Comments and Notes

Sterilisation and Intellectually Disabled Children: *In the matter of P & P*

Under what circumstances should society allow an intellectually disabled child to undergo a sterilisation procedure? In attempting to provide an answer to this question, *In the matter of P & P*[1] sets a number of important precedents, raises a number of intriguing questions, and ultimately leaves the original conundrum unresolved.

The decision whether or not to allow a sterilisation operation is based on a particular, inherently problematic kind of legal judgment. Rather than arbitrating between competing claims about past acts, the decision is based on predictions about future circumstances. That is, what will be in the best interests of the child?[2] Without the benefit of godly omniscience or a magical crystal ball, courts have the difficult task of weighing predictions and applying social values to try to decide whether or not a sterilisation operation will best protect a child's welfare. This decision-making process involves two distinct elements. First, a framework must be established within which to determine which issues are relevant and the process by which decisions will be made. Second, courts must examine the relevant, substantive issues in the current case and weigh these against each other in an attempt to determine what will be in the best interests of the particular child. A decision-making process that omits either of these elements is incomplete and inadequate. Yet this is arguably the outcome of the framework proposed by the Full Court in *P & P*.

1. *The Facts and Legal Context*

Authorisation by the Family Court (or, in some States, the Supreme Court or guardianship board)[3] is required before parents or guardians may consent to non-therapeutic sterilisation on behalf of an intellectually disabled child who

1 (1995) FLC 92–615; sub nom *P and P and Legal Aid Commission of NSW; Human Rights and Equal Opportunity Commission (Intervener)* (1995) 19 Fam LR 1. All following references to this case are from the Family Law Reports.

2 Child custody adjudication has been described in similar terms. See Mnookin, R H, "Child-Custody Adjudication: Judicial Functions in the Face of Indeterminacy" (1975) 39 *Law and Contemporary Problems* 226 at 251–2.

3 See, eg, *Children (Care and Protection) Act* 1987 (NSW) s20B; *Guardianship Act* 1987 (NSW) ss35, 36, 37, 45. For contrasting discussions of these complex jurisdictional issues, see Tait, D, Carney, T and Deane, K, "Legal Regulation of Sterilisation: The Role of Guardianship Tribunals in NSW and Victoria" (1994) 8 *AJ Family L* 141 and *Family Law Council, Sterilisation and Other Medical Procedures on Children: A Report to the Attorney-General prepared by the Family Law Council* (1994) Australian Government Publishing Service, Canberra.

is incompetent to consent.[4] The appeal in *P & P* followed such an application and overturned a trial decision that sterilisation should not be permitted in this case.

At trial,[5] Moore J dismissed an application by Mrs P[6] for authorisation of a hysterectomy on "Lessli", her epileptic and severely intellectually disabled daughter. Lessli's independent legal representative supported the mother's application while the Human Rights and Equal Opportunity Commission (HREOC) acted as intervener and submitted argument about legal principles and procedures relevant to determining how judicial discretion should be exercised in sterilisation cases.

The facts accepted by the Full Court portrayed Lessli as a friendly, attractive seventeen year old who, due to her intellectual disability, would never be competent to consent to the sterilisation procedure sought for her by her parents.[7] The reasons for the parents' application included: Lessli's dislike of and alleged difficulties with coping with menstruation;[8] the perceived risk that Lessli may become pregnant yet have no understanding of the nature or cause of the pregnancy, childbirth or the care of a child, and that pregnancy would be likely to cause her emotional distress and psychological confusion;[9] the risk that if Lessli became pregnant she would be likely to suffer more frequent epileptic seizures;[10] and the risk that, during pregnancy, necessary alterations to Lessli's medication to control her epilepsy may have a detrimental affect on her health (and that of her unborn child).[11]

The trial judge rejected the application for sterilisation after considering the issues of menstrual management and pregnancy, and finding each to be an invalid ground for permitting the operation. Moore J was not convinced that difficulties in coping with menstruation could justify the performance of the sterilisation procedure or that Lessli's circumstances were likely to subject her to any risk of pregnancy. Furthermore, she found that preservation of fertility would help protect Lessli against future sexual assaults,[12] and that sterilisation is a "step of last resort" that could only be taken once alternative, less invasive options had been exhausted.[13] Moore J found that, because an intellectually average woman with epilepsy would not be likely to undergo a hysterectomy as a form of contraceptive, arrival at the point of last resort had not been demonstrated in Lessli's case.[14]

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4 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 (*Marion's Case*). Competence is assessed by the test laid down by the House of Lords in *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112 and approved by the High Court's majority decision in *Marion's Case*. It should be noted that although, theoretically, the same law would apply to applications for the sterilisation of intellectually disabled boys, the reported cases in Australia all consider the law in matters involving intellectually disabled girls.

