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COMPETENCE AND HUMAN REPRODUCTION

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INSTITUTE OF LAW RESEARCH AND REFORM

The Institute of Law Research and Reform was established January 1, 1968, by the Government of Alberta, the University of Alberta and the Law Society of Alberta for the purposes, among others, of conducting legal research and recommending reforms in the law. Funding of the Institute's operations is provided by the Government of Alberta, the University of Alberta and the Alberta Law Foundation.

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ACKNOWLEDGMENTS

We have had much help in forming our opinions and developing the position presented in this report. We have not invariably followed the advice received, and the Board of Directors of the Institute assumes sole responsibility for the form which the tentative recommendations in the report have taken.

Professor W.F. Bowker, Director Emeritus of the Institute, first proposed the project to us. Professor Bowker provided us with an initial working paper. He has kept in touch with the project throughout and given us the benefit of his advice.

During most of the period when this project was in progress, the late Mr. J.W. Beames, Q.C. was Chairman of the Board. Acting in this capacity, Mr. Beames made a substantial and dedicated contribution to the work of the Institute. In addition to performing his functions as Chairman, Mr. Beames served on a sub-committee of the Board whose members met more frequently than the full Board to discuss policy, make suggestions and give direction to this project.

Other members of the sub-committee were Professor P.J. Lown (Director), who succeeded the former Director, Professor R.G. Hammond, mid-way through the project; M.B. Bielby of the Institute Board; and B.R. Burrows of Institute Counsel. We also appreciate the special contribution made by these persons to the project and report.

Margaret A. Shone of Institute Counsel had the primary responsibility for the carriage of the project and the drafting of the report.

In Report for Discussion No. 6, published in April 1988, we invited comment on our tentative proposals. A number of individuals and organizations obliged with a response. Most of the responses were made in writing, although some were made orally. We are of the firm opinion that, largely because of the comments made to us in these submissions, the proposals in this report mark a substantial improvement over the tentative recommendations presented in the Report for Discussion. We extend our thanks to all who made their views known to us. The contributors are listed in Appendix A to the report.

Prior to the publication of tentative recommendations in the Institute's Report for Discussion, Ms. Shone was assisted by an Advisory Committee. Professor Bowker was a member. Mr. Beames and Ms. Bielby also attended meetings. The other members were: Mr. Bal Abbi, psychologist; Mrs. Joan Charbonneau, parent; Dr. D.C. Dumming, obstetrician; Mr. Glyn Davies, Assistant Public Guardian (later succeeded by Mr. Hart Chapelle); Father Camille Dozois, priest; Dr. F. Harley, pediatrician; Dr. A. Donald Milliken, psychiatrist; Dr. E. Joseph Moriarty, physician; Dr. Elizabeth Savage, geneticist and lawyer; Dr. R. Sobsey, educational psychologist; and Dr. R.C. Von Borstel, geneticist. The members of the Advisory Committee gave generously of their time and expertise at this stage of the project. Their assistance has been invaluable and we are grateful to have received it.

PREFACE

Our proposals flow from the answers to two questions. The first is whether sterilization for any purpose other than physical health or mental health, narrowly interpreted, can be for the benefit of the person sterilized. The second is whether, if there is a benefit, the law should withhold it from a person who is unable to make an informed choice for or against it.

We think that it is clear that sterilization can be for the benefit of the person sterilized, whether for necessary medical treatment or for a purpose such as birth control or the management of menstruation. Our reasons are given at pages 43-44. It is beyond dispute that many people who are able to make informed choices choose sterilization.

In our view, the law must treat a person who is not competent to make an informed choice about sterilization as fully human with all the rights, needs and desires that being fully human implies. The denial of a benefit on grounds of incompetence to decide is, in our opinion, the denial of a human right. We know that some think that sterilizing a person without her own informed consent denies humanness, infringes rights, and ignores needs and desires. We think, however, that there are cases in which the contrary is true.

We are convinced that the greater justice is served by providing access to sterilization in cases where it would be available to any other person. We think that the greater error would be to deny sterilization in all cases in which physical or mental health is not directly threatened. We agree that, in the past, sterilizations have been performed when they should not have been performed. Our answer is to take all possible steps to ensure that a sterilization will be performed only where the best interests of the person require it.

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PART I - EXECUTIVE SUMMARY

The Need for New Legislation

In October of 1986, the Supreme Court of Canada declared in its judgment in the case of *Re Eve* that there is no authority at common law for anyone to consent to a "non-therapeutic" sterilization for a person who is not legally competent to consent personally. This effectively has stopped all such sterilization of minors or mentally incompetent adults; they can not give the consent themselves and the Supreme Court has ruled that parents, guardians or the courts can no longer consent on their behalf. Specific legislation would be required to create a consent mechanism, the court said.

Before this landmark judgment was handed down, the Institute of Law Research and Reform had already begun a review of the law related to the sterilization of minors and mentally incompetent adults. The view was widely held that more protection in law was needed, not only to prevent unwarranted sterilization but also to ensure that sterilization decisions are made in the best interests of the subject.

The Institute incorporated its response to the *Eve* judgment in its *Report for Discussion No. 6* (March 1988). After extensive consultation it has prepared draft legislation, in the form of a new *Competence and Human Reproduction Act* and an amendment to the *Dependent Adults Act*.

(The draft legislation covers males as well as females, but because the situations considered overwhelmingly involve women and girls, the feminine pronoun has been used to refer to the subjects of a proposed sterilization.)

History

The repeal in 1972 of the Sexual Sterilization Act, enacted in 1928 to permit sterilizations for eugenic purposes, ended a dark chapter in the history of the mentally disabled in Alberta. Drafted to protect the gene pool with no consideration of individual rights, this Act had allowed sterilization of mentally disabled persons without their consent. This discredited legislation has contributed greatly to the political sensitivity of this issue; no one wants a return to what amounted to forced sterilization. Research shows that the Act was disproportionately applied to those from poor, native or ethnic backgrounds.

After 1972, sterilizations on mentally disabled children were performed with the consent of a guardian, usually a parent. After 1978 (the year the Dependent Adults Act came into force), sterilizations on mentally disabled adults were performed with either the consent of a guardian or an order of the Surrogate Court.

With *Eve*, the ground rules have completely changed. Concern about the potential for unwarranted sterilization of vulnerable individuals has been replaced by concern about a situation in which those not competent to legally give their consent are barred from access to this form of birth control or menstrual management.

The message "we will not let you risk having babies" of the eugenic sterilization days has changed to the message "we insist that you risk having babies".

Case Histories

The Institute considered a number of case histories and chose two to illustrate the consequences of the judgment in *Eve* on the lives of affected individuals.

Case #1: Marie is a mentally handicapped woman in her mid-20s, with good verbal and motor skills but poor comprehension, living in the community in a stable relationship

with Joe who is also mentally handicapped. The couple met when they were younger and living in the same institution.

They have one child who is normal and healthy, whom they are able to raise with the help of house support and parent counselling. Marie had a difficult pregnancy and does not want to have any more children. Other forms of birth control have been rejected as impractical or medically inadvisable, and Marie is strongly in favour of sterilization by tubal ligation.

Because the procedure would be non-therapeutic, her guardian would not have authority to consent, and since *Eve*, neither would the courts. Unlike other women wishing to prevent conception, Marie must run the risk of future pregnancy and its effects which are, for her, adverse.

Case #2: Janice is a 14-year-old girl with multiple handicaps. Mentally, she functions at the level of a child of five. Because of her physical disability, any rotation or movement of her hips brings pain. Janice is also afflicted with a medical condition which causes much more frequent and heavier menstruation than normal. Because of her hip problem, every pad change is an agony.

Janice is unlikely ever to bear children. Her mother and physician agree that a hysterectomy is the best course to spare her the distress associated with menstrual hygiene. However, in *Eve*, the Supreme Court calls hysterectomy "excessive" for menstrual management. Because the doctor is not sure that the hysterectomy would be therapeutic in the sense of the *Eve* judgment, he has refused to accept the consent of the mother to perform the sterilization.

The Institute's Position

In preparing its draft legislation, the Institute sought to create a decision-making process for those not legally competent to make the decision themselves, replacing the

blanket prohibition of *Eve* with legislation which allows for a judgment based on the best interests of the individual and an empathy for her situation.

It considered the views of those who believe that no sterilization should ever be carried out, balanced against the fact that in the general population, sterilization has become the most popular form of birth control. With the exception of hysterectomy for menstrual management, which is major surgery, improvements in surgical technique have made sterilization relatively simple, with few complications.

Nevertheless, sterilization should be regarded as permanent and the Institute agrees with the Supreme Court of Canada that it is "*not* a decision to be lightly undertaken" and that "the great privilege of giving birth" and the "basic human right of procreation" is involved.

After searching deliberation, the Institute has concluded that no person should be denied access to sterilization because she is not competent to consent. As it does in other areas, the law must provide a means of making the decision for her, based strictly on her best interests and on consideration of her individual circumstances.

The Legislation

Under the draft *Competence and Human Reproduction Act*, a judge of the Court of Queen's Bench may, on application made by or on behalf of the person, make an order authorizing an elective sterilization or a hysterectomy for menstrual management where the subject is either a minor or an adult who is not competent to consent to the proposed sterilization.

Where a judge finds an adult subject of an application is competent to consent to a proposed sterilization the judge may make an order allowing her to consent to the procedure.

Definitions

The Act creates three categories of sterilization: sterilization for necessary medical treatment; elective sterilization; and hysterectomy for menstrual management. Sterilization for necessary medical treatment (performed for the protection of the physical health of the person to be sterilized) is excluded from the Act and will not need a court order.

In the case of elective sterilization and hysterectomy for menstrual management, the new legislation provides a process that did not exist before to allow these decisions to be made on the facts and circumstances of each individual case.

Procedural Protections

Before an application is heard, the judge will appoint a lawyer to provide independent representation. The lawyer will follow the instructions of the client to the extent that she is competent to give instructions, and represent her interests to the extent that she is not competent to give instructions.

Notice of the application will be given to the subject, her parents and/or guardians and other interested persons. During the course of the application any of these persons may appear to be heard by the judge. As well, the judge will consider the reports of a physician and a psychologist.

Wishes of the Subject

In deciding whether a sterilization would be in the best interests of the person concerned, the legislation directs the judge to consider the wishes and concerns of the person involved. The judge must ensure that she has been informed about factors relevant to the decision and assisted, to the full extent of her intellectual capacity, to participate in the decision.

What the Judge Must Consider

In the case of an elective sterilization, the judge is directed by the legislation to consider:

(a) the age of the person,

(b) the likelihood that the person will become competent to consent to the proposed sterilization,

(c) the physical capacity of the person to reproduce,

(d) the likelihood that the person will engage in sexual activity,

(e) the risks to the physical health of the person if the sterilization is or is not performed,

(f) the risks to the mental health of the person if the sterilization is or is not performed,

(g) the availability and medical advisability of alternative means of medical treatment or contraception,

(h) the previous experience, if any, of the person with alternative means of medical treatment or contraception,

(i) the likelihood that any child of the person would be born with a physical or mental disability and the likely effect of that disability on the ability of the person to cope,

(j) the ability of the person to care for a child at the time of the application and any likely changes in that ability,

(k) the likelihood that a child of the person could be cared for by some other person,

(l) the likely effect of foregoing the proposed sterilization on the ability of those who care for the person to provide required care,

(m) the likely effect of the proposed sterilization on the opportunities the person will have for satisfying human interaction,

(n) the religious beliefs, cultural and other values of the person,

(o) the wishes, concerns, religious beliefs, cultural and other values of the family or other interested person providing personal care insofar as they affect the interests of the person, and

(p) any other matter the judge considers relevant.

In the case of a hysterectomy for menstrual management, in addition to the factors above, the legislation directs the judge to consider:

(a) the availability and medical advisability of alternative means of menstrual management, and

(b) the previous experience, if any, of the person with alternative means of menstrual management.

PART II - PROPOSALS FOR REFORM

A. Competence and Human Reproduction Act

We recommend that the Legislature enact the legislation set out below in the form shown entitled the Competence and Human Reproduction Act, or in an alternative form that embodies the substance of the provisions.

Competence and Human Reproduction Act

[Interpretation]

1(1) In this Act,

(a) "facility" means any establishment or class of establishment designated as a facility in the regulations under this Act;

(b) "interested person" means an adult who, because of his or her relationship to the person in respect of whom an order is sought, is concerned for the welfare of the person;

(c) "guardian" means

(i) in the case of a minor,

A) a person who is or is appointed a guardian under Part 7 of the *Domestic Relations Act*, or

B) a person who is a guardian under an agreement or order made pursuant to the *Child Welfare Act*;

(ii) in the case of an adult, a person who is appointed a guardian under the *Dependent Adults Act*;

(d) "judge" means a judge of the Court of Queen's Bench;

(e) "sterilization" means a surgical operation or other medical procedure or treatment that will or is likely to render a person permanently incapable of natural insemination or of becoming pregnant.

