Reflection on The Legal Status of Sterilization in Contemporary Canada

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A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Laws

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Canada

Abstract

In light of its past eugenic use, and its often irreversible nature, non-therapeutic sterilization, the result of which is to deprive an individual of his/her capacity to procreate, has always enjoyed a particular status and its use and legal status engendered debate, discussion and controversy.
The purpose of this dissertation is to determine under which conditions non-therapeutic sterilization can lawfully be performed under Canadian law.
Whereas the legality of non-therapeutic sterilization when voluntarily consented to by a competent individual is today established in all Canadian provinces, it appears that Quebec is the only province to allow non-therapeutic sterilization to be performed on an individual lacking through age and/or disability the necessary capacity to consent, common law provinces denying any beneficial aspects to the procedure. The law on involuntary non-therapeutic sterilization however lacks clarity, certainty and consistency, a legislative reform is therefore advocated.

En raison de l'utilisation à des fins eugéniques qui en a été faite, et de son irréversibilité de principe, la stérilisation non-thérapeutique, privant l'individu de ses capacités reproductrices, bénéficie d'un statut particulier et, sa légalité fait l'objet de discussions, débats et controverses.
Le propos de cette discussion consiste en la détermination des conditions sous lesquelles une stérilisation non-thérapeutique peut être légalement effectuée sous l'empire du droit canadien.
Alors qu'aujourd'hui la légalité de la stérilisation non-thérapeutique volontaire ne fait plus de doute, Québec semble être l'unique province à accepter qu'une stérilisation non-thérapeutique soit effectuée sur un individu mineur et/ou handicappé incapable d'y consentir. Les provinces de common law refusent en effet de reconnaître tout caractère bénéfique à un tel acte. Aux vues du manque de clarté, de l'imprécision et de l'inconsistance des règles juridiques relatives à la stérilisation non-thérapeutique involontaire, une réforme du droit canadien sur cette question semble requise.

À Mamita et Pépito,

À ma mère et mon père,

À Marion, Louise et Matthieu,

Je vous dédie ces lignes avec tout mon amour et ma gratitude.

REMERCIEMENTS

Je tiens tout d'abord et tout particulièrement à remercier Mme le Professeur Margaret A. Somerville pour avoir accepté la tâche d'être mon guide éclairé au cours de ces longs mois de recherche et de rédaction, pour m'avoir permis d'enrichir ma réflexion au moyen de commentaires et conseils judicieux, pour m'avoir inspiré de sa plume. Je tiens également à exprimer ma gratitude envers le Gouvernement de Canada, qui, par la bourse octroyée, m'a donné la possibilité de venir étudier au Québec et de passer des moments inoubliables à Montréal. Mes sincères remerciements à la Faculté de Droit de l'Université de McGill qui m'a ouvert les portes d'un système juridique unique. Merci également à Tracey Nicholls qui, par son aide linguistique, m'a donné l'illusion d'un bilinguisme parfait.

Marylena, et Thuy, sans votre irremplaçable amitié mes premiers balbutiements ne seraient restés que soupirs, et mes pages désespérément blanches.
Mes amis de toujours, Camilo, Marieke et Ana Maria qui, malgré la distance, ont réussi à m'apporter de nombreux rayons de soleil papier et internet.
Toute la gang de Thomson House, et plus particulièrement Amy, votre joie de vivre, votre folie douce, vos discussions, vos cocktails ont été des soutiens inattendus et appréciés dans les moments d'angoisse et d'essoufflement.
Enfin, Elise, du fond de mon cœur, je te remercie pour tout et encore plus, pour ton amitié si douce, pour tes fous-rire, pour m'avoir écouté et apporté ton soutien quand le tunnel semblait sans issue, pour avoir partagé ma vie, mes espoirs, mes peurs et mes joies.

Finalement, je voudrais remercier tout spécialement ma famille, cocon rassurant quand la vie se fait ouragan, support émotionnel inconditionnel. Denis, toi qui me suis pas à pas, Tatie, toujours présente, mon père et mon frère pour votre attention particulière. Mes grands parents adorés pour votre tendresse. Pépito, sans ton précieux ordinateur, ton soutien, j'aurais été perdue, sans tes coups de téléphone j'aurais été moins confiante, sans tes encouragements je me serais sentie plus seule; Mamita, parce que ton épanouissement artistique, ta joie de vivre, ton franc parler, ton aide depuis que toute jeune je pianotais les premières notes d'une mélodie de Béla Bartok, m'ont permis de croire que tout est possible. Maman, pour ton exemple, ta rigueur intellectuelle, ton ouverture d'esprit, tu m'as permis de penser autrement, d'affirmer haut et fort ce que je n'osais penser tout bas; mais aussi pour tout ton amour, je ne peux t'exprimer toute ma gratitude. Enfin, à mes deux sœurs, Marion et Louise, mes complices de toujours, merci, merci, merci, merci pour avoir toujours cru en moi, pour m'avoir remonté les bretelles, pour être et avoir été toujours là.

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"Demanding the perfect is the enemy of achieving the possible"[1]

The desire to dissociate sexual intercourse from procreation goes back to earliest times. The Bible and ancient Greek literature contain descriptions of methods of contraception ranging from *coïtus interruptus*[2] to certain rituals such as sneezing or standing up after performance of the sexual act. In Rome, the man was responsible for contraception and the use of goat skin condoms was widely spread.

Surprisingly, despite these ancient roots, the improvement and the use of contraceptive methods in the western world have been hindered by the influence of Roman Catholic Church teachings which strongly objected to fertility control.[3] Sexual pleasure was considered obscene and sinful, and the use of contraceptive believed to be an attempt by men to break the unitive and procreative marital bond willed by God.[4] The development of effective contraceptive methods and their correlative spread and acceptance did not occur until the middle of the twentieth century with the discovery by Gregory Pincus,[5] a researcher, of the hormonal pill by synthesis of an orally effective progestin, and the numerous scientific projects that were launched thereafter.

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[1] Carl Djerassi, *This Man's Pill. Reflections on the 50th Birthday of the Pill* (New York: Oxford University Press, 2001) preface.

[2] See *The Bible*, Genesis 38 8-10.

[3] It has been said that, as a consequence, the "second century Greek author, Soramus, advanced in his Gynaecia both contraceptive technique and theory to a level surpassed only in the last 70 years." M. Potts, P. Diggory, *Textbook on Contraceptive Practices*, 2nd ed. (London, Chapman & Hall, 1983).

[4] Pope Paul VI, encyclical letter, *On the Regulation of Birth* (Boston: St. Paul Ed., 1968).

[5] Gregory Pincus, "Some Effects of Progesterone and Related Compounds upon Reproduction and Reproduction in Mammals" (Proceedings of the 5th International Conference on Planned Parenthood, Tokyo, 1955), at 175. Mr Pincus cooperated with John Rock, an endocrinologist and gynaecologist from Harvard who tested on humans the efficacy of norethynodrel, a contraceptive synthesized steroid. The experiments conducted by both Pincus and Rock, and sponsored by Searl, a pharmaceutical company, took place in the mid 50's in Puerto Rico.

Prior to Gregory Pincus, other scientists had tried to develop an adequate mean of oral contraceptive. In 1919, Ludwig Haberlandt, professor of physiology at the University of Innsbruck, discovered, in the course of his experiments on rabbits, that the injection of non-toxic *corpus luteum* (or yellow body) and placental extract, which he called "infecundin", caused temporary infertility. Convinced that his findings were equally applicable to humans, he found financial support from the firm Gideon Richter, a pharmaceutical company settled in Budapest, and continued his research. He however died before being able to accomplish his dream of creating the first oral contraceptive. For more details on the birth of the pill, see Carl Djerassi, *supra* note 1 at 11-63. The author argues that although Mr. Pincus' and John Rock's contribution to the creation of the hormonal pill is not to be disregarded, due honour should however be rendered to the many chemists who provided, thanks to their experiments, the necessary chemical active compounds for the pill to see the light of day.

Historically, contraception has not only been used for personal convenience but also for economic or social reasons, such as the control of population growth and its quality.[6]

The early twentieth century witnessed a new impetus for birth control with the launching by Sir Francis Galton,[7] in 1904, of the Eugenics[8] Movement. This movement was founded upon the rediscovery and the rearticulation of the principles of inheritance developed by Gregory Johann Mendel.[9] Eugenicists believed in biological determinism, they emphasized the importance of heredity in the explanation of mental illnesses, mental deficiencies, poverty, deviant behaviours or addictions, and dismissed the existence of acquired characteristics and the influence of economic and social conditions on the improvement of humankind. Proponents of this movement urged states to adopt both positive and negative breeding policies[10], with an emphasis on the latter. Examples of proposed solutions were: life segregation, sterilization, laws for the restriction of marriage and immigration, and polygamy.[11] In light of the evolution of surgical sterilization techniques and the support for the sterilization of

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[6] See Gillian Douglas, *Law Fertility and Reproduction* (London: Sweet and Maxwell, 1991), c.4; see, also generally Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto: McClelland and Steward, 1990).

[7] Sir Francis Galton (1822-1911), a cousin of Charles Darwin, was an English scientist and anthropologist who introduced his eugenic theory in 1869 at University College London.
In 1883, he stated

> We greatly want a brief word to express the science of improving stocks, which is by no means confined to questions of judicious mating, but which, especially in the case of man, takes cognisance of all influences that tend in however remote a degree to give to the more suitable races and strains of blood a better chance of prevailing speedily over the less suitable than they otherwise would have had.

Sir Francis Galton, *Inquiries into the Human Faculty and its Development*, 2nd ed. (London: Dent, reprinted in 1971) at 17, note 1.

[8] The words "eugenics" coined by Sir Francis Galton from the adjective "eugenic" in 1883, in *Inquiries into the Human Faculty and its Developments*, *supra* note 6, comes from the Greek word εύγενής which means *well-born* ("eu"-good, and "genics"-at birth). See, Ernest Klein, ed., *A Comprehensive Etymological Dictionary of the English Language*, 1st ed. (Amsterdam: Elsevier, 1966), *s.v.* "eugenics".

[9] Gregory Johann Mendel (1822-1884) was an Austrian monk who studied the principles governing the transmission of simple traits in plants.

[10] If positive eugenics consists of promoting the procreation of those individuals considered desirable by society, negative eugenics concentrates on the elimination in the gene pool of undesirable traits. Eugenicists believed that these policies would have the result of increasing the proportion of desirable [perhaps eliminate the first 'desirable', or find a synonym for one of them?] individuals. See e.g. Law Reform Commission of Canada, *Sterilization: Implication for Mentally Retarded and Mentally Ill Persons* (Working Paper 24) (Ottawa: Minister of Supply and Services Canada, 1979) at 24 [hereinafter LRCC WP N°24].

[11] In May 1911, the Research Committee of the Eugenics Section of the American Breeders Association selected life segregation and sterilization as the two most effective remedies to purge "*from the blood of the human race the innately defective strains*". D. S. Powell, *The Mentally Retarded in Society* (New-York: Columbia University Press, 1959) at 6.

those individuals considered unfit[12] by social reformers, eugenic sterilization was adopted by many states as the most effective method to improve the gene pool of the society.

The first eugenic sterilization laws were enacted in the State of Indiana, in United States, in 1907.[13] By 1937, in United States, thirty-one states[14] had passed such legislation.[15] Most of the individuals sterilized in accordance with those statutes were living in institutions, and gave their consent in exchange for their release into the community. Such practices were thought to be beneficial not only for the society, which would see the number of those regarded as undesirable individuals decrease, but also for the sterilized individuals who were offered the ability to remain in the community and enjoy sexual relationships unburdened by procreation. This opinion was supported by the jurisprudence of the courts as shown by the now infamous United States Supreme Court case *Buck* v. *Bell*[16]. In this case[17], the court upheld the constitutionality of the sterilization laws of the state of Virginia ruling that eugenic sterilization did not constitute a cruel and unusual punishment, was a justifiable and reasonable procedure under the police powers of the state, and did not violate the due process clause of the fourteenth amendment of the American Bill of Rights. This case is interesting in light of the now infamous words of Mr Justice Holmes, who, speaking for the court, made the following general statement:

> We have seen more than once that the public welfare call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for the lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence.

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[12] Herbert Spencer (1820-1903), an English philosopher, was the first author to use the coined expression "survival of the fittest", fitness being determined by reference to intelligence and technological innovativeness. Eugenicists strongly relied on those two criteria to distinguish undesirable individuals in society. Spencer also argued that the higher reproductive rate of people considered *unfit* constituted a threat for the gene pool, and that as a consequence sterilization was a desirable method to increase the proportion of the *fittest* in society.

[13] See M. E. Price & R. A. Burt, "Sterilization, State Action, and the Concept of Consent in the Law and the Mentally Retarded" (1975) 1 Law and Psychiatry Review 57 at 61. Although Indiana was the first state to introduce such laws, as early as 1897, the legislature of Michigan drafted a Bill authorizing eugenic sterilization. However, this Bill was defeated in the Parliament.

[14] See R. Sherlock & D. Robert, "Sterilizing the Retarded: Constitutional, Statutory and Policy Alternatives", (1982) 60 North Carolina Law Review 943.

[15] By 1944, in the state of California alone, 42 616 individuals had been officially sterilized. See A. Adamson, "A Womb of One's Own? Sterilizing the Mentally Handicapped" (New Hall Medical Law and Ethics Seminar, Book presented to the Squire Law Library by New Hall College, New Hall College, 11 September 1998) [unpublished].

[16] *Buck* v. *Bell*, 274 U.S. 200 (1927) (United States Supreme Court).

[17] The particular case was concerned with the request, made by the State of Virginia, to sterilize a mentally retarded 18-years-old girl whose mother and illegitimate daughter were also mentally retarded.

> It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.[18]

In Canada, the importation of eugenic beliefs led to the enactment of two sterilization statutes. In 1928, the *Sexual Sterilization Act*[19] was passed by the legislature of Alberta, and the *Sexual Sterilization Act*[20] of British Columbia was enacted in 1933. These two statutes, which were only repealed in the 1970s, will be examined in greater detail, in the course of our discussion.

The influence of the Eugenic Movement culminated with the Nazi policy of "social biology", a policy born from the collaborative work of American, English and German eugenicists, and the enactment in 1933 of "*The Law for the Prevention of Hereditary Diseased Offspring*"[21]. This statute, rendering sterilization of certain individuals compulsory, combined with the experiments conducted in concentration camps to improve the methods of sterilization, led to the sterilization of more than 200 000 persons.[22] Shockingly, at the time of their enactment, these policies were not denounced as outrageous or abusive by the international community and did not lead other countries to repeal similar statutes.[23]

The enthusiasm for eugenic theory began to fade in the end of the 1930's and the beginning of the 1940s as a result of the rejection by scientists and biologists of the fundamental premises of the movement[24], the abuses that took place under

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[18] *Buck* v. *Bell*, *supra* note 16 at 207.