5 Unreported, Family Court of Australia, Moore J, 23 September 1994 (SY4034 of 1989).

6 Mrs P's application was supported by Lessli's father, Mr P (the nominal respondent).

7 Above n1 at 4–5 and 13.

8 Id at 8–9.

9 Id at 10.

10 Id at 9–10.

11 Id at 15.

12 Id at 12.

13 Id at 19.

14 Id at 12 and 18.

Moore J's application of judicial discretion adopted a fundamentally proscriptive methodology whereby she rejected certain arguments as valid justifications for the interference with Lessli's reproductive capabilities. The judge considered and dismissed each of the factors separately and ultimately remained unconvinced that Lessli's welfare would be best served by allowing the sterilisation. She concluded:

> I could not be satisfied, to the requisite standard, that the proposed procedure would increase Lessli's capacity for enjoyment of life. Nor could I be satisfied that there is a present need for it.[15]

Certain of Moore J's reasons assume particular significance in light of their subsequent adoption by the Family Law Council in its report *Sterilisation and Other Medical Procedures on Children*.[16] The Council is established under the *Family Law Act* 1975 (Cth) to advise and make recommendations to the Attorney-General on family law related legislation and policy.[17] Following the decision in Marion's Case,[18] the Minister for Justice referred several questions to the Council for investigation and report. Among the terms of reference was "[w]hat principles should govern decisions whether a sterilisation should proceed?"[19] The Full Court's rejection of some of the Council's recommendations highlights seminal issues regarding the principles to be adopted in sterilisation cases, and emphasises the lack of general community consensus about the moral and ethical dilemmas faced in the making of such decisions.

In overturning the trial judge's decision in *P v P*, the Full Court of the Family Court of Australia (Nicholson CJ, Fogarty and Finn JJ) replaced the trial judge's proscriptive reasoning with a guideline based method of applying judicial discretion, and concluded:

> In our view there was an unanswerable case in favour of the desirability of permitting sterilisation in this case and *we considered it to be clearly in Lessli's best interests for sterilisation to take place*.[20]

In summary, the Full Court found that:[21]

- Lessli was unlikely to ever be competent to give consent to the operation;
- her severe intellectual disability was unlikely to diminish;
- her epilepsy made conventional contraceptive methods extremely difficult and contraception was not in her long-term interests;
- Lessli was unlikely to ever understand procreation or parenting and would never have the capacity to care for a child;
- she would have great difficulty coping with a pregnancy that went to full term, and her health would be likely to be detrimentally affected by pregnancy or by a termination of it;

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15 Id at 10.
16 Family Law Council, above n3.
17 *Family Law Act* 1975 (Cth) s115(3).
18 Above n4.
19 Family Law Council, *Sterilisation and Other Medical Procedures on Children: Discussion Paper* (1993) Family Law Council at 4.
20 Above n1 at 28–9 (emphasis added).
21 Ibid.

- Lessli was highly likely to engage in sexual intercourse with the consequent risk of pregnancy; and
- Lessli had difficulty coping with menstruation which distressed her and presented considerable difficulties for her carers.

The Court held that these factors combined to create a circumstance in which Lessli's welfare would be best served by authorising the application for the hysterectomy.

The Court held that questions about whether Lessli's welfare would be best served by allowing the operation should be decided by balancing these (and other) considerations according to enumerated guidelines for the exercise of judicial discretion in such matters. In so deciding, the Full Court rejected many of the trial judge's conclusions, as well as Council recommendations that an objective checklist-style of decision making should be followed by courts exercising judicial discretion in sterilisation cases. The Full Court's approach draws on reasoning adopted by the US Supreme Court in the important case of *In Re Grady*.[22] It clearly cements sterilisation cases to "best interests of the child" foundations, and provides an authoritative guide for the exercise of judicial discretion in these matters. But it nevertheless presents a largely indeterminate decision-making process which fails to offer guidance as to how the "best interests" test should be applied to the substantive issues. By contrast, the approach adopted by the trial judge and the Council offers both a decision-making framework and instructions about judging the substantive issues. But it is arguable that the Council's proscriptive rules are too utilitarian and thus desecrate the hallowed "best interests of the child" principle they aim to protect.

2. *A Proscriptive Rule Approach*

The trial judge's fundamentally proscriptive approach in *P v P* allows the sterilisation of an intellectually disabled child only where to do so would not infringe any of the rules on an objective checklist. This methodology was adopted and structured by the Council in its 1994 report, which summarised the approach as follows:[23]

1. Council proposes a three stage decision-making process to govern consideration of applications for authorisation of sterilisation. First, the legislation would indicate four situations in which sterilisation could never be authorised. These are:
   - sterilisation for eugenic reasons;
   - sterilisation for purely contraceptive reasons;
   - sterilisation as a means of masking or avoiding the consequences of sexual abuse; or
   - sterilisations performed on young women prior to the onset of menstruation, based on predictions about future problems that might be encountered with menstruation.

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22 *In Re Grady* NJ, 426 A 2d 467 (1981).
23 Family Law Council, above n3 at v–vi.

2. The legislation should provide that no person under the age of 18 shall be sterilised unless the procedure is necessary to save life or to prevent serious damage to the person's physical or psychological health.
3. In deciding whether there is serious danger to a person's physical or psychological health the decision maker *must* have regard to:
   - whether the feasibility of less permanent means of contraception has been explored, where relevant; and
   - an evaluation of the person's response to training in menstrual management

   If, at this stage, a decision maker is inclined to approve the application, s/he must not do so unless performance of the procedure would be in the child's best interests.