(2) For the purposes of this Act,

(a) a "sterilization for necessary medical treatment" is a sterilization that is medically necessary for the protection of the physical health of the person to be sterilized;

(b) a "hysterectomy for menstrual management" is a sterilization that

(i) is undertaken for the sole or primary purpose of eliminating menses,

(ii) is performed by the removal of the uterus, and

(iii) is not a sterilization for necessary medical treatment;

(c) an "elective sterilization" is a sterilization that is neither a sterilization for necessary medical treatment nor a hysterectomy for menstrual management;

(d) an adult is competent to consent to an elective sterilization if he or she is able to understand and appreciate

(i) the nature and consequences of natural insemination, pregnancy and childrearing,

(ii) the nature and consequences of the proposed sterilization including that it will or is likely to render the person permanently incapable of natural insemination or of becoming pregnant, and

(iii) the consequences of giving or withholding consent, and

(e) a female adult is competent to consent to a hysterectomy for menstrual management if, in addition to the matters described in clauses (i), (ii) and (iii) of paragraphs (d), she is able to understand and appreciate

(i) the nature and consequences of menstruation, and

(ii) the nature and consequences of the proposed hysterectomy including that the loss of the uterus will render the person permanently incapable of becoming pregnant.

[Scope]

2(1) Nothing in this Act affects

(a) the law regarding the performance of

(i) a sterilization for necessary medical treatment, or

(ii) a sterilization of an adult who is competent to consent to sterilization; or

(b) the jurisdiction of a judge to grant an injunction enjoining the performance of a sterilization.

(2) No sterilization other than a sterilization for necessary medical treatment shall be performed on

(a) a minor, or

(b) an adult who is not competent to consent to the proposed sterilization

unless it is authorized by an order made under this Act.

Part 1 - Sterilization Order

[Sterilization Orders Judge May Make]

3(1) A judge may make an order authorizing the performance of

(a) an elective sterilization, or

(b) a hysterectomy for menstrual management

on a person who is

(c) a minor, or

(d) an adult who is not competent to consent to the proposed sterilization.

(2) The judge may make the order subject to any conditions or restrictions the judge considers necessary.

(3) No elective sterilization shall be performed by hysterectomy unless a judge, by order, expressly so authorizes.

[Judge Must be Satisfied]

4(1) A judge shall not make an order under subsection (1) of section 3 unless the judge

(a) has found that the person in respect of whom the application is brought is

(i) a minor, or

(ii) an adult who is not competent to consent to the proposed sterilization,

(b) is satisfied that

(i) the person has been informed of the factors affecting the decision, and

(ii) has been assisted, to the full extent that his or her intellectual capacity allows, to participate in making a decision,

(c) has received evidence as to the wishes of the person after he or she has received such assistance, and

(d) is satisfied that the proposed sterilization would be in the best interests of the person to be sterilized;

(2) A judge shall not refuse to make an order under subsection (1) of section 3 merely because the sterilization is not necessary for the protection of physical or mental health.

[Wishes of Person in Respect of Whom Order Authorizing Sterilization is Sought]

5. In determining whether an order authorizing the performance of a sterilization would be in the best interests of the person in respect of whom the order is sought, the judge shall consider

(a) the steps taken

(i) to inform the person of factors relevant to the decision to undergo or forego a sterilization, and

(ii) to assist the person, to the full extent that his or her intellectual capacity allows, to participate in making a decision, and

(b) the wishes and concerns expressed by the person after having been so informed and assisted.

[Decision to Make Order for Elective Sterilization]

6(1) In addition to the matters referred to in section 5, before determining whether an order authorizing the performance of an elective sterilization would be in the best interests of the person in respect of whom the order is sought, the judge shall consider

(a) the age of the person,

(b) the likelihood that the person will become competent to consent to the proposed sterilization,

(c) the physical capacity of the person to reproduce,

(d) the likelihood that the person will engage in sexual activity,

(e) the risks to the physical health of the person if the sterilization is or is not performed,

(f) the risks to the mental health of the person if the sterilization is or is not performed,

(g) the availability and medical advisability of alternative means of medical treatment or contraception,

(h) the previous experience, if any, of the person with alternative means of medical treatment or contraception,

(i) the likelihood that any child of the person would be born with a physical or mental disability and the likely effect of that disability on the ability of the person to cope,

(j) the ability of the person to care for a child at the time of the application and any likely changes in that ability,

(k) the likelihood that a child of the person could be cared for by some other person,

(l) the likely effect of foregoing the proposed sterilization on the ability of those who care for the person to provide required care,

(m) the likely effect of the proposed sterilization on the opportunities the person will have for satisfying human interaction,

(n) the religious beliefs, cultural and other values of the person,

(o) the wishes, concerns, religious beliefs, cultural and other values of the family or other interested person providing personal care insofar as they affect the interests of the person, and

(p) any other matter that the judge considers relevant.

(2) The judge may make an order without considering a matter named in subsection (1) of this section or subsection (1) of section 7 where the judge is satisfied that evidence in respect of it cannot reasonably be obtained.

[Decision to Make Order for Hysterectomy for Menstrual Management]

7(1) In addition to the matters referred to in sections 5 and 6, before determining whether an order authorizing the performance of a hysterectomy for menstrual management would be in the best interests of the person in respect of whom the order is sought, the judge shall consider

(a) the availability and medical advisability of alternative means of menstrual management, and

(b) the previous experience, if any, of the person with alternative means of menstrual management.

(2) A hysterectomy for menstrual management shall be ordered only where no less drastic alternative method of menstrual management is reasonably available.

[Presumption of Physical Capacity]

8. For the purposes of this Act, the physical capacity of the person to reproduce shall be presumed if the medical evidence indicates normal development of sexual organs and does not raise doubt to the contrary.

[Declaration of Competence to Make a Sterilization Decision]

9. Where a judge finds that an adult person is mentally competent to consent to a proposed sterilization the judge may, by order, so declare.

Part 2 - Application for Order

[Applicant]

10. An application for an order under this Act may be made at any time by

(a) the person in respect of whom the order is sought,

(b) a parent of the person in respect of whom the order is sought,

(c) a guardian of the person in respect of whom the order is sought, or

(d) any interested person other than a person named in paragraph (b) or (c).

[Commencement by Originating Notice]

11(1) The application shall

(a) be made by originating notice, and

(b) include a request for the direction of a judge with respect to the appointment of a lawyer under section 15.

(2) The applicant shall file in support of the application the reports of

(a) a physician, and

(b) a psychologist

with respect to

(c) the competence of the person in respect of whom the application is brought to make a sterilization decision, and

(d) the risks to the physical or mental health of the person, as the case may be, that are relevant to the sterilization decision.

[Service of Notice]

12(1) The applicant shall serve notice of the application, together with the reports filed under section 11(2), on

(a) the person in respect of whom the application is made,

(b) the parents of the person in respect of whom the application is made, if any,

(c) the guardians of the person in respect of whom the application is made, if any,

(d) the person in charge of the facility, if the person in respect of whom the application is made is a resident of a facility,

(e) the lawyer appointed under section 15, and

(f) any other interested person whom the judge may direct.

(2) No order for service *ex juris* is required for service under subsection (1), but service outside Alberta must be effected at least 30 days before the date set for the hearing of the application, unless otherwise ordered by a judge.

(3) A judge may dispense with service on any of the persons referred to in subsection (1) except

(a) the person in respect of whom the application is made, and

(b) the lawyer appointed under section 15,

provided the judge is satisfied that it is not contrary to the best interests of the person in respect of whom the application is made to do so.

[Interested Person]

13. A judge may make an order that a person is or is not an interested person for a purpose named in this Act.

[Persons Who May be Heard]

14. A person served or required to be served under subsection (1) of section 12 or any other person whom the judge permits may appear and be heard on an application under this Act.

[Representation]

15. Before an application is heard, a judge shall appoint a lawyer to provide independent representation

(a) on the instructions of the person in respect of whom the application is made to the extent that the person is competent to give instructions, and

(b) of the interests of the person in respect of whom the application is made to the extent that the person is not competent to give instructions.

[Motion for Directions]

16. The lawyer appointed under section 15 may at any time apply to a judge for directions with respect to any matter arising in the proceedings, including

(a) the engagement of experts to provide evidence, and

(b) the payment of costs incurred in representing the interests of the person in respect of whom the application is made.

[Meeting with Person in Respect of Whom Application Made]

17. Where for any purpose connected with the application the judge is of the opinion that he or she should meet personally with the person in respect of whom the application is made, the judge shall do so.

[Investigation by Judge]

18(1) The judge may make whatever investigation the judge considers necessary with respect to any matter relating to the application.

(2) For the purpose of making an investigation pursuant to this section, the judge has the powers of a commissioner under the *Public Inquiries Act*.

(3) The judge shall give the parties an opportunity to be heard with respect to the evidence produced and matters arising from an investigation.

[Expert Reports]

19. Any party may cross-examine the person making a report filed in a proceeding under this Act.

Part 3 - General

[Effective Date of Order]

20. Notwithstanding anything in the Rules of Court to the contrary, an order under this Act shall not take effect until

(a) the dismissal or discontinuance of the appeal, where an appeal has been filed, or

(b) the expiration of the time allowed for appeal, where no appeal has been filed,

and the order shall be so endorsed.

[Costs]

21(1) A judge may at any time after the commencement of an application under this Act make an order that the costs of any application made or report or investigation ordered

(a) be paid by any or all of

(i) the person making the application;

(ii) the person in respect of whom the application is made;

(iii) the estate of the person in respect of whom the application is made where a trustee of the estate has been appointed;

(iv) the Crown in right of Alberta, where the judge is satisfied that it would be a hardship for any or all of the parties named in clauses (i), (ii) or (iii) to do so;

or

(b) be paid by the person making the application or a person opposing the application, where the judge is satisfied that the application or the opposition to the application, as the case may be, is frivolous or vexatious.

(2) An order for costs shall not be made under subsection (1) unless such notice as the Court thinks appropriate in the circumstances has been given to the person or party against whom costs are claimed.

[Order to Vary or Set Aside]

22. Where a judge is satisfied that, since the making of an order under this Act,

(a) there has been a material change in the circumstances of the person in respect of whom the application was brought, or

(b) material evidence is available which was not previously before the court,

and

(c) no substantial wrong or miscarriage of justice would result from his doing so,

the judge may

(d) vary or set aside the order, and

(e) make an order in substitution for an order that has been set aside.

[Appeals]

23(1) Any party to or person heard on an application under this Act may appeal the order of a judge to the Court of Appeal of Alberta.

(2) The notice of appeal shall be served on

(a) the person in respect of whom the application is made,

(b) the lawyer appointed under section 15,

(c) any parent, guardian or other interested person who appeared and made representations on the application in the Court, and

(d) any other interested person whom a judge of the Court of Appeal of Alberta may direct.

[Regulation-Making Power]

24. The Lieutenant-Governor in Council may, for the purposes of this Act, make regulations designating any establishment or class of establishment as a facility.

B. Dependent Adults Amendment Act

We recommend that the enactment of the *Competence and Human Reproduction Act*, or legislation of similar import, should be accompanied by the following amendment to the definition of "health care" in the *Dependent Adults Act*.

Dependent Adults Amendment Act

1. This Act amends the Dependent Adults Act.

2. The definition of "health care" in paragraph (h) of section 1 is amended by adding, at the end of clause (ii), the words "to which the *Competence and Human Reproduction Act* does not apply".

PART III - REPORT

CHAPTER 1 - INTRODUCTION

A. Background to the Institute's Report

On October 23, 1986, the Supreme Court of Canada rendered judgment in the case of *Re Eve*.[1] It held that *no* authority exists at common law to consent to the performance of a sterilization for a "non-therapeutic" purpose on a person who is not competent to consent personally. If authority is to exist at all, it is a matter for the Legislature.

The rendering of the *Eve* judgment marked the third time in this century that the Alberta position on sterilization decision making with respect to persons who are mentally disabled had been dramatically altered.

The first change, from an uncertain common law, was brought about by the enactment of the Sexual Sterilization Act by the Alberta Legislature in 1928.[2] The general view today is that that Act cast a dark shadow on the historical record of Alberta legislation and practice. It permitted the sterilization of mentally disabled persons for the eugenic purpose of improving the human gene pool. Because the purpose of the sterilization was to benefit the human race and not the individual, the consent of the person to be sterilized was not necessarily required, even where the person was competent to make the decision.[3]

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1 (1986) 31 D.L.R. (4th) 1 (S.C.C.). Also reported as *E. (Mrs.)* v. *Eve* [1986] 2 S.C.R. 388.

2 S.A. 1928 c. 37.

3 A 1937 amendment made consent unnecessary for a "mentally defective person" in named circumstances, including the risk of transmission to progeny of "any mental disability or deficiency": S.A. 1937, c. 47, s. 5.

The statistics indicate that, of the persons sterilized, the percentage of persons in minority groups was disproportionately high.[4]

The scientific assumptions on which eugenics theory was founded have since proven to have been based on a scientifically fallacious view about the hereditary transmission of recessive genes to produce a weakened human strain. Moreover, over the last two decades, the human rights and dignity of all members of society, regardless of ability, have gained long deserved recognition.

In the opinion of this Institute, a return to eugenic sterilization would be a backward step and we would ardently oppose any move in this direction.

The second change was brought about by the repeal of the Sexual Sterilization Act by the Alberta Legislature in 1972.[5] The repeal resulted in a return, in sterilization decision making, to an uncertain common law. The period coincided with the phenomenon of deinstitutionalization and increased family responsibility for the care of persons with developmental impairments and intellectual handicaps. We know from the accounts of persons involved that sterilizing procedures continued to be performed on mentally disabled persons who were not competent to consent for themselves. The sterilizations were performed for both therapeutic and non-therapeutic purposes. Physicians performing sterilizations on mentally disabled minors relied on the consent of parents who, as guardians at common law, have the authority to consent to medical treatment that is in the best interests of their child. After 1978, the year the Dependent Adults Act - Alberta's modern adult guardianship statute - came into force, physicians performing sterilizations on mentally disabled adults relied on either

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4 Tim Christian, "The Mentally Ill and Human Rights in Alberta: A Study of the Alberta Sexual Sterilization Act" (1974) unpublished paper cited in *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons* (Law Reform Commission of Canada, Working Paper 24) at 42-45.