[19] *Sexual Sterilization Act*, S.A. 1928, c. 37. [am. 1937, c.47; 1942, c.48; rep. 1972, c.87]

[20] *Sexual Sterilization Act*, S.B.C. 1933, c.59. [rep. 1973, c.79]

[21] *Gesetz zur Verhütung des erbkranken Nachwuches* of July 14th 1933, Reichsgeretzblatt I at 529. In 1935, a law legalizing male castration was also enacted, castration being considered as an adequate mean to purge men of their abnormal sexual desires. The Nazi sterilization law was repealed in 1946 by the occupying powers (Besetz no. 11, Kontrollrat (January 30, 1946).

[22] The "[e]stimates vary as to the precise number of sterilization performed during the Nazi era with numbers ranging from **200 000 to two million** [emphasis added].", S. Trombley, *The Right to Reproduce* (London: Weindenfeld & Nicolson, 1988) at 122.

[23] The report of the Committee of the American Neurological Association for the Investigation of Eugenic Sterilization constitutes a proof of the admiration that the Nazi sterilization policies aroused. See Report of the Committee of the American Neurobiological Association for the Investigation of Eugenic Sterilization, *Eugenic Sterilization* (New York: Macmillan Company, 1936) (reprinted by New York: Arno Press, 1980), especially the comment on the '*Law for the Prevention of Hereditary Diseased Offspring*' at 22.

[24] Indeed, as early 1930, the emphasis of heredity as the sole explanation for mental retardation, mental illnesses and other afflictions was denounced as fallacious. See e.g. R. L. Burgdorf & M.P. Burgdorf Jr., "The Wicked Witch is Almost Dead: *Buck* v. *Bell* and the Sterilization of Mentally Handicapped Persons" (1977) 50 Temporary Law Quarterly 995 at 1007.

sterilization legislation[25], the growing legal recognition of the fundamental importance of the right to procreate, and the improvement of less drastic contraceptive methods.

By the end of the 1950's and the beginning of the 1960s, the rationale underlying the use of contraceptive has shifted. Contraceptive measures, such as sterilization, are no longer contemplated or used arbitrarily for purely economic and social reasons in furtherance of eugenics beliefs but as a mean for individuals to control the number and spacing of their children.[26]

Eventually, the right to procreative choice was recognized by several international agreements. In 1968, the U.N. Conference on Human Rights at Teheran[27] in its *Proclamation of Teheran*[28] established that

> [t]he protection of the family and the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and spacing of the children.[29]

In 1979, the *Convention on the Elimination of All Forms of Discrimination Against Women*[30] asserted similar rights, as, under its paragraph 16(1) (e),

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Genetic researchers established the complexity of inheritance, the importance of the environment and of the social and economic conditions in the development of individuals. Upon such scientific evidence, many geneticists withdrew from the movement. Dr. Bernard L. Diamond, a special consultant to the American Psychiatric Association, in a report on the Mental Health Legislation of British Columbia, wrote in 1960:

> [A]ll laws for the sterilization of the mentally ill or defective which have as their basis the concept of inheritability of mental illness and mental deficiency are open to serious question as to their scientific validity and their social desirability...Present day psychiatry(...)avoids the sweeping generalizations so prevalent in the past... In short, the present state of our scientific knowledge does not justify the widespread use of the sterilization procedures in mentally ill or mentally deficient persons.

E. Z. Ferster, "Eliminating the Unfit—Is Sterilization the Answer?" (1966) 27 Ohio State Journal 587 at 603-604.

[25] The abuses not only took place under the Nazi "social biology" programme but also under the laws of the various North American states that were in force at the same period. In Unites States more than sixty thousand people were sterilized on the basis of their genetic unfitness. See e.g. E.J. Larson, L.J. Nelon III, "Involuntary Sexual Sterilization of incompetents in Alabama: Past, Present, Future" (1992) 43 Alabama Law Review 399 at 407.

[26] It is to be noted that after the Second World War, individuals have requested information on and access to contraceptives for personal purposes, in light of their scientifically proven efficacy.

[27] Resolution XVIII on Human Rights Aspects of Family Planning adopted by the conference Plenary Meeting on 12 May 1968.

[28] *Proclamation of Teheran*, 13 May, 1968.

[29] *Ibid.* art. 16. The inclusion of the right of access to the knowledge and means necessary for the exercise of the right to determine freely and responsibly the number and spacing of the children was unanimously voted for by the General Assembly, at the U.N Conference on Human Rights, which met at Teheran, the following year. *Declaration on Social Progress and Development*, G.A. Res. 2542 (XXIV) of 11 December 1969.

[30] *Convention on the Elimination on all Forms of Discrimination Against Women*, 1979, G.A. Res. 34/180, UN GARP, 34th Session, Supp. N° 46 at 193, UN Doc. A/34/46 (entered into force 3 September 1981).

it requires states to ensure that women enjoy

> rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.[31]

In Canada, the regulation of contraception has historically been the site of State regulation. Not only has Canadians' reproductive autonomy been limited for immigration and racial purposes[32], but, in the past, it has also been hindered by a criminal prohibition on information and access to contraception.

Until the end of the nineteenth century, birth control was considered to be a private matter and therefore was not the object of any regulation. However, in 1892, the Canadian legislature, enacting article 179 of the *Criminal Code*[33], criminalized any

> offer to sell, advertise, publish an advertisement of or have for sale or disposal any medicine, drug, article intended or represented as a means of preventing conception.[34]

This article, placed under the heading "Offences Against Morality" and denying Canadians any choice regarding parenthood, was supported by the widespread

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[31] *Ibid.* Para. 16(1) (e).

[32] See generally A. McLaren, *supra* note 6.

Armstrong, P., and Armstrong, H. also argue that, in light of the possibility of pregnancies, women were constantly discriminated against by the state as far as employment and salaries were concerned. Armstrong, P., Armstrong, H., *The Double Ghetto: Canadian Women and their Segregated Work* (Toronto: McClelland and Steward, 1979).

[33] *Criminal Code*, 55-56 Vict. C-29.

[34] *Ibid.* art. 179. Contraceptive means were described as obscene as shown by the comment made by John Charleton, Member of Parliament for North Norfolk, in the course of the debates preceding the adoption of article 179. Non contradicted, he declared

> Vile literature is secretly and widely circulated in Canada, literature of a character calculated to undermine the morals of the people, and entail the most disastrous consequences on society. Improper and obscene, or semi-obscene literature is imported into this country and openly sold. Drugs and instruments for procuring abortion and for kindred purposes are advertised secretly and are sold by agents, and this abuse cannot very readily be reached by the law as it now stands. (House of Commons Debates, 2 (1892) at 2458-2459, cited in Angus McLaren, Arlen Tigar McLaren, *The Bedroom and the State, The Changing Practices and Politics of Contraception and Abortion in Canada 1880-1980* (Toronto: McClelland and Steward Ltd, 1986) at 9.

One of the main reasons for limiting access to contraception lay in the decrease of the fertility rate in common law Canada as from the end of the nineteenth century. This decrease can be explained by the social and economic modifications Canada underwent at that time, such as urbanization and industrialization. Common law officials who qualified this lowering of the birth rate as 'race suicide' felt threatened by the high fertility rates of Irish and individuals from Quebec, the so-called 'revenge of the cradles' and accused working women of selfishness. In 1945, in a book entitled *The Revenge of the Cradles* (C.E. Silcox, *The Revenge of the Cradles* (Toronto: Ryerson, 1945), the author argues that the high fertility rate of Quebec is maintained by the welfare policies of the province. He further states that "[t]he only real threat is in the fact that the decline tends to be among the responsible people, while the less responsible still obey the injunction to be fruitful and multiply. It would seem as if society today were resolved that the morons shall inherit the earth."(C.E. Wilcox, *The Revenge of the Cradles* (Toronto: Ryerson, 1945) at 23).

puritanical Victorian belief that contraceptives would lead to lust and unfaithfulness, would cheapen marriages, and by the idea that motherhood was a blessing.[35] Its passing was the result of a strong lobbying by the Canadian Medical Association, and was supported by many members of the medical profession. The medical profession, in supporting the amendment made to the *Criminal Code*, seems to have been motivated by some selfish motives. Indeed, it is argued that the limitation of information about contraceptives permitted doctors to increase their income, and to retain control over the medical knowledge and therefore of the doctor-patient relationship. Constance Backhouse writes: "the major lobby force behind the legislation was a determined group of male physicians who wished to assert monopoly control over a profession they were struggling to create."[36]

Amended twice, in 1900 and 1927[37], the prohibition on information and access to contraception was only removed from the *Criminal Code* in 1969[38]. Factors that led

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[35] "The clamour asserting maternity the paramount feature of women's lives arose contemporaneously with the industrialization and urbanization processes of the nineteenth century, which had served to reinforce the separation between the sexes. Men were expected to leave home behind for the newly emerging public sphere of industrialized economic production. Women were to remain in the home, supervising the private realm of child-rearing with nurture and motherly love".
Constance B. Backhouse, "Involuntary Motherhood: Abortion, Birth Control and the Law in the Nineteenth Century Canada" (1983) 3 Windsor Yearbook of Access Justice 61 at 62, footnote 1 *in fine*.

[36] *Ibid.* at 130. See also Rhonda R. Shirreff, "For Them to Know and You to Find out: Challenging Restrictions on Direct-to-Consumer Advertising of Contraceptive Drugs and Devices" (2000) 58 *University of Toronto Faculty of Law Review* 121 at 126.

[37] Article 179 of the *Criminal Code* was first amended in 1900 (*Criminal* Code, 63-64 Vict., C-46, s. 179(c)) and then, again in 1927 (*Criminal Code*, R.S.C. 1927, c. C-36, s. 207(c)) to introduce a defence for selling and advertising with justification and excuse (a so-called professional defence) and a defence of public good when the incriminated act did not exceed what the public good required.

[38] Individuals and Associations (as early as 1930, the United Farm of Canada urged the government to legalize contraception seen as "the only humanitarian way of preventing a mother from being overburdened and broken in health with too numerous progeny." (United Farm of Canada, Saskatchewan branch, cited in *New Generation*, March 1030 at 36)) were strongly lobbying the government to amend the *Criminal Code* and permit individuals to have access to both information and means of achieving contraception. The call for the end of the prohibition was supported by the Badgley Committee. *Report of the Badgley Committee on the Operation of the Abortion Law* (1977), Chairman: Robin F. Badgley. Pierre Trudeau, Prime Minister at the time, expressed his support for the amendment declaring that "the state has no business in the bedroom of the nation."(G. Radwoski, *Trudeau* (Toronto, 1978) at 9, cited in A. McLaren & Arlene Tigar McLaren, *supra* note 34 at 9).
It is noteworthy that despite the criminal prohibition enacted under section 179 of the *Criminal Code,* many couples succeeded in limiting the size of their families. The methods used, information about them being gathered from foreign literature, were the traditional natural and mechanical methods, such as abstinence, *coïtus reservatus*, or douche, sheath and pessaries. However, the unwillingness of the medical profession to help families resulted in the failure by many families to control their procreation and in many dangerous behaviours. As from the 1920's the need to enhance access to reliable methods of birth control was acknowledged by the public and private spheres, as both the rate of illegal abortions and the number of maternal deaths rose. Angus and Arlene McLaren state that the birth control discourse was also used as a political tool by socialists opposing conservative parties, and by the Protestant Church in order to gain followers and to dissociate itself from the Vatican Catholic Church (Angus McLaren, Arlene Tigar McLaren, *supra* note 34, c.4 & c.6).

to this repeal included the evolution of societal attitudes, the increase in the costs of raising children by reason of compulsory education and the prohibition of child labour, the recognition of women's reproductive and professional autonomy, the increasing reliability of contraceptive methods, the growing practice of illegal abortions, and the awareness of the damages that unwanted and/or numerous pregnancies could have, and had, caused.[39]

By statute, the control over the advertisement and distribution of means of contraception was placed under the *Food and Drugs Act*[40] and the *Narcotic Control Act*[41]. Section 3(3) of the *Foods and Drugs Act*[42] currently provides that

> Except as authorized by regulation, no person shall advertise to the general public any contraceptive device or any drug manufactured, sold or represented for use in the prevention of conception.[43]

By regulation and for public policy purposes, pharmaceutical manufacturers are allowed to advertise contraceptive drugs or devices to medical intermediaries, who, in turn disseminate the information to the general public.[44]

> Whatever political stand was taken in Canada, however, it is clear that contraceptive methods never did have one single implication. They were not neutral tools that necessarily served either liberating or coercive purposes. Their implications depended on who interpreted them, who controlled them, under what conditions they were controlled, and for what ends. (Angus McLaren & Arlene Tigar McLaren, *supra* note 34 at 158.)

During the twentieth century, contraceptives methods went from being tabooed to becoming widely used; from being used as part of eugenic programmes to being the means of the limitation of family size, from being illegal to being legalized and their use encouraged.

[39] It is interesting to note that only three reported cases concerned prosecutions for the selling and the advertising of contraceptives. Furthermore, as shown by the holding of Clayton J. in the Ontario Magistrate Court's case *R.* v. *Palmer*, [1937] 2 D.L.R. 609 (Ontario Magistrate Court), aff'd [1937] 3 D.L.R. 493 (Ontario Court of Appeal) [hereinafter *Palmer* cited to 2 D.L.R. 609], judges were aware of the hardship of the provision of the *Criminal Code* and ready to interpret loosely the defences enacted by the legislature in 1900 and 1927. In *Palmer* at 616-617, Clayton J. held that

> Any person who has had any experience with Social Service work or Court work knows of countless poor families where children appear at regular year-apart intervals. The mothers are in poor health, pregnant 9 months out of every year....What argument is there from a humanitarian point of view, from the point of view of the public good of humanity that will deny to these people the knowledge and the means of properly spacing these children so that the mother and the child can enjoy good health, and so that parents can control the number of children to the number that they can support in a manner above the mere level of starvation subsistence?...I cannot see the harm of giving scientific truth and knowledge to the people.

[40] *Foods and Drugs Act*, R.S.C. 1970, c. F-27.

[41] *Narcotic Control Act*, R.S.C. 1968-1969, c. 41, s. 13, amending section 150(2) of the *Criminal Code*, R.S. (1985), c. C-46.

[42] *Supra* note 40.

[43] *Ibid.* section 3(3).

[44] Rhonda Shirreff argues that pharmaceutical manufacturers should also be allowed to inform individuals on a Direct-to-Consumer basis, as it would "promote the desirable objective of ensuring that women are fully apprised of the information need to balance the benefits and risks and to make informed, intelligent decisions regarding the use of contraceptives." *Buchan* v. *Ortho Pharmaceutical* (1986), 25 D.L.R. (4th) 658 (Ontario Court of Appeal) at 669 cited in Rhonda R. Shirreff, *supra* note 36.

Today, Canadian citizens thus have access to a *wide* range of contraceptives, including sterilization. Contraception has therefore fallen once more within the realm of private matters, subject to the limitations of the law.