This approach requires the decision to be made by progressing through a checklist of rules which deal with substantive matters. But the formula is arguably problematic in a system which focuses on the best interests of the child. Its requirement that "sterilisation could never be authorised" in certain situations creates objective rules which remove a decision-maker's discretionary power to act in the best interests of a particular child. It seems clear that "best interests" is not an objective standard and that, as discussed later in this case note, the indeterminacy of the test invites the construction of rules or guidelines to help a judge decide how best to further the child's welfare. But by proscribing various considerations before allowing final determination of the child's best interests, it is arguable that the approach adopted by the trial judge and the Council adheres too rigidly to proscriptive rules. The cost of strict adherence to such rules might be relinquishment of the best interests of the child — interests which can only be determined by the application of subjective judgment. And the treatment of substantive issues in the trial decision of *P & P* provides a clear example of how relevant considerations can be discarded and how arguments about the child's best interests may be subverted by adherence to a checklist of proscriptive rules.

Furthermore, by requiring various factors to be wholly ejected from the decision-making calculus, the "proscriptive rules" approach isolates and compartmentalises considerations, rather than uniting them as intrinsic parts of a large and intricate web.[24] By contrast, the Full Court argued that the circumstances in sterilisation cases can rarely be separated and considered in isolation:[25]

> The danger involved with the Council's approach is that, taken literally, it may lead to the adoption of an approach that these factors are to be ignored in the decision making process, which in our opinion would make a travesty of it. The other danger is that of compartmentalisation, which may lead a decision maker to lose sight of the overall object, which is that the best interests or welfare of the particular child are paramount.[26]

The Full Court preferred a "cumulative effects" approach which avoids isolating various considerations and instead contemplates them in conjunction with all other relevant factors. It is suggested here that the Full Court's approach is preferable as it acknowledges that, while some considerations may not alone be

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24 Above n1 at 11.
25 Id at 18.
26 Ibid.

strong enough to justify sterilisation, the cumulative effect of several such considerations may create a strong case in favour of allowing the operation. Or it may provide a strong case in favour of refusing permission to perform the operation. Either way, by applying the cumulative effects approach the court is arguably more likely to consider the best interests of the particular child.

Another concern about the Council's approach is that some of its proscriptive rules are based on utilitarian reasoning. That is, they would tend to create outcomes that are more likely to produce "the greatest happiness for the greatest number" rather than the greatest happiness for the particular child whose future is being considered. In doing so, they rest on reasoning which is itself rejected by the Council through its prohibition of eugenic considerations, and which disregards the best interests of the individual child.

In addition, proscribing some considerations can effectively result in treating some intellectually disabled children as though they were not disabled. This is demonstrated by the trial judge's "but for" test which would disallow sterilisation unless it would be contemplated for an intellectually competent girl in similar circumstances. That is, "but for" her intellectual disability, would sterilisation be authorised for Lessli? As the Full Court concluded, this test is logically dubious and discriminatory.[27] Sterilisation was sought for Lessli *because* of her intellectual disability. Lessli's needs were arguably different to those of a non-intellectually disabled girl in similar circumstances, so the needs of a non-intellectually disabled girl provide an irrelevant comparison in this case. If the best interests of an intellectually disabled child are assessed objectively by a scale that is drawn to measure the welfare of intellectually average children, then the special needs that created the demand for the "best interests" test are discounted. That is, the disabled child is assessed by an objective measure that is inappropriate for his or her individual needs, rather than by a subjective assessment of her or his particular, individual best interests.[28]

Finally, difficulties of enumerating matters which may never be considered in sterilisation cases are illustrated by examining some of the situations in which the Council envisaged the procedure would not be authorised.

A. Sterilisation for Eugenic Reasons

The dismissal of "irrelevant" eugenic arguments accords with the best interests principle as eugenic considerations are, by definition, justified on utilitarian grounds rather than the welfare of the individual.[29] Any assessment of an individual child's best interests would necessarily proscribe the use of

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27 Above n1 at 20–1.

28 Id at 21–3: "In cases such as Lessli's, it is precisely because a distinction is drawn between the child in question and others in the community by a party claiming that the proposed treatment is to the child's benefit that the matter falls to be decided under the protective jurisdiction of this Court in order that the strength and adequacy of the evidence can be evaluated."

29 See, eg, Heginbotham, C, "Sterilizing People with Mental Handicaps" in McLean, S (ed), *Legal Issues in Human Reproduction* (1989) at 147: "[A]s a rule, 'the happiness of the greatest number' (of both mentally handicapped people and the general population) will be served by sterilizing some severely handicapped people." See also, Little, H, "Non-consensual Sterilisation of the Intellectually Disabled in the Australian Context: Potential for Human Rights Abuse and the Need for Reform" (1993) 14 A *Ybk Int'l L* 203 at 212.

eugenic arguments in a particular case, thus creating a de facto proscriptive rule — without neglecting the subjective best interests assessment.