5 S.A. 1972 c. 87.

(i) the consent of a guardian appointed under the Act to make health care decisions, or

(ii) an order of the Surrogate Court granted on the authority thought to exist under the Act.

This was the situation when the Institute decided to undertake a project on this topic. We became concerned that the opportunity for abuse existed in the absence of clear substantive law and attendant procedural protections. Members of associations committed to improving the quality of the lives of mentally disabled persons claimed that mentally disabled persons were being sterilized when sterilization was not medically necessary and should not be taking place. These persons pointed out that, because of their dependence on others, persons who are not competent to consent for themselves (be they minors or adults) are in a vulnerable position and are relatively powerless to protect themselves from a sterilization that is either unwanted or unwarranted; that sterilization destroys the ability to reproduce, thereby infringing a right that is basic to the human enjoyment of life; and, moreover, that physical and psychological risks attend sterilization. Knowledge of past eugenic sterilization practices under the Sexual Sterilization Act contributed to the social sensitivity surrounding the issue. Although they did not uniformly object to the performance of sterilization in appropriate circumstances, they concluded that safeguards were needed to protect the interests of those who are not competent to consent personally.

During the same period, the rise of the doctrine of informed consent made physicians increasingly wary of performing sterilization in cases of doubt as to the competence of the person to decide combined with doubt as to medical reason for sterilization. Physicians were concerned that by performing sterilizations that were not medically necessary they placed themselves in legal jeopardy. The concern was based on the uncertain scope of the authority of a parent or guardian at common law to consent to medical treatment for a minor, and the uncertain scope of the authority of a guardian appointed under the Dependent Adults Act to make health care decisions for a dependent

adult. Some hospital solicitors were advising hospitals not to allow the procedure because of the legal uncertainty about consent and how to avoid liability in battery or negligence.

The issue was not confined to Alberta. In cases coming before them, superior courts across Canada were taking different views of

(i) the scope of the jurisdiction over sterilization exercisable by a court at common law, and

(ii) the limits of the authority of parents and guardians.

Many of the cases were being decided in the exercise of the *parens patriae* jurisdiction, an inherent general supervisory jurisdiction derived from the monarch conferring on superior courts the responsibility to protect the interests of persons who are unable to look after themselves. Dramatically different results were being produced.

Then came the landmark judgment of the Supreme Court of Canada, in 1986, in the case of *Re Eve*. Eve was a 24-year old physically attractive woman from Prince Edward Island. She was at least mildly to moderately mentally retarded and had limited learning skills. Eve had developed an affectionate relationship with a male student at the training school they both attended during the week. Eve's mother, a widow approaching the age of sixty with whom Eve lived on weekends, wanted to avoid the possibility that Eve would become pregnant and have a child neither of them could care for. She therefore brought an application for an order that she be authorized to consent to Eve's sterilization.

The Court refused the sterilization. In so doing, it held that without a statute allowing it *no one*, not even a superior court, has authority at common law to authorize the performance of a sterilization for a "non-therapeutic" purpose on a person who is not competent to consent to it personally. The basis was that a superior court exercising its inherent protective, or "*parens patriae*", jurisdiction can *never* safely determine that a non-therapeutic sterilization is in the best interests of a person who is not competent to consent.

The judgment characterizes a "therapeutic" sterilization as one that is undertaken for the protection of *physical or mental health*, and a "non-therapeutic" sterilization as one that is undertaken for *general social purposes*. A general social purpose would include a sterilization for birth control or menstrual management.

In exercising the *parens patriae* jurisdiction, superior courts supervise the conduct of parents and guardians making decisions on behalf of the persons for whom they are responsible. In restricting the jurisdiction of the courts to therapeutic sterilization, the Supreme Court has similarly restricted the decision-making authority of a parent or guardian to therapeutic sterilization - what the court cannot do, a parent or guardian cannot do. Unless it is provided by statute, no authority exists at all to consent to a non-therapeutic sterilization on behalf of a person who is not competent to consent personally.

With the judgment in *Re Eve*, the problem in the law had shifted. The law is no longer uncertain. The cause for concern post-*Eve* springs from the limited scope of authority that exists to allow sterilization of a person who is not competent. Now, those who are not competent have a much more limited right to sterilization than others. Competent adults may choose to be sterilized *not only* for the "therapeutic" purpose of the protection of physical or mental health, *but also* for the so-called "non-therapeutic" or general social purposes of birth control and menstrual management. The latter right is not available to those who are not competent. Recent figures indicate that sterilization has replaced the pill in Canada as the leading means of contraception (of the 68.4% of Canadian women choosing contraception, 35.3% have been sterilized themselves and another 12.7% have a male partner who has been sterilized). If sterilization is the preferred method of birth control in use by persons who are competent to consent, might there not also be cases where it would be the preferable method of birth control for use by persons who are not competent to consent?

Moved by a concern, post-*Eve,* that the absence of jurisdiction to make a sterilization decision on the merits in individual cases may act to the detriment of persons within the affected class, the Institute decided to continue its study. We regarded our review of this

subject of the law as timely and of public importance. As a statute could be passed to resolve the problem, in our research we addressed what such a statute might and could contain.

B. Purposes of the Project

The purposes of this project have been:

* to examine the law relating to sterilization decision making for persons who are not competent to consent to sterilization on their own behalf,

* to consider whether legislation governing sterilization decision making for such persons is needed,

* to propose the contents of legislation, if it is needed, and

* in so doing, to propose a balanced law that would permit a sterilization to be performed in an individual case where it is for the benefit of the person to be sterilized and prevent a sterilization from being performed in a case where it would not be for the benefit of the person.

C. Conduct of the Project

In April 1988, the Institute published Report for Discussion No. 6 *Sterilization Decisions: Minors and Mentally Incompetent Adults*. It contains our tentative recommendations for reform of the law. We also published draft legislation to implement those recommendations. Our purpose in publishing a Report for Discussion was to consult on our tentative views and recommendations before issuing a final report.

We explained our purpose and issued an invitation to comment in writing in the preface to the Report for Discussion. We also enclosed a separate notice in each copy of

the report sent out. In it, we again invited comment in writing and announced dates, times and places at which persons or groups wishing to make representation in person could make an appointment to meet with representatives of the Institute.

We sent the Report for Discussion to persons and organizations on our regular mailing list - Members of the Legislature, the media, law firms, judges, and libraries. We also sent it to persons and organizations on a supplementary "special interest" list which included Cabinet Ministers of government Departments concerned in or affected by our tentative recommendations, physicians and other health care professionals, hospitals, community interest groups, and the like.

In forming our final recommendations, we have benefited from the comments and criticisms of those individuals and groups who responded, though this report is our own responsibility. We are grateful to have received their assistance. A list of contributors appears in Appendix A.

D. Scope of This Report

This report covers sterilization for any purpose. It applies to minors and to adults whom the law does not recognize as able to give an informed consent to sterilization. It *does not* apply to most adults because most adults are competent to give an informed consent, and the law presumes them to be so. It *does* apply to adults whose mental functioning is impaired to the degree that it renders them incompetent to give an informed consent. It *does* apply to most minors because most minors, by reason of immaturity of age, are not competent to give an informed consent. A minor is a person who is under 18 years of age.

E. Approach to this Report

Our objective in this report has been to recommend law that serves the interests of individuals who are not competent, because of mental disability or immaturity of age, to

consent to sterilization. It is our view that the law should apply fairly. It should not add to the disadvantages, social or otherwise, experienced by persons who are unable to make legally valid decisions for themselves. Our proposals would *not* permit the performance of a sterilization that would be contrary to the interests of the person whose sterilization is in question. They would *not* permit sterilization solely to suit the purposes or interests of persons other than the person for whom sterilization is being considered, although they would permit the needs of persons providing personal care to be considered insofar as they affect the best interests of the person.

F. Form and Content of Report

In our Report for Discussion, we:

- traced the social history and current practices relating to sterilization in the general population and the special population groups, i.e. minors and adults who are not competent to consent to sterilization, with which we are here concerned,

- gave a thorough account of the law on sterilization decisions, including its evolution,

- identified a need for reform of the law relating to sterilization decisions for minors and adults who are not competent to consent to sterilization,

- set out principles to guide that reform, and

- made tentative recommendations for a new statutory regime which we thought would better reflect the present day and foreseeable future needs of Alberta citizens, and could also serve as a model for other Canadian jurisdictions.

In this report, we will not repeat the detailed account of the social background to sterilization decisions, the medical considerations, the evolution of the existing law, its limitations and our assessment of the need for reform contained in Report for Discussion

No. 6. Readers wanting that information should obtain the Report for Discussion and treat it as a companion to this report.

Here, we will:

* sketch the legal and social background giving rise to the project,

* provide examples of difficult cases,

* make the case for reform,

* state our principles for reform,

* recommend the adoption of the legislation that we propose,

* explain the proposals embodied in the legislation, reporting on the issues raised and views expressed in the consultation process, and

* present the draft legislation.

G. Pronoun Gender

In this report, as in the Report for Discussion, we have used feminine pronouns in the text to reflect an incidence of sterilization of persons who are not competent to consent that is much higher among women than among men.

In the accompanying draft legislation, we have avoided pronouns as much as possible, employing combined pronoun references where pronoun usage is unavoidable. This is in accordance with the drafting convention adopted by the Drafting Section of the Uniform Law Conference of Canada in 1986.

H. Principal Recommendation

Our report contains only one recommendation and that is that the Legislature enact the proposals contained in the legislation presented above in Part II. That legislation consists of a draft *Competence and Human Reproduction Act* which is item A in Part II, and a draft amendment to the *Dependent Adults Act* which is item B.

CHAPTER 2 - THE EXISTING LAW

In this Chapter we will summarize the existing law governing sterilization in Alberta, describe its strengths and shortcomings, and illustrate some of its effects. A fuller analysis is contained in the companion document, Report for Discussion No. 6.

A. Requirement of Consent to Sterilization

(1) General Rule

There is no statute expressly governing sterilization. Therefore the common law applies. The general rule at common law is that the person seeking a sterilization must consent to its performance. A physician who performs a sterilization without first receiving the patient's informed consent faces liability in battery or negligence for wrongful interference with the person. The hospital in which sterilization is performed without a valid consent may be vicariously liable.

The doctrine of informed consent applies to any medical treatment. It has three elements: the patient must be competent to give a consent, know the procedure being consented to and agree voluntarily to its performance. The concept of competence to consent to medical treatment is usually expressed in terms of the patient having the capacity to understand and appreciate the nature of the proposed treatment, including the consequences (i.e. risks and benefits) of undergoing or foregoing it. Subject to certain exceptions, all three elements - competence, knowledge and voluntariness - must be present to protect the physician from liability. An exception exists at common law for medical emergencies.

A physician would be ill-advised to proceed when he has doubt about the competence of the patient to consent to sterilization. The hospital in which the sterilization is performed would be similarly ill-advised to permit the sterilization to proceeed in a case of doubt about the competence of the patient.

(a) Adults

Adults are presumed competent under the common law. A competent adult can consent to sterilization for any purpose.

An adult who is not competent or whose competence to consent is in doubt is in a different position. Where that adult has no guardian, a superior court can exercise its *parens patriae* jurisdiction to consent to sterilization on behalf of the person. In the case of *Re Eve* the Supreme Court of Canada established that this jurisdiction is limited to a therapeutic sterilization, that is, a sterilization that is undertaken for the protection of *physical or mental health*. It does not include a non-therapeutic sterilization, that is, a sterilization that is undertaken for *general social purposes*. Marginal cases must be brought to court for resolution.

A guardian may be appointed under the Dependent Adults Act to make decisions relating to the person of an adult who is repeatedly and continuously unable to care for herself, and to make reasonable judgments in respect of matters relating to her person.[6] Where a guardian with authority to make health care decisions has been appointed, the guardian or the Surrogate Court may make a sterilization decision for the purpose of "health care". (The Surrogate Court is the court having jurisdiction under the Dependent Adults Act.) Although "health care" is defined to include "any procedure undertaken for the purpose of preventing pregnancy",[7] it is likely that the authority to consent to sterilization is limited to a therapeutic sterilization because the statute does not clearly and unequivocally say that the authority goes further. The jurisdiction of the Surrogate Court, and of the guardians it appoints, to make orders authorizing non-therapeutic sterilization in the name of "health care" was debatable prior to the judgment of the Supreme Court of Canada in *Re Eve*. The *Eve* judgment makes it all the more likely that the wording of the definition of "health care" in the Dependent Adults Act is not wide enough to include the

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6 R.S.A. 1980, c. D-32, as am. S.A. 1985, s. 6.

7 *Id.* s-s. 1(h).

authorization of non-therapeutic sterilization. This leaves Alberta with no statute governing this type of sterilization.

(b) Minors

Children are born dependent and require care for many years. Most minors, for this reason, are *not* competent to consent to sterilization. A sterilization decision would be made either by a parent, as guardian at common law, or by a guardian named or appointed by statute in substitution for a parent, or by a superior court exercising its *parens patriae* jurisdiction. Because of the limits set in the *Eve* judgment, the authority of the decision maker is restricted to therapeutic sterilization, it does not include non-therapeutic sterilization, and marginal cases must be brought to court for resolution. In other words, parents cannot validly consent to non-therapeutic sterilization for their children. With the possible exception of a "mature minor" described in the next paragraph, no one can. Non-therapeutic sterilizations cannot, therefore, be performed upon minors.

