio-Science Laboratories (1980), 165 Cal. Rptr. 477). The arguments that the wrong of wrongful life is not the life itself but the predictable pain and suffering a child with a foreseeable handicap suffers, and that the blessing of the experience of life can be weighed against the burden of such pain to assess compensation, if any, has not greatly promoted success of the action. It is clearly accepted in less than a full handful of United States' jurisdictions.

When the claim first arose in the Commonwealth, in the English case of McKay v. Essex Area Health Authority, [1982] 2 All E.R. 771, it was emphatically rejected. This was compatible with the English Law Commission's 1974 Report on Injuries to Unborn Children (No. 60, HMSO 1974 Cmnd. 5709), which was followed by enactment of the Congenital Disabilities (Civil Liability) Act 1976. In McKay, it was alleged that the defendant's laboratory negligently tested prenatal blood samples, thereby failing to inform a mother of rubella infection and denying her the opportunity to have an abortion. A severely handicapped child was born, who was plaintiff in the case, alleging negligence resulting in birth against the Area Health Authority, and against the attending doctor for negligent treatment of the mother, and negligent management of the child before birth resulting in aggravation of its injuries experienced upon birth. The High Court and Court of Appeal (above) dismissed the

claim, the latter presenting reasons of an absence of a duty of care owed to a child before birth, an absence of damages, since live birth is a benefit outweighing any disadvantage, and principles of public policy which preclude allowing wrongful life claims. These reasons may be faulted both in substance and in the way they were presented (see e.g. C.J. O'Neil, "Damages and the Unwanted Child" (1985), 5 Auckland Univ. L.R. 180, at pp. 186-189, and H. Teff, "The Action for 'Wrongful Life' in England and the United States" (1985), 34 Int'l and Comp. L.Q. 423, at pp. 438-441), but for the time being at least they seem likely to prevail in Commonwealth jurisprudence.

F. Spousal Veto

It has been seen (see Chapater I, E, above) that a state's enactment or tolerance of laws permitting husbands to veto their wives' sterilizations, whether therapeutic, eugenic or purely contraceptive, could be inconsistent with the United Nations' Convention on the Elimination of All Forms of Discrimination Against Women, and a violation by Commonwealth countries that are States Parties to the Convention. The same would be true of laws giving only wives veto power over husbands, although no Commonwealth provisions to this effect are apparent. More difficult to assess are laws providing for mutual veto power which are applied in fact to place one sex under the control of spouses. The same is true of formal and informal practices lacking a legislative foundation which discriminate against one sex. Since the experience of laws and practices in the Commonwealth is that discrimination in form or effect is directed against women, they may be assessed according to the provisions and values of the Convention. It must be observed in addition that, even in countries which have not ratified or acceded to the Convention, spousal veto of a woman's therapeutic sterilization will violate laws obliging a husband or parent to provide a wife or dependent with necessaries of life, which include therapeutic care.

The differential opportunity for spousal veto under laws or practices which appear applicable mutually to husbands and wives is evidenced in, for instance, the 1983 Annual Report of the National Family Planning Programme of Trinidad and Tobago. This shows (at p. 9) that, while 1,313 tubal ligations were performed on women, 52 vasectomies were performed on men. Practices at clinics where sterilizations are offered not uncommonly differentiate between women and men patients. The 1985 paper Status of Family Planning Practices and Policies in Dominica observes on voluntary sterilizations, of which 3,257 have been done since 1967, that (at p. 6) "Where clients are married the husbands' written consent must be obtained prior to sterilization." On vasectomy, the paper observes only that "Few of these were done in the past." Since vasectomy is considerably safer than women's treatments, some agencies have

promoted it in effective campaigns. The 1984-85 Annual Report of The Family Planning Association of Hong Kong, for instance, shows that, while 451 female sterilizations were done in 1984, a Male Responsibility Campaign raised the annual vasectomy total to 632.