B. Sterilisation for Purely Contraceptive Reasons

The Council's recommendation that sterilisation could never be authorised "for *purely* contraceptive reasons" reflects the extreme and invasive nature of such procedures. But it is not entirely clear how the Council defines "purely" in its proscriptive rule,[30] as is demonstrated by applying the rule to various scenarios in which parents might offer "contraceptive reasons" when requesting a sterilisation procedure for their child. For example:

i "Our daughter requires a sterilisation operation because she needs contraception."

ii "Our daughter requires a sterilisation operation because she needs contraception and no other form of contraception is appropriate to her circumstances."

iii "Our daughter requires a sterilisation operation because she needs contraception and because she experiences difficulties coping with menstruation."

The first scenario obviously relies on purely contraceptive reasons for applying for the sterilisation operation as no additional justification, such as the health of the child, is offered. It is difficult to conceive how such an operation could be in the best interests of a child when other forms of contraception provide reasonable alternatives. Therefore the welfare of the child is unlikely to be the reason for the application for the operation and, as in the case of eugenic considerations, a de facto proscriptive rule is probably created — without neglecting the subjective best interests assessment.

Whether the proscriptive rule would apply to the second scenario is less clear. This application could be viewed as being based on purely contraceptive reasons as no justification, other than contraception, is offered for seeking the operation. Viewed in this way, the application of the Council's proscriptive rule could cause neglect of the best interests of a particular child. There may be an occasional case in which it is found to be imperative for a woman's health that she has access to contraception to protect her from pregnancy but no form of contraception, other than sterilisation, is medically appropriate. In such a situation, it may be found to be in the woman's best interests that she undergo a sterilisation operation. In P & P, the Full Court agreed that sterilisation would not usually be authorised for purely contraceptive purposes, but nevertheless suggested that there are some cases where the contraception element "looms much more largely than would normally be the situation".[31] The second scenario would appear to present such a situation. And to deny an intellectually disabled person an operation that would

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30 The Council offered little discussion of sterilisation for contraceptive reasons. The Council simply stated, at par 4.28 of its Report: "*Solely as a means of contraception.* Most submissions agreed that because of its invasive and irreversible characteristics, sterilisation is too radical an interference with bodily integrity to be an appropriate form of contraception for a young woman under 18. This is the case irrespective of the young woman's purported consent." See Family Law Council, above n3 at 47.

31 Above n1 at 24.

be available to a non-disabled person in similar circumstances seems unreasonably discriminatory, especially when the former's special needs could render the operation of considerable benefit to that person. Thus, if the Council envisaged this type of scenario in its discussion of "purely contraceptive reasons", it may be argued that application of the proscriptive rule risks ignoring the best interests of the individual whose welfare it seeks to protect.

Alternatively, the second scenario could be understood as offering an additional fact in justification for the operation — that additional fact being that no other form of contraceptive is appropriate in the case. If so, the moment a reason is given for wanting sterilisation as the form of contraception, the judicial contemplation moves beyond "*purely* contraceptive" considerations and the Council's proscriptive rule would not apply. Similarly, the Council's proscriptive rule would not apply to the third scenario as that situation obviously does not involve an application for sterilisation for purely contraceptive purposes. In these cases, the basis of the court's decision would revert, by default, to a subjective assessment of the best interests of the child.

Finally, it is accepted that an intellectually average woman would be unlikely to undergo sterilisation by hysterectomy simply because other forms of contraception proved unsuitable. However it may be argued that an intellectually average woman would understand the possible repercussions of engaging in sexual intercourse and could therefore make a reasoned decision about her actions. By contrast, the Court found that Lessli could not understand the potential consequences of sexual intercourse. Thus the question remains: would sterilisation be in the disabled woman's best interests in the circumstances of the case? If the response is affirmative, questions about the form the operation should take are for separate and subsequent consideration.

C. *Sterilisation to Mask or Avoid the Consequences of Sexual Abuse*

It is also problematic to remove "sterilisation to mask or avoid the consequences of sexual abuse" from the factors relevant to best interests considerations. The Council adopted Moore J's suggestion that, as Lessli could not understand sexual relations, any intercourse engaged in by Lessli would be an outcome of an assault — a crime. Therefore, sanctioning sterilisation would amount to protecting Lessli from something against which she is already protected by the criminal law, and alleviating a consequence of this crime. But this misunderstands the nature of the issue.[32] Assuming that an intellectually disabled woman was likely to engage in sexual intercourse[33] — whether willingly or by force — the "best interests" question is not whether the other person would be guilty of assault, but whether Lessli could be protected from one of the consequences that that sexual activity may cause.[34]

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32 Id at 17.

33 This was in contrast to the trial judge who examined Lessli's environment and concluded: "I am unable to be satisfied that her present or foreseeable circumstances are or will be such as to expose her to a level of risk of sexual attention that would warrant the interference proposed. Moreover, I cannot be satisfied, even if the risk to her of sexual assault is real, that sterilisation would necessarily be in her best interests." Id at 11–2.

34 It has been noted that sterilisation case discussions about the consequences of sexual activity tend to focus on pregnancy and ignore issues such as sexually transmitted diseases. See, eg, Douglas, G, *Law, Fertility and Reproduction* (1991) at 59.