The need of children to be cared for continues through minority, although as a child matures, she becomes increasingly capable of caring for herself. A minor with sufficient maturity may be competent to consent to sterilization. In this case parental authority ceases, the "mature minor" rule applies and the minor may make a sterilization decision as if she were a competent adult.

B. Persons Not Competent to Consent: Restriction to Therapeutic Sterilization

The *Eve* judgment is examined in detail in Report for Discussion No. 6. Here we will simply summarize the advantages and disadvantages of the restriction, in the *Eve* judgment, of the consent of a parent or guardian or the court to *non*-therapeutic sterilization.

(1) Advantages

The foremost advantage of the restriction placed on the authority to consent by the *Eve* judgment is this:

* in saying that non-therapeutic sterilization lies beyond the reach of the court's *parens patriae* jurisdiction, the judgment underscores

  * the seriousness of sterilization as an intervention,

  * the importance of respect for the autonomy of the individual, and

  * the enormity of the consequences of sterilization.

    (The judgment emphasizes that sterilization is "in every case a grave intrusion on the physical and mental integrity of the person" which "ranks high in our scale of values"; it "removes from a person the great privilege of giving birth"; and it is "for practical purposes irreversible".)

Other advantages are that the judgment:

* settles the common law,

  (The court has said, unanimously, that superior courts do not have *parens patriae* jurisdiction to authorize a non-therapeutic sterilization on behalf of a person who is not competent to consent personally and, following from this, if courts cannot make the decision neither can parents or guardians.)

* requires parents, guardians or others to bring cases where the presence or absence of competence is not certain to court for decision, and

* specifies certain evidential and procedural standards that must be satisfied in the cases that are brought to court, for example,

    * the onus of proof lies with the person seeking to have the sterilization performed,

    * the burden of proof, "though a civil one, must be commensurate with the seriousness of the measure proposed", and

    * it is "essential that the mentally incompetent have independent representation".

(2) Disadvantages

At the same time the judgment leaves the law with a number of shortcomings:

* The limitation on the jurisdiction to consent to a non-therapeutic sterilization is a blanket one - the superior courts are denied the opportunity to consider individual cases on their own merits in order to determine whether a sterilization would be in the best interests of a person who is not competent to consent for herself notwithstanding that its purpose is non-therapeutic.

* The consequences are extreme - whereas a parent or guardian can consent to a therapeutic sterilization, no one, not even a superior court, can consent to a non-therapeutic sterilization.

* The judgment gives little guidance on where the line between therapeutic and non-therapeutic sterilization lies.

* The judgment takes a restrictive approach to the meaning of "best interests", having placed the preservation of the capacity to reproduce above other values and human needs such as:

    * avoiding the adverse side effects of long-term (or even short-term) use of birth control pills or hormonal suppressants like Depo-provera,

    * escaping the physical risks and pain of delivery,

    * being spared the burden of children and the stress of parenting (e.g. family planning for a young woman who already has or has had children, or who is disinterested in children, loathes them or has shown physical abusiveness toward them,

    * avoiding the sense of loss associated with the removal, by child welfare authorities, of an infant for whom the parent lacking competence to consent may have the normal feelings of love and attachment,

    * maintaining the sense of accomplishment and satisfaction from paid employment or social recreation that would be jeopardized by pregnancy and child care responsibilities,

    * facilitating the freedom to form relationships and experience sexuality without risking pregnancy or paternity, and

    * having the chance to lead a relatively free, minimally supervised life in the community.

* The judgment is silent about the scope of authority, if any, for the common practice of parents and guardians and courts to make decisions about the use of birth control methods other than sterilization on behalf of mentally disabled persons in their care.

* The judgment does not discuss the placement of the line between competence and incompetence to make a sterilization decision.

* The judgment gives little help on the application of the *Canadian Charter of Rights and Freedoms*, saying essentially nothing more than that it would apply.

C. Effect of the Restriction

The blanket prohibition on sterilization for a "non-therapeutic" purpose laid down in the *Eve* judgment changed the picture dramatically for persons who are not competent to consent to sterilization.

As stated in the opening paragraphs of Chapter 1, prior to the *Eve* judgment, sterilizations for a wide range of purposes were being performed on minors and adults who were not competent to give an informed consent. Concerns were being expressed about the absence of sufficient legal safeguards.

The judgment in *Re Eve* laid these concerns to rest by sheltering persons who are not able to give an informed consent from non-therapeutic sterilization. It established that no authority exists at common law to consent to sterilization for birth control or menstrual management on behalf of a person who is not competent to consent for herself.

In foreclosing consideration of the circumstances in individual cases, the *Eve* judgment deprived members of the class of persons who are not competent to consent to sterilization of access to the most popular form of birth control of choice among persons in the general population. Where other forms of birth control have proven inadequate, females who are members of this class are now unable to engage in normal sexual activity without running the risk of becoming pregnant; males are now unable to do so without running the risk of causing pregnancy. The message "we will not risk letting you have babies" of the eugenic sterilization days has changed to the message "we insist that you risk having babies" of the modern era.

Access to the elective use of hysterectomy for menstrual management is likewise denied to individuals who are not competent to give an informed consent for this purpose.

Because the position of the boundary between a therapeutic sterilization and a non-therapeutic sterilization is not entirely clear, a parent or guardian may have difficulty determining the limits of the decision-making authority.

Post-*Eve*, acting on the advice of their solicitors, physicians and hospitals are choosing to err on the side of caution. They are refusing to accept the consent to sterilization for birth control or menstrual management of a person whose competence to give it is uncertain. The person seeking the sterilization must bring the case to court or abandon thought of obtaining a sterilization. A consequence is that the class of persons denied access to non-therapeutic sterilization in practice is likely larger in size than the class of persons denied access to non-therapeutic sterilization in law.

Two cases will serve as illustrations. Both are based on the facts of true Alberta situations.

Case #1 - Marie is a mentally handicapped woman in her mid- 20's. She has good verbal and motor skills but poor comprehension, and is a dependent adult, a guardian having been appointed under the Dependent Adults Act to make health care and other decisions for her. Marie lives in the community in a stable relationship with Joe. Joe is also mentally handicapped. Both Marie and Joe had been institutionalized when they were younger and that is where they met.

Marie and Joe have one child - a normal, healthy girl. In proceeding to have a child they faced repeated obstacles. First, her doctor advised that because she was "mentally handicapped" Marie should undergo an abortion. Later, another doctor suggested that Marie should undergo a tubal ligation at the time of birth. Then, child welfare authorities threatened to apprehend the child at birth on the basis that the couple would be unable to provide proper care. The guardian's assistance was essential in overcoming

all three obstacles. The child welfare authorities were persuaded to allow the couple to demonstrate their child rearing skills before assuming that there was a problem, and they cooperated by providing house support and parent counselling.

Six months after the birth of the child, Marie raised the subject of birth control. The pregnancy had been difficult for her. She was bewildered by her changing figure, her awkwardness and her sense of fatigue. While Marie and Joe were able to care for the baby with help provided by child welfare authorities, Marie was adamant that she did not want more children. Marie had experienced many vaginal infections which her doctor felt precluded the use of an intra uterine device. The pill, condoms and diaphragms were rejected as impractical to manage, and not fully reliable. Joe refused to consider a vasectomy.

Sterilization by tubal ligation appeared to be the most appropriate method of birth control. Marie was strongly in favour of the sterilization but legally she could not give consent. Her guardian supported her decision as the only practical and viable solution for the couple. However, the purpose of the sterilization was non-therapeutic. It could not be justified on the basis of medical need. Therefore the guardian would not have authority to consent to its performance. Going to court would not help, because the *Eve* judgment establishes that the court would not have jurisdiction to consent to a non-therapeutic sterilization either.

Again, impediments stand in the way of normal decision making. Unlike other women wishing to prevent conception, Marie must run the risk of future pregnancy and its effects which are, for her, adverse.

Case #2 - Janice is a multiply handicapped 14-year-old girl. Mentally, she functions at the level of a child of 5 years. Because of her physical disability, any rotation or movement of her hips brings pain. Janice is also afflicted by menorrhagia. With this condition she menstruates much more frequently than normal. During menstruation she

bleeds so profusely that her pads require changing as many as 12 times a day. Because of her hip problem, every change causes her discomfort which is agonizing to observe.

Janice is unlikely ever to bear children. Her mother, a concerned, caring and conscientious person, favours hysterectomy to spare her the repeated distress associated with the management of her menstrual hygiene. Her physician agrees that hysterectomy would be the best course. However, one purpose of the hysterectomy would be menstrual management and the Supreme Court said in the *Eve* case that hysterectomy would be excessive for this purpose. Because the physician is not sure that the hysterectomy would be therapeutic in the sense of the *Eve* judgment, he has refused to accept the consent of the mother to perform the sterilization. The mother is left with the option of applying to the court for an order authorizing the sterilization as therapeutic. Lacking financial means, she is unable to take this course of action. As a result Janice is left to endure her situation.

CHAPTER 3 - THE CASE FOR REFORM

In this Chapter, we will restate the problem, examine the need for reform of the law by the Legislature, state the Institute's position and give our principles of reform.

A. Statement of the Problem

According to law, some persons are not competent to give an informed consent to sterilization. The law provides a means of authorizing sterilization on behalf of a person who is not competent for some, but *not* all, of the purposes for which sterilization is available to persons who are competent. The problem is to determine whether the distinction in the availability of sterilization is appropriate and, if it is, whether the distinction applies fairly.

B. Perspectives on the Need for Reform

Is there a need for reform? This threshold question was the most contentious issue we faced in consultation on the Report for Discussion. The dramatic shifts in law and practice outlined in the introductory paragraphs of Chapter 1 underscore the complex and controversial nature of the issue of sterilization decision making with respect to persons who are not competent to consent personally. The subject calls into play questions about rights of autonomy and privacy and a diverse array of values relating to procreation and to the constitutents of a quality life.

The comments we received stretched across a broad spectrum of opinion. At times, the opinions were laden with emotion.

The view at one end of the spectrum was that sterilization should be left to the parent or guardian to decide in consultation with the physician. The view at the other end was that no sterilization should be performed except with the "informed consent" of the person to be sterilized. Between these two views lay other views. One such view was

agreement that *Eve* is overbroad. According to this view, some legislated mechanism should be developed that would (i) permit careful decisions for sterilization and (ii) satisfy the depth of scrutiny under the *Charter* that the Supreme Court said, in *Eve*, the courts would give such legislation.

Some respondents complimented the Report for Discussion as being "very noteworthy and appropriate", "both useful and fruitful", and providing "an exceptionally valuable stimulus to informed discussion". Other respondents saw it as being premised on treating persons who are not competent to consent to sterilization "unequally, unjustifiably and contrary to what is acceptable in Canadian society", "perpetuating attitudes we should be working to change", and "an affront to the notion of 'individual choice' implicit throughout the *Canadian Charter of Rights and Freedoms*".

Some respondents favoured legislation, saying that "sterilization of handicapped individuals at one time may have been too routine but the law has now gone to the other extreme"; that there should be "consideration of individual cases"; that each case should be "judged on its own merits"; and that we "do not believe that non-therapeutic sterilization decisions must, in all circumstances, remain with the person". Other respondents were opposed to our tentative recommendations, vowing to marshal all the resources at their command to resist the introduction of legislation that would allow sterilization to be performed for birth control or menstrual management without the consent of the person to be sterilized. They asserted that legislation would "seriously undermine some of the most fundamental rights due individuals with a mental disability", that it would "undermine the constitutional right of individuals to provide 'informed consent' prior to the performance of medical procedures upon their person".

Some pointed out the importance of affording adequate protection to the person for whom sterilization is being considered. Others stated that the procedures should not unduly delay decision.

C. The Institute's Position

The Institute agrees fully with the Supreme Court of Canada in saying that sterilization is "*not* a decision to be lightly undertaken". We are acutely aware that "the great privilege of giving birth" or "basic human right of procreation" is involved. We are also acutely aware that "a very difficult situation is presented when a person is physically capable of reproduction yet unable to understand or appreciate any of the physical, intellectual or emotional aspects involved," to borrow the words of one respondent.

After searching deliberation, we continue to be of the opinion that no person should be denied access to sterilization because she is not competent to consent. In other areas of law where a person is not competent to make her own decision the law provides a means of making the decision for her. The decision must be for her benefit.

Sterilization for birth control is in widespread practice among members of the general population. We infer from this fact that members of the general population regard sterilization for this purpose to be personally beneficial. We are persuaded that there are cases in which sterilization for birth control or menstrual management would be personally beneficial to a person who is not competent to consent. The cases described at the end of Chapter 2 provide two examples. In our opinion, the law should not deprive a person in the affected class of access to a decision based on her individual circumstances.

In coming to this conclusion, we have weighed "[t]he irreversible and serious intrusion on the basic rights of the individual" against "the possible advantages" which, according to the Supreme Court of Canada, "from the standpoint of the individual, are highly debatable."[8] We have weighed the public interest in protecting from abuse members of the class of persons who are not competent to consent to sterilization against the interest of individual members of that class in obtaining a decision on the merits of the individual case. Protecting a class of persons involves the risk that the individual interests of some

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8 *Supra* n. 1 at 32.

members of that class will be sacrificed. Permitting decision in individual cases involves the risk of a wrong decision being made.

