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CHAPTER 1

INTRODUCTION

Where a person, due to youth, mental health disability or intellectual disability,[1] is legally incapable of consenting to a doctor's performance of a non-therapeutic sterilization procedure,[2] who can lawfully consent on that person's behalf?

No one, said the Supreme Court of Canada in the 1986 case of *Re Eve*.[3] The Supreme Court unanimously decided that, in the absence of legislation, a court can never consent on behalf of such a person where the proposed sterilization is non-therapeutic in nature (that is, performed for social reasons like contraception and not for the protection of the person's physical or mental health).

This decision leads to the same limitation on the authority of parents and guardians: "what the superior courts . . . [can] not do in the exercise of their broad discretionary protective jurisdiction, parents and guardians . . . [can] not do."[4]

Since no one can lawfully consent, a doctor who performs a non-therapeutic sterilization on a person incapable of consent could be sued for battery or charged with assault.

Eve's blanket prohibition settled the common law in Canada. Before this case, the law had been uncertain about whether any limits existed on the ability of parents, guardians or courts to give substituted consent for non-therapeutic sterilizations of legally incompetent people.[5]

It was in the context of this previous legal uncertainty that the Hon. G.W.J. Mercier, Q.C., then Attorney General of Manitoba, requested in late 1980 that the Manitoba Law Reform Commission examine whether the law should, under any circumstances, provide for substituted consent to the non-therapeutic sterilization of people legally incompetent to consent personally.

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[1]This terminology was chosen in accordance with Department of the Secretary of State of Canada, *A Way with Words: Guidelines and Appropriate Terminology for the Portrayal of Persons with Disabilities* (1991). The Commission thanks those respondents who pointed out that some of the terminology used in our Discussion Paper is now considered outdated and less than sensitive.

[2]This Report concerns no medical procedure other than sterilization which, for our purposes, means any usually irreversible medical procedure that permanently terminates the ability to procreate. Common examples of sterilization procedures are tubal ligation, hysterectomy and vasectomy.

[3]*Re Eve* (1986), 31 D.L.R. (4th) 1 (S.C.C.). Also reported as *E. (Mrs.)* v. *Eve*, [1986] 2 S.C.R. 388. All subsequent references are to the D.L.R. citation.

[4]Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988) 12. The Institute of Law Research and Reform is now known as the Alberta Law Reform Institute.

[5]See, e.g. the discussions in Law Reform Commission of Canada, *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons* (Working Paper #24, 1979) 57-59 and Institute of Law Research and Reform, Report for Discussion, *supra* n. 4, at 56-62.

The law, however, was clear in Alberta and British Columbia until the early 1970's because those jurisdictions had involuntary sterilization statutes, originally based on now-discredited eugenic ideas and aimed primarily at people with intellectual disabilities: *Sexual Sterilization Act*, S.B.C. 1933, c. 59 and *Sexual Sterilization Repeal Act*, S.B.C. 1973, c. 79; *The Sexual Sterilization Act*, S.A. 1928, c. 37 and *The Sexual Sterilization Repeal Act, 1972*, S.A. 1972, c. 87.

The Commission commenced its research; shortly thereafter in 1981 leave to appeal to the Supreme Court of Canada was granted in the *Eve* case. This case promised to be the badly-needed clarifying precedent in this area of the law and would, accordingly, be the seminal Canadian case. Therefore, the Commission decided to defer work on this project until the Supreme Court rendered its decision, which it did not do until late 1986.

The Supreme Court decision in *Eve* certainly clarified the common law but, since the common law may be altered by statute, it did not fully answer the reference given by the Attorney General to the Commission.

The *Eve* decision also proved to be controversial. Its blanket prohibition is seen by some as necessary to prevent any possible return to the shameful and still recent history of routine, almost automatic, mass involuntary sterilization of people with intellectual disabilities. Others are concerned that the blanket prohibition is too rigid and prevents a consideration of individual circumstances in those occasional cases where, in the absence of any other alternative, non-therapeutic sterilization could truly be in a person's best interests.

The Commission therefore recommenced work on the project. Following the disruption in 1987-88 when the Commission itself was discontinued and then reinstated, the decision was made to wait and analyze the recommendations to be made by the Alberta Institute of Law Research and Reform which had recently released an exhaustive Discussion Paper in this area.[6] The Institute's final Report was released in 1989.[7]

The Commission issued its Discussion Paper in November, 1990.[8] The Discussion Paper neither advocated nor recommended any legislative proposal, but simply sought to describe the current state of the law, to outline the possible options, and to elicit the opinions, judgments and concerns of the public on the issues and options. The Discussion Paper was distributed to various concerned individuals and organizations.[9]

Fourteen written briefs were received. All the submissions were of a very high quality and demonstrated a profound sensitivity to the difficult issues in this area. The differing viewpoints expressed by the respondents were of invaluable assistance to the Commission in its consideration of these issues. The Commission thanks all the respondents for making their opinions known.

Over the years, we have obtained much information in consultation with many officials of various government offices and departments, government and private service-providing agencies, and hospitals throughout the province. The Commission wishes to thank all those who generously gave their time and attention to helping us with these issues.

In particular, the Commission would like to acknowledge the assistance of Dr. Glen Lowther, former Director of Mental Retardation Programs with the Province of Manitoba and Prof. Barney Sneiderman of the Faculty of Law, University of Manitoba. As well, the Alberta Institute very kindly allowed us access to their background documentation and manuscripts in this area.

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[6]Institute of Law Research and Reform, Report for Discussion, *supra* n. 4.

[7]Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989).

[8]Manitoba Law Reform Commission, *Sterilization of Minors and Mentally Incompetent Adults* (Discussion Paper, 1990).

[9]Appendix A to this Report contains a list of all recipients of, and respondents to, the Discussion Paper.

CHAPTER 2

THE EXISTING LAW

A. NECESSITY FOR CONSENT TO MEDICAL PROCEDURES

Except in situations of medical emergency[1] or where a statute provides otherwise,[2] a doctor must obtain a patient's consent before proceeding with medical treatment. A doctor who proceeds without such consent commits the tort of battery (unauthorized interference with a person's body) and can be sued. The doctor could also face a criminal charge of assault.[3]

Obtaining consent "is not a mere formality; it is an important individual right to have control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed . . . ."[4]

Consent is valid if it meets all three of the following requirements:

(1) **The patient must know what kind of medical treatment or surgery is proposed and what it may accomplish.** A doctor cannot use consent to one procedure as authorization to perform a different or more extensive procedure. For example, consent to an operation on a toe does not authorize the performance of a spinal fusion,[5] nor does consent to the extraction of two teeth constitute consent to extraction of all the patient's teeth.[6] In both these cases, battery was committed.

Even if a patient is not informed by the doctor of all the attendant risks of the treatment, the patient's consent is still valid and the doctor will not commit battery by proceeding. But this same lack of "informed consent" means the doctor has breached the duty of disclosure owed to the patient; such a doctor could be sued for negligence.[7]

(2) **The consent must be voluntary.** The exercise of the patient's free will must be unclouded by coercion, deceit or fraudulent misrepresentation about the nature of the treatment.[8]

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[1]The "principle of necessity" is the legal concept that justifies a doctor proceeding without consent in a medical emergency because immediate action must be taken to save life or to preserve physical or mental health.

[2]See, e.g. *The Public Health Act*, C.C.S.M. c. P210, ss. 19(1)(g) and 19(7)(g), where certain government officials or a justice can order a person with a communicable disease to "submit to or obtain medical treatment". This statute creates a special situation where a person's forced consent given under duress is nevertheless valid.

[3]*Criminal Code*, R.S.C. 1985, c. C-46, ss. 265 and 266.

[4]*Allan* v. *New Mount Sinai Hospital* (1980), 109 D.L.R. (3d) 634 at 642 (Ont. H.C.), rev'd on pleading issue (1981), 125 D.L.R. (3d) 276 (Ont. C.A.).

[5]*Schweizer* v. *Central Hospital* (1974), 53 D.L.R. (3d) 494 (Ont. H.C.).

[6]*Parmley* v. *Parmley*, [1945] S.C.R. 635.

[7]*Reibl* v. *Hughes*, [1980] 2 S.C.R. 880.

[8]*Re Dr. "D"* (1970), 73 W.W.R. 627 (B.C.S.C.); *R.* v. *Maurantonio* (1967), 2 C.R.N.S. 375 (Ont. C.A.), leave to appeal to S.C.C. refused 2 C.R.N.S. 375n; *Bolduc* v. *The Queen*, [1967] S.C.R. 677.

(3) **The patient must be competent to give consent.** A person is legally competent to consent to medical treatment where the person fully understands and appreciates the nature and consequences of the particular treatment or operation, including the benefits and risks involved both in undergoing and in failing to undergo the procedure.

Two main groups of people are, very generally speaking, more unlikely to meet the above-noted test of competence and would therefore be legally incompetent to give consent: minors (persons under 18 years of age, whether they have intellectual or mental health disabilities or not) and some adults who have intellectual or mental health disabilities.

Sometimes, a minor close to the age of majority is sufficiently mentally mature to be considered legally competent to consent. In such cases, which are always judged on an individual basis, the "mature minor" exception operates and the minor's consent is valid.[9] However, the more serious the operation or treatment is (for example, non-therapeutic sterilization), the more prudent it would be for a doctor to consider any minor to be incompetent to consent.

In regard to adults who have intellectual or mental health disabilities, it is crucial to understand two facts. First, not all these adults are automatically incapable of legal consent. Those who are legally competent to consent should under no circumstances ever undergo a sterilization procedure in the absence of their fully informed consent.

Secondly, a person can be legally competent in some areas but legally incompetent in other areas. A person's legal competence must be judged in relation to the specific choice that must be made. For example, a person may be legally incompetent to make a will, enter into a contract or enter into marriage but may be capable of consenting to medical treatment. A person may even have the legal capacity to consent to certain types of treatment but not to other types.[10]

In short, "a person's mental ability to consent to treatment must not be assumed from his status within either the health care system or the legal system."[11] Capacity to consent must be carefully judged in every set of circumstances.

When a person is incompetent to give personal consent to the proposed medical treatment, the doctor can seek and accept the necessary consent only from a legally authorized substitute decision-maker.

B. WHO CAN BE SUBSTITUTE DECISION-MAKERS?

1. For Minors

The usual substitute decision-maker for a minor is either a parent or a legal guardian.[12] Parental authority (as judicially created in the common law) includes the legal power to consent

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[9] *J.S.C and C.H.C.* v. *Wren* (1986), 76 A.R. 115 (C.A.); *Johnston* v. *Wellesley Hospital* (1970), 17 D.L.R. (3d) 139 (Ont. H.C.).

[10] L.E. Rozovsky and F.A. Rozovsky, *The Canadian Law of Consent to Treatment* (1990) 39-40.

[11] *Ibid.*, at 40.

[12] A guardian is a person who is not the child's parent and who is generally ordered by a court to be legal guardian of the child's person during the child's minority. A guardian can either be an individual (for example, where a private guardianship application is brought to court by a grandparent applying to be a grandchild's guardian) or a Child and Family Services agency (for example, where a court orders temporary or permanent guardianship because of child abuse). A parent can also voluntarily surrender guardianship of a child to a Child and Family Services agency for the purpose of putting the child up for adoption; this transfer of guardianship is the only kind that can be done by private agreement, without the need for a court order. See: *The Child and Family Services Act*, C.C.S.M. c. C80, ss. 16, 38, 77-81.

to medical treatment on behalf of minor children in the parent's legal custody.[13] A court-appointed guardian has the same authority and obligation as a parent to consent to medical treatment, unless a court or a statute provides otherwise.

Legal guardianship and parental custody terminate when a child reaches adulthood at eighteen and the parent or guardian can no longer give substituted consent to medical treatment.[14] This termination of authority is final and absolute; it does not and cannot continue simply because a now-adult offspring is legally incompetent to consent personally to medical treatment.