The likely consequences of the trial judge's suggestion that a disabled person's fertility should be retained to act as a deterrent to a potential assailant, and the recommendation by both the trial judge and the Council that maintaining fertility could assist with the identification of an assailant,[35] give rise to some concern. Each year thousands of Australian women fall victim to sexual assault,[36] and while the suggested approach may benefit some intellectually disabled women by deterring assailants, this approach perhaps involves placing at risk the welfare of a greater number of intellectually disabled women. It seems problematic to suggest that a person should be left in a vulnerable position so that if she or he is assaulted, it might be easier to identify the culprit. And surely it would be impossible to argue that to leave a person in this vulnerable position could be in his or her best interests? [37] Yet this is arguably a logical outcome of the approach recommended by Moore J and the Council. Furthermore, such an approach suggests undertones of a utilitarian rationale that the interests of the individual must be sacrificed for the public good, which is served by apprehending offenders and preventing them from attacking other members of society.

Many assailants of intellectually disabled women have undoubtedly been male "carers" and some of these people may have been influenced in their choice of victim by the fact of her fertility or infertility. Nevertheless, in cases where other factors suggest it would enhance a woman's general welfare to undergo a sterilisation procedure, it seems difficult to justify the retention of her fertility solely because a potential assailant may be dissuaded and an actual assailant may be more easily identified. Although the approach taken by the trial judge and the Council is undoubtedly well-intentioned, it does not promote confidence about the safety of intellectually disabled girls. Lessli's fertility had not protected her against sexual assault in the past.[38] And in a society where many victims of sexual assault are intellectually normal, fertile women who are presumably better able to defend themselves than women with profound intellectual disabilities, it seems unlikely that a woman's fertility will play a significant role in protecting her against assault. In a better world, sexual assault would be stopped by preventing the abusers from abusing. But the courts' decisions must be made against the backdrop of the reality of sexual assault and its consequences in the society in which we live.

Examination of the Council's proposal therefore points to severe deficiencies in the ability of a proscriptive rule based approach to take the best interests of the child into account. By incorporating substantive issues into proscriptive rules which must be enforced prior to subjective consideration of the specific child's welfare, the Council creates predictability of outcome but risks sacrificing the "best interests" principle. By contrast, the Full Court's guideline

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35 Above n1 at 15–6.

36 In 1994, 13 277 cases of sexual assault were reported in Australia: Australian Bureau of Statistics, *National Crime Statistics: January–December 1994* (1995) Commonwealth of Australia at 10.

37 This general attitude was adopted by the Full Court which acknowledged criticism that it: "could not seriously be supposed that it is germane to the interests of Lessli to permit her to become pregnant in order to demonstrate that some carer or fellow patient was the other person involved in making her pregnant". Above n1 at 15–6.

38 Id at 9 and 11.

approach provides a decision-making methodology which clearly focuses on the individual child's welfare but which omits to provide guidance about how to determine what is, in fact, in the child's best interests — the substantive element.

3. *A Guideline Approach*

The Full Court's adoption of a "best interests" guideline approach[39] reflected its agreement with HREOC's submission that it would be advantageous if lucid guidelines were enunciated to guide the Family Court's exercise of discretion in determining "best interests" in sterilisation cases.[40] Consequently the Court approved a revised version of the "Nicholson Guidelines", outlined in *In Re Marion (No 2)*,[41] and recently embraced by Chisholm J in the Family Court, as a "useful practical application" of the principles.[42] This approach adopts a "cumulative effects" formula and counters the Council's proposal that a three-stage checklist should be employed to eliminate cases in which sterilisations should never be authorised.[43]

The Full Court approved guidelines which require that each of the following issues be considered:

1. The particular condition of the child which requires the procedure or treatment;
2. The nature of the procedure or treatment proposed;
3. The reasons for which it is proposed that the procedure or treatment be carried out;
4. The alternative courses of treatment that are available in relation to that condition;
5. The desirability of and effect of authorising the procedure for treatment proposed rather than available alternatives;
6. The physical effects on the child and the psychological and social implications for the child of:
   (a) authorising the proposed procedure or treatment;
   (b) not authorising the proposed procedure or treatment;
7. The nature and degree of any risk to the child of:
   (a) authorising the proposed procedure or treatment;
   (b) not authorising the proposed procedure or treatment;
8. The views (if any) expressed by:
   (a) the guardian(s) of the child;
   (b) a person who is entitled to the custody of the child;

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39 Id at 25.
40 Family Law Council, above n3 at 34–5.
41 *In Re Marion (No.2)* (1994) FLC 92–448 at 80,665; originally adapted from the judgment of Pashman J in *In Re Grady*, above n22.
42 *Re W* unreported, Family Court of Australia, Chisholm J, 10 April 1995: see above n1 at 26.
43 Family Law Council, above n3 at v–vi: Recommendation 3.

(c) person who is responsible for the daily care and control of the child;

(d) the child;

to the proposed procedure or treatment and to any alternative procedure or treatment.