Our conclusion is that the law should provide the means whereby a sterilization decision that any other person in society can make for herself can be made for a person who is not competent to consent. In arriving at this conclusion, we take up the challenge left open by the Supreme Court of Canada when it said that if non-therapeutic sterilization is to be permitted at all, then it is up to the legislature to enact legislation.[9]

We are confident that the contents of our proposals meet and overcome the reasons given by the Supreme Court in *Eve* for excluding non-therapeutic sterilization from the scope of the *parens patriae* jurisdiction of superior courts. Our proposals provide the "well thought-out policy determinations reflecting the interest of society, as well as of the person to be sterilized"[10] to which the Court referred in extending the invitation to legislators to legislate on this subject. They require that specific information be introduced in evidence to adequately inform the judge hearing the case of the factors that are relevant to the sterilization decision. They provide principled guidance for the judge to follow in applying the best interests test to the facts at hand. If enacted, we are confident that the safeguards contained in our proposals would protect against a wrong decision. Furthermore, we think that our position is consonant with the goals of equality and normalization.

D. Principles of Reform

In Report for Discussion No. 6, we espoused four guiding principles for reform of the law to permit decisions regarding sterilization for medical treatment, birth control or menstrual management to be made on behalf of a person who is not competent to consent to sterilization. We now adopt these principles, expanding on the fourth one:

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9 *Id.* at 32-33.

10 *Id.* at 33, quoting from *Re Guardianship of Eberhardy* 307 N.W. 2d 881 at 895.

* A sterilization should be performed only where it is in the best interests of the person for whom sterilization is sought, and not where its purpose is to benefit others.

* A sterilization should be a last resort, other alternatives having been shown to be inadequate for the intended purpose.

* The dignity, welfare and total development of the mentally incompetent person for whom sterilization is sought should be respected at all times.

* The procedure for decision should require that

    * the person whose sterilization is being considered be informed of the factors affecting the decision,

    * the person be assisted, to the full extent that her intellectual capacity allows, to participate in making a decision, and

    * the wishes of the person, after having been so assisted, be ascertained and made known to the decision maker,

and otherwise ensure the protection of the first three principles.

CHAPTER 4 - THE PROPOSALS FOR REFORM

A. Principal Recommendation

Our proposals are for the introduction of a new, statutory regime of sterilization decision making for a person who is not competent to consent to sterilization. If enacted, the proposals would empower a judge of the Court of Queen's Bench to make a sterilization decision on behalf of a person after giving full consideration to the circumstances of the individual case. The proposals are replete with protections designed to ensure that the performance of a sterilization would be authorized only where it is in the best interests of the person for whom it is being considered.

We are not saying that the new legislation should be enacted in the precise form of our drafts. We do, however, recommend that the Legislature enact legislation which will give effect to the substance of what the two pieces of draft legislation contain.

The discussion in this chapter is explanatory of the proposals put forth in Part II. In this chapter, we will draw attention to points raised in consultation and changes made in the final proposals, because of them, to the tentative recommendations in the Report for Discussion.

B. Scope of Legislation

(1) Definition of "Sterilization"

We have defined "sterilization" to mean "a surgical operation or other medical procedure or treatment that will or is likely to render a person permanently incapable of natural insemination or of becoming pregnant." The definition is not restricted to sterilization by surgical means but includes a medical procedure or treatment that is likely to cause permanent infertility.

It is not unusual for caregivers to administer contraceptive pills to a female who is not competent to consent, or to arrange for the insertion of an intra-uterine device for birth control. It is not unknown for caregivers to administer chemical substances for menstrual management. Such measures are usually employed as short-term expedients, and fertility or menstruation returns when their use is abandoned. But they are not risk-free. In some instances, sterilization may even occur, as an (unintended) secondary effect, with use over time. Although interference with the reproductive capacity takes place, the bodily invasion is less dramatic than sterilization by surgical operation, the causal connection between the procedure or treatment and the (eventual) infertility is more tenuous, sterilization is not inevitable and it does not occur (or is not discovered) instantaneously.

The focal issue from the legal, ethical and political perspectives would appear to be the preservation of the *capacity* to reproduce. Provided that the measure introduced does not obviously *eliminate* the capacity, interference with reproduction seems to be generally regarded as *un*objectionable.

Despite popular attitudes to the contrary, the considerations relating to the use of contraceptives or other means to control birth, and of chemical substances to suppress menses, are similar in kind, if not degree, to the considerations relating to surgical sterilization. Moreover, medical advancements are being made in the development of orally ingested and injectable contraceptives and menstrual suppressants with longer term effects. Concurrent medical advancements are being made in the search for ways to successfully reverse surgical sterilizations. With improvements in medical knowledge and technology, the now vivid distinction between surgical sterilization and other methods of inhibiting reproduction can be expected to fade.

Our proposals make ready for the future. But we do not want them to affect the practice of parents, guardians and other caregivers who are employing temporary measures of birth control and menstrual management. The emphasis in our definition of sterilization is therefore on the likely *permanence* of the loss of the ability to procreate.

(2) Purposes of Sterilization

Our proposals distinguish between three purposes of sterilization: (i) sterilization for necessary medical treatment; (ii) sterilization for non-necessary medical treatment and birth control, which we have called "elective sterilization" in recognition of the optional nature of the sterilization, and (iii) sterilization for menstrual management, which we have called "hysterectomy for menstrual management" to emphasize the major surgery required. The latter two categories together approximate the concept of non-therapeutic sterilization used in the *Eve* decision.

(a) Sterilization for Necessary Medical Treatment

(i) Definition

We have defined a "sterilization for necessary medical treatment" as one that is medically necessary for the protection of the physical health (including the life) of the person to be sterilized. Examples are:

* sterilization to remove a diseased organ, and

* sterilization of a sexually active, fertile woman with a disease (e.g. active tuberculosis, or severe heart, kidney or circulatory disease) that makes pregnancy dangerous to her physical health.

(ii) *Exclusion* from Proposals

Sterilization for necessary medical treatment would be statutorily excepted from the new regime. The effect of the exception would be that the existing law of consent to medical treatment would apply to a sterilization for necessary medical treatment, without the need for a court order. In most cases the consent would be given by the guardian of

the person, who in the case of a minor would be a parent. Any delay and cost associated with bringing an application under the legislated procedure would thereby be avoided.

A point to note is that *mental* health has been excluded from the definition. The reason for the exclusion is *not* that we do not construe mental health as a health risk. Rather, it is that we want the protection afforded by the statute to be applied where there is doubt about the benefit to the person to be derived from sterilization. Such doubt is more likely to arise where the person for whom sterilization is being considered suffers from a mental health problem alone.

(b) Elective Sterilization

(i) Definition

We have defined "elective sterilization" to mean a sterilization that is neither a sterilization for necessary medical treatment nor a hysterectomy for menstrual management. The category is residual.

We would give the definition of "elective sterilization" wide scope because we find the line between sterilization for a therapeutic purpose and sterilization for a non-therapeutic purpose difficult to discern. Similar factors are likely to be raised where the purpose of the sterilization is the protection of mental health and where the purpose is birth control. We think that the full circumstances of the person should be looked at and all relevant factors considered.

Examples of elective sterilization include sterilization where:

* a further pregnancy would increase the probability of serious complication with subsequent births (e.g., a series of prior births by Caesarian section),

* a congenital or hereditary disease makes it probable that pregnancy would result in a still-born child,

* a further pregnancy would jeopardize a woman's mental health (e.g., she has two children now and can't cope with the stress, or she suffered a post-partum depression after a previous birth, or agonized over the removal of a child whom she was incapable of raising),

* menstruation would provoke a phobic reaction to blood,

* offspring are not wanted, or the social and psychological burden of bearing and caring for offspring would be inordinate,

* the financial burden associated with raising children would be intolerable, or

* the care available for the person for whom sterilization is being considered would become less personal or otherwise less beneficial (e.g., she may have to be moved out of the home if the family or other primary caregiver would be overburdened by the supervision of social conduct and monitoring of sexual activity or caring for offspring).

(ii) Inclusion in Proposals

Elective sterilization would come under the new regime. Sterilization for optional medical treatment for the protection of physical health would come in here, as would sterilization for the protection of mental health. Sterilization for these purposes is possible under the existing law, on the consent of a parent or other guardian or of a superior court in the exercise of the *parens patriae* jurisdiction.[11] Bringing the cases into the new regime

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11 *Id.* at 32.

would better protect the individual for whom sterilization is being considered from the risk of wrong decision.

Sterilization on the boundary between therapeutic and non-therapeutic sterilization would come in here. Marginal cases - cases lying near the boundary - ought to be brought to a superior court under the existing law for a decision rendered *parens patriae*.[12], in any case.

Sterilization for birth control alone would also be brought under the definition. Here the new regime would clearly extend the jurisdiction of superior courts under the existing law in a case where the benefit of sterilization to the person outweighs the disadvantages.

The inclusion, in the definition of "elective sterilization", of a wide range of elective purposes does *not* mean that an order authorizing the sterilization would be granted. To the contrary, defining a broad residual category helps to ensure that a sterilization would *not* be performed *unless* it has been authorized by an order granted under the legislation. The rigorous substantive and procedural protections against wrongful sterilization afforded by the proposed statutory regime would come into play.

To make it absolutely clear that the jurisdiction is interpreted to extend this far, the proposed legislation would stipulate that the authority to perform a sterilization shall not be refused merely because the sterilization is not necessary for the protection of the physical or mental health of the person.

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12 *Id.*

(c) Hysterectomy for Menstrual Management

(i) Definition

We have defined "hysterectomy for menstrual management" to mean a sterilization that is performed by removal of the uterus for the purpose of eliminating menses, but is not a sterilization for necessary medical treatment. An example is a hysterectomy to facilitate the integration into the community of a mentally disabled woman who cannot manage menses.

(ii) Inclusion in Proposals

Hysterectomy for menstrual management would come under the new regime. We have struggled in coming to the decision to include it. The Supreme Court of Canada came down hard against sterilization for menstrual management in the *Eve* judgment, calling hysterectomy a "drastic measure" that is "clearly excessive" for this purpose.[13] Advocates for mentally handicapped persons assert that "to justify this invasion of a person's bodily integrity on the basis of the right to have the opportunity to avoid menses is unethical".

We do not doubt that the circumstances in which hysterectomy for menstrual management could be justified would be extremely rare. We have, however, been presented with the facts of a case in which caring and concerned parents have decided to seek a hysterectomy for their daughter, a woman who "could not manage menstruation properly - in the manner most females would". The parents have the support of the local association for the mentally handicapped, an association that would ordinarily be opposed to hysterectomy for menstrual management.

We will not detail the facts here except to say that the situation is a moving one. Without a realistic solution to the menstrual problem, the daughter stands to lose

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13 *Id.* at 32.

educational and social opportunities. She would not be capable of parenting in the future, so has little to gain from continuing menstruation. In defending their position, the parents point out that within the 'normal' population, interference with the reproductive function is permitted where persons *cannot cope* with the consequences.

After careful deliberation, we remain of the view that jurisdiction to authorize a hysterectomy for menstrual management in exceptional circumstances should be conferred under the new regime. Our proposals provide for the jurisdiction to be exercised by a superior court judge who may *grant* or *refuse* an order following presentation of the facts and argument on the issue. Authority would be given to grant such an order only where sterilization by other means would not solve the particular problems in a given case.

On balance, we adhere to the view that the law should permit the facts in a case like this to be presented and the issue argued, and that a superior court judge should have jurisdiction to grant an order where he is satisfied that the short and long term gains to the person to be sterilized outweigh the disadvantages. We again express our confidence that the many protections provided in the proposed legislation would more than adequately protect the person who is the subject of the application from the risk of error.

(3) Persons Affected

Our proposals cover individuals in two categories. One category is adults who are not competent to consent to sterilization. The other category is minors.

(a) Adults who are not Competent to Consent to Sterilization

(i) Meaning of "Competent"

Our proposals would apply in the case of an adult who is *not competent* to consent to sterilization. The test of competence that we propose is modelled on the language most

frequently used in law to express the test of competence to consent to medical treatment.

A person would be competent to consent to an elective sterilization if he or she is able to understand and appreciate

(a) the nature and consequences of natural insemination, pregnancy and childrearing,

(b) the nature and consequences of the proposed sterilization including that it will or is likely to render the person permanently incapable of natural insemination or of becoming pregnant, and

(c) the consequences of giving or withholding consent.

A female adult would be competent to consent to a hysterectomy for menstrual management if, in addition to being competent to consent to an elective sterilization, she is able to understand and appreciate

(a) the nature and consequences of menstruation, and

(b) the nature and consequences of the proposed hysterectomy including that the loss of the uterus will render her permanently incapable of becoming pregnant.

(ii) Determination that an Adult is "Not Competent"

Because adults enjoy a presumption of competence in law, under the proposals jurisdiction to make a substitute sterilization decision would not arise until a finding had been made that the person to be sterilized was not competent to consent personally. The finding is a prerequisite to the jurisdiction of the court to make a sterilization order. It is extremely important to the outcome because, where the person to be sterilized is an adult,

the finding overturns the presumption of competence and removes from her the right to make the decision for herself.

We point out that the words "not competent" are used in this report in a narrow and technical *legal* sense. Competence, in law, is a concept that is specific as to the ability of a person to perform a given *legal* task at the time in question. The words "not competent" should not be confused with clinical classifications of mental dysfunction - such as mental retardation, dementia, or (rarely) mental illness - employed for diagnostic and treatment purposes, or for assessment leading to placement in training or other programs. They do not imply a moral judgment. The distinction is not always easy to grasp.