2. For Legally Incompetent Adults

For adults who are legally incapable of consent, the law specifies a limited number of legally authorized substitute decision-makers, the most common of whom are custodians and committees[15] of the person.

A custodian is a person in whose custody a "mental retardate"[16] is placed by order of a provincial court judge.[17] A custodian has "such powers as would be exercisable by that person if the person were a parent of the mental retardate and the mental retardate were a child . . . ."[18]

A committee is someone to whom the custody of a "mentally disordered" person is committed under *The Mental Health Act*. The concept of "mentally disordered" includes, for this purpose, the condition of "mental retardation".[19]

There are two kinds of committees: a "committee of the person" is authorized to make personal decisions for the "mentally disordered" person (like consent to medical treatment),[20] but cannot handle the person's finances or business decisions unless also appointed as "committee of the estate".

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[13]Apart from the legal authority to consent to medical treatment, parents have a positive legal duty to provide their children with the "necessaries of life", a concept which includes essential medical treatment and, therefore, the giving of their consent to it. The state and the courts will intervene to apprehend and protect a child whose parents fail to permit proper medical care necessary for the child's health or well-being: *The Child and Family Services Act*, C.C.S.M. c. C80, s. 17(2)(b)(iii).

[14]Of course, the "mature minor" exception has (in most cases) usually eroded a parent's or guardian's substituted consent authority by this stage anyway.

[15]"Committee" is a legal term referring to the person to whom the care of another has been *committed*. It is pronounced with the accent on the final syllable.

[16]Our statutes use terminology now considered outdated and insensitive. When discussing a specific statutory scheme, that statute's language must (unfortunately) be used for strict legal accuracy.

[17]*The Mental Health Act*, C.C.S.M. c. M110, ss. 33-38. Such a court order requires parental or guardian consent except in special circumstances: *The Mental Health Act*, C.C.S.M. c. M110, s. 34(4).

[18]*The Mental Health Act*, C.C.S.M. c. M110, s. 37(2).

[19]*The Mental Health Act*, C.C.S.M. c. M110, s. 1.

[20]The Manitoba Court of Queen's Bench has recently commented that, in light of *Eve*'s illustration that not all medical decisions may be made by substituted consent, a court should not appoint a private individual as a committee of the person without a clear and exact definition of the scope of the committee's powers, contained either in the statute or in the court order. This specificity is required to ensure that there will be no possibility of any action or inaction being taken that the court would not approve or that might be beyond the court's jurisdiction to approve. An open-ended or vague grant of substituted consent power over a person is unacceptable: *Winser* v. *Winser*, [1991] 4 W.W.R. 331 at 334-335, per Wright, J.

A committee of the person is usually appointed by a court after a hearing,[21] but can also be automatically established by operation of *The Mental Health Act* itself, in certain specified circumstances, without the need for a court order.[22]

In all cases, the Public Trustee of Manitoba will be the committee, where none other exists.[23] The Public Trustee, as committee, is generally authorized to consent to medical or psychiatric treatment or health care on the person's behalf[24] but only where a doctor, using specified criteria, determines that the person is not legally competent to make treatment decisions personally.[25]

3. For Both Minors and Legally Incompetent Adults

Apart from a couple of situations where a caregiver without legal custody or other status may still be able to give limited substituted consent to medical treatment,[26] the major remaining source of substituted consent applicable to both minors and legally incompetent adults is the courts.

The courts exercise a special jurisdiction called the *parens patriae* jurisdiction. This jurisdiction originated "in the mists of antiquity"[27] as a power vested in the sovereign to protect from harm or exploitation those who are incapable of looking after themselves (basically, children and those adults with an intellectual or mental health disability). Eventually the exercise of this power became vested in the sovereign's courts; it continues to exist today in superior courts like the Manitoba Court of Queen's Bench.

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[21]The court must find the person to be either "mentally disordered" or otherwise incapable of managing his or her own affairs due to "mental infirmity" (for example, through senility or habitual drunkenness): *The Mental Health Act*, C.C.S.M. c. M110, ss. 56, 76 and 80(1).

[22]This occurs where a doctor certifies that a patient in a psychiatric facility (which does not include an institution for the "mentally retarded") is incapable of managing his or her own affairs, or where the provincial Director of Psychiatric Services makes an Order of Supervision concerning a "mental retardate", a person who is not in a psychiatric facility, or a person who is about to be released from one: *The Mental Health Act*, C.C.S.M. c. M110, ss. 26.11, 26.12, 32 and 80(1).

[23]*The Mental Health Act*, C.C.S.M. c. M110, s. 80(1).

[24]Special provisions govern the giving of substituted consent for legally incompetent adults in psychiatric facilities: *The Mental Health Act*, C.C.S.M. c. M110, ss. 24, 24.1, 24.2 and 25. In certain circumstances, a decision made by an authorized substitute decision-maker can be overridden by a review board. Similar provisions in Ontario were recently struck down by the Ontario Court of Appeal for breaching "due process" as guaranteed by section 7 of the *Charter*: *Fleming* v. *Reid* (1991), 82 D.L.R. (4th) 298 (Ont. C.A.).

[25]*The Mental Health Act*, C.C.S.M. c. M110, ss. 80(1.2) and 24(3). When giving substituted consent, the Public Trustee is obliged to consult with the person's family, where reasonably possible, and must exercise its power in the best interests of the person having regard to certain specified statutory principles and criteria: *The Mental Health Act*, C.C.S.M. c. M110, ss. 80(1.4), 24.1(3) and (4).

[26]The first situation is where a Child and Family Services agency has an allegedly abused child under apprehension but has not yet received court-ordered guardianship: *The Child and Family Services Act*, C.C.S.M. c. C80, ss. 25(1)(b) and 25(2). The second situation arises out of the *Criminal Code* provision that imposes a legal duty to provide "necessaries of life" to a child under the age of sixteen: *Criminal Code*, R.S.C. 1985, c. C-46, s. 215(1). "Necessaries of life" include medical aid or treatment needed to preserve life and health: *R.* v. *Brooks* (1902), 5 C.C.C. 372 (B.C.S.C.); *R.* v. *Cyrenne* (1981), 62 C.C.C. (2d) 238 (Ont. Dist. Ct.). This duty is imposed on parents, legal guardians and on children's caregivers who, without legal custody or guardianship, have a child under their care and control (foster parents, "factual" guardians, and the vague category of "head of a family"). It is also imposed on those who have any person under their charge who is unable to provide personally for necessaries of life, and who is unable to withdraw from the charge of the caregiver by reason of "detention, age, illness, insanity or other cause". This category of people to whom the duty is owed could include an adult with an intellectual or mental health disability who lives with parents, relatives, professional caregivers or others, whether or not an order of custodianship or committeeship is in existence. It is arguable that a legal duty to provide medical treatment carries with it the authority to consent to that treatment on behalf of a patient who is incompetent to do so: *Ritz* v. *Florida Patient's Compensation Fund* 436 So.2d 987 (Fla.App. 5 Dist. 1983); but see: *Re Osinchuk* (1983), 45 A.R. 132 (Surr. Ct.). In life-threatening or very serious therapeutic situations, consent could possibly be given by these caregivers who otherwise have no general legal authority to consent. This point, however, is unlikely ever to be legally decided, since those same circumstances would allow a doctor (due to the principle of necessity) to proceed without consent.

[27]*Re Eve*, (1986), 31 D.L.R. (4th) 1 at 14 (S.C.C.), quoting H. Theobald, *The Law Relating to Lunacy* (1924).

This jurisdiction is broad, open-ended and therefore flexible to deal with new or previously uncontemplated situations; ". . . the situations in which the courts can act where it is necessary to do so for the protection of mental incompetents and children have never been, and indeed cannot, be defined."[28]

Parens patriae power must only be used in the best interests of the person being protected.

Where common law or statute law is absent or inadequate to protect children or adults with intellectual or mental health disabilities, a court can intervene and use its *parens patriae* jurisdiction to order what is in the person's best interests, including the giving or refusing of consent to medical treatment.

C. CONSENT TO NON-THERAPEUTIC STERILIZATION

In Canada, however, there is a significant limitation on the legal ability of an authorized substitute decision-maker to consent to medical treatment. No authorized substitute decision-maker can consent on behalf of a legally incompetent minor or adult to the performance of a non-therapeutic sterilization procedure. This law results from the decision of the Supreme Court of Canada in the *Re Eve* case.[29]

"Eve" was a 24-year-old woman who had a mild to moderate intellectual disability. She suffered from extreme expressive aphasia, so that she was unable to communicate perceived thoughts or concepts. At the school for adults with intellectual disabilities which Eve attended, she became close friends with a male student; however, the school authorities intervened to end the relationship.

Her mother, called "Mrs. E." by the courts, wanted Eve sterilized. Mrs. E. was concerned about the emotional effect on Eve if she were to experience pregnancy and childbirth, and felt that Eve could not cope with the duties of motherhood, so that the responsibility for raising the child would fall on Mrs. E. This would be difficult since Mrs. E. was widowed and nearly sixty. Evidence showed that Eve was incapable of effective alternate means of contraception.

Eve was incompetent to consent to medical treatment. Being an adult, she was no longer in her mother's legal custody. Therefore, Mrs. E. asked the Court to make her the committee of Eve's person and to authorize her to consent on Eve's behalf to a tubal ligation for the purpose of contraception.

The Supreme Court stated that strong and unequivocal legislative language would be needed to give a committee the power to authorize a non-therapeutic sterilization. Legislative language that merely empowers a committee to consent to medical treatment is insufficient for that purpose.[30]

Since making Mrs. E. the committee of Eve would not therefore authorize the mother to give consent, the Court went on to consider whether it could authorize the sterilization under its *parens patriae* power.

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[28]*Re Eve*, *supra* n. 27, at 17.

[29]*Re Eve*, (1986), 31 D.L.R. (4th) 1 (S.C.C.); rev'g *Re Eve* (1981), 115 D.L.R. (3d) 283 (P.E.I.S.C., *in banco*); rev'g *sub nom Re E.* (1979), 10 R.F.L. (2d) 317 (P.E.I.S.C.).

[30]*Re Eve*, *supra* n. 27, at 11.

Parens patriae jurisdiction must only be exercised in the best interests of the person concerned. Mr. Justice La Forest, speaking for the unanimous Supreme Court, decided that:

> The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly, the procedure should never be authorized for non-therapeutic purposes under the *parens patriae* jurisdiction.[31]

The Court said that the possibility of being wrong about whether a non-therapeutic sterilization is in a person's best interests makes the risk of authorizing the procedure too high; the sterilization cannot be reversed later if an error of judgment was originally made.[32]

If a court cannot lawfully consent to a non-therapeutic sterilization, it follows that neither can a parent or other substitute decision-maker. The practical result of the *Eve* decision is that no one can consent to a non-therapeutic sterilization on behalf of a person who is legally incapable of consenting personally due to youth, mental health disability or intellectual disability.

This decision does not affect the ability of courts, parents and other substitute decision-makers to consent to therapeutic procedures, including therapeutic sterilization (an obvious example of which is removal of the ovaries to cure ovarian cancer). The Supreme Court defined a "therapeutic" operation as one whose performance is necessary to the physical or mental health of a person.[33] This definition excludes any consideration of social purposes.

An operation performed for social purposes is non-therapeutic by the Supreme Court's definition. The Court clearly considers sterilization for contraception and hysterectomy for menstrual management to be procedures performed for social reasons alone and therefore non-therapeutic.[34]

The Supreme Court did not discuss the specifics of where the line is to be drawn between therapeutic and non-therapeutic sterilization, but simply stated that "utmost caution must be exercised"[35] and that "[m]arginal justifications must be weighed against what is in every case a grave intrusion on the physical and mental integrity of the person."[36]

As an example, the Supreme Court referred to a case where the British Columbia Court of Appeal had ordered a hysterectomy for menstrual management for a pre-menstrual girl with a serious intellectual disability who allegedly had a phobic aversion to blood.[37] The Court of Appeal had characterized the sterilization as therapeutic, but the Supreme Court considered this case to be "at best dangerously close to the limits of the permissible."[38]

If social purposes are to be given a role in these matters, said the Supreme Court, the appropriate body to make that decision is the Legislature. It has the power to enact, subject to

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[31] *Re Eve*, *supra* n. 27, at 32.