Contraception understood as "any device or substance that inhibits conception"[45] in a temporary or permanent manner, encompasses such procedures as the hormonal pill, the intra-uterine device, condoms or sterilization. Sterilization, whose technique goes back to the beginning of the twentieth century, is a

> surgical procedure for the permanent prevention of conception by removing or interrupting the anatomical pathways through which gametes –i.e., ova in the female and sperm cells in the male- travel.[46]

Various techniques of sterilization are currently used. Whereas female sterilization is commonly achieved through tubal ligation,[47] male sterilization is performed by vasectomy[48], a procedure that seems to involve fewer risks, is simpler and less expensive than sterilization in women.

Sterilization is a particular contraceptive and medical procedure in two respects: the purposes for which it is performed, and its often irreversible nature.

Although, since the 1970's, the advances of microsurgical techniques and scientific knowledge have rendered possible the reversal of some closure and the performance of recanalizations, these procedures are complex, expensive and their success at most uncertain and unpredictable.[49] Thus, in our discussion, we will consider sterilization to often be "for all intents and purposes irreversible."[50]

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[45] *Standard Comprehensive International Dictionary*, Bicentennial ed., *s.v.* "contraception".

[46] *The New Encyclopaedia Britannica*, vol. 11, 15th ed., *s.v.* "sterilization". If surgical sterilization dates back to the twentieth century, this is not to say that it was not practised beforehand. Indeed, sterilization was performed in a cruel manner as part of religious rites or punishment. See, e.g. Helen MacMurphy, *Sterilization? Birth Control? A Book for Family Welfare and Safety* (Toronto: The MacMillan Company of Canada Ltd, 1934) at 9.

[47] Tubal ligation is performed either by tying the Fallopian tubes closed with silk thread combined with the crushing or severance of a section of the tubes, or by electronically or chemically coagulating a segment of the tubes. This is the oldest and most wide spread form of surgical sterilization.
Two other methods can be used in order to achieve a sterilization, which, in light of their intrusive nature and of the risk they expose the women to, is usually required for therapeutic purposes: oophorectomy which consists of the removal of the ovaries and hysterectomies by way of which the uterus is removed. These two techniques are used in a limited manner as removing an organ can have an effect on the sexual function or the desire of the person, and constitutes a major interference with women's bodily integrity.
Other techniques of female sterilization include salpingectomy or laparoscopy.
See for a more general description of those methods James Willocks, Kevin Phillips, *Obstetrics and Gynaecology*, 5th ed. (New York: Churchill Livingstone, 1997).

[48] Vasectomy is a procedure which consists of the severance, through a small incision in the scrotum, of the vas deferens, the tube connecting the testes with the urinary canal. See James Willocks, Kevin Phillips, *supra* note 47.

[49] This has led the Comité Consultatif National D'Ethique, a French committee analysing ethical issues and issuing recommendations, to state that "[t]outefois, l'argument de la réversibilité ne peut être

The second particularity of sterilization stems from the underlying reasons for its realization. If sterilization can, sometimes, be medically indicated, and thus, therapeutically necessary,[51] in most instances it is an elective procedure, chosen by individuals to avoid the conception of children. Furthermore, as we have seen, sterilization has a shameful past, eugenics rationales having been used to justify its performance on many persons considered *unfit*.

The purpose of our dissertation, is to determine under which conditions sterilization, the end result of which is often to deprive permanently an individual of his/her capacity to procreate and thus constitutes an interference with a person's integrity, can be lawfully performed under Canadian law[52]. Our discussion will lead us to analyse separately the legal status of sterilization when voluntarily consented to by a competent individual, and the legal issues surrounding sterilization when either imposed on certain individuals by the state for economic and social reasons, or requested on behalf of a person who through age and/or disability is unable to consent for him/herself.

The first chapter will be devoted to the examination of the law on sterilization for mentally capable individuals. Indeed, if the lawfulness of therapeutic sterilization is hardly doubted, the legal status of purely contraceptive sterilization of capable and consenting people has remained unsettled for many decades. The discussion will lead us to study the legality *per se* of non-therapeutic operations as well as the law on consent to treatment in both civil and common law provinces.

The second chapter will focus on the particular situation of those individuals unable through age and/or disability to consent to a medical procedure such as sterilization. Parents, guardians, or other carers have repeatedly requested the ability to consent to such procedure on behalf of those they care for, invoking hygienic reasons, the trauma that childbearing or parenthood could cause, or the enhancement of the mentally

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honnêtement retenu: si des progrès dans les techniques chirurgicales font que l'on peut l'envisager, cette réversibilité exige un acte chirurgical supplémentaire dont le succès ne peut être garanti pour chaque personne individuellement". France, Comité Consultatif National d'Ethique, *La Contraception chez les Personnes Handicapées Mentales* (Avis N° 49) (1996) 8 Les Cahiers du CCNE 1 at 12. It is noteworthy that hysterectomies and oophorectomies, which involve a removal of either the uterus or the ovaries, are permanent in their effects and reversal is therefore impossible.

[50] LRCC WP N° 24, *supra* note 10 at 3.

[51] For instance, when a woman is sterilized in light of the danger to her health and life another pregnancy could pose, or when sterilization occurs as a secondary result of some other necessary therapy, such sterilization are defined as therapeutic.

[52] Federal, criminal, civil and common law.

disabled person's quality of life. A reference to the eugenic sterilization laws enacted at the turn of the 30's in Canada will be made as Canadian law, and more particularly Canadian common law, on non-voluntary sterilization cannot be fully understood without referring to its historical use in furtherance of public interests. Indeed, in the past, in Canada, mentally disabled people have been the targets of eugenic sterilization laws. Although these laws have now been repealed, the issue of involuntary sterilization is still a current concern. The Canadian position on contraceptive sterilization of mentally incompetent individuals will therefore be examined, as well as its effect and reception both nationally and internationally. *In fine* the desirability, if any, of a reform will be addressed. We will argue that the law on non-voluntary sterilization is less than satisfactory, being either too permissive in Quebec, or too uncompromising in common law provinces for fear of opening the door to eugenics. We will advocate a more temperate approach to the issue through the examination of foreign legal response and law commission reports, and propose guidelines, which do not claim to be perfect, for a legislative reform, as well as outline the pitfalls to be avoided. We will conclude by stressing the fact that a reform cannot be undertaken successfully without reviewing certain areas of the law pertaining to guardianship, and more specifically to the issue of determining competence, and that efforts should be made to ensure that mentally disabled individuals are treated with respect, their wishes taken into account, protected from abuses, and given the necessary psychological and financial support to pursue their sexual lives as fully as possible.

Part One: Canadian law on voluntary non-therapeutic sterilization

Because sterilization is a medical act, it must comply with the legal requirements governing medical acts, in particular, the law on consent to treatment. Indeed, medical procedures may only be performed after the obtaining of a voluntary informed consent. However the particularity of sterilization, its irreversibility and the reasons underlying its performance, might lead one to primarily question both the legality of such a major interference with bodily integrity, and the sufficiency of consent to justify the intervention when sought for personal convenience.

Chapter I: The legality of voluntary non-therapeutic sterilization in Canadian Law

Before examining the position adopted by common and civil law provinces as far as the relationship between sterilization and more specifically voluntary contraceptive sterilization and provincial public policy is concerned, it is necessary to determine whether, under Canadian criminal law, common to all the provinces, the operation is in itself legal, as one cannot consent to an illegal act.

A. Sterilization and Canadian criminal law

Despite the absence of any specific sections of the *Criminal Code* dealing with the issue of sterilization, several provisions of the Code might help us find out whether or not this medical operation is legal. Although it never occurred, theoretically, a surgeon performing sterilization procedures could be held criminally liable under section 265 of the *Criminal Code*[53] dealing with assault.

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[53] *Criminal Code*, R.S. (1985), c. C-46. It is to be noted that when the surgical act is one that may endanger the life of the patient (which is seldom the case when sterilization is concerned), and performed out of necessity, section 216 of the aforementioned code applies. Under the terms of this section:

> Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

Thus, in the situation covered by section 216, negligence will result in criminal liability.

However, sterilization amounting to a surgical intervention, the outcome of such a prosecution would ultimately depend on the success of a defence based on section 45 of the same code.[54]

According to this section:

> Every one is protected from criminal responsibility for performing a surgical operation on any person for the benefit of that person if
>
> **(a)** the operation is performed with reasonable care and skill; and
>
> **(b)** it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.[55]

This article was mistakenly interpreted[56] as implying that the performance of a surgical operation, **even when consented to**, could only result in a criminal conviction if it is considered non-beneficial to the patient. In the absence of legislative definition[57], the task of determining the scope of the notion of "benefit" as far as non

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[54] It is to be noted that a surgeon so sued could also rely on a defence based on the victim's consent to the medical act. Indeed, consent is a common law defence protected by section 7(3) of the *Criminal Code*.

[55] *Criminal Code*, *supra* note 53, s.45.

[56] As outlined by various authors, the application of section 45 of the *Criminal Code* as a justification for the performance of surgical operations even where consent has been given by a capable individual was not intended by the writers of the Code. Indeed, this defence had originally been drafted with the purpose of providing a defence to medical practitioners carrying out treatment on unconscious patients, or on conscious patients, rendered of unsound mind due to an accident, and refusing a life-saving treatment. The physicians were to be protected from criminal liability as long as the aim of the act performed was to save the patient's life or limb, and thus as long as the overall benefit of the act outweighed its risks. According to Bernard Starkman

> In light of the above [analysis], it would appear that section 45 of the *Criminal Code* was intended to deal with the situation where the patient is not capable of consenting. If the patient is not capable, the person performing the operation is protected from criminal liability provided the patient's condition necessitates surgery for the preservation of life or limb. If these conditions are met, the surgeon is protected even if the patient resists treatment. Support for this interpretation of section 45 of the *Criminal Code* is obtained from editions of the Digest published after the Draft Code, which is state that article 67 of the Draft Code, which is now section 45 of the *Criminal Code*, is based on article 205 of the Digest. (Bernard Starkman, *Preliminary Study on Law and the Control of Life*, (August 23, 1974) [unpublished, prepared for the Law Reform Commission of Canada] at 5-6.)

Section 45 was not designed to apply to situations where the patient is able to consent, as benefit was to be presumed in such situations, nor was it intended to introduce a distinction between therapeutic and non-therapeutic medical acts, as many non-therapeutic treatments only became available with the development of modern medical technology. The doubts raised as to the legality *per se* of non-therapeutic sterilization stems from the misinterpretation of section 45 of the *Criminal Code* in considering consent and benefit to constitute cumulative validating criteria of a medical treatment. See e.g. Carol Anne Polowich Finch-Noyes, "Sterilization of the Mentally Retarded Minor: The *Re K* case" (1986) 5 Canadian Journal of Family Law 277 at 281. See also Bernard Starkman, "Sterilization of the Mentally Retarded Adult: the Eve Case" Case Comment (1981) 26 McGill Law Journal 931; Margaret A. Somerville, "Medical Interventions and the Criminal Law: Lawful or Excusable Wounding?" (1981) 26 McGill Law Journal 82.

[57] According to Jacques Fortin, "[i]l faut cependant préciser que le législateur n'a pas cru nécessaire de définir ce qu'il entend par ce bien du patient", Jacques Fortin, in André Jodouin & Arian Popovici, "Sanctions et Réparations des Atteintes au Corps Humain en Droit Québécois" (1975) 6 Revue de Droit de l'Université de Sherbrooke 150 at. 180.

therapeutic acts were concerned was left to the courts. In light of the dearth of judicial decisions on the matter, the issue remained for decades subject to the suppositions of enlightened scholars and jurists.

In 1975 Jacques Fortin expressed his opinion as to the reasons explaining this lack of jurisprudence stating

> Canadian courts have not yet had the occasion to deal with this question, the importance of which will no doubt arise in respect of esthetic surgery, trans-sexuality or in voluntary sterilization.[58] The fact that these practices have for some time become customary doubtless explains the absence of the jurisprudence. It may therefore be thought that the courts would only intervene in cases of extreme gravity. The result is that criminal law holds a sword of Damocles above the operating table.[59]

This legal uncertainty was felt to be particularly inadequate in the case of voluntary sterilization, and many favoured the passing of legislation shedding light on its legality.[60] As early as 1970, the Royal Commission of Inquiry into the Status of Women in Canada urged the Federal Government to clarify the criminal status of sterilization. Its recommendation 223 noted

> Therefore, we recommend that the criminal law be clarified so that sterilization performed by a qualified medical practitioner at the request of his patient shall not engage the criminal responsibility of the practitioner.[61]

However, for many years, scholars have advocated a narrow interpretation of the notion of "benefit", limiting the protection of section 45 to surgical procedures beneficial to the patient's mental and/or physical health, and thus requiring a therapeutic benefit. Therefore, whereas no doubts were raised as to the validity of therapeutic sterilization, medically necessary and performed with the aim of improving the patient's physical or mental health, Canadian jurists expressed some reserve in recognizing the legality of purely contraceptive sterilization in light of its

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[58] It should be noted as outlined by Bernard Starkman (*supra* note 56) that section 45 was not meant to differentiate between therapeutic and non-therapeutic surgical acts. Such a distinction was indeed alien to the criminal law as most non-therapeutic acts only became available after the drafting of the code.

[59] *Ibid.* at 180, translated by Deschênes C.J. in *Dame Cataford et al.* v. *Moreau* (1978), 114 D.L.R. (3d) 585 at 590 [hereinafter *Cataford*].

[60] It is interesting to observe that the Government of Canada did not seem to believe that the legality of sterilization was in doubt. As early as 1973, in the course of the First Session of the Twenty-ninth Parliament, the Honourable John Munro, Minister of Labour, spoke the following words on behalf of the Government of Canada: "[t]he Minister of Justice would take the position that sterilization is a *matter for* medical discretion and that sterilization performed by a qualified practitioner at the request of his patient does not "engage the criminal responsibility of the practitioner". Therefore, it is considered that no action is required to clarify the criminal law in respect of sterilization.", Canada, *Debate of the House of Commons*, First Session, Twenty-ninth Parliament (2 April 1973) 2817.

[61] Royal Commission of Inquiry into the Status of Women in Canada, (Ottawa: Canadian Information, 1970) at 281.

socio-economic, and personal rationales.[62] Furthermore, scholars discussed the opportunity of adopting a subjective rather than an objective approach to the notion of "benefit".