Only a small proportion of persons classified for some other purpose as having a mental disability would not be competent in law to make a sterilization decision. To the extent that our proposals, when applied, are restricted to persons who are unlikely to become competent, they would reduce the class of persons who may be sterilized without personal consent even further.

We do *not* presume that persons with mental handicaps are not competent to consent. One respondent to our Report for Discussion mistakenly believed the opposite.

Again we emphasize that notwithstanding the finding that a person is not competent, the order authorizing sterilization may be *refused*. Sterilization would *not* follow automatically.

(b) Minors

This project deals with the manner in which a sterilization decision would be made for a minor who is not competent to make the decision personally. It does not involve reform of the law relating to the competence of minors.

As previously stated, in normally developing minors, under the "mature minor" rule, a minor who has the requisite degree of understanding and appreciation for the purpose at hand can give a valid consent. (On the attainment of age 18, the presumption of competence applicable to adults comes into effect.)

We accept the common law view that a "mature minor" may be competent to consent to medical treatment. The application of the "mature minor" rule would include consent to the performance of a sterilization for necessary medical treatment. Our proposals would recognize the competence of a *mature* minor to consent to sterilization for necessary medical treatment by excepting a sterilization for this purpose from the proposed regime.

It is uncertain whether the common law would recognize the competence of a "mature minor" to consent to sterilization for any purpose. This issue has been discussed in academic writings, but it has not been determined by the courts. Our proposals would require the sterilization of a minor for any purpose other than necessary medical treatment to be authorized under the new regime. The proposals include *both* minors who are expected to mature to competence in the normal course of development *and* minors whose mental disabilities are so severe that they may *never* attain competence. Minors in both groups ordinarily lack the maturity to make decisions for themselves and, where this is the case, are regarded as *not competent* for many purposes of law.

We have included *all* minors in the category of persons for whom the authority to perform an elective sterilization or a hysterectomy for menstrual management must be obtained under the Act for several reasons:

* The proposed legislation applies generally to persons who are *not* competent to consent to sterilization - it is this inability that is the common trigger to its operation.

* The proposed legislation is rooted in the philosophy of decision based on individual circumstances - in our view, it would not be appropriate to introduce artificial distinctions requiring minors to be divided into classes for purposes of the operation of the legislation.

* The proposed legislation is protective in purpose - the many stringent requirements embodied in the proposals are intended

    * to protect a person who is not competent from a sterilization that is not in her best interests as well as to make possible a sterilization that is in her best interests,

    * to ensure careful consideration of the decision to undergo or to forego sterilization, and

    * to guard against ill-thought out decisions, premature decision, the whims of youth, the vulnerability of dependency, and the unchecked influence of others on the consent to sterilization of a person whose competence is marginal.

In all cases, the judge would be required to consider:

* the age of the person for whom sterilization is sought - we have added "age" to the list of factors in this report - and the likelihood that the person will become competent to make her own decision, and

* the wishes and concerns of the person which would be ascertained after she has been informed of the relevant facts to the full extent that her capacity allows.

In all cases,

* the person for whom sterilization is being considered would be independently represented by a lawyer who would take instructions from the person to the extent that she is able to give them and, to the extent that she is not, would represent her interests.

In consultation, we received two vastly disparate responses to our proposals with respect to minors. At one extreme, it was suggested that a minor who is competent to consent to medical treatment at common law should be regarded as competent to consent to sterilization for any purpose. Her consent should be the only prerequisite needed for a physician or hospital to perform a sterilization procedure.

There is apparent merit in this position. The equality section of the Canadian Charter guarantees protection against discrimination on the basis of age,[14] as does our provincial human rights legislation.[15] However, given the strong cultural value attached to preservation of the capacity to procreate, we think a distinction based on age is justified where sterilization for non-necessary medical treatment is in issue. Our justification runs thus: (i) the power of procreation is a valuable one, (ii) young persons do not have sufficient maturity to foresee the long-term implications of its irreversible removal, and (iii) the passage of a relatively short period of time will remove the obstacle (i.e., the person can give consent and be sterilized upon obtaining the age of majority, currently 18 years of age).

At the other extreme, it was urged that sterilization procedures "ought never to be performed on minors", even where the mental disability leaves modest or no hope that the minor will ever become competent to make a sterilization decision. (An exception would

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14 Canadian Charter of Rights and Freedoms, s. 15, enacted as Schedule B to the *Canada Act 1982*, (U.K.) c. 11.

15 Individual's Rights Protection Act, R.S.A. 1980, c. I-2.

presumably be made for sterilization for necessary medical treatment.) The proponents of this view take the position, as an undisputed fact, that "the full potential of any child remains undiscovered until sometime beyond the age of majority". The prohibition on sterilization would give all minors an equal opportunity to develop their potential capabilities. This would allow a more accurate assessment to be made of the extent to which incompetent behaviour is attributable to immaturity and the extent to which it is attributable to other causes.

We think that the adoption of this position would lead to real injustice in certain exceptional cases. For example, the evidence in a particular case may not support the hypothesis that appreciable improvement in the capabilities of the person will occur in the future. In our view, a superior court judge can be relied on to act prudently and with due caution when properly informed of the facts in a case before him.

C. Decision Maker: A Judge of the Court of Queen's Bench

Under our proposals, the jurisdiction to make an order authorizing the performance of a sterilization on a minor or adult who is not competent to consent would be conferred on a judge of the Court of Queen's Bench.

The Court of Queen's Bench is appropriate because it is a superior court having plenary jurisdiction. Superior court judges are practiced in recognizing and enforcing individual rights, and in determining competence for various purposes. This forum has the advantages of independence, impartiality, and established public credibility. Judges are accustomed to providing the persons who should be heard with an opportunity to be heard. They are used to hearing and assessing the evidence of witnesses, including experts. Reasons for court decisions are published. Furthermore, in light of the judgment in *Re Eve*, it is our opinion that both courts and legislators would regard the issue as too important to be left to any decision maker other than a judge of a superior court.

One respondent expressed concern about the added expense on the caregivers of going to court for a judgment and suggested that the parents and at least two doctors should make the sterilization decision. While we acknowledge that one of the disadvantages of going to court could be the cost of the proceedings to the participants, the still recent history of excessive use of sterilization militates against the suggested solution. More stringent safeguards are needed to protect against error or abuse in decision making leading to interference with what is to many persons a "fundamental right of human reproduction". The provision which we propose on costs is designed to alleviate the expense associated with going to court for an order authorizing sterilization where financial hardship exists in an individual case.

D. Sterilization Decision: Best Interests Test

Before making an order authorizing sterilization, the judge would be required to satisfy himself that it would be in the best interests of the person for the sterilization to be performed. He would do so on the basis of the evidence put forward by the parties or the evidence obtained as a result of his own inquiry, or a combination of the two.

In consultation, some respondents objected that the "best interests" test does not protect against improper considerations being taken into account - that it is "often a subjective test of the judge hearing the case rather than one that injects a guarantee of objectivity". These respondents were not convinced that the tentative recommendations in Report for Discussion No. 6 would resolve this problem.

It is true that the "best interests" test is not easily defined. It is also true that, in attempting to apply the opinion of a reasonable person to the particular circumstances of the individual for whom the decision is being made, the test leaves considerable discretion with the decision maker. We know that in the *Eve* judgment the Supreme Court of Canada held that the "best interests" test was inadequate to guide the court in making a decision about sterilization for a non-therapeutic purpose under its *parens patriae* jurisdiction, but

that courts in other jurisdictions have not held these reservations.[16] We also know that the Court in *Eve* left the door open for the enactment of legislation.

The disadvantages of the "best interests" test viewed from the perspective of those who are strictly opposed to sterilization for birth control and menstrual management where personal consent cannot be given are, of course, the advantages viewed from the perspective of those who see the possibility of benefit from sterilization in an individual case. Persons holding the former view will take objection to the application of *any* test that permits the authorization of sterilization in these circumstances.

We have adopted the latter point of view. From that perspective, we can see several good reasons for adopting the "best interests" test:

* It is known in law, being the common law test traditionally invoked for making decisions on behalf of another.

* It is consistent with the test applied in making related decisions, being the test that applies to medical treatment decisions made by a parent or guardian for a person in his charge, and by the superior courts in the exercise of their *parens patriae* jurisdiction.

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16 Other courts have held that drawing a line at the boundary between therapeutic and non-therapeutic sterilization is not helpful in determining whether a sterilization is in the best interests of a particular individual. The House of Lords, in the English case of *Re B (A Minor)* [1987] 2 All E.R. 206; 2 W.L.R. 1213, held that the proper test is the best interests of the individual in all of the circumstances of the case. So did Anderson J. of the British Columbia Court of Appeal, in the Canadian case of *Re K and Public Trustee* (1985) 19 D.L.R. (4th) 255 decided before *Eve*. There is also a line of American authority to this effect: *e.g. In re Grady*, 426 A. 2d 467 at 479-81 (N.J.S.C. 1981); *Wentzel* v. *Montgomery General Hospital*, 477 A. 2d 1244 at 1253 (Md. C.A. 1982); *In re C.D.M.*, 627 P. 2d 607 at 609-12 (Alaska S.C. 1981).

* It is a flexible test, capable of being applied to meet "all of the evolving dimensions" of the interests of the incompetent person.[17]

* It is an expansive test, extending consideration to all relevant evidence including the views of the person whose sterilization is in issue.

It is our opinion that our proposals satisfactorily answer the criticisms about the best interests test. They provide the guidance the Supreme Court of Canada found wanting under the *parens patriae* jurisdiction. Among other safeguards, we point to strictures such as:

* the requirement of decision by a superior court judge,

* the inclusion of a list of factors the judge is obliged to consider to ensure that he has the fullest possible information on which to decide

* the requirement of expert evaluation on competence, and on factors affecting the sterilization decision, and

* the zealous independent representation of the interests of the person whose sterilization is in issue.

E. Factors for Judge to Consider

(1) The Factors

Before making an order authorizing a sterilization the judge would be required to consider the factors enumerated in a statutory list - factors of the sort that a person who

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17 Bernard M. Dickens, "Reproduction Law and Medical Consent" (1985) *U.T.L.J.* 255 at 271.

is competent would ordinarily weigh in coming to a personal decision. All of the factors would be weighed from the perspective of their impact on the best interests of the person for whom sterilization is being considered, and not from the perspective of their impact on the interests of others.

The factors are simply listed in this section and will be discussed in paragraphs (2) to (4) below.

(a) Elective Sterilization

For an elective sterilization, the foremost factor would be:

* the wishes and concerns expressed by the person for whom sterilization is being sought, to the extent they can be ascertained.

(These wishes and concerns would be ascertained and introduced in evidence after steps have been taken to inform the person of the factors affecting the decision, and to assist the person, to the full extent her intellectual capacity allows, to participate in making a decision.)

There would be fifteen other specific factors:

* the age of the person,

* the likelihood that the person will become competent to consent to the proposed sterilization,

* the physical capacity of the person to reproduce,

* the likelihood that the person will engage in sexual activity,

* the risks to the physical health of the person if the sterilization is or is not performed,

* the risks to the mental health of the person if the sterilization is or is not performed,

* the availability and medical advisability of alternative means of medical treatment or contraception,

* the previous experience, if any, of the person with alternative means of medical treatment or contraception,

* the likelihood that any child of the person would be born with a physical or mental disability and the likely effect of that disability on the ability of the person to cope,

* the ability of the person to care for a child at the time of the application and any likely changes in that ability,

* the likelihood that a child of the person could be cared for by some other person,

* the likely effect of foregoing the proposed sterilization on the life of the person as it limits or otherwise affects the ability of those who care for the person to provide required care,

  (It is the consequential effect on the person for whom sterilization is being considered that would be weighed in considering this factor.)

* the likely effect of the proposed sterilization on the opportunities the person will have for satisfying human interaction,

* the religious beliefs, cultural and other values of the person, and

* the wishes, concerns, religious beliefs, cultural and other values of the family or other person providing personal care insofar as they affect the interests of the person.

(We emphasize that the decision must be made in the best interests of the person whose sterilization is in issue. The views of family members or other personal caregivers are relevant only to the extent that they affect the best interests of the person. We have kept the category narrow because we think that a real and substantial connection with the person ought to be shown before the views of any other person are taken into consideration.)

To these would be added as a residual factor:

* any other matter that the judge considers relevant.

(b) Hysterectomy for Menstrual Management

For a hysterectomy for menstrual management, the following would be added to the above list of factors:

* the availability and medical advisability of alternative means of menstrual management, and

* the previous experience, if any, of the person with alternative means of menstrual management.

As well, the proposed legislation would permit the judge to make the order authorizing the performance of a hysterectomy only where no less drastic alternative method of menstrual management is reasonably available.

(c) In General

In a situation where evidence on a factor is not available or not readily available, the judge would be able to make an order in the absence of evidence only if he is satisfied that evidence cannot reasonably be obtained.

As one respondent observed, the requirement that the factors *must* be considered is a strength of our proposal in that it goes a long way toward ensuring that a decision would be based on the fullest possible information and consideration.

(2) Factors Raising Risk of Confusion with Interests of Others

The choice of the "best interests" test confirms our guiding principle that a sterilization should be authorized only where it would be for the benefit of the person to be sterilized. Benefit to others - be it the family, caregivers, a future spouse, or a child who may be conceived and born - is not a consideration.