[32] *Re Eve*, *supra* n. 27, at 32.

[33] *Re Eve*, *supra* n. 27, at 29.

[34] *Re Eve*, *supra* n. 27, at 31-32.

[35] *Re Eve*, *supra* n. 27, at 34.

[36] *Re Eve*, *supra* n. 27, at 34.

[37] *Re K and Public Trustee* (1985), 19 D.L.R. (4th) 255 (B.C.C.A.), leave to appeal denied [1985] 4 W.W.R. 757 (S.C.C.).

[38] *Re Eve*, *supra* n. 27, at 34.

compliance with the *Canadian Charter of Rights and Freedoms*, a statute that would give a substitute decision-maker the authority to consent to a non-therapeutic sterilization and that would specify the procedure which must be followed.[39]

D. REACTION TO THE *EVE* DECISION

This judgment has engendered a striking divergence of opinion[40] that is notable for its polarization.

To many people, the *Eve* decision is a landmark human rights case[41] that is a "turning point in the fight for recognition of the rights of the mentally handicapped"[42] precisely because it creates an absolute prohibition against the performance of any non-therapeutic sterilization using substituted consent. Since there can be no exception to an absolute prohibition, it is the greatest protection that can be devised to prevent any potential abuse of legally incompetent people by involuntary sterilization.

There is ample historical precedent that such abuse, shameful though it is, can occur all too readily on a collective scale. Mass involuntary sterilization of people with intellectual or mental health disabilities occurred routinely within living memory, rationalized by the pseudo-scientific social theory called eugenics.

Eugenics theory, prevalent from the late 19th century until the 1930's, stated that all manner of physical, mental and social problems (including criminal behaviour, prostitution, illegitimacy, venereal disease, and poverty) could be eradicated by the simple device of involuntary sterilization of people having such problems, so that "undesirable" characteristics would not be genetically transferred to offspring.[43]

Although now known to be manifestly unscientific, sometimes racist and always irrational, this "genetic" explanation of human behaviour was supported by many social theorists, reformers, doctors, psychologists and social workers.[44] It also received a considerable degree of judicial and legislative acceptance in both the United States[45] and Canada. British Columbia[46] and Alberta,[47] for example, had involuntary sterilization legislation, originally based on eugenic ideas and aimed primarily at people with intellectual disabilities, in effect until the early 1970's.

Especially susceptible to abuse by involuntary sterilization were people perceived to be "mentally undesirable" by those having power over them. Even after the popularity of strict

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[39]*Re Eve*, *supra* n. 27, at 32-33.

[40]P. Peppin, "Justice and Care: Mental Disability and Sterilization Decisions" (1989-1990), 6 C.H.R.Y.B. 65 at 66.

[41]See, e.g.: "Supreme court requires consent for sterilization", *Can. Human Rights Advocate*, November, 1986, 7; M. Rioux and K. Yarmol, "The right to control one's own body: A look at the 'Eve' decision" (1987, No. 1), 2 *Entourage* 26.

[42]P. Poirier, "Groups for mentally handicapped hail ruling banning compulsory sterilization", *The Globe and Mail* (Nat. ed.), October 24, 1986, A3.

[43]See, e.g.: B.M. Dickens, "Eugenic Recognition in Canadian Law" (1975), 13 Os. Hall L.J. 547; R.J. Cynkar "*Buck v. Bell*: 'Felt Necessities' v. Fundamental Values?" (1981), 81 Colum. L. Rev. 1418.

[44]Dickens, *supra* n. 43; Cynkar, *supra* n. 43.

[45]For example, the case of *Buck* v. *Bell*, 274 U.S. 100 (1927) where Justice Oliver Wendell Holmes of the United States Supreme Court made the notorious eugenics-based statement, while ordering the involuntary sterilization of a woman who allegedly had an intellectual disability, that "[t]hree generations of imbeciles are enough."

[46]*Sexual Sterilization Act*, S.B.C. 1933, c. 59; *Sexual Sterilization Repeal Act*, S.B.C. 1973, c. 79.

[47]*The Sexual Sterilization Act*, S.A. 1928, c. 37; *The Sexual Sterilization Repeal Act, 1972*, S.A. 1972, c. 87.

eugenics theory waned, the unexamined assumption remained that sterilization is always and unquestionably in the best interests of people with intellectual disabilities. Only recently has this assumption begun to be challenged.

Although attitudes and beliefs about people with intellectual or mental health disabilities are changing for the better, many of our social values (and therefore, our judgments) continue to be clouded by prejudice and misinformed ideas. For this reason, supporters of the *Eve* decision argue that the rights to procreation, to inviolability of the body and to self-determination of these people must always be given priority over concerns that relate to childbirth and child rearing, unless those concerns have a medical foundation.

Another common reason to support *Eve* is because this judgment affirms that, even where it might otherwise appear that non-therapeutic sterilization could be in the best interests of a person, the consequences risked by being wrong are unacceptably high due to the irreversible nature of the procedure and, therefore, such a decision must never be made using substituted consent.

Supporters of the absolute prohibition state that any benefits of non-therapeutic sterilization are outweighed by evidence that involuntary sterilization has a significant negative psychological impact on people with intellectual disabilities, who view it as a symbol of "reduced" or "degraded" human status.[48] This position states that, at a time when "normalization" of lifestyle and "integration" into the larger community are becoming the major goals of our social response to the needs of people with intellectual disabilities, the importance to the achievement of these goals of positive self-image among members of this group cannot be over-emphasized.

Opponents of substituted consent reject the concept that, where a person is legally incompetent to choose non-therapeutic sterilization, such a person's choice can be exercised on that person's behalf by a proxy giving substituted consent. They would state that, on the contrary, no such choice continues to exist and accordingly its exercise cannot be transferred to a third party.[49] The *Eve* decision also rejects that legal fiction and asserts that "[p]roposed non-therapeutic medical treatment such as contraceptive sterilization must be approached by courts as procedures to be done *to* dependent persons, and not procedures to be done *for* them."[50]

However, *Eve*'s blanket prohibition has also been the subject of criticism. The most common criticism is that an absolute prohibition forecloses all possible consideration of individual circumstances that might, in occasional cases, support a non-therapeutic sterilization as being in a legally incompetent person's best interests. According to this view, the position that "non-therapeutic sterilization can never under any circumstances" be in the best interests of a legally incompetent person is just as extreme, inflexible and ultimately unjust as the position that "non-therapeutic sterilization is always" in their best interests. Must the issue be characterized solely as an "either/or" choice between two polarized extremes?

> Once again mentally retarded people have been treated not as individuals, but as a class. Certainly if one were to choose between "let's sterilize them all" and "let's not sterilize any of

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[48]*Re Eve*, *supra* n. 27, at 30; P. Roos, "Psychological Impact of Sterilization on the Individual" (1975), 1 Law & Psychology Rev. 45 at 52. Roos concludes in his article that involuntary sterilization can also result in alienation, depression, sexual insecurity, anxiety due to symbolic castration, regret over loss of child-bearing ability, negative self-esteem, accentuation of conditioned helplessness, and frustration of the need for intimacy.

[49]An example by way of analogy is found in N.K. Rhoden, "Litigating Life and Death" (1988), 102 Harv. L. Rev. 375 at 388: ". . . [I]t is misleading to justify or characterize . . . [an act of substituted consent] as proxy implementation of a right to choose, much as it would be misleading to say that a social worker assigned to bring a profoundly retarded person to some church or other is exercising the incompetent's 'right' to freedom of religion."

[50]B.M. Dickens, "Case Comment: Eve v. E. -- No parental or *parens patriae* power to authorize non-therapeutic sterilization of mentally incompetent persons" (1987), 2 Can. Fam. L.Q. 103 at 112 [emphasis in original].

them," the latter would be preferable. Yet do not such persons, who have so many special needs and challenges, deserve individualized attention on this intensely personal issue? The Supreme Court of Canada said no.[51]

The British House of Lords, while deciding a 1987 case with facts similar to *Eve*, severely criticized the Supreme Court of Canada's blanket prohibition approach. The House of Lords found this absolute prohibition to be "totally unconvincing and in startling contradiction to the welfare principle which should be the first and paramount consideration"[52] in these cases.[53] The Supreme Court's distinction between "therapeutic" and "non-therapeutic" situations was dismissed by the House of Lords as "totally meaningless, and, if meaningful, quite irrelevant to the correct application of the welfare principle."[54]

The Supreme Court's shifting of the focus from the individual to the collectivity has been criticized as a legal contradiction of the fundamental basis, or essence, of the *parens patriae* jurisdiction under which the Court was functioning. This essence requires that a particularized focus be placed on the individual involved in the case. In other words, if a non-therapeutic sterilization was not in Eve's individual best interests, the Court should have made that decision solely for Eve, without going on to pre-judge, in a factual vacuum, every case ever to arise in the future. By using an absolute prohibition to pre-judge all future cases, the Court resolved the general issue on an abstract, disembodied level of collective justice and rights.[55]

According to one critic of the decision,

> . . . the Court had lost sight of the individual, "Eve", in its concern about the social problem. This judgment fails to conform to the normative bases of the *parens patriae* jurisdiction. Its individualized focus is lost and its beneficial thrust is overridden. In this part of the judgment, Eve has become an abstraction, a representative of a class. The individual subject of the application has virtually disappeared.
>
> It was perhaps for this reason that the risks and harm resulting from the Court's own refusal to authorize the sterilization were given such little weight.[56]

An additional criticism is that, not only does an absolute prohibition contradict the essential basis of the *parens patriae* jurisdiction, it places a *de facto* limitation on a jurisdiction that has always been regarded as limitless.[57]

The distinction drawn by the Supreme Court between the concepts of "therapeutic" and "non-therapeutic" as the determinant of whether substituted consent may be given has been

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[51]M.A. Bolton, "Whatever Happened to Eve? A Comment" (1988), 17 Man. L.J. 219 at 226.

[52]*Re B (a minor) (wardship: sterilisation)*, [1988] 1 A.C. 199 at 203 (H.L.). The House of Lords is the British equivalent to our Supreme Court. Its decisions have no legal effect in Canada, but are regarded as influential. The *Re B* case has itself been criticized on numerous factual and legal grounds by British commentators. See, e.g.: R. Lee and D. Morgan, "Sterilisation and Mental Handicap: Sapping the Strength of the State?" (1988), 15 Journal of Law and Society 229; J. Montgomery, "Rhetoric and 'Welfare'" (1989), 9 Oxford J. Legal Stud. 395.

[53]The "welfare principle" is another name for the "best interests" test applied on an individualized basis.

[54]*Re B (a minor) (wardship: sterilisation)*, *supra* n. 52, at 204. *Eve* has also been similarly criticized by Australian judges who have rejected Canada's absolute prohibition approach: *Re a Teenager* (1988), 94 F.L.R. 181 at 201 (Fam. Ct.) and *Re Jane* (1988), 94 F.L.R. 1 at 19 (Fam. Ct.).

[55]Peppin, *supra* n. 40, at 67, 72-73, 107.

[56]*Ibid.*, at 74.