Promoting the legality of voluntary contraceptive sterilization if such an intervention was not in contravention of public policy, Robert P. Kouri favoured self-determination stating that

> [a]s Glainville Williams once wrote: "Human beings are usually the best judges of their own interest."[63] If this is indeed true (and we have no reason to doubt it), then every sane, capable adult who seriously desires a surgical operation not otherwise prohibited by public policy considerations, normally draws gratification, mental tranquility or some other equivalent form of satisfaction from it. As a result, these subjective advantages derived from a sterilization, objectively improve the emotional outlook of the patient, or in other words, they confer a "benefit" upon the person in question.[64]

The ambit of the protective nature of section 45 of the *Criminal Code* was first examined by the Supreme Court of Canada in 1976, in *Morgentaler* v. *The Queen*[65]. Whereas Laskin C.J.C., speaking for the minority, considered that a physician was protected from criminal charges as soon as a consent had been given to the surgical procedure, the majority, whose opinion is contained in the judgement of Dickson, J., limited the scope of section 45 "to a charge arising out of a surgical operation performed on an unconscious patient"[66]. The majority view was to resort to section 45 only in those situations where a person was unable to provide consent, the legality of surgeries being presumed in the absence of an express criminal prohibition. Consent

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[62] See e.g. W.C.J. Meredith's comment in *Malpractice, Liability of Doctors and Hospitals* (Toronto: Carswell Co Ltd, 1956) at 257 when he wrote:

> [b]ut a needless operation causing injury to the patient is obviously not for "his benefit" and notwithstanding his consent to undergo it, may be the subject of a criminal charge. Included in this category are operations for the sterilization of a male or female, unless performed for the patient's health, or in virtue of special statutory provision.

Such a narrow interpretation of the notion of "benefit" was also advocated by the Canadian Medical protective Association. Indeed, in 1964, Dr J.L. Fisher stated that "[t]his leaves no doubt. The benefit shall not be to the spouse, to a companion, to a pocket-book, to society as a whole, to an idea or theory, or to any other nebulous thing; it shall be "to that person", Dr J.L. Fisher, "Legal Implications of Sterilization" (1964) 91 Canadian Medical Association Journal 1963 at 1965.
See also LRCC WP N°24, *supra* note 10 at 57-58.

[63] G. Williams, *The Sanctity of Life and the Criminal Law* (New York: Alfred A. Knopf, 1957) at 106.

[64] Robert, P. Kouri, "The Legality of Purely Contraceptive Sterilization" (1976) 7 Revue de Droit de l'Université de Sherbrooke 1 at 14. It is to be noted that not everyone shared this stance. In 1973, in the first *Mortengaler* case, Associate Chief Justice Hugessen expressed the opinion that although consent to a procedure should be taken into account "the simple fact that a patient asks to perform some operation upon her does not mean necessarily that this operation is for her good", (*Mortengaler*, November 12, 1973. Text unpublished. However a translation can be found in 42 D.L.R. (3d) 448 at 450, 14 C.C.C. (2d) 459 at 461.)

[65] *Morgentaler* v. *The Queen*, [1976] 1 S.C.R. 616.

[66] *Ibid.* at 646.

and benefit were therefore considered as alternative criteria. Supported by scholars[67], that opinion, which constituted an attempt to take into account the development of the doctrine of consent and the changes in the doctor-patient relationship, was however rejected in the subsequent cases.

The uncertainty surrounding the legality of voluntary contraceptive sterilization ended in 1987 with the holding of the Quebec Superior Court in the case *Cataford* v. *Moreau*[68]. Although it seems rather unlikely, other courts could choose to disregard its conclusion, as it was decided by the Superior Court of Quebec and, therefore does not set precedent and involved a civil and not a criminal case. This decision rendered by Chief Justice Deschênes dealt with an action in "*wrongful birth*" and "*wrongful life*" brought by a married couple and on behalf of their 11th child against the surgeon who had negligently performed a sterilization operation on the woman. The couple, an illiterate French-speaking worker and his English-speaking native Indian wife, decided to resort to sterilization after the birth of ten healthy children and the low tolerance of Mrs Cataford to contraceptive pills. Upon the recommendation of their family doctor and the assurance that the operation would permanently prevent any further pregnancy, the couple consented by signing a "sterilization request" form to a ligature of the fallopian tubes. However, neither the wife nor her husband understood or were aware of the content of the form, a document written in English and containing a clause discharging the surgeon of any liability no matter what the consequences of the operation were. Due to the negligent performance of the operation, Mrs Cataford gave birth to her eleventh child 13 months later. The couple consequently sued the surgeon for breach of contract, claiming damages for the birth of this unplanned child. Upon the naming of the child's guardian[69], the Honourable Justice Amédée found in favour of the plaintiffs.[70]

Although the parties had assumed the lawfulness of sterilization procedures, Chief Justice Deschênes questioned their legality *per se* before resorting to the "*wrongful life*" and "*wrongful birth*" actions. This initiative was opportune as a finding of illegality would have barred or at least reduced the damages that could be awarded to the couple. Indeed, two different theories concerning the consequences

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[67] See e.g. Carol Anne Polowich Finch-Noyes, *supra* note 56 at 282.
[68] *Cataford*, *supra* note 59.
[69] On trial, Mr. Justice Amédée, judge of the Quebec Superior Court, ordered that a guardian or surrogate guardian be appointed to protect the child's own interests.
[70] The child's claim in "*wrongful life*" was however rejected.

that can stem from the conclusion that an act is illegal have been enunciated by scholars.[71] According to the first one, the performance of an illicit act prevents the recovery of any damages in light of the *nemo auditur propriam turpitudinem* adage.[72] Under the second doctrine the responsibility deriving from an illegal act is to be shared between the performer and the person who consented to the harmful act.[73]

Acknowledging the lack of consensus concerning the definition of the notion of "benefit", the Superior Court of Quebec in *Cataford* adopted a liberal attitude, considering that such a concept could and should encompass not only health but also socio-economic and other considerations such as age, familial situation, or quality of life. Chief Justice Deschênes concluded on the issue stating that

> In the instant case, taking into account the age of the parties, the number of their children, their economic and social situation[74], there can be little doubt that "all the circumstances of the case" to cite the language of s. 45 of the Criminal Code, would lead one to the conclusion that the operation was performed "for the benefit" of the plaintiff.
> Canadian Criminal law then does not erect any barriers to the action which the plaintiffs have brought[75]

Once, the courts had established that sterilization was not *per se* illegal, the provinces had to determine whether voluntary contraceptive sterilization was prohibited on grounds of public policy, that is to say contrary to principles or standards considered of fundamental importance by the community as a whole. Assuming that voluntary sterilization is not prohibited by the criminal law, let us now look at its acceptability under provincial law. A distinction must be drawn between common law and Quebec provinces with respect to public policy.

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[71] A more detailed explanation of these two different theses can be found in Robert P. Kouri, "Non-Therapeutic Sterilization-Malpractice and the Issues of "Wrongful Birth" and "Wrongful Life" in Quebec Law" (1979) 57 Can. Bar Rev. 89 at 92-93.

[72] See e.g. *Juris-classeur civil*, "La Règle *nemo auditur*", art. 1131 to 1133, fasc. 10 bis, N° 72 to 74, by Philippe LeTourneau; J. Savatier, "Stérilisation Chirurgicale de la Femme: Aspects Juridiques" [1964] Cahiers Laënnec 54 at 61.

[73] See e.g. M.T. Meulders-Klein, "Considérations juridiques sur la stérilisation chirurgicale" [1967] Annales de la Faculté de Louvain 3 at 30-31.

[74] Although extending the notion of benefit beyond those medical acts which are clearly therapeutic is to be welcomed, some doubts have to be voiced concerning the taking into account of socio-economic factors. Indeed, we believe that such elements can never justify the sterilization of mentally handicapped persons to save costs to society of their having children, or to alleviate the burden felt by those caring for them. This issue will be developed later in when discussing non-voluntary non-therapeutic sterilization.

[75] *Cataford*, *supra* note 59 at 590.

B. Voluntary non-therapeutic sterilization and provincial law

1) Common law provinces

The law of Canadian common law provinces originally comes from English law[76]. It is thus interesting to examine the status of sterilization in England, in order to see how two legal systems which started from the same base have come to solve the issue of purely contraceptive sterilization as far as public policy is concerned.

In the early thirties, although no provision in the law formally forbade them, English courts believed that sterilization operations could only be legal when performed for therapeutic purposes. This attitude was essentially influenced by moral and religious thinking according to which sexual pleasure was sinful, and the conception of children considered to constitute the primary aim of marriages.

In 1954, Lord Denning, relying on the holding of the King's Bench in *Rex* v. *Donovan*[77] underlying the irrelevance of consent when illegal acts were concerned, declared *obiter* in the case *Bravery* v. *Bravery*[78]

> Take a case where a sterilization operation is done so as to enable the man to have the pleasure of sexual intercourse without the responsibilities attaching to it. The operation then is plainly injurious to the public interest. It is degrading to the man himself. It is injurious to his wife and any woman whom he may marry, to say nothing to the way it opens to licentiousness; and unlike contraceptives, it allows no room for a change of mind on either side. It is illegal, even though the man consents to it[79]

Although Lord Denning's opinion was not adhered to by the majority of the Court of Appeal[80], it nevertheless influenced medical practitioners and the British Medical Association for many years. In today's England, however, in the absence of any law to the contrary, sterilization is considered a contraceptive method to which consenting competent individuals can have access by virtue of the

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[76] Indeed, by the adoption of the *Upper Canada Statutes*, (1792) 32 Geo III, c.1, the new-born Upper-Canada province decided to reintroduced English law in its territory. It is important to remember that in contemporary Canada, English law enjoys a persuasive authority and, is only relevant to Canadian law as of its date of reception.

[77] *Rex* v. *Donovan*, [1934] 2 K.B. 498 (King's Bench). In this case, concerned with sexual violence exercised on a consenting female, Mr Justice Swift stated that "if an act is unlawful in the sense of being in itself a criminal act, it is plain that it cannot be rendered lawful because the person to whose detriment it is done consents to it", (*Rex* v. *Donovan*, [1934] 2 K.B. 498 at 507).

[78] *Bravery* v. *Bravery*, [1954] 3 All E.R. 59 (Court of Appeal).

[79] *Ibid.* at 68. Lord Denning considered sterilization to be equivalent to a maim in the criminal law, and therefore unlawful.

[80] See for an overview of the criticisms voiced against this statement Robert P. Kouri, "The Legality of Purely Contraceptive Sterilization", *supra* note 64 at 5-6.

National Service (Family Planning) Act 1977[81]. Sterilization is seen as "an operation of sufficient personal benefit and sufficiently small likely harm to be justified if a patient understandingly and autonomously agrees to it, and there are no generally overriding considerations of justice in terms of people's rights or in terms of distribution of resources to prevent such operations."[82]

In Canada, despite the implications that could be drawn from the Ontario decision of *Chivers and Chivers* v. *Weaver and McIntyre*[83], where the court's approach suggested its acceptance of the legality of purely contraceptive sterilization,[84] the Canadian Medical Protective Association followed the same path as the British Medical Association, recommending that practitioners only perform sterilization on therapeutic grounds.[85] The Association's attitude changed in the 1970's, in light of the increase the increase in the public's favouring of, and reliance on, such a contraceptive mean. It indeed enunciated in a statement in 1970

> The Association's thinking has reached the point where it now feels the problem should be left for decision to the individual doctor faced with the patient requesting the operation, to be decided just as he would decide about any other request for non-essential treatment. They [the doctors] should think in terms of "reasons" and then they should weigh their patient's reasons for wishing the operation to decide if they, the doctors, feel those reasons are valid[86]

This comment was and is to be criticized as it equalizes public opinion with public policy considerations and ultimately leaves the matter of determining the opportunity for the performance of sterilization in the arbitrary hands of the doctor, and not in those of the patients, and thus depriving them of their right to self-determination.[87] However, following this statement, it seemed that jurists and

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[81] *National Service (Family Planning) Act 1977* (U.K.), 1977, c.34.
[82] *Ibid.*
[83] This case, which is undated, was referred to in "Comment Upon the Law Relating to Abortion and Sterilization", annexed to F.E. Black, "Abortion and Sterilization" (1961) 33 Manitoba Bar News 33 at 42-43.
[84] In this case, a woman sued the surgeon that had rendered her sterile claiming that no consent had been given to the procedure. The court's holding solely concentrated on the issue of consent, an attitude interpreted as an implicit recognition of the legality of the operation. Authors such as F.E. Black supported such a holding. See F.E. Black, *supra* note 83.
[85] See Dr J.L. Fisher, "Legal Implications of Sterilization", *supra* note 59 at 1365.
[86] "Sexual Sterilization for Non-Medical Reasons" Note (1970) 102 Canadian Medical Association Journal 211.
[87] Acknowledging the importance of the physician's role in determining whether a patient is competent and in a good mental and physical health, Dr. Philip M. Alderman, a doctor from Vancouver, wrote in the journal of Medical Protective Association that once this duty had been performed by the physician, "the final decisions as to contraceptive method can legitimately be left to the intelligent patient", Dr. Philip M. Alderman, "Voluntary Sterilization" Correspondence (1970) 103 Canadian Medical Association Journal 1391-1392. This attitude favouring the patient's right to self-determination, has

scholars, the medical profession, and even the provincial governments agreed upon the *de facto* legality of voluntary sterilization in that it was not contrary to any public policy consideration.

As stated by Robert Kouri and Margaret Somerville

> [a]lthough there is some dicta in English case law to the effect that non-therapeutic sterilization was contrary to public policy, this policy (at least as far as the common law provinces of Canada are concerned) must be regarded as having changed in content, as the operation is carried out relatively frequently in hospitals supported by Government funds and by doctors who not only are not prosecuted, but are paid for the procedure by the Government. [88]

The courts ultimately recognized the legality of voluntary purely contraceptive sterilization as shown by *Re Eve*[89], a case decided by the Supreme Court of Canada.

2) Quebec

In the absence of any provision of the Civil Code of Quebec expressly dealing with sterilization, and in contrast with therapeutic sterilization the legality of which had been established as early as 1930,[90] the legal status of purely contraceptive sterilization in its relation with public policy, remained unanswered until 1987.

The task of the Quebec courts was to determine whether a purely contraceptive sterilization was violative of the civil law rule in respect of public order and good morals as understood by the now repealed article 13 of the Civil Code of Quebec. This additional requirement was justified as "consent would not be sufficient to make good a situation which would otherwise be illegal"[91]. Under the terms of article 13:

> No one can by private agreement validly contravene the laws of public order and good morals[92]

Until the beginning of the 1970's, doubts concerning the legitimacy of voluntary contraceptive sterilization were prevalent among commentators.

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been considered as enjoying "extraordinary merit" for its logical and respectful implications. See more generally Robert P. Kouri, *supra* note 71 at 17-18.

[88] Robert P. Kouri, Margaret A. Somerville, "Comments on the Sterilization of Mental Incompetents in Canadian Civil and Common Law" (1980) 10 R.D.U.S. 599 at 617.

[89] *Re Eve* (1986), 31 D.L.R. (4th) 1 (Supreme Court of Canada); [1986] 2 S.C.R. 388 [hereinafter *Re Eve* cited to S.C.R.].

[90] See *Caron* v. *Gagnon* (1930), 68 S.C. 155; *E.* v. *M.* (1937), 77 S.C. 298.