These guidelines suggest a similar methodology to that employed in determining the best interests of the child in custody and access disputes under the *Family Law Act*.[44] They give the court extremely broad discretionary powers and consequently highlight the problem of indeterminacy — a difficulty which has similarly been observed in custody matters.[45]

As noted earlier, the application of the best interests test is inherently indeterminate. How can it be foreseen what will be in a child's best interests? Should one look at the child's present "best interests" or predictions of "best interests" in the (near or distant) future? What values should be assigned to judging what is in a child's best interests? For example, is it better for an intellectually disabled child to live within a loving and supportive, but financially strained, family environment? Or would the child's welfare be better served in a residential institution especially equipped with facilities to ease the disabled person's management of daily tasks? These are questions of moral value. But which values should prevail? How can we know what is best for a child?[46]

The guidelines approved by the Full Court in *P & P* provide answers to none of these questions, and leave difficult value judgments such as these to the discretion of the decision-maker. Thus, although the Nicholson Guidelines provide a best-interests based framework to guide a decision-maker's discretion about what to consider, questions about how to consider the substantive issues remain unresolved. That "there is no societal consensus about what is 'best' or even 'good' for all children",[47] is abundantly evident from the variety of conflicting opinions offered in Lessli's case. That the decision is based on predictions of future events and that it is unrealistic to expect judges to predict what the child would prefer[48] is similarly apparent. In sum, it is clear that the decision-maker must generally apply his or her own preferences[49] (or his or her interpretations of what society prefers) in making the judgment. This is the practical consequence of the indeterminacy of the best interests test. So while the Nicholson Guidelines provide a helpful guide to the framework by which relevant considerations can be identified, they are virtually useless for a determination of what is actually in the specific child's best interests.

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44 *Family Law Act* 1975 (Cth) s64(1)(bb).

45 For a detailed analysis of the indeterminacy problem, see Elster, J, *Solomonic Judgements: Studies in the Limitations of Rationality* (1989) ch 3 "Solomonic Judgements: Against the Best Interests of the Child" at 123ff. Also, Mnookin, R H, *In the Interest of Children: Advocacy, Law Reform, and Public Policy* (1985) ch 2 "The Enigma of Children's Interests" at 16ff.

46 Mnookin, id at 17–8.

47 Goldstein, J, Freud, A, Solnit, A J, *Before the Best Interests of the Child* (1980) at 133.

48 This is the substituted judgment approach which has been used in place of the best interests approach in some jurisdictions. See Mason, J K, and McCall Smith, R A, *Law and Medical Ethics* (3rd edn, 1994) at 84; and Elster, above n45 at 137.

49 Elster, id at 136.

Furthermore, in situations where each option is thought likely to be equally beneficial for the child's welfare, it has been suggested that the natural response is to err on the side of caution and take the more conservative of the available options.[50] In sterilisation cases, where the operation is presumably irreversible and the consequences for the patient are immense, considerable caution is obligatory. The Full Court has suggested that there is always a "better option" to be discerned in best interests judgments:

> It would not promote the welfare of the children to reach a conclusion that all factors relevant to the children's welfare weigh evenly in the balance and then determine the issue by calling some extraneous factor with no relevance to that welfare. When matters are said to weigh evenly or to be finely balanced all that has occurred is that the court has not yet determined which of the factors of most relevance to welfare should be given pre-eminence over the others.[51]

Yet it is clear that a determination about the relevance of a particular consideration is a personal judgment based on prediction and uncertainty. In matters where neither societal consensus nor clear guidelines instruct decision-makers about how to weigh the substantive issues, the limitations of the best interests principle are obvious. Thus judicial or legislative guidelines about how to balance the substantive considerations within the best interests framework would be helpful.

4. *Are the Guidelines Too Exclusive?*

While decision-makers must be careful to ensure that consideration of an "extraneous factor with no relevance,"[52] does not precipitate an outcome in which the best interests of the child become confused with other (possibly competing) interests, it is possible that some incidental factors are nonetheless relevant to the child's welfare. Two such factors are the welfare of the family and the interests of society in general.

Incorporating the interests of society is distinctly problematic and, it is argued, the risks of doing so outweigh any potential benefits. As noted in the above discussion of proscriptive rules, utilitarian considerations present a stark conflict with the welfare of the child. Eugenics and economics can be powerful arguments,[53] and even the *parens patriae* jurisdiction of the court may not provide sufficient protection to the individual child.[54] Therefore, it is preferable that the interests to be considered in sterilisation cases are not broadened so far that they open the doors to the interests of society.

In contrast, allowing some recognition of the interests of the family could bolster the foundations of a judgment in favour of sterilisation in cases where the cumulation of considerations suggests the best interests of the child will be served by authorising the procedure. A recurring theme pervading child sterilisation cases is the impact of the child's disability on the rest of the family. "Best

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50 Ibid.
51 *Smythe and Smythe* (1983) FLC 91-337 at 78,287.
52 Ibid.
53 Little, above n29 at 212.
54 See, eg, *Buck v Bell* 274 US 200 (1927).

interests" reasoning means the interests of caregivers must not play a principal role in the decision-making process, but this arguably leads to incongruity.