[57]Bolton, *supra* n. 51, at 222.

characterized as an artificial[58] and unclear[59] distinction that diverts attention to semantics,[60] away from a consideration of best interests.[61] Because this distinction really means that "social" purposes like contraception are excluded from a consideration of best interests, it has been argued that

> [t]he effect of the distinction is to fragment the person. In separating physical and mental health from social considerations, the Supreme Court has implicitly rejected the World Health Organization definition of "health" as a "state of complete physical, mental *and social* well-being and not merely an absence of disease or infirmity".[62]

A related criticism of the *Eve* decision focuses on the Court's assertion that ". . . it is difficult to imagine a case in which non-therapeutic sterilization could possibly be of benefit to the person on behalf of whom a court purports to act, let alone one in which that procedure is necessary in his or her best interest."[63] The Court appears to be essentially saying that a "social" purpose like contraception can never be of personal benefit but serves always and only the interests of others. It is argued that this ignores the fact that many people who are legally competent find personal benefit in contraceptive sterilization or they would not choose it over other contraceptive measures.[64] As one critic states, "[m]ight not some of the reasons why mentally competent persons are choosing sterilization be relevant to the consideration of the best interests of a mentally incompetent person?"[65]

The Supreme Court's assertion assumes that the only possible reasons for anyone to undergo sterilization are reasons of simple convenience because sterilization requires no on-going expense, effort or maintenance to be effective. Such reasons would, of course, be dangerous if unthinkingly transferred to a consideration of best interests in a substituted consent situation because here the convenience served would be that of third parties.

Yet, these critics point out, there are other legitimate reasons why people choose sterilization -- for example, to avoid the potential or apprehended adverse medical side effects of long-term use of birth control pills or other contraceptive measures. Sometimes oral or other contraceptives can be medically contra-indicated due to a conflict with a person's medication or medical condition. This criticism argues that considerations such as these, related solely to the person involved, should be equally applicable when assessing the best interests of legally incompetent people.

The *Eve* decision is also criticized because the Supreme Court gave priority, regardless of individual circumstances, to the preservation of reproductive capacity over other values and

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[58]*Re B (a minor) (wardship: sterilisation)*, *supra* n. 52, at 204; M.A. Shone, "Mental Health -- Sterilization of Mentally Retarded Persons -- *Parens Patriae* Power: *Re Eve*" (1987), 66 Can. Bar Rev. 635 at 639.

[59]Shone, *supra* n. 58, at 638; E.W. Keyserlingk, "The Eve Decision -- A Common Law Perspective" (1987), 18 R.G.D. 657 at 670.

[60]Bolton, *supra* n. 51, at 225.

[61]Although one commentator has characterized the distinction as simply being new terminology for the traditional concepts of "best interests" and "non-best interests" and suggests "that all the Supreme Court meant by 'non-therapeutic' was an operation designed for the benefit of others, whether the patient's family or society as a whole": K.McK. Norrie, "Sterilisation of the Mentally Disabled in English and Canadian Law (1989), 38 Int. & Comp. L.Q. 387 at 390.

[62]Shone, *supra* n. 58, at 639 [emphasis in original].

[63]*Re Eve*, *supra* n. 27, at 32.

[64]Peppin, *supra* n. 40, at 73. The most recent statistics apparently show that tubal ligation is the world's most popular method of contraception among married women both in developed countries and in the Third World; "[a]mong developed countries, the procedure is thought to be most popular in Canada, where it's estimated that . . . 30.6 per cent of married women of reproductive age have undergone the procedure. . . .": "Tubal ligation popular", *Winnipeg Free Press*, December 12, 1991, C32.

[65]Shone, *supra* n. 58, at 641.

needs that a person with an intellectual disability might legitimately have. This criticism states that such other values and needs could be jeopardized, in some cases and where alternative means of contraception cannot be used, by pregnancy or child care responsibilities. Examples of these other values and needs include the person's continued ability to accomplish goals and receive satisfaction through participation in work, educational and social activities; the ability to form relationships and experience sexuality without risking pregnancy or paternity; and the ability to maximize personal potential for living a minimally supervised, relatively free life in the community.[66]

Some of the respondents to our Discussion Paper also propounded the foregoing view as part of their reaction to the *Eve* decision, while others stated that, on the contrary, non-therapeutic sterilization would simply lead to more labelling, more restrictions and increased vulnerability. Contradictory opinions were also expressed about the potential efficacy in all cases of education and training concerning birth control or menstrual management. Opinion further split over whether non-therapeutic sterilization would increase the danger of sexual abuse (since the abuser would know pregnancy could not make the abuse evident) or whether it was more realistic to acknowledge the fact of vulnerability to sexual abuse and seek to shield its victim from further unnecessary trauma.

E. THE LAW IN OTHER JURISDICTIONS

A brief survey of the common law in some other major jurisdictions reveals different approaches to these issues.

1. Britain

The principle of necessity that allows doctors to proceed without consent in medical emergencies has recently been used by the British House of Lords to allow doctors to perform non-therapeutic sterilizations on legally incompetent adults where such an operation is considered to be in a patient's best interests. "Best interests" are judged by whether the doctor is acting reasonably and in good faith, in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in that particular form of treatment. It is not mandatory to obtain an advance court order authorizing the procedure, although the Court suggests that to do so would be a matter of good practice. This approach essentially leaves to doctors the substitute decision-making power in this area.[67]

This judgment has been greatly criticized for leaving almost total discretion in the private hands of doctors, for using an inappropriately low and vague test of best interests and for abdicating judicial responsibility to establish stringent guidelines.[68]

This decision has also led to calls in Britain for statutory reform and regulation of substitute decision-making in this area and generally. Both the English and Scottish Law Commissions have recently issued discussion papers on this topic. Neither adopts the blanket prohibition approach of *Eve*; both suggest as their initial position that, for non-therapeutic

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[66]Peppin, *supra* n. 40, at 80; Shone, *supra* n. 58, at 640; See, generally: R. Macklin and W. Gaylin (eds.), *Mental Retardation and Sterilization: A Problem of Competency and Paternalism* (1981) 91.

[67]*F.* v. *West Berkshire Health Authority*, [1989] 2 All E.R. 545 (H.L.). In regard to minors, however, the law continues to require that a prior court order be obtained: *Re B (a minor) (wardship: sterilisation)*, *supra* n. 52.

[68]See, e.g.: M.A. Jones, "Justifying medical treatment without consent" (1989), 5 Prof. Neg. 178; D. Ogbourne and R. Ward, "Sterilization, the Mentally Incompetent and the Courts" (1989), 18 Anglo-Am. L. Rev. 230.

sterilization of legally incompetent adults, prior court or tribunal approval should be mandatory.[69]

2. Australia

Australian courts have generally followed British precedent in this area, rejecting the Canadian blanket prohibition approach. The main controversy has been whether a court's approval is needed before parents may consent to a non-therapeutic sterilization on behalf of a child with an intellectual disability.[70] The latest case in this area[71] is a Full Court decision of the Family Court which adopts the British approach and makes prior court approval optional, in the absence of a statutory requirement.[72]

Two states, New South Wales and South Australia, do have legislation necessitating prior approval by a special tribunal or by a court. These statutes make it clear that non-therapeutic sterilization must be in the person's best interests and be the method of last resort.[73]

3. United States

Historically, eugenic justification for involuntary sterilization was accepted by the United States Supreme Court[74] but the highest Court implicitly overruled itself in a later involuntary sterilization case by declaring the right to procreate to be a constitutional right requiring careful judicial protection.[75] State sterilization laws were, however, widely used until the late 1960's to perform mass involuntary sterilizations on people with intellectual or mental health disabilities.

In 1978, the United States Supreme Court made clear that American courts have equitable jurisdiction to order involuntary sterilizations, even in the absence of statute.[76] However, it is not unfair to say that American courts are currently divided on virtually every other issue in this area. The source of the equitable jurisdiction, the circumstances in which it may be exercised, and the standards to be applied are all questions which divide American courts.

Some cases attempt to establish very specific guidelines to structure judicial discretion when deciding whether to order an involuntary sterilization.[77] Another on-going controversy is whether these cases should be judged using the "best interests" test or the "substituted judgment" test.[78]

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[69]The Law Commission (England), *Mentally Incapacitated Adults and Decision-Making: An Overview* (Consultation Paper #119, 1991) 150-159, 166-170 and especially 178; Scottish Law Commission, *Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances* (Discussion Paper #94, 1991) 108 and 315.

[70]*Re a Teenager* (1988), 94 F.L.R. 181 (Fam.Ct.); *Re Jane* (1988), 94 F.L.R. 1 (Fam.Ct.); *In re Elizabeth*, [1989] F.L.C. 77,361 (Fam.Ct.); *Attorney-General (QLD)* v. *The Parents; In re S* (1989), 98 F.L.R. 41 (Fam.Ct.).

[71]*Re Marion*, [1991] F.L.C. 78,275 (Fam. Ct. F.C.).

[72]Note that the British approach developed for adults has been followed in Australia for children as well.

[73]P. Parkinson, "Family Law" in R. Baxt and G. Kewley (eds.), *An Annual Survey of Australian Law 1989* (1990) 154-155.

[74]*Buck* v. *Bell*, 274 U.S. 100 (1927).

[75]*Skinner* v. *Oklahoma*, 316 U.S. 535 (1942).

[76]*Stump* v. *Sparkman*, 435 U.S. 349 (1978).

[77]See, e.g.: *In re Grady*, 426 A. 2d 467 (N.J.S.C. 1981).

[78]An explanation of these tests is found at pp. 35-36 in Appendix B to this Report.

While many American courts are quite prepared to order involuntary sterilizations in certain circumstances, the divided American case law does contain jurisprudence that, directly or indirectly, supports some elements of the Canadian approach.

For example, the Supreme Court of Wisconsin has also (like the Supreme Court of Canada) declined to exercise its jurisdiction in this area, although for a different and more narrowly stated reason. It held that, in the absence of legislation containing a state's public policy definition of the "best interests" of people with intellectual disabilities, it is inappropriate for a court to exercise its jurisdiction to order an involuntary sterilization or even to set out judicial guidelines for the making of such an order because "a court is not the preferred branch of government to enunciate general rules of public policy. This task should initially be the legislature's."[79] This reasoning would not, of course, support an overt court imposition of a blanket prohibition since that would itself be a general rule of public policy. However, this case and the *Eve* case do end up producing the same practical result.

The Colorado Supreme Court has stated that a court should order an involuntary sterilization only where it is medically necessary to preserve the life or physical or mental health of the incompetent person;[80] in other words (using the terminology of *Eve*), a court should not order a non-therapeutic sterilization. Other cases, however, hold that medical necessity is simply one of many factors and should not, by itself, be determinative.[81]

F. ACTUAL OR PROPOSED LEGISLATIVE RESPONSES TO *EVE* IN OTHER PROVINCES

To date, two provinces (Alberta and Ontario) have seen some kind of actual or proposed legislative response to the *Eve* decision. In addition, Québec has recently enacted legislation affecting the question of substituted consent and non-therapeutic medical care, although the legal impetus for such legislation is not directly attributable to the decision in the *Eve* case.[82]

Like the public and academic reaction to *Eve*, these various approaches manifest opposing views.

1. Alberta

The Institute of Law Research and Reform (Alberta's law reform agency) was the first to issue a Discussion Paper[83] in this area. Following extensive consultation and opinion-gathering, the Institute issued its final Report[84] in 1989.

The Institute finds that contraceptive sterilization is widely practised among the general population, who regard it as personally beneficial. On occasion, there will be individual circumstances that would also make contraceptive sterilization beneficial to a legally incompetent person. The effect of *Eve*, however, is to deny access to the procedure (and,

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[79]*In the Matter of the Guardianship of Joan I. Eberhardy*, 307 N.W. 2d 881 (Wisc. S.C. 1981) at 898.

[80]*In the Matter of A.W.*, 637 P. 2d 366 (Col. S.C. 1981).

[81]*In the Matter of Mary Moe*, 432 N.E. 2d 712 (Mass. S.J.C. 1982).

[82]Apart from statutes, the law in Québec is determined by codified civil law; it is not governed by common law like the rest of Canada. Because the Supreme Court of Canada's decision in *Eve* concerned the common law, it did not affect the law in Québec.