[91] *Ibid.* at 591.

[92] Art. 13 C. C. Q. (1980).

The honourable Mr. Justice Mayrand wrote in 1975

> Sterilization is permitted when it is necessary to avoid a dangerous pregnancy; but its legitimacy is still disputed when its purpose is to avoid the normal responsibility of paternity or of maternity...The validity of consenting to a sterilization for purely economic or social reasons may be doubted.[93]

Furthermore, in its encyclical *Humanae Vitae* of the 29th of July 1968, the Catholic Church reaffirmed its condemnation of all contraceptive methods. In a highly religious province, this position of the Church was felt by many as compelling and reflecting the actual state of the law in Quebec.[94]

However, the legitimacy of purely contraceptive sterilization soon became implicitly recognized by public opinion, the medical profession and the Government of Quebec.

The number of purely contraceptive sterilizations performed in the Province of Quebec, as well as its safety as a surgical operation, increased drastically in the 1970's and 1980's, becoming one of the most wide spread means of contraception. As for the medical profession, the Order of Physicians of the Province of Quebec by a Resolution adopted on February 24th, 1971,[95] and the Canadian Medical Protective Association by a proposition agreed upon on June 15th 1970,[96] expressed their opinion concerning the status of purely contraceptive sterilization. These two statements, similar in approach, considered voluntary sterilization acceptable provided the patient's interest remained the paramount consideration of the medical profession, the spouse was informed of the act and provided his/her consent whenever possible,[97] and the medical practitioner performed the intervention with skill and care. The Order of Physicians of the Province of Quebec left the doctor with the task of evaluating the desirability of his/her patient's demand stating that "[t]he decision to perform such a procedure is for the doctor who must evaluate each specific case, after having given to

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[93] Albert Mayrand, *L'Inviolabilité de la Personne Humaine* (Montréal: Wilson & Lafleur Ltée, 1975), at 19 translated in *Cataford, supra* note 59 at 592 by Deschênes C.J.

[94] However, Mr Justice Davidson, in a case where a Catholic person was seeking the annulment of his contract to purchase Victor Hugo's books on the basis of their immorality as far as Catholicism was concerned, stated that "the clear duty of a court is to give universal application to "..." our code- that is to interpret it as that the interpretation will not vary because of the person concerned, but be broad enough to cover all contracts of like classes, no matter what the contracting party might be." (*Taché* v. *Derome et al.* (1890), 35 L.C.J. 180 (S.C.)at 183). He was therefore implying that religious concern should have no bearing in a law deemed to be secular.

[95] Quoted by Robert P. Kouri, *supra* note 64 at 41.

[96] *Supra* note 86.

[97] The issue of spousal consent to non-therapeutic sterilization will be examined in greater detail in the next part of our first title.

the patient and to his or her spouse when it is possible, explanations as to the nature and consequences of the operation"[98].

In 1971, the Quebec Government acknowledged the legality of voluntary non-therapeutic sterilization adopting a regulation under the *Health Services and Social Services Act*[99] whereby "any person desiring sterilizing surgery must apply in writing using the required form"[100]. Furthermore, sterilization procedures were included in the category of insured services listed under directive No 49, issued on the first of July 1971 by the Quebec Health Insurance Commission.[101]

Ultimately the Quebec Superior Court in the case *Cataford*[102] resolved the issue. It is noteworthy that on two previous occasions, Quebec courts were faced with cases dealing with sterilization.[103] However, its legality was not questioned; the courts concentrating on determining whether a consent had been obtained prior to the surgical operation. After holding that sterilization procedures were not illegal *per se*, the court questioned the offensive nature of such a medical act when performed for purely contraceptive purposes according to public order and good morals considerations. Chief Justice Deschênes, delivering the opinion of the court, acknowledged the evolving and relative nature of the notion of public order and good morals, illustrating his point by referring to several cases where the courts had enjoyed

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[98] Quoted in Robert P. Kouri, *supra* note 64 at 41. It is to be noted that this aspect of the order's Resolution was criticized by enlightened commentators, criticisms that we give support to. Reviewing the position of the Order of Physicians on voluntary non-therapeutic sterilization, Robert P. Kouri noted

> [w]e are more hesitant when it comes down to the question as to upon whom the sterilization decision rests. Of course, a physician (emergency situations excepted) cannot be forced to accept patients that are not desired, nor must he perform surgery which is morally, philosophically or professionally repugnant to him. This does not imply that the decision to operate is his alone. On the contrary, we feel that if no medical or psychological contra-indications are present, then the decision should be left to the patient.

Robert P. Kouri, *supra* 64 at 42.

The age-parity formulae used by many institutions and medical practitioners to select the consenting individuals who would undergo a sterilization was also criticized for its arbitrary nature. Indeed, the most widespread method suggested by the Quebec Obstetricians and Gynaecologists Association was based on a multiplication of the age of the patient by the number of her living children, and was derived from the "One Hundred Rule" proffered by the World Health Organization. See Robert P. Kouri & Monique Ouelette-Lauzon, "Congrés H. Capitant: Corps humain et liberté individuelle" (1975) 6 Revue de Droit de l'Université de Sherbrooke 86 at 97.

[99] *Health Services and Social Services Act*, S.R.Q. 1971, c.48.

[100] *Regulation to Amend the Health Services and Social Services Act* , O.C. 832 72, 8 November 1972, G.O.Q. 1972. II. 10566.

[101] Under the terms of this directive "[a]ll acts performed with the purpose of family planning are recognized as insured services. Vasectomy and ligature of the Fallopian tubes are insured services", Directive No 49, issued on July 1971 by the Quebec Health Insurance Board and mentioned by S. Mongeau, "La Vasectomie: Évolution Récente" (1972) 7 Le Médecin du Québec 44, at 46, translated by Deschênes C.J. in *Cataford*, *supra* note 59 at 593.

[102] *Cataford*, *supra* note 59.

[103] See *Caron* v. *Gagnon*, and *E.* v. *M.*, *supra* note 90.

the hard task of determining whether certain books were contrary to good morals in light of their obscene nature. In holding that voluntary purely contraceptive sterilization could not be perceived as contrary to article 13 C.C.Q., Deschênes C.J. relied on the public acceptance of sterilization as a mean of contraception[104], the recognition of the procedure by the medical profession, the recommendations expressed by the Royal Commission of Inquiry into the Status of Women in Canada or Bird Commission[105], and Quebec Government's and Quebec Health Insurance Commission's regulations[106]. In light of the aforementioned external elements, Chief Deschênes concluded :

> In these circumstances, the court has no hesitation in concluding that, if there had been a time in which voluntary sterilization could have offended public order and good morals, this time, for better or for worse, is over and Quebec civil law is not opposed to the existence of contracts in respect of same.[107]

Voluntary non-therapeutic sterilization is therefore not only a legal act *per se*, but also one that does not violate public policy either at common law or under the law of the province of Quebec. Thus, purely contraceptive sterilization is not to be considered differently than any other medical procedure, and cannot be performed or sought without complying with the rules and principles governing medical acts, and particularly, with the law on consent to treatment.

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[104] However, Deschênes C.J. noted that the public's favour of sterilization was not conclusive as to its legal status as "a definition of what is and what is not violative of public order and good morals cannot be arrived at by public opinion polls or through statistical analysis of public reactions, and on this basis alone." On this basis alone only "an "educated"opinion as to the validity of purely contraceptive sterilization" can be issued. *Cataford*, *supra* note 59 at 591.

[105] Royal Commission of Inquiry into the Status of Women in Canada, *supra* note 61. This Commission recommended the passing of legislation as far as voluntary sterilization was concerned stating in its recommendation number 224: "Further we recommend that the provinces and territories adopt legislation to authorize medial practitioners to perform non-therapeutic sterilization at the request of the patient free from any civil liabilities toward the patient or the spouse except liability for negligence", at 281.

[106] See, *supra* note 101.

[107] *Cataford*, *supra* note 59, at 593.

Chapter II: Sterilization, a medical act: the law of consent to medical treatment briefly outlined.

Under Canadian law, not only must a consent be obtained before any doctor may proceed with medical treatment, including sterilization, but this consent must also enjoy certain characteristics to be legally valid.

A. The necessity of a consent

One of the fundamental concepts pertaining to medical law is the notion of consent. All intentional touching of another person, including through medical interventions, however slight the application of physical force might be, constitute assault under criminal law unless consented to or authorized by statute. A person commits an assault and is criminally liable when "without the consent of another person, he applies force intentionally to that person directly or indirectly." [108] In private law, the slightest touching also constitutes, unless within a social exception or consented to or authorized through the operation of the law, a trespass to the person (assault or battery).[109]

The fundamental nature of the prohibition on touching a person without consent derives from the high value placed by any democratic society on the respect for a human being's physical and mental integrity and finds expression in the principles of integrity[110] and inviolability,[111] self-determination and autonomy.

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[108] *Criminal Code, supra* note 53, section 265(1) (a). It is to be noted that, in order for the consent to legally be acceptable, it needs to be given freely and cannot be the result of threats or fear of use of force, fraud, or obtained by exercise of authority. As held in *R.* v. *Stanley* (1977), 36 C.C.C. (2d) 216, [1977] 4 W.W.R. 578 (B.C.C.A.), "to be effective the consent to the assault must be freely given with appreciation of all the risks and not merely submission to an apparently inevitable situation."(36 C.C.C. (2d) 216 at 223).

[109] See the case *Reibl* v. *Hughes* where it was held that in such an occurrence the tort is "an intentional one, consisting of an unprivileged and unconsented invasion of one's bodily security" *Reibl* v. *Hughes,* [1980] 2 S.C.R. 880, 14 C.C.L.T. 1, 114 D.L.R. (3rd) 1, 33 N.R. 361 (Supreme Court of Canada) [hereinafter *Reibl* cited to D.L.R.] (at 9 D.L.R.).

[110] "Le droit à l'intégrité de la personne humaine [...] vise [...] à préserver l'essence même de ce qui fait un être humain et lui permet de se réaliser, en assurant la sauvegarde du corps et la sauvegarde de l'esprit. C'est à partir de cette "sphère protégée" que peut se développer l'être relationnel et se construire les faisceaux d'échange constitutifs de la vie en société." Jean Bernard, Marie, "La Convention Européenne pour la Prévention de la Torture et des Peines ou Traitements Inhumains ou Dégradants, Adoptée le 26 juin 1987. Un Instrument Pragmatique et Audacieux" (1988) 19 R.D.G. 109 at 110.

[111] These rights have been recognized by several legislative instruments in the Canadian legal system. Under article seven of the *Canadian Charter of Rights and Freedoms Canadian*, (Part 1 of the *Constitution Act, 1982*, being Schedule B of the *Canada Act* (U.K.), 1982, c. 11, art.1) [hereinafter *Canadian Charter* or *Charter*].

The right to self-determination and inviolability have long been established at common law. As early as 1914, Mr. Justice Cardozo, in the United States case *Schloendorff* v. *N.Y. Hospital*[112] states that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[113]

This fundamental nature of a human being's right to bodily integrity was confirmed in the Canadian Supreme Court case *Ciarlariello* v. *Schachter*[114] where it was held that

> It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has a right to decide what is done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law.[115]

It was not until the 1st December of June 1971 that the right to inviolability was explicitly referred to in the law of Quebec[116] under article 19[117] of the Civil Code of Lower Canada. Harmonized with the Quebec Charter of Rights and Freedoms[118], the new Civil Code of Quebec[119] recognizes both the right to inviolability and the right to integrity of every individual,[120] as well as the importance of consent.

> [e]veryone 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.

In Québec, article 1 of the *Quebec Charter of Rights and Freedoms*, (R.S.Q., c. C-12; 1975, c.6; 1982, c.61) states that "[e]very human has a right to life, and to personal security, inviolability and freedom". Furthermore, the right to inviolability constitutes one of the corner-stone principles underlying criminal law. See especially Margaret A. Somerville, *Consent to Medical Care* (Ottawa: Law Reform Commission of Canada, 1979) at 8 and following..

[112] *Schloendorff* v. *N.Y. Hospital*, 211 N.Y. 127; 105 N.E. 92 (1914).

[113] *Ibid.* 211 N.Y. 127, at 129; 105 N.E. 92, at 93.

[114] *Ciarlariello* v. *Schachter*, [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609 (S.C.C.) [hereinafter *Ciarlariello* cited to D.L.R.].

[115] *Ibid.* at 135.

[116] Albert Mayrand, *supra* note 93 at 11. Although, such a right was implicitly recognized in civil law, it had never been expressly codified before 1971.

[117] Article 19 C.C.L.C:

> The human person is inviolable.
>
> No one may cause harm to the person of another without his consent or without being authorized by law to do so

[118] *Quebec Charter of Rights and Freedoms*, *supra* note 111.

[119] *Civil Code of Quebec*, [hereinafter C.C.Q.].

[120] According to the Government of Quebec, these two rights have a different scope. Indeed, the right to integrity is interpreted as protecting individuals from non-beneficial physical and psychological acts inflicted by the person herself; "[...] l'atteinte à l'intégrité peut être le fait de la personne elle-même [...]". Québec, Ministre de la Justice. *Commentaires du Ministre de la Justice*, t.1 (Québec: Les Publications du Québec, 1993) art. 10 at 12.

As for the concept of inviolability, defined as "une sorte de sphère privée, relevant de la seule volonté et dans laquelle chacun est libre de s'autodéterminer, d'organiser selon ses propres interêts et au gré de

Article 10 C.C.Q., slightly modifying article 19 C.C.L.C, asserts that

> Every person is **inviolable and entitled to the integrity of his person**. Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent. [Emphasis added][121]

In light of the previous comments, it can safely be said that Canadian Civil and Common Law acknowledges the importance of the right to inviolability. However, it is interesting to note that for many years, doctrine and jurisprudence have been supporting two different interpretations of the right to inviolability.

The first body of opinion views this right as absolute. According to the proponents of this assertion, an individual's will and right to inviolability must be respected in all circumstances, even though his/her acts can be non-beneficial and ultimately lead to death. Under this doctrine "the purpose of the inviolability principle is to preserve autonomy, in which case it parallels the common law self-determination value"[122]. This thesis has been acknowledged in several cases. In the Ontario case *Malette* v. *Shulman*[123], the Court of Appeal held liable a doctor who ordered the administration of a blood transfusion on an unconscious patient carrying a Jehovah's Witness card categorically rejecting the application of such a medical act. Robins J. A. speaking for the court considered that "the interest in the freedom to reject, or refuse to consent to, intrusions of her bodily integrity outweighs the interest of the state in the preservation of life and health and the protection of the integrity of the medical profession"[124]. The Superior Court of Quebec, in the case *Nancy B.* v. *Hôtel-Dieu de Québec et al.*[125], upon the request of Nancy B., the plaintiff, gave permission to the attending physician to stop the respiratory support treatment being given to the plaintiff, even though this act would cause her to die prematurely. Dufour J., speaking for the court, held that "putting a person on a respirator and constantly keeping her on it without her consent

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sa morale, sa propre conviction" (Grégoire Loiseau, "Le Rôle de la Volonté dans le Régime de Protection de la Personne et de son Corps" (1992) 37 McGill Law Journal 965 at 989.), it is considered as protecting an individual from non-beneficial third-party acts. "L'atteinte à l'inviolabilité provient de tierces personnes [...]; les exceptions légales à l'inviolabilité se justifient d'ailleurs par le droit à l'intégrité". Québec, Ministre de la Justice. *Commentaires du Ministère de la Justice*, t. 1 (Québec: Publications du Québec, 1993) art. 10 at 12.