Recent Family Court decisions have defined the welfare of parental caregivers as a "best interests of the child" consideration, reasoning that if conditions become too difficult for the caregiver, the welfare of the child is likely to suffer.[55] In *In re Jane*[56] it was deemed to be in the child's best interests to remain in the care of her family rather than being institutionalised. Any step which eased the family's burden of caring for Jane increased the likelihood that she would continue to live at home and this, according to the court, was clearly in her best interests. Nicholson CJ made a similar argument in a paper delivered to the *First World Congress on Family Law and Children's Rights* where he suggested that, where the burden of providing care means a child will remain living with the family if the sterilisation procedure is performed but will otherwise be institutionalised, the operation is likely to be justified having regard to the paramount interests of that child.[57]

The argument that the parents' best interests are therefore the child's best interests can be problematic.[58] To some extent, such reasoning would seem to be a "backdoor" attempt to find a method of infiltrating the best interests balancing process with irrelevant extrinsic considerations. Yet perhaps these considerations are relevant for their recognition that other people can be significantly affected by the requirements of caring for a disabled child, and this may have an impact on the child's welfare. Should, after all, the personal interests of one person prevail over those of other people who are closely affected?[59] Or might the child's welfare be better served by including limited environmental considerations? If so, might it be reasonable to add the interests of a caregiving family to the guidelines approved in *P & P* in order to gain a broader perspective of the child's welfare?

The effects on parents of raising an intellectually disabled child have been well documented by medical researchers.[60] Emotional rewards are often offset by heightened stress, excessive demands on parental time and energy, and

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55 Above n1 at 23: "Although the primary focus must always remain on the child, the position of caregivers is relevant insofar as it reflects upon their capacity to care for the child. We think that this is particularly so when the primary caregiver is the parent...." The trial judge, above n1 at 12, also alluded to this concern: "I fully appreciate ... the view taken by her parents, particularly her mother who has the ongoing responsibility for her day to day care in the future ... and recognise the impact which their own anxiety and concern may have upon Lessli's welfare." See also *In re Marion (No 2)* above n41 at 80,666: "[I]t may be that the welfare of the child could require the carrying out of such a procedure if the alternative were the institutionalisation of the child or the absence of any other caregiver."

56 *In re Jane* (1989) FLC 92–007 at 77,253.

57 Nicholson, A, "The Medical Treatment of Minors and Intellectually Disabled Persons — United Nations Convention on the Rights of the Child, Article 23" presented at the First World Congress on Family Law and Children's Rights, Sydney, 4–9 July 1993.

58 Elster, above n45 at 154.

59 Ibid. Elster argues (in the context of custody disputes) at 142: "The child's welfare, the rights of the parents and the needs of the parents all give rise to prima facie claims that must be balanced against each other."

60 This literature is reviewed in Fisman, S and Wolf, L, "The Handicapped Child: Psychological Effects of Parental, Marital, and Sibling Relationships" (1991) 14 *Psychiatric Clinics of North America* 199, and Konstantareas, M M and Homatidis, S, "Effects of Developmental Disorder on Parents: Theoretical and Applied Considerations" (1991) 14 *Psychiatric Clinics of North America* 183.

concerns about the future care of their disabled child.[61] Similarly, brothers and sisters may feel anger and resentment about the diversion of parental attention to their disabled sibling while simultaneously experiencing confused feelings of guilt, responsibility, love, devotion and protectiveness.[62] Donne's poetic wisdom that "[n]o man is an Island, entire of itself; every man is a piece of the Continent, a part of the main"[63] is echoed in medical literature suggesting that it is myopic to view a family as a mere sum of its parts:

> In families the whole is greater than the sum of the parts. All family members are interconnected, interdependent and exist in a fragile balance. What happens to one affects all the others. Having a child with a chronic illness or disability creates permanent change in family dynamics. Often roles become stratified, communication may break down and personal needs can go unmet.[64]

Not only is the disintegration of a supportive family framework obviously counterproductive to the protection of a disabled child's best interests, but it could also be argued that to focus on one child's welfare to the exclusion of that of his or her siblings is inherently contradictory. Best interests of whom? Can a "family" court be morally justified in taking a myopic view that protects the welfare of one child while ignoring other children who will also be affected by its decision? Is the welfare of the disabled child more important than the welfare of his or her brothers and sisters? Might the welfare of the disabled child not be better served by broadening the spectrum of considerations to include the family environment in which the child lives?

This is not to suggest that courts should facilely grant permission for non-therapeutic operations on intellectually disabled children simply to soothe tense family environments. They should not. And decision-makers must be careful to ensure that sterilisation is never permitted as the easier option or because it is less expensive than providing the family with less dramatic support measures such as government-funded financial assistance, counselling or community nursing. Nevertheless, perhaps courts could widen the scope of their considerations in recognition of the impact that the family environment has on a child's welfare. It would be extreme and inappropriate to allow the interests of parents and siblings to prevail over those of the child whose life will be permanently affected by a sterilisation operation. But in a guideline based approach where all relevant considerations are taken into account in the decision-making process, it would seem to be in keeping with the Family Court's role to at least give the interests of the rest of family some contemplation.