[83]Institute of Law Research and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988).

[84]Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989).

therefore, to its benefit) to one class of people -- those who are legally incompetent to consent personally. The Institute finds this to be discriminatory and unfair, requiring the creation of a legislative mechanism to obtain substituted consent in these circumstances.[85]

The Institute stresses that any mechanism in this area must be carefully devised so that contraceptive sterilization of a legally incompetent person can occur only as a last resort in the absence of all other alternatives and can never be used to benefit third parties rather than the person involved.[86] Thus the model statute prepared by the Institute emphasizes several procedural protections to ensure that maximum "due process" is observed.

Briefly, the Institute's model statute names the province's superior court[87] as the single substitute decision-maker to decide two separate issues. First, the person in respect of whom the application is brought must be proven to be incompetent to consent personally.[88] Secondly, if the person is incompetent, the court must decide whether a sterilization procedure is in that person's best interests.[89]

Procedural protections include independent legal representation for the person in respect of whom the application is brought, a full hearing of all the issues, and mandatory expert evaluations concerning competence and the risks of sterilization.[90] The judge must consider a list of various factors[91] designed to screen out cases where sterilization is excessive or really serves the purposes of others.

To date, the Alberta government has neither endorsed nor implemented the Institute's recommended legislation.

2. Ontario

Ontario currently has a bill before its Legislature that statutorily affirms (and indeed, widens) the *Eve* decision. Bill 108, the *Substitute Decisions Act, 1991*,[92] is part of a wider legislative package[93] designed to reform and codify the law governing substitute decision-making for legally incompetent people in the areas of both property management and personal care decisions, including consent to medical treatment.

Bill 108 provides that a substitute decision-maker can be established for an incompetent person either by a written power of attorney granted by the incompetent person when competent or by being appointed as guardian by a court. The Bill expressly provides that no substitute

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[85]*Ibid.*, at 43-44.

[86]Institute of Law Research and Reform, Report, *supra* n. 84, at 44-45.

[87]Institute of Law Research and Reform, Report, *supra* n. 84, at 60-61.

[88]Institute of Law Research and Reform, Report, *supra* n. 84, at 55-56.

[89]Institute of Law Research and Reform, Report, *supra* n. 84, at 61-63.

[90]Institute of Law Research and Reform, Report, *supra* n. 84, at 74-82.

[91]Institute of Law Research and Reform, Report, *supra* n. 84, at 63-73.

[92]Bill 108, *Substitute Decisions Act, 1991*, 1st Sess., 35th Leg. Ont., 1991.

[93]The package is composed of three bills in addition to Bill 108: Bill 74, *Advocacy Act, 1991*, Bill 109, *Consent to Treatment Act, 1991*, and Bill 110, *Consent and Capacity Statute Law Amendment Act, 1991*, 1st Sess., 35th Leg. Ont., 1991. The package as a whole is generally based on Advisory Committee on Substitute Decision Making for Mentally Incapable Persons (Ontario), *Report* (1989), chaired by Stephen V. Fram.

decision-maker, howsoever established, can give substituted consent to a "sterilization that is not medically necessary for the protection of the person's physical health."[94]

The *Eve* decision left intact a substitute decision-maker's ability to give substituted consent to a therapeutic sterilization; the Supreme Court of Canada defined the concept of "therapeutic" as a procedure necessary to the *physical or mental health* of a person, but excluded any consideration of social purposes.[95] However, the corollary of Ontario's proposed statutory prohibition is that a substitute decision-maker would presumably have the authority to give substituted consent to a sterilization that is medically necessary for the protection of the person's *physical health* only. Note that Ontario excludes the availability of any sterilization based not just on factors of social purposes but also any based on factors of mental health. The practical effect of this is to widen the prohibition established by *Eve*.[96]

As of the time of writing this Report, this Bill and the legislative package of which it is a part are not yet the law of Ontario.[97] It is, of course, unknown whether amendments might occur during the legislative process.

3. Québec

In December, 1991, Québec enacted a massive revision of its *Civil Code* which will come into effect on January 1, 1993.[98] The *Code* creates a system whereby an authorized substitute decision-maker may consent on behalf of a legally incompetent person to "care of any nature, whether for . . . treatment or any other act."[99] It is clear in the *Code* that substituted consent may be given both for therapeutic and non-therapeutic procedures.

A substitute decision-maker must act "in the sole interest" of the incompetent person, taking that person's wishes into account as far as possible, and must ensure that the care is

> . . . beneficial notwithstanding the gravity and permanence of its effects, that it is advisable in the circumstances and that the risks incurred are not disproportionate to the anticipated benefit.[100]

Where a substitute decision-maker consents to care or treatment that is "not required by . . . [the incompetent person's] state of health"[101] (in other words, non-therapeutic), a court's authorization is also required if the care "entails a serious risk for health or if it might cause

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[94]Bill 108, *Substitute Decisions Act, 1991*, 1st Sess., 35th Leg. Ont., 1991, ss. 47(7)(a) and 56(5)(a).

[95]*Re Eve*, *supra* n. 27, at 29.

[96]The model legislation contained in Advisory Committee on Substitute Decision Making for Mentally Incapable Persons, *supra* n. 93, did not propose a similar widening effect (see pp. 256 and 278 of that *Report*).

[97]Bill 108 received Second Reading on June 20, 1991: *Canadian Current Law -- Legislation* (1991, No. 6, August 23, 1991) 286. It and the rest of the legislative package are to be the subject of public hearings commencing in February, 1992 before the Ontario Legislative Assembly's Standing Committee on Administration of Justice (information given on January 27, 1992 by Rosemary Hnatiuk, Communications Advisor with the Ontario Ministry of the Attorney General).

[98]D. Sanger, "Distinct Quebec legal code undergoes major overhaul", *Winnipeg Free Press*, December 19, 1991, A8. The new *Civil Code* will be brought into effect by an implementing statute to be introduced in the session of the Québec National Assembly scheduled to open in March, 1992.

[99]Art. 11 *C.C.Q.*

[100]Art. 12 *C.C.Q.*

[101]Art. 18 *C.C.Q.*

grave and permanent effects."[102] In a non-therapeutic situation, the court must respect any refusal by the incompetent person to undergo the procedure.[103]

It appears, therefore, that Québec will be the only province in Canada where a court could authorize a non-therapeutic sterilization for a legally incompetent person.

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[102]Art. 18 *C.C.Q.*

[103]Art. 23 *C.C.Q.* This is not the case when the proposed treatment is therapeutic.

CHAPTER 3

SHOULD THERE BE A LEGISLATIVE RESPONSE IN MANITOBA TO THE *EVE* CASE?

The central and most sensitive issue of this whole contentious area is, of course, whether legally incompetent people should ever have access to or be subject to non-therapeutic sterilization when they do not have the legal capacity to choose this procedure personally by consenting. By issuing a Discussion Paper without advocating or recommending any specific legislative proposal, the Manitoba Law Reform Commission sought to raise this issue in an impartial and non-judgmental way for public response.

Some conclusions about that public response were immediately apparent to the Commission from the written briefs received. First, the briefs are fairly evenly divided for and against a legislative response to *Eve*. Secondly, the views on both sides are held and argued with passionate conviction. Thirdly, the opposing camps are extremely polarized; it is not unfair to say that they are diametrically opposed with no possible middle ground that could reconcile the two positions.

The passion and polarization of the opposing positions illustrate a fact that has become a troubling consideration for the Commission: while a resolution of the central issue in this area will lead to one of two legal consequences, the real decision to be made here is not a legal one. No legal criterion, in the narrow or technical sense, is of any assistance in making the difficult choice necessary to settle the central issue.

Nor is this decision a social policy decision of the kind typically handled by law reform commissions. Many (if not most) law reform questions simply require the making of a subjective choice or value judgment between legal solutions where both or all of these solutions nevertheless share the same ultimate set or framework of social assumptions and philosophy. In other words, any chosen solution will not constitute a fundamental challenge to an entire infrastructure of generally accepted social values or norms, even though it will have social policy implications.

By contrast, however, this decision involves the making of a subjective choice or value judgment precisely between two legal solutions that represent two different and irreconcilable sets of underlying assumptions and philosophical viewpoints. It is an ideological decision in the most fundamental sense, qualitatively different from the previously discussed "social policy" type of decision.

It appears that two of the most basic differences between these competing sets of assumptions and viewpoints concern the exact nature of the human rights issue at stake and how best to protect human rights generally.

The position advocating a legal mechanism to provide for substituted consent frames the human rights issue as one of equality of access among groups of people. If access can result in a benefit to a person, then denial of such access on the basis of group membership is clearly a breach of human rights, since human rights exist precisely to guarantee equal access to benefits. The central issue is, therefore, the question of benefit.

This side adopts the more traditional view of how human rights may best be protected in general. This view emphasizes that the rights of the individual are more important than collective rights, in that the former should never be sacrificed for the latter. It is based on the premise that doing justice to the individual cannot result in injustice on a collective scale.

The position advocating no substituted consent under any circumstances frames the human rights issue as security of the person against unauthorized interference. Whether or not unauthorized interference is beneficial should not be the main focus of inquiry; the real issue is when, if ever, society's interests in interference should be allowed to outweigh a person's private interest in bodily integrity.

This side adopts the less traditional view of how human rights may best be protected in general. This view emphasizes that protection of the collectively-defined group is the best protection for the individual. It is based on the premise that doing justice to the collectivity cannot result in injustice on an individual scale.

The conclusions drawn by either position flow automatically, in a logical and supportable manner, from acceptance of that particular position's underlying assumptions and premises. It is important to keep in mind, as stated in the context of a slightly different analysis of this issue, that

> . . . those on both sides of this debate take their stance on the basis of ethical considerations; it is not a matter of one approach being ethical and the other unethical. Rather there is a clash between two different ethics, one holding that sterilization can sometimes make it possible for the mildly retarded to enter more completely into the moral community, the other holding that sterilization is an abridgment of human rights, regardless of the good that may issue from it. The object of those on both sides of this question is to *help* the retarded, however different the results of the application of the two points of view may be.
>
> . . . The complexity of these issues ensures that equally caring and perspicacious individuals will continue to find themselves in opposition on certain points.[1]

Any decision about which of the two competing positions should prevail is (and can only be) a subjective decision to prefer one ideological set of underlying assumptions and premises over the other.

The recognition of the issue of substituted consent and non-therapeutic sterilization as a fundamental human rights issue (however framed) acknowledges its qualitative difference from other questions of social choice. It is not an overstatement to say that no more serious or important decisions exist in our society than those concerning human rights. These issues demand the most prudent and cautious of approaches.

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[1]R. Macklin and W. Gaylin (eds.), *Mental Retardation and Sterilization: A Problem of Competency and Paternalism* (1981) 117-118 [emphasis in original].

The necessity of deciding this issue on ideological grounds of social philosophy rather than on narrower, more technically "legal" considerations is again illustrated when it comes to making the legal assessment whether legislation in this area (no matter how great its protection of due process) would comply with section 15 of the *Canadian Charter of Rights and Freedoms*.[2] Here, too, it appears that whether any legislation would be held to breach the equality rights guaranteed by subsection 15(1)[3] of the *Charter* or would fail to be saved under section 1[4] depends precisely on which of the two competing frameworks of assumptions and premises is accepted by the court as the starting point of its legal analysis -- and, of course, these are the same two competing views, with all the same arguments, involved in deciding whether or not a legislative response is needed to *Eve* in the first place.