[121] Article 10 C.C.Q.. The Quebec Civil Code also recognizes both the right to inviolability and integrity as amounting to personality rights under article 3 C.C.Q. which reads

> "[e]very person is the holder of personality rights, such as the right to life, **the right to inviolability and integrity of his person**, and the right to the respect of his name, reputation and privacy.[emphasis added]"

[122] Margaret Somerville, *supra* note 56 at 9.

[123] *Malette* v. *Shulman* (1990), 67 D.L.R. (4th) 321 (Ontario Court of Appeal).

[124] *Ibid.* at 334.

[125] *Nancy B.* v. *Hôtel-Dieu de Québec et al.* (1992), 86 D.L.R. (4th) 386 (Quebec Superior Court).

clearly constitutes intrusion and interference which violates the person of Nancy B."[126]

According to the second thesis the notion of inviolability is perceived in its relativity. Under this theory, state's interests in preserving life and health "will justify overriding a patient's will which is to the contrary."[127]

"La théorie de l'intervention forcée est alors justifiée par l'état de nécessité, la préservation de la vie doit l'emporter sur le respect de la volonté d'un individu."[128] .

This interpretation of the right to inviolability, related to the abuse of rights doctrine, is supported by several cases.

In Quebec, the Superior Court in *Canada* v. *Hôpital Notre-Dame de Niemec*[129] held that

> Le principe de l'inviolabilité de la personne n'est pas absolu; [...] le respect de la vie, parce que conforme à l'intérêt même de la personne prime le respect de sa volonté. [...] Si chaque être humain est, en principe, maître de sa destinée, son droit d'autodétermination demeure assujetti aux restrictions prévues par la loi.[130]

As we can see, these two different approaches of the right to inviolability have received attention from the court, and are equally justifiable.

As a final comment, a reference to the qualified position of the Law Reform Commission of Canada is necessary as we share such a cautious approach to the issue. In its working paper entitled *Euthanasia, Aiding Suicide and Cessation of Treatment*, it stated that: "the law should not make the preservation of life an absolute principle. Rather it should continue to respect individual's right to self-determination over his own existence, while protecting and promoting the maintenance of life as a fundamental value."[131]

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[126] *Ibid.* at 393.

[127] Margaret Somerville, *supra* note 111 at 9.

[128] Suzanne Gascon, *L'Utilisation Médicale et la Commercialisation du Corps Humain*, coll. Minerve (Québec: Ed. Yvon Blais, 1993) at 13.

The judge Mayrand explained this theory as follows

> C'est précisément dans le principe de l'inviolabilité de la personne que l'on puise la justification d'une intervention imposée. L'inviolabilité de la personne aurait pour but sa protection, or, les droits doivent être exercés dans le sens de leur finalité. Ce serait fausser le droit à l'intégrité corporelle d'un malade que de lui permettre de l'invoquer pour faire échec à ce qui peut conserver sa vie, et, par là même, son intégrité corporelle. « ... » La règle de la raison proportionnelle doit toujours s'appliquer. La volonté du malade est une valeur qu'il faut respecter ; on ne peut la mettre de côté que pour atteindre un avantage supérieur.
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> Albert Mayrand, *L'Inviolabilité de la Personne Humaine*, *supra* note 93 at 40.

[129] *Canada* v. *Notre-Dame de Niemec*, [1984] C.S. 426 (Superior Court of Quebec).

[130] *Ibid.* at 427.

[131] Law Reform Commission of Canada, *Euthanasia, Aiding Suicide and Cessation of Treatment* (Working Paper N°28) (Ottawa: Minister of Supply and Services Canada, 1982) at 38.

Recognized in both civil and common law, the only lawful interferences with the right to inviolability are those that are not prohibited by law and are consented to by the person subject to them. Thus, before any medical intervention can be undertaken by a medical practitioner and, in the absence of any law to the contrary, a consent must be obtained. However, if a consent must exist before sterilizing a person, this consent has to enjoy certain characteristics before being considered legally valid. We will first examine the necessary conditions a consent to treatment must fulfill before examining the exceptions to these rules and the consequences of the failure to obtain a consent at all or an informed one[132].

B. The necessary elements for a consent to be legally valid

Although a consent must exist in order for a doctor not to be criminally liable, the existence of such a consent is not sufficient in itself to avoid all legal liability. It must therefore meet certain criteria before being considered legally valid. At common law, not only must any medical touching and the manner in which it is performed be voluntarily consented to (battery-avoiding consent, or minimal consent) but such consent to treatment must also be obtained upon the disclosure of adequate information in order to enable the patient to make an enlightened decision (negligence avoiding consent, or maximal consent).The rules relating to "informed consent" [133] to treatment have been developed at common law within the law of torts, the principles of which have been codified in several Canadian common law provinces.[134] Quebec's

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[132] "The logical corollary to this doctrine is that the patient generally has the right not to consent, that is to say the right to refuse treatment and to ask that it cease where it has already begun", *Nancy B.* v. *Hôtel-Dieu de Québec et al.*, *supra* note 125 at 390. This right not to consent is also recognized in common law provinces, see e.g. *Ciarlariello*, *supra* note 114 at 618-619.

[133] Some authors criticize the use of the expression "informed consent". They argue that it is a misleading term that puts too much emphasis on the link between information and consent, rendering the obtaining of the consent the primary purpose of the disclosure of information. They prefer the expressions "informed decision-making" or "informed choice". (See e.g. Bernard Dickens, "Informed Consent", in Jocelyn Downie & Timothy Caulfield, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999) c. 5 at 117).
The latter expression was used by Justice Laskin in the case *Reibl* v. *Hughes*, as he referred to "an informed choice of submitting to or refusing recommended and appropriate treatment", *Reibl* v. *Hughes*, *supra* note 109 at 9.

[134] See e.g. *Health Care Consent Act*, S.O. 1996, c.2; *Health Care (Consent) and Care Facility (Admission) Act*, S.B.C. 1993, c. 48. This latter act is interesting to quote as the dispositions about consent are clearly exposed. It is also the first statute that deals with the issue of consent. It imposes on

dispositions about consent are contained under articles 10 and following of the Quebec Civil Code. According to the doctrine of "informed consent" or to the codified dispositions mentioned above, a consent[135], which is understood as an authorization to treatment[136], will only be legally valid if it has been given voluntarily, or freely, by a competent individual, upon the reception of an adequate disclosure of information.[137] To these three main requirements, the necessity for the consent to relate to the particular medical act contemplated must be added.

1) Common law: the necessity of a voluntary and informed consent

a) Voluntariness

At common law, in order to be valid, a consent must be given voluntarily. It cannot be obtained as a result of coercion or undue influence or upon a misrepresentation as to the nature of the treatment. Voluntariness is assessed *in concreto*, each situation being decided on its own facts.

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medical practitioners the dual duty of asserting the mental capacity of the patient and obtaining his/her consent. Under part II, section 6, a consent is legally valid if

> (a) the consent relates to the proposed health care,
> (b) the consent is given voluntarily,
> (c) the consent is not obtained by fraud or misrepresentation,
> (d) the adult is capable of making a decision about whether to give or to refuse consent to the proposed health care,
> (e) the health care provider gives the adult the information a reasonable person would require to understand the proposed health care and to make a decision, including information about (i) the condition for which health care is proposed,
> (ii) the nature of the proposed health care,
> (iii) the risks and benefits of the proposed health care that a reasonable person would expect to be told about; and,
> (iv) alternative courses of health care; and,
> (f) the adult has an opportunity to ask questions and receive answers about the proposed health care.

[135] A consent to a medical treatment can be either oral or written. It is to be noted that when a purely contraceptive sterilization is performed on a consenting individual, Quebec Civil Code requires this consent to be given in writing in virtue of article 24 C.C.Q., the care being non-therapeutic. Under the terms of this article

> Consent to care not required by a person's state of health, to the alienation of a part of a person's body, or to an experiment shall be given in writing

At common law such a practice is highly recommended. Consent can also be either express or implied. The existence of consent might be implied from the conduct of the patient, a written form or a verbal conversation. In order to determine whether consent exists at common law, the courts rely on a reasonable person's test. In *Canadian Aids Society* v. *Ontario* (1995), 250 O.R. (3rd) 388 (Gen. Div.), the court held that a blood donor did not implicitly consent to the testing of his blood ten years after the taking of a blood sample, as no reasonable person would be expected to consent to such a medical testing.

[136] See Lorne E. Rozovsky, *The Canadian Law of Consent to Treatment*, 2nd ed. (Toronto: Butterworths, 1992) at 2.

[137] In civil law, the requirements of competence and information are contained under the term "enlightened", see art. 10 C.C.Q., *supra* note 121.

i. Coercion, undue influence and fear

The difficulty in assessing coercion lies in determining what influencing factors ought to be considered as unacceptable.[138] Indeed, amongst the various factors, external or internal, influencing one's decision, only a limited number can be held to vitiate an otherwise valid consent. Whereas economic considerations, fear or aversion of certain medical procedures could constitute acceptable pressures, and thus not amount to coercion, the same could not be said of a threat uttered by a medical professional to a patient in order to make the patient accept a certain treatment.[139]

It is interesting to note that Canadian courts do not automatically invalidate a consent given under the influence of sedatives or medication.[140] However, we strongly agree with Ellen I. Picard and Gerard Robertson[141] when they write that consents obtained under those circumstances should always be closely scrutinized and preferably avoided as "the evidence of voluntariness in such cases usually comes from the defendant or their employees and even if the patient testifies, that evidence may be suspect because of the medication."[142]

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[138] See more generally, Lorne E. Rozovsky, *supra* note 134 at 19-20. See also Margaret A. Somerville, *The Ethical Canary: Science, Society and the Human Spirit* (Toronto: Viking, 2000) at 185-186.

[139] In the United Kingdom, the English Court of Appeal, in the unusual *Re T* case (*Re T.*, [1992] 4 All E.R. 649 (Court of Appeal), held that under certain circumstances, the strong religious beliefs of parents could unduly influence their children, even though of age, in accepting or refusing a required medical act. In this case, a father had applied to the court to request that a blood transfusion be performed on his 21-years-old pregnant daughter. Following private conversation with her mother, the girl had refused to consent to this medical act relying on some of the beliefs of the Jehovah's Witness' faith. Not a Jehovah's Witness herself, unlike her mother, she argued that she nevertheless agreed with some of its beliefs, and that it motivated her refusal to be transfused. Although the Court of Appeal outlined the right of any capable adult to chose which medical treatment to undergo or refuse no matter how unreasonable or irrational that choice might be, the mother's religious influence was nevertheless held to amount to a coercive factor, and a blood transfusion was ordered. The Law Lords concluded that the girl's decisional capacity had been overborne by her mother.

[140] For example in *MacKinnon* v. *Ignacio* ((1978), 29 N.S.R. (2nd) 656 T.D.), consent to a thyroid operation given under sedation was considered voluntary. There are however circumstances under which a consent obtained while the patient is under the influence of sedation will be held invalid by the courts.

[141] Ellen I. Picard & G. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996).

[142] *Ibid.* at 57. We believe that the burden of proof should be on the defendant to establish that sedatives or medication did not have an adverse effect on the patient's understanding. See, for an example of a court of law defending such a position, *Kelly* v. *Hazlett* (1976), 15 O.R. (2nd) 290, 75 D.L.R. (3rd) 536, 1 C.C.L.T. (H.C.) where a woman changed her mind after being sedated and consented to another treatment than the one originally scheduled. The court held that

> I do not think that it could be suggested otherwise than that the giving of a consent under such circumstances, at the very least, leaves the validity of the consent open to question [...] and that it would be incumbent on the defendant to prove affirmatively that the effect of the sedation probably did not adversely effect the patient's understanding of the nature of the contemplated operation (at 563).

ii. Misrepresentation

Misrepresentation vitiates consent and gives rise to an action in battery when it relates to the nature and inevitable consequences of the treatment. A medical practitioner cannot provide the patient with information or withhold material details in order to mislead his or her patient as to the basic nature and character of the treatment. However, the extent of information that can be said to relate to the nature of the treatment and not to its result or other factors collateral to the actual treatment remains an unsettled issue in Common Law provinces[143]. If omitting to tell the patient the exact scope of the medical intervention can constitute misrepresentation[144], it was held that "misrepresentation sufficient to vitiate consent given to surgery would have to be as to the very nature of the procedure to be carried out ... and not to the result."[145] Thus, whereas in the situation where a physician tells a patient he is operating for an abscess when, in fact, he is performing an hysterectomy, the patient's consent would not be valid because of fraud, an omission to disclose the failure rate of a sterilization procedure would, in all likeliness, not amount to a misrepresentation of the basic nature of the act.[146]

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[143] See e.g. for a more detailed discussion, Ellen I. Picard & G. Robertson, *supra* note 141 at 60. See also Margaret Somerville, "Structuring the Issues in Informed Consent" (1981) 26 McGill Law Journal 740 at 746-747. In this article, the author discusses whether, following the *Reibl* v. *Hughes* case (*Reibl* v. *Hughes*, *supra* note 109), the non-disclosure of the risks of a treatment, as compared with that of its inevitable consequences, can amount to a misrepresentation vitiating battery avoiding consent. In the *Reibl* v. *Hughes* case, it was held that "unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than battery."(*Reibl*, *supra* note 109 at 10). This statement can be and has been criticized as lacking clarity as it fails to establish whether the disclosure of the risks of a medical treatment can, under certain circumstances, relate to its basic nature and therefore constitute a fraud or misrepresentation vitiating battery avoiding consent. In her article, Margaret Somerville suggests the adoption of an approach whereby provided the risk left undisclosed or misrepresented is so essential as to form an integral part of the nature of the treatment, the physician's liability in battery ultimately would depend on whether his/her failure is negligent or intentional.

[144] See e.g. *Gerula* v. *Flores* (1995), 126 D.L.R. (4th) 506 (Ont. C.A.) where a patient consented to a second surgery without his physician disclosing him the fact that this second medical act was rendered necessary as a result of a negligent performance of the first surgery.

[145] *Lokay* v. *Kilgour* (1984), 31 C.C.L.T. 177 (Ont H.C.) at 189.