In consultation, a number of respondents expressed the concern that some of the factors listed in the proposed legislation would permit the interests of others to be brought in through the back door. They pointed to factors such as:

* the ability of the person to care for a child at the time of the application and any likely changes in that ability,

* the likelihood that any child of the person would be born with a physical or mental disability and the likely effect of that disability on the ability of the person to cope,

* the likelihood that a child of the person could be cared for by some other person,

* the likely effect of foregoing the proposed sterilization on the ability of those who care for the person to provide required care, and

* the wishes, concerns, religious beliefs, cultural and other values of the family or other person providing personal care insofar as they affect the interests of the person.

We hasten to dispel any such misapprehension. Under our proposal, these factors are to be considered only insofar as they have an impact on the best interests of the person for whom sterilization is sought. We emphatically do not intend that the consideration of these factors should derogate from our overriding principle of benefit to the person herself. They are *not* to be considered from the point of view of the interests or welfare of any other person.

At the same time, we think it would be a mistake to pretend that persons who are not competent to make sterilization decisions live in a social vacuum when in fact they depend on a network of family, friends and others to assist them in living as normal a life as possible. As we see it, the nature and extent to which a person can count on others is relevant to the determination of her present and likely future circumstances and this, in turn, is relevant to the consideration of her best interests.

Admittedly, the distinction between the interests of others insofar as they affect the interests of the person whose sterilization is sought and the interests of others in their own right carries with it the risk of misapplication. However, we think the risk is minimized, if not eliminated, by the choice of a superior court judge as decision maker and by the provision of a broad range of substantive and procedural safeguards for the judge to observe. We have revised the proposed legislation in an effort to make it irrefutably clear that these factors are to be considered only insofar as they relate to and impact on the best interests of the person for whom sterilization is sought.

Finally, in our tentative recommendations, the last factor set out above was phrased to include the wishes, concerns, religious beliefs and other values of the family "or other interested person" insofar as they affect the interests of the person. The definition we propose for an "interested person" would be an adult who, because of his relationship to the

person in respect of whom an order is sought, is concerned for the welfare of the person. The judge would have the authority to decide whether a person is or is not an interested person for a purpose named in the legislation.

Some respondents felt that the definition of "interested person" would require consideration of the wishes, concerns, religious beliefs and other values of primary caregivers including medical professionals and persons who are employed in an institution where the person is resident. We do not think a judge would interpret the words this widely. However, we do agree that the definition of "an interested person" is overly broad for this section. In our final proposal we have substituted the words "or other person providing personal care" for the words "an interested person" in this factor. Where the judge considers the views of an individual who is not a family member to be relevant, he would be obliged to consider them under the residual factor in any event.

(3) Other Factors Attracting Specific Comment

(a) Wishes of the Person for Whom Sterilization is Sought

As already stated, the factor to receive the foremost attention of the judge would be:

* the wishes and concerns expressed by the person for whom sterilization is being sought.

These would be ascertained after the person has been informed of the factors affecting the decision and assisted, to the full extent of her intellectual capacity, to participate in making a sterilization decision.

Embodied in this factor is the recognition that a person who is not competent to consent may nevertheless indicate preferences or wishes that should be considered. A minor would be able to do so more and more expressly as she approaches adulthood when the presumption of competence would apply.

Some respondents felt that the objection to sterilization by a normally developing minor should be decisive of the issue. While we are of the view that a case in which the decision of the judge would prevail over the wishes of a normally developing minor would be highly unusual, we have stopped short of this position for two reasons. First, a minor is, by our definition, a person who is not competent to make a decision about an elective sterilization or a hysterectomy for menstrual management. Second, it should not be overlooked that sterilization for optional medical treatment and for the protection of mental health comes within the statutory regime. Bearing these points in mind, we think it best to entrust the decision to the judge after hearing all the facts of an individual case.

(b) Religious Beliefs, Cultural and Other Values

In Report for Discussion No. 6, we listed the religious beliefs and other values of the person for whom sterilization is being sought along with the wishes and concerns of the person. In the final proposals we have added *cultural* values to this factor in response to a suggestion received during consultation. *Cultural* values have also been added to the parallel factor which now requires the judge to consider the wishes, concerns, religious beliefs, *cultural* and other values of the family or other person providing personal care to the person for whom sterilization is sought.

(c) Likelihood of Future Competence

Another factor the judge would be required to consider is:

* the likelihood that the person will become competent to consent to the proposed sterilization.

The discussion of the wishes and concerns of the person to be sterilized underscores the significance of the likelihood of future competence as a factor in the case of a normally developing minor. The latter factor is also significant for a person whose lack of

competence stems from a mental disability that is transient in nature and unlikely to persist for the whole of the person's reproductive life.

One respondent submitted that if there is evidence of past competence and evidence making it reasonable to conclude that the person may be competent again in the future, such evidence should be conclusive and no non-therapeutic sterilization decision ought to follow. We take the point, but can imagine a case in which the likelihood of return to competence is remote and the reasons for sterilization lie at the medical treatment end of the spectrum of sterilization purposes under the new regime. Again, we think it preferable to trust to the discretion of the judge who is in a position to weigh this evidence along with all the other circumstances in an individual case.

(d) Age

Discussion on the issue of the likelihood of future competence has prompted us to add as a specific factor:

* the age of the person.

One reason for specifying age is that its inclusion in the list helps to draw attention to the fact that maturation can be expected of minors for whom sterilization is being considered. Another reason for enumerating age is that reproductive choices tend to vary with age. For example, in the general population persons nearing the end of their reproductive years are more likely to choose sterilization than persons in younger age groups. Recognizing such tendencies would facilitate normalcy in decision making on behalf of persons who are not competent to consent personally.

(e) Physical Capacity to Reproduce

A further factor the judge would be required to consider is:

* the physical capacity of the person to reproduce.

In the Report for Discussion, we tentatively recommended that a presumption of fertility should be raised if the medical evidence indicates normal development of sexual organs and the evidence does not otherwise raise doubts about fertility. We made our recommendation because fertility is difficult to prove. Nevertheless, it would obviously be pointless and wrong to perform a sterilization on a person who is physically unable to reproduce.

Some repondents observed that the presumption has the effect of placing the onus on the person under a disability to prove there is some existing physical dysfunction that has rendered her sterile. They suggested that the more appropriate and reasonable evidentiary requirement would be to place the onus on the applicant to prove that the person is capable of reproduction. This point was made by respondents who are opposed in principle to sterilization for birth control or menstrual management. The onus they suggest would be virtually impossible to meet in cases where no prior offspring have been conceived.

We are satisfied that the proposed presumption reflects the more reasonable likelihood of normal reproductive functioning.

(f) Alternative Means of Birth Control or Menstrual Management

Two further factors the judge would be required to consider are:

* the availability and medical advisability of alternative means of medical treatment or contraception, or of menstrual management, and

* the previous experience, if any, of the person with alternative means of medical treatment or contraception, or of menstrual management.

The tentative recommendations in the Report for Discussion referred only to the "availability and medical advisability" of alternatives. The factor referring to "the previous experience, if any, of the person" has been added for both elective sterilization and hysterectomy for menstrual management as a result of a suggestion made in consultation on our tentative recommendations. Although information about previous experience is likely to form part of the foundation for an expert opinion on medical advisability, we agree that it would be helpful to specify it for consideration by the judge.

(4) Factors Attracting Little or No Comment

Most of the remaining factors received little or no specific comment one way or the other. We have omitted from our final proposals one factor that was included in our tentative recommendations. It is the likelihood that the person might in the future be able to marry. We are now persuaded that flagging this factor would be misconceived. Because we are living in an era when reproduction decisions are being made independently of marriage, marriage is not of direct relevance to the sterilization issue. The reference to the likelihood of marriage in the future could unduly arouse the traditional view that having children is fundamental to marriage and unacceptable outside of marriage, thereby tipping the balance against the weight of other factors in an individual case. That is to say, it could lead to the undue approval of sterilization in cases where marriage is unlikely and the undue refusal of sterilization where marriage is a possibility.

Where there is a chance that a future spouse would be able to provide help with the care of a child, our proposals cover the possibility in the factor relating to any other care that might be available for a child if born.

F. Method of Sterilization

The choice of surgical operation or other medical procedure to be used for sterilization would, in most instances, be a matter for medical decision. Our proposals do, however, contain two provisions relating to the method of sterilization. In the case of an

elective sterilization, the proposed legislation would prohibit the sterilization from being performed by hysterectomy unless the judge, by order, expressly authorizes it on the basis of persuasive medical evidence. In the case of a *hysterectomy for menstrual management*, the proposed legislation would permit the judge to make an order authorizing the performance of a hysterectomy only where no less drastic alternative method of menstrual management is reasonably available.

In both cases, our proposals reflect the principle that the least injurious or least intrusive means of accomplishing the intended purpose should be used.

G. Representation

Our proposals would require a judge to appoint a lawyer to represent the person whose sterilization is the subject of the application. To facilitate the making of this mandatory appointment, we would require the originating notice to include a request for the direction of a judge with respect to the appointment of a lawyer. We emphasize that we regard the provision of legal representation as a matter of fundamental importance to any reform of the law in this area. Without such a provision the person for whom sterilization is sought may well not secure the first protection offered by the legislation. Legislation is only as effective as the mechanisms in place to see that it is enforced.

Two points came through in consultation. The first is that the role to be taken by the lawyer requires clarification. The second is that the independence of the lawyer selected should be assured.

(1) Role of Lawyer

The role we see for the lawyer is an admixture of counsel and *amicus curiae* - counsel to the person whose sterilization is sought to the extent that the person is competent to give instructions, and *amicus curiae* responsible to fully inform the judge on the issues to the extent that the person is not competent to give instructions. In the latter

circumstance, the lawyer should represent the interests of the person as zealously as possible, by:

* ensuring that the procedural requirements specified in the legislation are met,

* presenting proof and cross-examining to ensure that the judge has full and accurate information regarding the issues of competence, sterilization, the alternatives and other matters set out in the list of factors, and

* making argument on behalf of the person.

In the Report for Discussion, we tentatively recommended that the lawyer should represent the interests of the person whose sterilization is sought. However, in our final proposals, we have specified that the lawyer should act:

* on the instructions of the person for whom sterilization is sought to the extent that the person is competent to give instructions, and

* in the interests of the person for whom sterilization is sought to the extent that the person is *not* competent to give instructions.

(2) Selection of Lawyer

The lawyer appointed to represent the person whose sterilization is sought should give *independent* counsel. That is to say, the lawyer should *not* take instructions from anyone else purporting to speak on the person's behalf - be it parent, guardian or another. Independence is essential, as the Supreme Court of Canada recognized in *Re Eve* when it made "independent representation" a requirement in cases brought to court under the *parens patriae* jurisdiction.[18] Indeed, one respondent characterized independent

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18 *Re Eve, supra* n. 1 at 37.

representation by a lawyer as "the most important protection afforded" in our proposals. This respondent emphasized the importance of the *independence* of the legal representation to prevent the proceedings from being tainted by systemic or institutional bias, actual or apparent.

We have revised our proposal to include reference to the appointment of a lawyer to provide *independent* representation of person for whom sterilization is being considered.

H. The Procedure

(1) Commencement by Originating Notice

An application for a sterilization order would be commenced by originating notice. This is the method by which an application for guardianship is commenced under the Dependent Adults Act. No pleadings are required and the evidence may be taken by affidavit or orally at a hearing on the application. If the case is a complex one, or the evidence contentious, the judge may direct the trial of an issue and give directions as to the procedure to be followed.

We have considered these arguments closely, but remain satisfied that the originating notice procedure amply meets the requirements of justice, especially when it is combined with the other safeguards provided in the proposal. We point out that a proceeding commenced by statement of claim is adversarial in nature. The plaintiff makes a claim against the defendant in a dispute between the two of them and the parties, by and large, decide what evidence to present. In contrast, the application we are proposing has as its purpose the ascertainment of the best interests of a person who is unable to make a decision for herself. It is less in the nature of a dispute and more in the nature of an inquiry by the judge into the full circumstances of the case.

We are confident that our proposals would provide a full and proper hearing of the issue. We are also confident that they would protect the fundamental human rights of the

individual. As already stated, the originating notice procedure gives the judge control and allows him to expand the procedure to accommodate the requirements of individual cases. Two more advantages of the originating procedure are as follows. First, it avoids the unnecessary delay and expense that may result from use of the full panoply of interlocutory procedures available as of right to parties in proceedings commenced by statement of claim. Second, it avoids the wastefulness associated with going to trial in a case where a trial is not necessary.

(2) Applicant

An application for an order would be brought by:

* the person to be sterilized,

* a parent,

* a guardian, or

* any other interested person.

The list of those who may apply has been described broadly to facilitate ease of commencement of the proceedings because their purpose is to further the best interests of the person for whom sterilization is sought.

Our tentative recommendations did not single out a parent or guardian, but referred instead to "an interested person". We have specified "parent" and "guardian" in our final proposals to highlight the special claim to standing arising out of their relationship.

As mentioned previously, we would define an "interested person" as an adult who, because of his relationship to the person in respect of whom an order is sought, is concerned for the welfare of the person. In a case of doubt as to who is an interested

person for the purpose of bringing an application, or for any other purpose under the legislation, a judge would be authorized to make an order resolving the issue.

(3) Notice and Service

Notice of the application would be given to:

* the person in respect of whom the application is made,

* the parents of the person in respect of whom the application is made, if any,

* the guardians of the person in respect of whom the application is made, if any,

* the person in charge of the facility, if the person in respect of whom the application is made is a resident of a facility,

  (A "facility" would be defined to mean any establishment or class of establishment designated as a facility in the regulations.)

* the lawyer appointed to represent the person in respect of whom the application is made, and

* any other interested person whom the judge may direct.