It is now settled that a law can treat various groups differently without automatically violating equality rights.[5] The crucial question is the purpose of differential treatment, not the simple existence of differential treatment in and of itself. If the singled-out group is seen by the court as a vulnerable group receiving a protective benefit from the impugned statute, differential treatment is more likely to be seen as enhancing, not impairing, the group's equality rights.[6] Therefore, if a court accepts that legislation allowing substituted consent for non-therapeutic sterilizations confers a protective benefit upon legally incompetent people so that they may have the same access to a particular birth control method as legally competent people, it would likely be held not to offend section 15 or, at least, to be justifiable under section 1.[7]

However, if a court accepts that sterilization legislation is designed to target people with intellectual or mental health disabilities for the purpose of subjecting them to forced sterilization in derogation of the rights to procreate and to security of the person from unauthorized interference that are enjoyed by everyone else, then obviously it cannot survive a section 15 challenge and is unlikely to be justifiable under section 1.

Whatever choice is made between the two sets of starting assumptions and premises determines both how the human rights issue is delineated and whether section 15 is judged to be breached or affirmed by any given position. Since commentators on this issue, whether they be private respondents to our Discussion Paper or academic critics, accept as their starting position

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[2]*Canadian Charter of Rights and Freedoms*, being Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11.

[3]"Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

[4]"The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

[5]*Andrews* v. *Law Society of British Columbia* (1989), 56 D.L.R. (4th) 1 (S.C.C.).

[6]See, e.g.: *Dayday* v. *MacEwan* (1987), 62 O.R. (2d) 588 (Dist. Ct.) [upholding mental health legislation permitting involuntary detention]; *Abrahamson* v. *Buckland*, [1989] 6 W.W.R. 762 (Sask. Q.B.) [upholding an infant (incompetent) party's immunity from examination for discovery].

[7]Under the *Oakes* test to have a statute upheld under section 1 despite its breach of a *Charter* right, a government has to be able to show that the statute addresses a pressing and substantial objective, that the law is rationally connected to that objective, that it is the least drastic means necessary to accomplish the objective (here all the due process and mandatory considerations of the Alberta model would be crucial), and that the law must not have a disproportionately severe effect on the persons to whom it applies. The Supreme Court is currently unclear about whether the *Oakes* test is appropriate in equality cases: *Andrews* v. *Law Society of British Columbia*, *supra* n. 5; P. Hogg, "Section 1 Revisited" (1991), 1 Nat. J. Constit. L. 1 at 2.

one doctrine or the other, they often simply assume (and regard as self-evident) that section 15 of the *Charter* will accordingly affirm their position and be breached by the other.[8]

Therefore, as with the threshold issue of legislative response, no "legal" criteria *per se* are particularly useful in trying to assess the section 15 situation. The constitutionality of any legislation in this area will thus also be determined by a subjective decision to prefer one ideological set of underlying assumptions and premises over the other.

Any court deciding this issue would, of course, be referred to the judicial attitude present in *Re Eve* where the Supreme Court clearly did not view the human rights issue as one of access but, rather, as one of security of the person and the right to procreate. Although the facts of *Re Eve* arose prior to the coming into force of section 15 of the *Charter* so that this section could not play an official part in the judgment, Mr. Justice La Forest did make *obiter*[9] comments on this issue.

Mr. Justice La Forest said that preventing access to non-therapeutic sterilizations is not a denial of equality rights on the basis of "mental disability". In fact, to frame the issue as such essentially requires the use of a legal fiction already rejected by the Court in the context of the "substituted judgment" test -- namely, the legal fiction that what is really going on is somehow the choice of the legally incompetent person and not that of a third party. The court's protective function

> . . . must not . . . be transformed so as to create a duty obliging the court, at the behest of a third party, to make a choice between two alleged constitutional rights -- the right to procreate or not to procreate -- simply because the individual is unable to make that choice.[10]

Certainly these *obiter* comments lend weight to the position advocating no substituted consent, but these comments are not necessarily determinative of the *Charter* issue. The presence of *obiter* comments cannot guarantee that any future court (including the Supreme Court itself) would take the same approach.

Another troubling issue for the Commission has been trying to determine whether, in practical terms, there is a "need" for law reform in this area. In other words, does *Eve*'s prohibition now work a hardship in actual fact on any legally incompetent people, such that law reform is needed to rectify the situation?

The problem is that even how this particular issue is framed and explored is also largely a question of ideological starting point. The concept of "need" presupposes that the object of the need is a "benefit", not a detriment. This presupposition cannot be made in this context, however, because the question of benefit or detriment is itself one of the central controversies in this area.

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[8]As a result, section 15 receives little actual analysis in this area. See, e.g,: E.W. Keyserlingk, "The Eve Decision -- A Common Law Perspective" (1987), 18 R.G.D. 657 at 674-675. Because the author frames the issue as one concerning right of access, the only equality issue seen is that a denial of such access would be discrimination. The Alberta Institute of Law Research and Reform also gave no more than a passing mention to section 15 in both *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion #6, 1988) and *Competence and Human Reproduction* (Report #52, 1989), again because it framed the issue as one concerning right of access to a benefit.

One academic reviewer criticized the Institute for framing the issue in this way because "[t]o classify sterilization as a privilege *de facto* determines the conclusion. Whatever the merits of the views presented in the Report, the reader is immediately struck with a sense of being set-up." The author did, however, also recognize that framing the issue as one concerning security of the person "could also be seen as equally determinative of the result": M.L. McConnell, "Review of *Competence and Human Reproduction*" (1990), 69 Can. Bar Rev. 411 at 411-412.

[9]An *obiter* comment is a statement of opinion that is not essential for deciding the judgment and so is not a binding precedent on any other court or judge.

[10]*Re Eve*, (1986), 31 D.L.R. (4th) 1 at 36 (S.C.C.).

Thus, those who advocate no substituted consent usually state that there is no practical "need" for a consent mechanism because they believe that non-therapeutic sterilization can never be classed as a benefit to legally incompetent people. From their perspective, any "need" that exists is not an individual need for a particular method of contraception but, rather, a collective need for security against the possible misuse of any legal mechanism for substituted consent, which possible misuse threatens every Manitoban with an intellectual disability.

Those who advocate the creation of a substituted consent mechanism do accept, of course, that non-therapeutic sterilization can sometimes be a benefit to an individual who is legally incompetent. This acceptance makes it possible for them to assert that a practical "need" for non-therapeutic sterilization now exists or will occur sooner or later (given the infinite variety of human circumstances), even though they acknowledge that it will be an occasional, even rare, situation where required birth control cannot be effectively or safely provided other than through the method of non-therapeutic sterilization.[11]

The only way to approach this issue without pre-judging the results is to try simply to determine whether there continues to be, after the *Eve* decision, a "demand" for the now-prohibited procedure. If a demand continues to exist, it is then an ideological decision whether such demand constitutes "need".

Unfortunately, the Law Reform Commission found it impossible to measure demand in any scientifically or statistically valid manner;[12] our assessment is therefore necessarily based on anecdotal information that is often hearsay and not necessarily representative or complete. However, with that caveat in mind, it appears from our discussions with numerous doctors, hospital executives, service organizations and advocacy organizations that demand[13] has definitely decreased since the *Eve* decision and now occurs only infrequently.

By way of example, we were advised by officials of the Manitoba Developmental Centre in Portage la Prairie that, since *Eve*, there have been only two cases among their 585 residents where, at the request of the family, they would have wanted to have sterilizations performed if a legal mechanism existed for consent.[14] The Office of the Public Trustee, which perhaps in many ways is in an ideal position to assess potential overall demand, estimated for us that, if a legal mechanism to obtain consent existed, there might be a maximum of one court application per year and possibly not even that.[15]

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[11]The Alberta Institute of Law Research and Reform, in its final Report, was able to cite two current Alberta cases where the *Eve* prohibition prevents the performance of non-therapeutic sterilizations that the Institute believes would be a benefit for the specific women involved and not in any way for the benefit of others: Institute of Law Research and Reform, Report, *supra* n. 8, at 38-40.

[12]No relevant statistics are kept by the Manitoba Bureau of Statistics or Statistics Canada. While the Manitoba Health Services Commission can generate statistics concerning the number of sterilizations performed per year, we were advised that the statistics cannot distinguish between therapeutic and non-therapeutic procedures, nor can they identify the presence of intellectual or mental health disabilities, and only at great expense could the statistics be made even to distinguish the demarcation year of 18 between minors and adults.

[13]During the course of our inquiry into demand, disturbing rumours were cited on various occasions that, despite the *Eve* prohibition, parents of minor children with intellectual disabilities could sometimes still obtain a non-therapeutic sterilization from some Manitoba doctors willing to operate on the strength of parental consent. There was no way to substantiate whether such rumours have a basis in fact or are completely unfounded.

[14]Interview of February 22, 1990 with Mr. Steve Bergson, Acting Chief Executive Officer, Dr. S. Kang, Medical Director, Mr. Byron Flatman, Director of Nursing, and Dr. Rae Lowther, Program Director, all of the Manitoba Developmental Centre.

[15]Interview on January 25, 1990 with Anne Bolton, Counsel, Office of the Public Trustee of Manitoba.

There is even the view that demand will virtually disappear in time due to scientific advances in contraception[16] that would make irreversible surgical sterilization an obsolete method.[17] But this scenario remains in the future and is not without its own problems.[18]

In any event, calculating demand (however imprecisely) is ultimately an inadequate basis on which to justify a decision about law reform. There can be a large demand for an unjust law; the size of the demand would not justify a recommendation for law reform. There can be a small demand for a just law; the size of the demand would not justify a failure to recommend law reform.

In other words, an ideological choice must still be made about the moral or social interpretation to be placed on the factual existence of demand. Thus, this approach also illustrates that the real decision to be made here is not a legal decision or even a social policy decision, but a more fundamental ideological decision.

The Commission has been more troubled by the issues raised in this Report than perhaps by any other law reform issues we have faced. We have carefully considered each side of this emotional debate and, in doing so, we share some of the reservations about *Re Eve* that have been expressed by critics of that decision.

Yet, after long deliberation and for the reasons explored in this Chapter, the Commission does not feel in a position to recommend what would be, in either case, a subjective choice preferring one ideological set of underlying assumptions and premises over the other. While the Commission recognizes that social policy decisions are an integral part of making law reform recommendations, we perceive this particular issue to be one of those qualitatively different, albeit rare, instances where an acute ideological choice must be made.

Such a fundamental question of ideology that carries profound human rights implications is, we believe, best handled directly by, and addressed in the first instance by, the government and the Legislature composed, as they are, of elected members representative of the entire population. Their mandate and moral authority to recommend to the public (let alone to enact) changes in fundamental social areas have been conferred directly by that public to whom these bodies are accountable for any action taken or not taken. The Legislature is in the best position to provide an open and accessible atmosphere for the necessarily non-partisan exploration required by the two ideologies at stake here.

These bodies also have the advantage, in this particular case, of directly overseeing the health and social services system that serves the population involved in this issue; they may accordingly be in a better position to obtain scientifically or statistically valid information concerning both demand and whether there is any factual basis to the rumours of continuing non-therapeutic sterilizations.

It goes without saying, of course, that should the government make the ideological decision that a legislative response to *Eve* is required in Manitoba, the Commission would be

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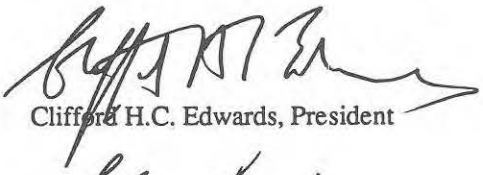
[16]For example, a new kind of long-lasting hormonal contraceptive that is reversible and virtually "maintenance-free" has recently been approved for use in the United States. The contraceptive, called "Norplant", is inserted just beneath the skin in a woman's upper arm, requiring only a brief, minor surgical procedure once every five years. Fertility is restored, if desired, less than 48 hours after removing the contraceptive. In clinical trials, Norplant has proven more effective than currently-available oral contraceptives. However, its long-term safety has yet to be fully studied. Its known side effects are longer or irregular menstrual bleeding: A. Purvis, "A Pill That Gets Under the Skin", *Time* (Can. ed.), December 24, 1990, 44. Norplant is currently undergoing clinical trials in Canada, but has not yet been approved for use in this country.