[146] However, whereas an action in battery would be avoided, an action in negligence could stand as there may be liability in negligence for failing to disclose information which is not part of the basic nature and consequences of a medical act. See, for a more detailed discussion on the issue of consent to treatment, Margaret Somerville, *supra* note 143 at 742.

b) Informed consent[147]

Even if given voluntarily, a consent to treatment will only be valid if it is informed. Physicians have a positive duty to inform their patient, a duty which stems from the fiduciary obligations or perhaps relationship they enjoy with their patient,[148] one based on trust. The need for disclosure of information seems to have ancient origins. For many years, at common law, the standard of disclosure reflected the paternalistic and authoritarian conception of medical law of the medical profession. The extent of disclosure first left to the discretion of the medical practitioners was later determined on the basis of good medical practice.[149] This paternalistic attitude of the courts changed in the beginning of the 1980's as a result of the numerous criticisms voiced[150] as well as of an evolution of the perception of the nature of the relationship between a physician and his/her patient. The need to preserve the patient's autonomy recognized, the information disclosed by physicians is today intended to enable patients to choose between the various options offered according to their personal wishes. The doctor-patient relationship is no longer one of power or authority, where the physician, master of the medical knowledge, is the sole judge of the appropriate course of action to undertake, but is rather considered as a partnership, where cooperation and trust are paramount.

As a result of this aforementioned evolution, the Supreme Court of Canada embraced an attitude more protective of the patients' interests, reassessing the contours of the duty to disclose and causation, and thus intervening in the conduct of medical practice. By two cases, *Hopp* v. *Lepp*[151] and *Reibl* v. *Hughes*[152], it adopted a

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[147] In this paragraph we will not consider the particular issue of experiments which must conform to a "full disclosure" standard as far as the physician's duty to disclose is concerned. Even where the experiments can be labelled as therapeutic (if such a distinction exists), courts are unwilling to allow any justification for non-disclosure. See e.g. *Halushka* v. *University of Saskatchewan and al.* (1965), 53 D.L.R. 436 (Saskatchewan Court of Appeal) where the Court of Appeal of Saskatchewan held that "the subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent." (at 443-444).

[148] See e.g. *Kenny* v. *Lockwood*, [1932] O.R. 141 (Ontario Court of Appeal).

[149] See e.g. *Kenny* v. *Lockwood*, *ibid.* Similar rules governed the disclosure of risks in United Sates. See e.g. W. F. Bowker, "Minors and Mental Incompetents: Consent to Experimentation, Gifts or Tissue and Sterilization" (1981) 26 McGill Law Journal 951.

[150] See e.g. E.S. Glass, "Restructuring Informed Consent" (1970) 79 Yale Law Journal 1533. Furthermore, this change was also influenced by a certain jurisprudence of the United States Supreme Court. See e.g. *Canterbury* v. *Spence,* (1972) 464 F2d 772 (United States Court of Appeal for the District of Columbia District), certiorari denied 409 U.S. 1064 (United States Supreme Court), 34 L.Ed. (2nd) 318.

[151] *Hopp* v. *Lepp*, [1980] 2 S.C.R. 192, 13 C.C.L.T. 66, [1980] 4 W.W.R. 645, 112 D.L.R. (3rd)1, 33 N.R. 145, 22 A.P.R. 361 (Supreme Court of Canada).

[152] *Reibl* v. *Hughes*, *supra* note 109.

reasonable patient standard of disclosure. According to this standard, a medical practitioner must disclose all the information that would be material to a reasonable patient in the same circumstances. The Supreme Court's adoption of an objective reasonable patient's standard test was motivated by its merits and practicality as compared with other possible tests.[153] According to this test, in order to evade any liability in negligence[154], a physician must disclose to his/her patient all the "material risks"[155] that a reasonable person in the patient's circumstances would wish to be aware of. Disclosure must extend to the nature and material risks of the treatment, its effects and side-effects, any special and unusual risks[156], the existing alternatives, their characteristics and risks, and the consequences that would result from not having the treatment at all. To fully discharge his/her duty of disclosure, a physician must take the necessary steps to become aware of the particularity of the patient's situation and preferences in order to determine the susceptibility of the patient to certain risks and the materiality of some risks otherwise immaterial to the "reasonable patient".

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[153] The Supreme Court analyzed the comparative advantages of three different tests in determining the issues of the scope and breach of the duty to disclose.
The first of these standards, the medical professional standard or subjective physician standard, was applied in common law provinces prior to *Reibl* (*supra* note 107), and is still in existence in England (see e.g. *Sidaway* v. *Bethlehem Royal Hospital Governors*, [1985] 1 ALL E.R. 643 (H.L.). However it can be inferred from the case *Bolitho* v. *City & Hackney Health Authority*, [1997] 4 All E.R. 771, and two more recent cases (*Smith* v. *Tunbridge Wells*, H.A. [1994] 5 Med. L.R. 334, (1995) 3 Med. L. Rev. 198 (AG), *Pearce* v. *United Bristol HealthCare N.H.S. Trust*, (1998) May 20 (CA) (unreported)) that English courts are not applying as rigidly as before the medical professional test.). This test, whereupon a doctor will only be held liable in negligence if he fails to provide his/her patient with information that a reasonable medical professional would have disclosed, was however rejected by the Supreme Court of Canada. The Court considered this test not to serve the patient's but rather the medical profession's interests. Judge Laskin, speaking for the court stated that "[t]o allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty", *Reibl* v. *Hughes*, *supra* note 109 at 13.
Two other tests were considered by the Supreme Court, the "subjective patient's" and the "modified objective patient's" standards with a preference given to the latter. With regards to causation see *Arndt* v. *Smith* (1997), 148 D.L.R. (4th) 48 5S.C.C. where Justice McLaughlin held that the "modified objective patient's" test was fair for both plaintiff and defendant (para. 66).
Although the Supreme Court has opted for an objective reasonable patient's standard, this is not to conclude that expert or medical evidence is irrelevant to the issue of disclosure. However, courts enjoy the discretion to reject such evidence as inadequate

[154] The issue of negligence as well as that of battery will be covered by the section reviewing the legal consequences arising out of a failure to obtain a consent or an informed one.

[155] *Reibl* v. *Hughes*, *supra* note 109 at 1.

[156] Risks must be disclosed when either common and important or rare but severe. As noted by Margaret Somerville "the more serious the consequences and the higher the probability, the more likely it is that the patient should be informed."(Margaret A. Somerville, *supra* note 143 at 757). It should also be noted that patients are expected to be aware of the fact that any medical act carries its own risks and side-effects. This is a "common knowledge" exception to the duty of disclosure which applies to "matters which men of ordinary knowledge are presumed to appreciate."(*Kelly* v. *Hazlett*, *supra* note 142 at 319).

Furthermore, medical practitioners must promote dialogue, answer any question raised even though outside the normal scope of disclosure, and address any concern he/she knows or ought to know his/her patient to have. It should be added that the more elective the medical act the more complete the information disclosed must be.

The Supreme Court also clarified the fact that physicians have an additional duty to ensure that their patients understand the information provided. As reaffirmed in *Ciarlariello* v. *Schacter*[157]

> Prior to Reibl v. Hughes, there was some doubt as to whether the doctor had the duty to ensure that he was understood. However, Laskin C.J. made it quite clear in that case that it was incumbent particularly where it appears that the patient had some difficulty with the language spoken by the doctor.[158]
>
> Once a treatment has started, a new duty to disclose only arises where the circumstances have changed from the time of the initial explanation.[159]

2) Civil law: the necessity of a free and enlightened consent

In the past few decades, there has been a debate as to the nature of the relationship linking a patient with his/her medical practitioner. The majority of the doctrine and jurisprudence supports the contractual theory of the relationship patient/medical practitioner. This relationship is, then, considered as essentially based on an exchange of consents, whereby a patient voluntarily chooses to see a particular

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[157] *Ciarlariello*, *supra* note 114 at 622.

[158] *Ibid.* at 140. In a negligence action, whether a physician breached his/her disclosure duty by failing to ensure the patient's understanding of the information provided will have to be proved by the patient. He/she will have to establish that a reasonable patient in the same circumstances "would have understood the information communicated to him, or that he did not understand the information and the physician knew this."(Margaret Somerville, *supra* note 143 at 778).
When the information targeted at relates to the basic nature and character of the treatment (battery avoiding consent), the *Reibl* v. *Hughes*, *supra* note 109, case seems to impose on physicians the higher duty, obligation of result, that of ensuring that the patient actually understood the information provided (subjective understanding).We agree with Margaret Somerville when she proposes the implementation of an alternative "apparent understanding standard", therefore limiting the *Reibl* v. *Hughes* conclusion to its specific facts (the difficulties of the patient with the English language) (Margaret Somerville, *supra* note 143 at 776-783).

[159] See e.g. *Ciarlariello*, *supra* note 114. In this case, a woman became agitated in the course of a cerebral angiogram and asked that it be stopped. After being reassured by her surgeon, she agreed to the continuation of the test. Although the physician had not provided her with any new explanation of the procedure, the court considered that this was not required as the circumstances had not changed. "There was no evidence that the hyperventilation or tetany suffered by Mrs Ciarlariello had increased the risk associated with any further angiogram injections. The trial judge was therefore correct in his conclusion that there was no need to repeat the details of the procedure or its attendant risks before carrying out the last injection." (at 622). Some have expressed their disagreement towards the conclusion reached by the Court arguing that consent to the continuation of the test was vitiated, the subject still being under a trauma caused by the first part of the testing. See Louise Bellanger-Hardy, "Le Consentement aux Actes Médicaux et le Droit à l'Autodétermination: Développements Récents" (1993) 25:3 Ottawa Law Review 475 at 483.

doctor or to attend a given hospital, hospital or medical practitioner whom, upon the decision to treat the patient makes a diagnosis and prescribes medicine that the patient is required to take.[160]

Those supporting the extra-contractual nature of the patient-doctor relationship argue that in many situations either the patient or the medical practitioner or the hospital does not voluntarily enter the relationship. They base their arguments on the fact that under certain circumstances the patient is unable to provide a consent due to unconsciousness, or incapacity, and that due to the preponderance of state governance in the medical area doctors or hospitals are unable to refuse to treat a patient in many cases, and that their activities are highly controlled.[161]

For the purpose of our discussion we will consider the relationship between a doctor and his/her patient to be primarily contractual. Consent to the formation of such a contract obeys to the rules set forth under the articles 1398 C.C.Q. and following.[162] However, even though a contract has validly been formed between a patient and a physician, the latter has an obligation to inform the patient and obtain his/her free and enlightened consent to the particular medical treatment to be performed.

As stated under the terms of article 10 C.C.Q.

> Every person is inviolable and entitled to the integrity of his person.
> Except in cases provided by law, no one may interfere with his person without his **free and enlightened consent**. [emphasis added]

This obligation constitutes one of the obligations[163] created upon the formation of the contract. As in common law, consent to treatment needs to be given voluntarily, it must therefore be exempt from any intellectual, moral or circumstantial constraint.[164]

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[160] See e.g. P.A. Crépeau, "La Responsabilité Civile de l'Etablissement Hospitalier en Droit Civil Canadien" (1981) 26 McGill Law Journal 673; R. Boucher, "La Responsabilité Hospitalière" (1974) 15 Cahiers de Droit 220; *Berneard* v. *Cloutier*, [1982] C.A. 289 ; *X.* v. *Mellen,* [1957] B.R. 389 where it was held that "[d]ès que le patient pénètre dans le cabinet du médecin, prend naissance entre celui-ci et le malade, par lui-même ou pour lui-même un contrat de soins professionnels." (at 408). It is to be noted that such a contract is not nominate, therefore in order to determine the obligations that will arise upon its formation, reliance must be made on the general provisions on contracts of the Civil Code.

[161] See e.g, A. Lajoie, P. Molinari, & J.L. Baudouin, "Le Droit aux Services de Santé: Légal ou Contractuel" (1983) 43 Revue du Barreau 704; P. Legrand, "Epistémologie Juridique: le Cas du Contrat Hospitalier", in Ernest Caparros, ed., *Mélanges Germain Brière* (Montréal: Wison & Lafleur, 1993) at 439.

[162] According to article 1399 C.C.Q.:

> Consent may be given in a free and enlightened manner.
> It might be vitiated by error, fear or lesion.

What might amount to fear, coercion or lesion vitiating consent is defined in the following articles.

[163] Except in certain limited circumstances, physicians' obligations are only means and not of result. See e.g. *Tremblay* v. *Claveau*, [1990] R.R.A. 268 (C.A.). As stated by article 2.03.13 of the *Code de Déontologie des Médecins*, R.R.Q., c. M-19, r.4: medical practitioners must "s'abstenir de garantir directement ou indirectement "..." la guérison d'une maladie"

In Quebec, doctors' duty to inform their patients on both the nature and collateral features of medical treatments[165] has greatly developed since 1980 with the influence of the two Supreme Court cases of *Hopp* v. *Lepp*[166] and *Reibl* v. *Hughes*[167].[168]

Although, today, Quebec civil law specifically requires physicians to inform their patients,[169] the Civil Code of Quebec is silent as to the extent of disclosure that needs to be provided before any treatment may take place. Subsidiarily, article 2.03.29 of the *Code de Déontologie des médecins*[170] specifies that the information must relate to the nature, aim and consequences of the medical procedure whereas article 8 of the *Act Respecting Health Services and Social Services*[171] extends this disclosure to the patient's state of health, the alternatives, risks and usual consequences of the treatment. In spite of these provisions, the scope of the duty of disclosure was left for the Quebec courts to shape.

Although the standards adopted at common law in the cases of *Hopp* v. *Lepp*[172] and *Reibl*[173] are not binding in Quebec and were considered with caution by both the jurisprudence[174] and scholars[175], their influence on the jurisprudence of the

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[164] On the difficulty to assess coercion or undue influence, see our comments, *supra* at 29. As in common law, although the courts do not automatically invalidate a consent given under the influence of sedatives, there are circumstances where such a consent will be held not to have been given voluntarily. See, e.g. *Beausoleil* v. *La Communauté des Soeurs de la Charité de la Providence*, [1965] Q.B. 37. In that case a patient consented to the administration of a local anaesthetic upon the insistence of the surgeon while under the influence of a pre-anaesthetic. The Queen's Bench rejected the validity of such a consent as, prior to the intervention, the patient had expressed her desire to be administered a general anaesthetic.

[165] As will be seen later in our discussion, as far as physicians' liability is concerned, Quebec law does not differentiate between the information related to the basic nature and consequences of the medical act on the hand, and its collateral features on the other hand.

[166] *Hopp* v. *Lepp*, *supra* note 151.

[167] *Reibl* v. *Hughes*, *supra* note 109.

[168] See more generally S. Rodgers-Magnet, "Legislating for and Informed Consent to Medical Treatment by Competent Adults" (1981) 26 McGill Law Journal 1056; E. Picard, "Consent to Medical Treatment in Canada" (1981) 19 Osgoode Hall Law Journal 140; R. Robertson, "Informed Consent Ten Years Later: The Impact of *Reibl* v. *Hughes*" (1991) 70 Canadian Bar Review 423.