5. *Conclusion*

The decision of the Full Court of the Family Court of Australia in *P & P* is a useful foundation for the development of a sensitive and rational law guiding the discretion of decision-makers in cases requesting approval for the sterilisation of an

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61 Konstantareas and Homatidis, id at 183.

62 Seligman, M, "Adaptation of children to a chronically ill or mentally handicapped sibling" (1987) 136 *Canadian Medical Association Journal* 1249 at 1250.

63 Donne, J, "Devotions XVII".

64 May, J, "Rebalancing the Mobile: The Impact of Chronic Illness/Disability on the Family" (1992) 19 *The Journal of Rheumatology Supplement 33* 2 at 2.

intellectually disabled child. The elucidation of clear guidelines which focus on the best interests of the particular child is arguably preferable to the Family Law Council's recommendation that proscriptive rules be imposed to eliminate various categories of argument. A proscriptive rules approach risks neglecting the individual child's best interests in the process of decision-making, and such rules should be unnecessary where careful judicial assessment of the interests of the individual child would automatically rule out any consideration of inappropriate or utilitarian based justifications — thus creating de facto proscriptions. Nevertheless, the "Nicholson Guidelines" are substantively indeterminate. While they provide a framework to help discover which issues are relevant, they do not assist with questions about the weight that should be given to those considerations. Thus these guidelines offer little assistance to a decision-maker who is faced with a variety of competing social values which must be balanced in a subjective judgment of the child's best interests.

As Brennan J (as he then was) has noted,[65] it is probably impossible to achieve an objective evaluation of the best interests of a child. If this is the case, there is no "right answer" and decision-makers cannot escape the indeterminacy of the best interests test. Society must therefore choose between several imperfect options. We might, for example, adopt a methodology (such as that promoted by the Nicholson Guidelines) and accept that decision-makers in sterilisation cases act with concern and goodwill, and do their best to reach a conclusion that will be of the greatest benefit to the child. We might (as the Family Law Council has done) enumerate situations in which the interests of society or carers are likely to conflict with the best interests of the child, and remove these from the factors a decision-maker may consider when attempting to determine which outcome would most benefit the child. Or we might try to blend elements of these approaches. For example, we might combine a decision-making methodology, outlining what factors should be considered, with substantive guidelines about the minimum standards that are socially acceptable conclusions when the best interests of a particular child are unclear. This would not proscribe some considerations, but it would weaken their persuasive force in the final determination. Then sterilisation would only be authorised if consideration had been paid to all the enumerated substantive elements and it had been found that authorising the operation would not be contrary to the child's welfare.

In *P & P*, the Full Court's decision to authorise sterilisation ultimately relied upon the conclusions that Lessli's fertility — her ability to parent a child — had no practical significance when she could not understand procreation or parenting, her health would suffer during pregnancy, she would never have the capacity to care for a child, and she would have great difficulty coping with a pregnancy that went to full term. In this case, the symbolic significance of Lessli's fertility, the argument that fertility and menstruation are intrinsic to femininity, was not considered — probably because Lessli was not perceived to have a comprehension of her womanliness.[66] Coupled with the Court's findings that Lessli found menstruation distressing, that she was at risk of

65 *Marion's Case*, above n4 at 272.
66 Above n1 at 21.

pregnancy and that conventional contraceptive methods were inappropriate in this case, the Full Court concluded that Lessli's welfare would be better served by allowing her sterilisation than by preventing it. In doing so, the Full Court demonstrated the application of the Nicholson Guidelines and argued strongly against the alternative approach propounded by the Family Law Council.

The Full Court's rejection of many of the Council's substantive recommendations may have a significant and lasting impact if Australian governments seek to legislate about this matter. In *Marion's Case*, the High Court invited States to enact legislation regulating the sterilisation of children,[67] and the 1992 "Terms of Reference" given to the Council foreshadowed legislative moves in this area.[68] The Council responded with the recommendation that a new division be added to the *Family Law Act* to regulate the sterilisation of young people.[69] If governments do choose to follow the legislative road, the Full Court's decision in *P & P* is likely to act as a persuasive counter-balance to the recommendations of the Council and other advisory bodies.

Ultimately however, sterilisation of children is an issue that will always be fraught with emotions and competing values. Sterilisation is a grave and generally irreversible measure, and a decision to authorise such an operation should not be made unless less dramatic and invasive alternatives have been found to be inadequate or inappropriate. The Full Court's decision in *P & P* does not solve the problem of reconciling the moral dilemmas and does not provide us with a "right" answer. Nevertheless this case does focus the court's attention on the subjective issue of the individual child's best interests, and tries to ensure that while the procedure would never be authorised unless the welfare of the child is clearly served, sterilisation will not be withheld where the operation would be in a particular child's best interests.

ALEXANDRA GEORGE*

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67 *Marion's Case* above n4 at 253.

68 Above n19 at 4: "3. Whether determinations on sterilisation should be made by existing courts or tribunals, or whether a new body should be established to make these decisions?; 4. Whether uniform legislation on sterilisation of children should be introduced by the Commonwealth and the States?"

69 Family Law Council, above n3 at 39.

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