[17]See, e.g.: B. Sneiderman, "Sterilization poses difficult problem", *Winnipeg Free Press*, December 28, 1990, 7.

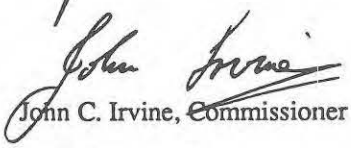
[18]It raises, primarily, the usually unconsidered and unexplored issue of the validity of substituted consent given to non-therapeutic, but reversible, treatments or procedures like birth control. Should simple reversibility of superficial medical effect justify these substituted decisions and, moreover, justify them in the absence of any protection of due process?

prepared to assist in the consequent devising of a statutory model that would best protect an individual's right to due process.

This is a Report pursuant to section 15 of *The Law Reform Commission Act*, C.C.S.M. c. L95, signed this 27th day of January, 1992.



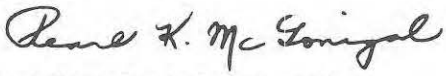
Clifford H.C. Edwards, President



John C. Irvine, Commissioner

Gerald O. Jewers, Commissioner

Eleanor R. Dawson, Commissioner



Pearl K. McGonigal, Commissioner

APPENDIX A

LIST OF PERSONS AND ORGANIZATIONS TO WHOM COPIES OF THE DISCUSSION PAPER WERE SENT

Hon. James C. McCrae, Minister of Justice and Attorney General, Province of Manitoba

Graeme Garson, Deputy Minister of Justice and Attorney General, Province of Manitoba

Tom Hague, Acting Assistant Deputy Minister of Justice and Director, Legal Services Branch, Manitoba Justice Department

Gary Doer, Leader of the Official Opposition, Province of Manitoba

Sharon Carstairs, Leader of the Liberal Party, Province of Manitoba

F.A. Maynard, Deputy Minister of Health, Province of Manitoba

R. Freedman, Deputy Minister, Department of Family Services, Province of Manitoba

R.W. Toews, Assistant Deputy Minister, Mental Health Division, Province of Manitoba

Joe Cels, Assistant Deputy Minister of Family Services, Province of Manitoba

R.J. Ross, Executive Director, Regional Operations, Departments of Health and Family Services, Province of Manitoba

Martin Billinkoff, Executive Director, Research and Planning, Department of Family Services, Province of Manitoba

Brian Law, Director, Children's Special Services, Child Welfare Directorate, Province of Manitoba

Office of the Public Trustee, Winnipeg

Dr. D.D. Rodgers, Chief Provincial Psychiatrist, Province of Manitoba

Dr. Glen Lowther, Chief Medical Consultant, Department of Family Services, Province of Manitoba

Manitoba Human Rights Commission

Debra Beauchamp, Manitoba Human Rights Commission

Ontario Ministry of Health

Association for Community Living -- Manitoba [which then distributed copies to its 19 constituent groups: Arborg, Beausejour, Brandon, Carman, Dauphin-Grandview, Portage la Prairie, Red River Branch (St. Malo), Flin Flon, Gimli, Interlake Branch, Morden, Touchwood

Park (Neepawa), Thompson, Selkirk, Steinbach, Swan Valley Branch (Swan River), Virden, Winkler, and Winnipeg]

Canadian Association for Community Living, North York, Ontario

Opportunities for Independence, Inc., Winnipeg

Brandon Citizen Advocacy Inc.

Citizen Advocacy Winnipeg, Inc.

Coalition of Provincial Organizations of the Handicapped (C.O.P.O.H.), Winnipeg

Independent Living Resource Centre, Winnipeg

Manitoba Association for Rights and Liberties

Manitoba Action Committee on the Status of Women

Consulting Committee on Status of Women with Disabilities, Winnipeg

Charter of Rights Coalition of Manitoba

Manitoba Association of Women and the Law

Canadian Disability Rights Council, Winnipeg

Women's Resource Centre, Winnipeg

Manitoba Developmental Centre, Portage la Prairie

St. Amant Centre, Winnipeg

S.P.I.K.E. Inc., Winnipeg

The Pas Children's Home Inc.

Winnserv Inc., Winnipeg

L'Arche Winnipeg, Inc.

College of Physicians and Surgeons of Manitoba

Manitoba Medical Association, Ethics Committee

Manitoba Medical Association -- Manitoba Bar Association Liaison Committee

Manitoba Medico-Legal Society

Manitoba Health Organizations Incorporated

Canadian Medical Association, Ottawa

Women's Health Clinic, Winnipeg

Victoria General Hospital, Winnipeg

Seven Oaks General Hospital, Winnipeg

Misericordia General Hospital, Winnipeg

Concordia General Hospital, Winnipeg

Grace General Hospital, Winnipeg

St. Boniface General Hospital, Winnipeg

Health Sciences Centre, Winnipeg

Health Sciences Centre, Ethics Advisory Committee, Winnipeg

Brandon General Hospital

Portage District General Hospital

Dauphin General Hospital

Flin Flon General Hospital

Thompson General Hospital

Dr. P. Hall, Head, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. S. Banchez, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. S. Gader, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. S. Taylor, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. T. Cosalka, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. R. Ke, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. A. Marzouki, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. G. Reid, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. C. Conrod, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. G. McTavish, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. A. El-Sayed, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. C. Stark, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. D. Black, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. M. Burnett, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. C. Lalonde, Department of Obstetrics, St. Boniface General Hospital, Winnipeg

Dr. B.B.K. Pirani, Winnipeg

Dr. J. Arneja, Winnipeg

Dr. C. Shah, Winnipeg

Canadian Mental Health Association -- Manitoba Division

Central Region Community Health Centre, Portage la Prairie

Brandon Mental Health Centre

Child and Adolescent Program (Mental Health Centre), Brandon

John Simpson, Brandon Mental Health Centre, School of Psychiatric Nursing

Community Mental Health Services (Manitoba Health), Winnipeg

Child & Adolescent Mental Health Services, Winnipeg

Manitoba Adolescent Treatment Centre (M.A.T.C.), Winnipeg

Selkirk Mental Health Centre

Central Winnipeg Child and Family Services

Winnipeg West Child and Family Services

North West Child and Family Services, Winnipeg

North East Region Child and Family Services, Winnipeg

Child and Family Services of Eastern Manitoba

Winnipeg South Child and Family Services

Jewish Child and Family Services, Winnipeg

Child and Family Services of Western Manitoba, Brandon

Child and Family Services of Central Manitoba, Portage la Prairie

West Region Child and Family Services, Dauphin

Anishinaabe Child and Family Services, Fisher River

Awasis Agency of Northern Manitoba, Thompson

Dakota Ojibway Child and Family Services, Brandon

Sagkeeng Child and Family Services, Pine Falls

Ma-Mawi-Wi-Chi-Itata Centre Inc., Winnipeg

Peter Donovan, Winnipeg

Catherine Mullane, Winnipeg (now of New South Wales, Australia)

Margaret Halloway, Winnipeg

Dean Roland Penner, Faculty of Law, University of Manitoba

Prof. Barney Sneiderman, Faculty of Law, University of Manitoba

Prof. Karen Busby, Faculty of Law, University of Manitoba

Prof. Arthur Schaeffer, University of Manitoba, Winnipeg

Prof. Jim MacKenzie, Department of Law, Carleton University, Ottawa

Master M.A. Bolton, Court of Queen's Bench, Province of Manitoba

Arne Peltz, Director, Legal Aid Public Interest Law Centre, Winnipeg

Martin Glazer, Chairperson, Civil Liberties Subsection, Manitoba Bar Association

Sherri Wiebe, Chairperson, Health Law Subsection, Manitoba Bar Association

Jack King, Chairperson, Family Law Subsection, Manitoba Bar Association

A.L. Gunson, lawyer, Winnipeg

Joan McPhail, Family Law Branch, Manitoba Justice Department

Doug Buhr, City of Winnipeg Law Department

Irwin Warkentin, lawyer, Winnipeg

Debbie Carlson, Constitutional Law Branch, Manitoba Department of Justice

Glen Lupton, Civil Litigation Branch, Manitoba Justice Department

Indra Maharaj, lawyer, Winnipeg

Kristin Dangerfield, lawyer, Winnipeg

Gurdeep Chahal, lawyer, Winnipeg

Michael Williams, lawyer, Winnipeg

Terri Deller, lawyer, Brandon

E.A. Wehrle, lawyer, Winnipeg

Jayne Kapac, lawyer, Winnipeg

Koren Kaminski, lawyer, Winnipeg

Bob Fisher, lawyer, Winnipeg

LIST OF PERSONS AND ORGANIZATIONS WHO RESPONDED TO THE DISCUSSION PAPER

Association for Community Living -- Interlake Branch, Stonewall

Association for Community Living -- Manitoba, Inc.

Association for Community Living -- Virden

Canadian Association for Community Living, North York, Ontario

Canadian Medical Association, Ottawa, Ontario

Child and Family Services of Western Manitoba, Brandon

College of Physicians and Surgeons of Manitoba

Marje Kawchuk, Virden

Manitoba Action Committee on the Status of Women

Manitoba Health Organizations Incorporated

Manitoba Medical Association

Catherine Mullane, New South Wales, Australia

Dr. D.D. Rodgers, Chief Provincial Psychiatrist, Province of Manitoba

St. Amant Centre Inc., Winnipeg

APPENDIX B

SUMMARY OF RESPONSES CONCERNING DUE PROCESS

A. INTRODUCTION

The Commission's Discussion Paper included, for the sole purpose of eliciting opinion, a copy of the model legislation prepared in this area by Alberta's Institute of Law Research and Reform.[1] The Commission did not formally recommend the adoption of the Alberta model statute in our province, but merely presented it to provide a framework or focal point for discussion since it represented at that time the most recent, thoroughly-considered and comprehensive legislative model in Canada.

Many respondents to the Discussion Paper commented at length on aspects of the Alberta model.[2] Should the government ultimately make the decision that a legislative response creating a consent mechanism is required in Manitoba, these comments may then be of some use in considering what elements a legislative model should contain for the protection of due process and are accordingly summarized here for that reason.

B. WHO SHOULD BE SUBSTITUTE DECISION-MAKER(S)?

1. One Decision-maker or Two?

Should a statute in this area specify the same or different decision-makers for the separate questions of competence and whether to authorize a non-therapeutic sterilization? Most respondents who commented on this issue favoured a single decision-maker, although without discussing reasons for this preference.

A minority favoured two decision-makers, with suggested combinations being a superior court (concerning competence) and a special tribunal (about whether to authorize sterilization); a different special tribunal for each question; and doctors (concerning competence) and a superior court (about whether to authorize).

2. Potential Decision-makers

Who should be vested with the authority to decide the question of competence or to give the substituted consent necessary to authorize a non-therapeutic sterilization? A majority of respondents who commented on this issue favoured a special tribunal as decision-maker(s), while a superior court was the next favoured option. One respondent supported doctors as decision-makers; no respondent suggested that decision-making be left in the private hands of parents, guardians or committees.

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[1]Institute of Law Research and Reform, *Competence and Human Reproduction* (Report #52, 1989) 9-20.

[2]While not all respondents commented on every issue, a couple of respondents refused for explicit reasons of principle to comment on any aspect of the model statute, in order to emphasize that attention must not be too hastily diverted from the central threshold question of whether a legislative response is needed or appropriate.

Respondents who favoured special tribunals often suggested an interdisciplinary mix of experts and lay people. Suggested experts included lawyers, doctors, psychiatrists, psychologists and social workers. Suggested lay people included independent advocates for people with intellectual or mental health disabilities, parents, and community representatives (including relatives) who have personal experience with people who have intellectual or mental health disabilities.

An opponent of special tribunals expressed the fear that a body especially established for the purpose of potentially authorizing sterilizations might authorize a certain number of these procedures in order to justify its own continued existence. Therefore a court should be the preferred decision-maker since it is already established for general and other purposes.