The list includes persons who would be expected to be interested in the outcome of the proceedings and would want an opportunity to participate.

Our tentative recommendations included a provision authorizing a judge to dispense with service on the person whose sterilization is sought, if the judge is satisfied that it is in the best interests of that person to do so, and the lawyer appointed to represent the person

consents. We had in mind a case where service on the person would be pointless (e.g. in a case where the individual concerned, although physically mobile and sexually active, has no chance of comprehending the purpose of the application or nature of the proceedings). A similar provision in the Dependent Adults Act[19] requires the consent of the Public Guardian before service may be dispensed with. That consent is given only where the person is comatose, or a medical certificate attesting that harm will flow from service has been obtained.

Because a case in which service would not be in the best interests of the person to be sterilized would be extremely rare, we now think that service ought to be required in all cases. This would avert the possibility of an injustice occurring.

Our final proposals would authorize a judge to make an order dispensing with service on anyone who is entitled to notice, except the person in respect of whom the application is brought and the lawyer appointed to represent that person. Before making the order, the judge would have to be satisfied that it would not be contrary to the best interests of the person whose sterilization is in issue to dispense with service.

(4) Right to Appear and be Heard

Any person served or required to be served with an application and any other person whom the judge permits would be entitled to appear and be heard on an application.

(5) No Roles for Public Guardian and Children's Guardian

In the Report for Discussion, we envisaged a role for the Public Guardian in the case of an adult, and the Children's Guardian in the case of a child. The Public Guardian

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19 R.S.A. 1980 c. D-32, s-s. 3(3)(c).

is established under the Dependent Adult(s) Act, and the Children's Guardian under the Child Welfare Act.[20]

In consultation, we have been persuaded to drop the references to the Public Guardian and Children's Guardian from our proposals. We now think that the roles are neither necessary nor desirable and that:

- the public interest would be adequately protected by the judge guided by the proposed legislation,

- the lawyer whom we propose be appointed to provide independent representation would give protection to the interests of the person for whom sterilization is sought,

- the monitoring or watchdog role would be extraneous,

- the standardization of procedures would be the responsibility of the court,

- the justification for the intervention of the state in what are essentially private matters is questionable, and

- the proposed legislation provides other means of obtaining expertise if it is found wanting.

Referring to the Public Guardian and the Children's Guardian when there is no obvious role for them would raise the misleading expectation that they are in a position to do something.

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20 Recent amendments to the Child Welfare Act, enacted but not yet proclaimed, would substitute the Children's Advocate for the Children's Guardian in a significantly modified role. *See* Child Welfare Amendment Act, 1988, S.A. 1988 c. 15.

I. Expert Evaluation of Person to be Sterilized

A comprehensive evaluation of the condition and circumstances of the person whose sterilization is sought is central to the fair determination of an application, as courts have recognized.[21] Two provisions in the proposals are intended to ensure independent expert evidence evaluating the person. The expert evaluations would assist the judge:

* in determining whether the person is or is not competent to make a sterilization decision for herself, and

* in weighing the advantages and disadvantages of the proposed sterilization.

(1) Expert Reports Filed in Support of Application

The first provision ensuring expert evaluation would be the requirement that the applicant file the reports of a physician *and* a psychologist in support of the application. The reports would provide expert opinions relating to the issues of competence and sterilization. They would be served with the notice of the application.

(2) Engagement of Experts by Lawyer Representing Person for Whom Sterilization is Sought

The second provision ensuring expert evaluation would be the opportunity for engagement, by the lawyer appointed to represent the person for whom sterilization is sought, of experts to conduct independent evaluations and provide evidence. The lawyer

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21 *E.g.*, the judgment of MacDonald J. on appeal to the Prince Edward Island Supreme Court, sitting *in banco* in *Re Eve* (1981) 115 D.L.R. (3d) 283 (P.E.I.S.C.); the judgment of Wood J. of the British Columbia Supreme Court in *Re K; K* v. *Public Trustee* [1985] 3 W.W.R. 204; and judgments in a number of recent American cases: *see e.g. In re Guardianship of Hayes* 608 P. 2d 635 (Wash. S.C. 1980) 641; *In re Grady*, *supra* n. 16 at 482-3; *In re C.D.M.*, *supra* n. 16 at 613; *Wentzel* v. *Montgomery General Hospital*, *supra* n. 16 at 1254; and *In re Moe* 432 N.E. 2d 712 at 720 (1982).

would be able to apply to a judge for directions with respect to both the engagement of experts and the payment of the costs incurred in doing so.

J. Investigation by Judge

The judge hearing the application would be able to make whatever investigation he considers necessary with respect to any matter relating to the application. This power would enable him to inquire further into the facts, and to order further independent evaluation, where he has doubt as to whether an order authorizing sterilization should be made. The judge would be required to give the parties to the hearing an opportunity to be heard with respect to the evidence produced and matters arising from an investigation.

K. Meeting by Judge With Person for Whom Sterilization is Sought

The judge would have a duty to meet personally with the person named in the application where the judge is of the opinion that he should do so for a purpose connected with it. Where the person is unable to be present in court, the judge would be able to meet with her to obtain his own impression of her competence to consent to sterilization, and of the likely effect on her of the proposed sterilization.

In the Report for Discussion, we gave our opinion that the judge would have jurisdiction to take this step without a legislated provision. We decided to include a provision in the tentative recommendations to draw the possibility of taking this extraordinary step to the attention of the judge and the parties.

We received two sets of comments in response. One point of view was that the meeting should be mandatory. To this point of view, our answer is that the evidence in a given case may show that a meeting would be pointless and we do not think that a meeting should be required in this circumstance.

The other point of view was that "judges having the opportunity to meet the person under a disability in his or her Chambers 'in camera' is problematic" for three reasons. First, it puts the judiciary in a very difficult position due to the lack of contact and experience of many of its members with the disabled population. Second, because such meetings are the exception rather than the rule, to incorporate them systematically in legislation for persons who are mentally disabled creates a double standard of justice. Third, errors in judgment would be virtually impossible to rectify by way of an appeal to a higher court.

Here, our answer to the first and third reasons is that they are objections to general judicial process. The same or similar objections could be made whenever a judge draws conclusions based on his observation of the parties and witnesses in a proceeding. Our answer to the second reason is that we think the "exception" is justified because it exists for the benefit of the person whose sterilization is in issue. Without it, the person, if unable to be present in court, would not be able to participate in the hearing leading to a sterilization decision.

In our opinion, the judge making the decision should be as fully informed as possible of all of the facts of the case. The opportunity to meet with the person whose sterilization is in issue would assist him to be so informed. If adopted, our proposals would bring home the possibility, while leaving the decision that a meeting is needed to the judge.

L. Cross-Examination on Expert Reports

Any party would be entitled to cross-examine the person making a report admitted in evidence in the proceeding. The right would encompass the reports of the physician and psychologist filed in support of the application, the reports of independent experts engaged by the lawyer representing the interests of the person for whom sterilization is being considered, the reports of persons conducting investigations pursuant to a direction of the judge made in furtherance of his power to inquire, and any other report.

M. Costs

The costs of the application would be in the discretion of the judge who would be able to award them against any or all of:

* the applicant,

* the person in respect of whom the application is made,

* the estate of the person in respect of whom the application is made where a trustee of the estate has been appointed, or

* the Crown in Right of Alberta where it would be a hardship for any or all of the above to pay them.

The expense of going to court is a disadvantage associated with the choice of a judge as decision maker. The provision enabling the judge to order the Crown to pay any or all of the costs of an application would alleviate the financial burden on the person or her family where it would be a hardship for them to pay. The payment of costs by the Crown would be an avenue of last resort.

Alternatively, the judge would be able to award costs against the applicant or a person opposing the application on frivolous or vexatious grounds.

An order for the payment of costs would be able to be made at any time after the commencement of an application.

It was suggested to us that the Crown should have notice in a case where costs are going to be claimed against it. We agree with the common sense of this suggestion. Our final proposals would prevent an order for costs from being made unless appropriate notice

has been given to the person or party against whom costs are claimed. The Court would have the discretion to determine the notice that is appropriate in the circumstances.

N. Other Matters

(1) Standard of Proof

Under the proposals, the finding that the person whose sterilization is sought is or is not competent to consent to sterilization would be subject to the ordinary civil burden as it is under the existing law. The onus of proof would be on the applicant or other person alleging that the person is *not* competent. We have taken this position because the finding disturbs existing rights.

The standard of proof that sterilization is or is not in the best interests of the person would be to the satisfaction of the judge. Once the applicant has opened up the issue, the onus of proof would not rest with any party; instead, it would be up to the judge to satisfy himself of the person's best interests before making an order. The power of the judge to make whatever investigation of the matter he considers necessary would enable him to properly satisfy himself where he is in doubt about what decision to make.

It was suggested to us in consultation that the standard of proof of fertility should be that of "clear and convincing evidence". The introduction of this rule into Canadian law has been rejected by Canadian courts[22] and we do not endorse it.

(2) Conditions or Restrictions on Order

The judge would have the authority to make an order subject to any conditions or restrictions he considers necessary.

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22 *See e.g. Re K, supra* n. 16 at 741-42, 747; *Re Eve, supra* n. 1 at 37; and *M* v. *Alberta* (1985) 63 A.R. 14 at 25-27 (Alta. Q.B.).

(3) Effective Date of Order

An order made under the proposed legislation would not take effect until the dismissal or discontinuance of the appeal where an appeal has been filed, or the expiration of the time allowed for appeal where no appeal has been filed. The order would be so endorsed. Under the present Rules the time allowed for filing and service of a notice of appeal is 20 days after a judgment, order or direction has been signed, entered or issued, and served.[23]

The effect of these provisions is to forestall the performance of a sterilization that has been authorized by the order of a judge, or consented to by a person whom a judge has declared competent to make her own sterilization decision, until the legal proceedings have been concluded.[24]

(4) Variation of Order

Provided that no substantial wrong or miscarriage of justice would result from his doing so, a judge would have jurisdiction to vary an order or set it aside before a sterilization is performed where circumstances have changed materially or new evidence has come to light. Where the order is set aside, he would be able to substitute a new order in its place.

Our proposals would also accommodate changes in circumstance by permitting an application for an order authorizing sterilization to be made notwithstanding that a previous application had been refused. The proposal relating to costs would give the judge discretion to order that costs be paid by the applicant where the application is frivolous or vexatious.

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23 Alberta Rules of Court, Alta. Reg. 390/68, Rule 506.

24 *See infra* p. 17.

(5) Other Orders Judge May Make

(a) Order Declaring Competence to Make a Sterilization Decision

The legislation would authorize a judge to declare a person competent. This provision would apply to those "borderline" cases where a person's competence to give consent is in doubt. Where a judge determines that a person is competent, that person could then give her physician a valid consent to sterilization. Where a judge determines that a person is not competent, the balance of the legislation would apply to allow the judge to give an order permitting sterilization in an appropriate case.

(b) Order Enjoining Sterilization

The general principles governing injunctions would continue to apply, as now, so that an injunction could be ordered in an appropriate case, for example, to enjoin the performance of a sterilization that has not been authorized by an order as required by the legislation.

(6) Protection From Liability

The proposals would not confer any special protection on professionals making reports or providing information for the purpose of a proceeding under the legislation. In our opinion, adequate protection is afforded by the general law.

(7) Appeal

An appeal would lie from the decision - be it an order, direction or finding - of a judge of the Court of Queen's Bench to the Court of Appeal of Alberta.

(8) Regulation-Making Power

The Lieutenant-Governor in Council would be authorized to make regulations designating facilities for the purpose of service of notice of an application on the person in charge of a facility in which the person whose sterilization is sought is resident. It would be appropriate to include in the designation institutions designated in the regulations under the Dependent Adults Act, facilities designated in the regulations under the Mental Health Act, and social care facilities licensed under the Social Care Facilities Licensing Act.

O. Enactment of Legislation

(1) Location

Our proposal is presented as a separate statute. It will however, be recalled, that our principal recommendation is that the Legislature enact legislation which will give effect to the substance of our proposals. That could be in the form of our draft Act, or as part of another statute, or otherwise.

If the Legislature should decide to enact a separate statute, we would propose that the Act be named the Competence and Human Reproduction Act.

(2) Amendment to the Dependent Adults Act

The amendment that we propose be made to the Dependent Adults Act would prevent a guardian appointed to make health care decisions from consenting to sterilization for any purpose except necessary medical treatment.

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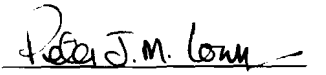

DIRECTOR

February 1989

APPENDIX

LIST OF CONTRIBUTORS

Alberta Association for Community Living	Edmonton, Alberta
Alberta Social Services	Edmonton, Alberta
Canadian Association for Community Living	Downsview/Ottawa, Ontario
Canadian Mental Health Association	Calgary, Alberta
Professor Bernard Dickens	Toronto, Ontario
Dr. Janice Goerzen	Calgary, Alberta
Fairview and District Association for the Handicapped	Fairview, Alberta
Dr. C. LeBlanc	Calgary, Alberta
Linda and Rick Nicholson	Fairview, Alberta
Newfoundland Association for Community Living	St. John's, Newfoundland
People First Alberta (the Self-Advocacy Advisory Committee to the Board of Directors of the Alberta Association for Community Living)	Calgary, Alberta
SKILLS Training & Support Services Association	Edmonton, Alberta
Ms. Pat White	Edmonton, Alberta
Yukon Association for Community Living	Whitehorse, Yukon