An opponent of courts disputed a statement made in the Discussion Paper that judges are experienced in determining competence. All judges do, said this respondent, is place unquestioning trust in medical opinions; judges may actually be one of the least informed professional groups about people with intellectual or mental health disabilities.

C. THE NEED FOR PROCEDURAL SAFEGUARDS (DUE PROCESS)

Extensive procedural safeguards would have to be built into any mechanism for substituted consent not only in order to comply with section 7 of the *Charter*[3] but also because such safeguards are the strongest protection that our legal system can provide against abuse of process or capricious decision-making.

1. Independent Legal Representation

The majority of respondents who commented on this issue endorsed mandatory independent legal representation for the person in respect of whom the application was brought.

One respondent, whose decision-making model included an appeal route to the courts, felt that independent legal representation would not be necessary at the special tribunal level since it would be available later if any appeal were taken.

Another respondent felt that this requirement was misleading, patronizing and illogical because a person who is legally incompetent to consent would also be legally incompetent to instruct counsel. This makes the requirement mere "window dressing" that only gives the appearance of fairness.

2. Full Hearing of the Issues

(a) Mandatory expert evaluations

The model statute obliges the person who initiates the application to file immediately a report from a physician and a psychologist containing their expert opinions on the questions of competence and any sterilization-related risks to the physical or mental health of the person in respect of whom the application is brought.

Of the respondents who commented on this issue, six were in favour of this requirement. One other respondent stated that it is illogical to have this requirement for minors. According to

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[3]"Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice": *Canadian Charter of Rights and Freedoms*, s. 7, being Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11.

this respondent's view of the law, minors are subject to a positive legal presumption of incompetence until the age of majority. The onus for refuting that presumption (by demonstrating that the minor is a "mature minor" and therefore capable of consent) falls on the minor. Therefore, in regard to minors, it is not up to the applicant to prove incompetence but for the minor to refute it if possible.

(b) Decision-maker has powers of commissioner

This feature would essentially allow the decision-maker to take an active role in calling witnesses and obtaining evidence rather than being bound by the traditionally passive role of a judge who can hear only what the parties choose to present.

Of the respondents who commented on this issue, six supported it and one opposed it (apparently for the reason that it would make a special tribunal too much like a court).

(c) Discretionary meeting between the decision-maker and the legally incompetent person

The model statute proposed this feature so that, in cases where the person in respect of whom the application is brought is not present at the hearing, the decision-maker could (if desired) obtain a personal impression of the person's competence or of the likely effect of sterilization.

Of the seven respondents who commented on this issue, one opposed it because the decision-maker's personal observations or personal knowledge would not be a matter of public record. The six respondents who favoured this feature split evenly over whether the meeting should be discretionary or mandatory in all cases. One respondent further suggested that the affected person's advocate should be present at any private meeting.

3. Other Suggested Procedural Safeguards

One respondent suggested that it should be mandatory that the person in respect of whom the application is brought be present at all times during the hearing.

Another respondent suggested that interested parties (like parents, guardians or caregivers) should have the right, with public funding, to hire or to act themselves as advocates with status in the proceedings.

D. BASIS FOR STERILIZATION DECISION: "SUBSTITUTED JUDGMENT" OR "BEST INTERESTS" TEST?

This issue concerns which of two possible conceptual standards should be used to assess whether a non-therapeutic sterilization would be beneficial.

The "substituted judgment" test (derived from American law) requires the decision-maker to assess all relevant factors and to make the decision that the legally incompetent person would have personally made if that person were not legally incompetent. The decision-maker must pretend, in the most subjective manner possible, to be the person involved and must make the choice that person would have made, even if it is not the "best" or "most reasonable" choice.

The "best interests" test (which is the traditional English and Canadian approach) combines the objectivity of a reasonable person with the subjectivity of the particular individual's circumstances in an effort to determine what is in the person's best interests, whether or not that

person would have personally made a similar choice. It is vaguely defined and leaves great discretion in the hands of the decision-maker.

No respondent favoured the "substituted judgment" test. Seven respondents approved of the "best interests" test as the proper standard to be applied. One respondent rejected both tests. Two respondents proposed an amalgam of both tests.

E. WHAT FACTORS MUST THE DECISION-MAKER CONSIDER BEFORE AUTHORIZING A NON-THERAPEUTIC STERILIZATION?

The Alberta model lists a large number of mandatory considerations about which we asked our respondents to consider and comment. This list of mandatory factors was mainly compiled from Canadian and American case law and is really a distillation of what the judiciary has said is necessary to fully consider the question of best interests.

The primary mandatory consideration is contained in section 5 of the Alberta model. It provides that the decision-maker must consider the steps taken to inform the legally incompetent person of factors relevant to undergoing or not undergoing sterilization and to assist the person in participating in the decision. The decision-maker must then consider the wishes and concerns expressed by the person after having been so informed and assisted. The purpose of this provision is to ensure that the incompetent person is fully informed and involved in the decision-making process to the extent that this is possible.

In addition to this primary factor, the Alberta model lists, in section 6, another fifteen mandatory considerations, plus a final category of "any other matter that the judge considers relevant" to cover any special or extraordinary individual circumstances not covered in the other categories. The fifteen mandatory considerations listed in section 6(1) are:

(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, and

(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.

Where the application concerns a hysterectomy for menstrual management, there are an additional two factors to be considered in section 7: the availability and medical advisability of alternative means of menstrual management, and the previous experience (if any) of the person with such alternative means. Their purpose is to ensure a full exploration of all less drastic options.

These mandatory factors were favourably received and approved in general terms by the majority of respondents who chose to comment on this issue. One factor that received a lot of emphasis as important in the responses was the requirement that the decision-maker must assess "the availability and medical advisability of alternative means of medical treatment or contraception" (s. 6(1)(g)). This reflects respondents' concerns that non-therapeutic sterilization must be strictly a measure of last resort.

One respondent had several criticisms of the list. The respondent felt it was misleading and patronizing to require the decision-maker to take into consideration the wishes and concerns of the person involved (s. 5) after that person had just been found to be unable to participate in the decision-making process due to legal incompetence. The consideration whether any child of that person could likely be cared for by some other person (s. 6(1)(k)) was criticized as a factor unrelated to either the best interests test or the substituted judgment test.

This respondent condemned as eugenics-based the factor directing consideration of "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" (s. 6(1)(i)).

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REPORT ON STERILIZATION AND LEGAL INCOMPETENCE

EXECUTIVE SUMMARY

The Manitoba Law Reform Commission's Report on *Sterilization and Legal Incompetence* explores the two irreconcilable positions emanating from the complex issue of whether legally incompetent people should ever have access to or be subject to non-therapeutic sterilization when they do not have the legal capacity to choose this procedure personally by consenting. The Report does not choose between or resolve these polarizations, concluding that such an acute ideological choice is best handled directly by the Government and Legislature.

BACKGROUND

The common law in Canada used to be uncertain about whether there were any limits on the ability of parents, guardians or the courts to give substituted consent in this area. It was in the context of that legal uncertainty that this project was referred to the Manitoba Law Reform Commission in late 1980 by the then Attorney General, G.W.J. Mercier.

The project did not proceed quickly, due to such diverse factors as waiting for the Supreme Court of Canada to render its 1986 judgment in the leading Canadian precedent case of *Re Eve*, and studying the exhaustive investigation and recommendations prepared in this area in 1989 by the Alberta Institute of Law Research and Reform.

THE CURRENT LAW

No medical treatment or procedure can lawfully occur without the patient's consent. Valid consent cannot be given by a person who is legally incapable of it. Some (but not all) adults who have intellectual or mental health disabilities and most minors are legally incompetent to give consent.

In this situation, the law permits certain substitute decision-makers to give consent on behalf of the legally incompetent person. The substitute decision-maker must make the decision that is in the best interests of the person on whose behalf consent is being given.

The main authorized substitute decision-makers for minors are parents, legal guardians or the courts (under their inherent, non-statutory *parens patriae* jurisdiction). However, the authority to give substituted consent ends when the child attains the age of majority. The main

authorized substitute decision-makers for adults who have intellectual or mental health disabilities are the courts (under their *parens patriae* jurisdiction) or custodians or committees of the person under *The Mental Health Act.*

The 1986 *Re Eve* decision of the Supreme Court of Canada settled the previously uncertain Canadian common law by placing a significant limitation on the legal ability of an authorized substitute decision-maker to consent to medical treatment: they cannot consent on behalf of a legally incompetent person to the performance of a non-therapeutic sterilization procedure ("sterilization" refers to any usually irreversible medical procedure that permanently terminates the ability to procreate).

Authorized substitute decision-makers continue to be able to give substituted consent where a therapeutic sterilization is involved. A "therapeutic sterilization", according to the Supreme Court, is a sterilization performed to protect a person's physical or mental health. By contrast, a "non-therapeutic sterilization" is one performed for social reasons, like contraception or hysterectomy for menstrual management.

The blanket prohibition against non-therapeutic sterilization created by the *Eve* case does prevent any possibility of a repetition of the shameful history of routine, mass involuntary sterilization of people having intellectual disabilities. Yet the case has caused concern to some who say that this blanket prohibition can also unjustly prevent a legally incompetent person from having access to a non-therapeutic sterilization procedure in those occasional cases where it would truly be in the person's individual best interests.

The law as it now exists due to the *Eve* case could be changed by provincial legislation. A statute could give a substitute decision-maker the authority to consent to a non-therapeutic sterilization on behalf of a person legally incompetent to consent personally. Whether such a legislative response is appropriate is the central issue of this contentious area.

DISCUSSION PAPER

In November, 1990 the Commission, without advocating or recommending any legislative proposal, distributed a Discussion Paper to concerned individuals and organizations in order to elicit the opinions, judgments and concerns of the public about the issues and available options in this area. More than a dozen written briefs were received; their differing viewpoints provided invaluable assistance to the Commission in its consideration of these issues. These briefs are fairly evenly divided for and against a legislative response to *Eve.* They also illustrate the passionate convictions and polarization of viewpoints that characterize this debate.

UNIQUE NATURE OF ISSUE

All the various arguments about the central issue, contained both in the public responses and academic commentary, basically fall into one of two camps that proceed from diametrically opposed sets of underlying assumptions that share no middle ground.

A major example of these irreconcilable starting points concerns the characterization of the human rights issue posed by the question of substituted consent to sterilization. The side advocating substituted consent proceeds from the fundamental assertion that failure to ensure equal access to a beneficial procedure is discrimination and constitutes the real human rights issue at stake here. The side opposing substituted consent proceeds from the fundamental assertion that failure to ensure security of the person against unauthorized interference is discrimination and constitutes the real human rights issue.

Whichever set of underlying assumptions is adopted determines and colours all subsequent social and legal analyses by each side, including whether sterilization may be considered a benefit, whether there is a "need" for legislation to address *Eve*'s blanket prohibition, and whether the equality provisions of the *Charter of Rights and Freedoms* would be breached or affirmed by such legislation or by its absence.

Where there exist two competing but apparently equally supportable frameworks of contradictory philosophies and underlying assumptions, any choice between them can only represent a subjective ideological decision. Such an acute ideological choice is qualitatively different from the usual "social policy" questions handled by law reform commissions that simply require the making of a subjective choice or value judgment between competing legal solutions that nevertheless ultimately share the same fundamental framework of social assumptions and philosophy.

CONCLUSION

For the foregoing reasons, the Manitoba Law Reform Commission does not feel in a position under these unique circumstances to recommend a subjective ideological preference for one set of underlying assumptions and premises over the other.

While the Commission has some reservations about the rigidity of *Eve*'s absolute prohibition of substituted consent in this context, it nevertheless believes that such fundamental questions of ideology carrying profound human rights implications are best handled directly by the Government and Legislature. The mandate and moral authority of those elected and accountable bodies place them in the best position to provide an open and accessible atmosphere for the necessarily non-partisan exploration required by the two irreconcilable ideologies at issue here.