[169] Indeed, article 10 paragraph 2 C.C.Q. states that "except in cases provided for by law, no one may interfere with his person without his free and enlightened consent."

[170] *Code de Déontologie des Médecins*, R.R.Q. 1981, c. M-9

[171] *An Act Respecting Health Services and Social Services*, R.S.Q., c. S-4.2.

[172] *Hopp* v. *Lepp*, *supra* note 151.

[173] *Reibl* v. *Hughes*, *supra* note 109.

[174] See e.g. *Gingues* v. *Asselin*, [1990] R.R.A. 630 (Superior Court); *Pelletier* v. *Roberge*, [1991] R.R.A. 726 (Court of Appeal). However, other courts have applied the standards established by the Supreme Court of Canada. See e.g. *Chaussé* v. *Desjardins*, [1986] R.J.Q. 358 (C.S.).

[175] See e.g. R. Kouri, "L'Influence de la Cour Suprême sur l'Obligation de Renseigner en Droit Médical Québécois" (1984) 44 Revue du Barreau 851 at 868; B. Knoppers, "Vérité et Information de la Personne" (1987) 18 Revue Générale de Droit 819 at 837. However, some authors were of the opinion

Quebec courts should not be overlooked. A distinction must however be made between situations where the care is required by the patient's state of health and the cases where it is not.[176]

a) Care required by the patient's state of health[177]

As far as treatments required by the patient's state of health are concerned, the majority of Quebec cases do not abide by the criteria established at common law by the Supreme Court of Canada, even though the result can appear to be similar. The standard of disclosure is close to a "professional disclosure test", however it is blended by the obligation incumbent on the medical practitioner to individualize the information given and adapt to the particularities of each situations.[178] A physician must therefore disclose all probable risks, alternatives that he does not consider as dangerous or inadvisable, and the consequences of refusing the procedure[179], but is under no obligation to inform his patient, unless specifically asked for, about improbable or very rare risks[180], or about usual risks of the procedure contemplated[181].

b) Care not required by the patient's state of health[182]

The standard of disclosure for those treatments that are not required by the patient's health such as contraceptive sterilization is higher than for therapeutic treatments. Disclosure does not vary according to the frequency of the risk but

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that common law standards as far as the duty to disclose and causation were concerned should be opted for and applied in Quebec. While commenting on the case *Hamelin-Hankins* v. *Papillon*, [1980] C.S. 879, Louise Potvin wrote that "Il s'agissait de trouver une solution à un problème humain aux dimensions universelles, celui de la normalisation de l'étendue de l'obligation de renseignement. C'est pourquoi, nous croyons que cet emprunt au common law canadien est justifié en droit québécois." (Louise Potvin, *L'Obligation de Renseignement du Médecin* (Cowansville: Ed. Yvon Blais Inc., 1984) at 49).

[176] However, whether or not the care is required by the patient's state of health, the physician must use terms that are simple enough to be understood by the patient according to his/her education and medical knowledge. See e.g. *Morrow* v. *Hôpital Royal Victoria*, J.E. 78-824 (C.S.), aff'd [1990] R.R.A. 41 (C.A.). Furthermore "la nécessité d'informer le patient et d'obtenir son consentement sont des obligations continues. Il n'existe donc pas un seul consentement mais des consentements." (P. Lesage Jarjoura, J. Lessard, & S. Philips-Nootens, *Le Droit dans le Quotidien de la Médecine* (Cowansville: Ed. Yvon Blais, 1995) at 111). Therefore, a new duty to disclose and obtain a free and enlightened consent arises where the circumstances have changed from the time of the initial explanation. See e.g. *Leroux* v. *Sternthal*, [1999] R.R.A. 939 (C.S.).

[177] The Civil law, under article 11 C.C.Q. gives a non-exhaustive list of the type of treatment encompassed by the term "care required by the patient's state of health". Examinations, specimen taking, removal of tissue are example of such treatments.

[178] See e.g. *Dineen* v. *The Queen Elisabeth Hospital*, [1988] R.R.A. 658 (C.A).

[179] See e.g. *Dunant* v *Chong*, [1986] R.R.A. 2 (Court of Appeal).

[180] See e.g. *Murray-Vallancourt* v. *Clairoux*, [1989] R.R.A. 762 (Superior Court)

[181] See e.g. *Blais* v. *Dion* J.E. 85-657 (Superior Court) where the court, *obiter*, stated that the risks inherent to an anaesthesia did not have to be disclosed.

[182] Sterilization or contraceptives are examples of non-therapeutic medical procedures.

according to its severity.[183] A doctor will have to inform his patient of the alternatives of the treatment, their success rate, as well as their possible side-effects.[184]

Our brief review of the law on informed consent leads us to the conclusion that, in civil and common law provinces, a similarity exists between the extent of information required from a physician as far as non-therapeutic medical acts are concerned. A high standard of disclosure is imposed by the courts as there can be no excuse in neglecting to fully inform a patient in situations where the procedure is elective. This is particularly true of sterilization which affects, often in an irreversible manner, reproductive capacity. In such situations, doctors will be required to explain the nature, consequences, results[185] (more specifically the likelihood of permanency of the operation) and associated risks of the act, its success rate,[186] as well as all the possible alternatives, especially when less intrusive, and the need for the patient to use contraceptive measures following until confirmation of the success of sterilization.[187]

3) Capacity

The legal validity of consent to treatment is dependant upon the capacity of the patient. As will be examined later in greater detail, where a patient through age and/or disability is incompetent, a physician will have to obtain the necessary consent from a person authorized by law to consent on the patient's behalf.

The issue of capacity raises particular difficulties when a patient is mentally disabled and/or a minor.

A distinction should be made between legal and factual competence. Under Canadian law, every individual of adult age, whether or not living in an institution, is presumed to be legally competent to give an authorization to treatment. However, this presumption is rebuttable by legislation or an order from the courts. *A contrario*, minors, unless emancipated or mature are legally incompetent.

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[183] See, e.g., *Drolet* v. *Parenteau*, [1991] R.J.Q. 2956, at 2983, (Superior Court), aff'd in appeal *Parenteau* v. *Drolet,* J.E. 94-576 (Court of Appeal).
[184] See e.g. *Johnson* v. *Harris*, [1990] R.R.A. 832 (Quebec Superior Court).
[185] See e.g. *Cryderman* v. *Ringrose*, 6 A.R. 21, [1977] 3 W.W.R. 109, 89 D.L.R. (3rd) 32 (Dist. Ct.); aff'd. [1978] 3 W.W.R. 481, 89 D.L.R. (3d) 32 (Alta. C.A.).
[186] For instance, a physician must inform patients about the possibility of spontaneous recanalizations following tubal litigations and vasectomies. See e.g. Robert P. Kouri, *supra* note 71 at 95. See also Gerald B. Robertson, "Civil Liability from 'Wrongful Birth' following an Unsuccessful Sterilization Operation" (1974) 4 American Journal of Law and Medicine 138.
[187] See e.g. Arthur J. Meagher, Peter J. Marr, & Ronald A. Meagher, *Doctors and Hospitals: Legal Duties* (Toronto: Butterworths, 1991) at 57ff.

Factual competence is assessed in relation to a particular act, a specific decision; an individual will be considered factually competent if he enjoys the necessary capacity to understand the nature and consequences of the function under scrutiny.

a) adults with a disability and the assessment of competence

The notion of "mental disability" will be used throughout our paper as an umbrella term encompassing situations where an individual is affected with any mental disorder, developmental disability, that is to say any mental illness, mental disorder or related developmental disabilities.[188] Mental disability is not in itself conclusive of the legal incompetence of an individual, no presumption of incompetence is attached to people who are mentally disabled.

Furthermore, competence is a relative concept. A person's competence for the purposes of the law is to be judged in relation to a specific situation or legal issue. As noted by Gerald Robertson "there is no such concept as "total" or "global" legal incapacity arising from mental disability"[189]. A person can therefore be legally incapable of drafting a will or marrying, but competent to consent to a medical treatment. "Competence is not to be understood in any global sense, but rather as reflecting incapacities with respect to specific decisions or areas of decisions."[190]

A legally incompetent patient can still be factually competent to consent to a specific treatment even though, depending on the effect of the finding of legal incompetence, the factually competent person may or may not be legally competent to consent. Indeed, in assessing the competence on an adult, the courts have adopted a functional approach whereby an individual is considered competent if he/she is able to understand the nature, purpose and effect of the proposed treatment.[191] Whereas refusal of treatment, however unreasonable it might seem is not in itself conclusive of

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[188] This definition of mental disability matches the definition adopted by some Canadian human rights legislation such as the *New Brunswick Human Rights Act* which describes "mental disability", under section 2 as

> Any condition of mental retardation or impairment.
> Any learning disability, or dysfunction in one or more of the mental processes involved in the comprehension or use of symbols or spoken language; or
> Any mental disorder

New Brunswick Human Rights Act, R.S.N.B. 1973, c. H-11, s.2.

[189] Gerald B. Robertson, *Mental Disability and the Law*, 2nd ed. (Toronto: Carswell, 1994) at 3.

[190] Ontario, Parliamentary Inquiry, *Final Report of the Ontario Enquiry on Mental Competency* (Toronto: Queen's Printer, 1996) (Chairman: Professor David Weisstub) at 35.

[191] A certain number of legislations have codified this approach of competence. See e.g. in Manitoba, the *Health Care Directives Act*, S.M. 1992, c.33, s.2; or in British Columbia, the *Health Care (Consent) and Care Facility (Admission) Act*, *supra* note 134.

incapacity[192], patients who deny the existence of their illness and are therefore unable to understand the beneficial aspects of proposed treatments may be held incompetent by the courts.[193]

As far as voluntary sterilization is concerned, only consent given by a legally and factually competent adult will be valid, a consent provided by a patient who understands both the nature of sterilization and its often irreversible consequences. Another issue needs clarification in relation to voluntary sterilization: whether the consent of a competent adult alone is sufficient to authorize the performance of sterilization or whether an additional consent is required.

b) Spousal consent

Traditionally, under both the civil and common law, spousal consent was required when sterilization was performed on a married woman. This requirement was based on the husband's right over his wife's "marital services", services which included marital and sexual relationship and the conception of children.[194] Its abolition was the result of the criticisms voiced against its discriminatory nature as understood by provincial human rights legislation or the *Canadian Charter of Rights and Freedoms*[195], as no additional consent was solicited for male sterilization or unmarried persons[196], and, its impracticality, as the necessity of spousal consent applied to all married couples whether or not separated. Furthermore, the law on this particular issue was unclear as far as common law spouses were concerned, and in relation to the consequences arising out of a refusal by a spouse to consent to a sterilization even where such a medical act was therapeutically necessary.

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[192] See e.g. *Malette* v. *Shulman*, *supra* note 123, where an unconscious carrier of a Jehovah's Witness card successfully sued a doctor who administered her a life-saving blood transfusion. The Court of Appeal held that "people must have the right to make choices that accord with their own value regardless how unwise or foolish those choices may appear to others.", (at 328).

[193] In *Khan* v. *St. Thomas Psychiatric Hospital* (1992), 87 D.L.R. (4th) 289 (Ontario Court of Appeal), a paranoid schizophrenic while understanding what the disease consisted of, and what anti-psychotic were, was held by the court of appeal to be incompetent to consent to the taking of this medication as she did not believe herself to be ill.

For other similar examples, see e.g. *McKay* v. *O'Doherty*, [1989] O.J. No. 965 (Ontario District Court); *Institut Pinel de Montréal v. Dion* (1983), 2 D.L.R (4th) 234 (Quebec Superior Court); *Re G* (1991), 96 Nfld. & P.E.I.R. 236 (Prince of Island T.D.); *Howlett* v. *Karunaratne* (1988), 64 O.R. (2d) 418 (District Court).

This means that under certain circumstances, when the treatment is aimed at curing a mental illness or a disability, not only do the courts require patients to enjoy the capacity to understand but also to appreciate the consequences of refusing treatment.

[194] See G. Sharpe, *The Law and Medicine in Canada* (Toronto: Butterworths, 1987) at 67-68; L.E. Rozovsky, *Canadian Hospital Law*, 2nd ed. (Ottawa: Canadian Hospital Association, 1979) at 50-51; see more generally L.E. Rozovsky, *supra* note 136 at 40-43.

[195] *Canadian Charter of Rights and Freedoms*, see *supra* note 111.

[196] The discrimination was therefore gender and marital status based.

Today, even though medical practitioners are advised to discuss the matter with both partners, married or unmarried, the only consent to be obtained is the one of the person seeking access to sterilization. This rule has received legislative recognition in the province of Ontario. The *Family Law Act*[197] specifies under section 64

> (1) For all the purposes of the law of Ontario, a married person has a legal personality that is independent, separate and distinct from that of his or her spouse.
> (2) A married person has and shall be accorded legal capacity for all purposes and in all respects as if he or she were an unmarried person and, in particular, has the same right of action in tort against his spouse as if they were not married.
> (3) The purpose of subsection (1) and (2) is to make the same law apply equally, to married men and women and to remove any difference in it resulting from any common law rule or doctrine.[198]

Any provincial statute or policy that would selectively request a spousal consent before performing sterilization would be in breach of the equality rights guaranteed by section 15 of the *Canadian Charter of Rights and Freedom*[199] which reads

> (1) 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.
> (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.[200]

c) Minors and the assessment of competence

Minors are considered by common law as legally incompetent and thus inherently in need of protection, unless emancipated or mature.

The age of majority, a matter left to the discretion of provincial law[201], is used to determine when an individual becomes legally capable to enter certain transactions, when he/she can drink, drive, or vote. However, being below the age of majority is not

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[197] *Family Law Act*, R.S.O. 1990, c. F-3, amended by 1992, c. 32, section 12; 1993, c. 27, Sched. D.; 1997, c.20; 1997, c. 25, Sched. E, section 1; 1998, c. 26, section 102; 1999, c. 6, section 25; 2000, c.4, section 12; 2000, c. 33, section 22.
[198] *Ibid.* section 64.
[199] *Canadian Charter or Rights and Freedoms, supra* note 111.
[200] *Ibid.* section 15.
[201] In British Columbia, for instance, according to the *Age of Majority Act*, R.S.N.B. 1973, c. A-4, s1 (1), and in Nova Scotia under section 2(1) of the *Age of Majority Act*, R.S.N.S. 1989, c.4, the age of majority is 19 years old, whereas in Quebec, the Civil Code sets the age of majority at 18 years old (article 153 C.C.Q.).

determining as far as consent to medical acts is concerned. Unless provincial legislation specifically states an age above which a child can authorize treatment, the issue is governed by the principles developed by common law.

i. Legislation

Some Canadian provinces have enacted provisions specifying the conditions under which, and the treatments for which, a minor of the stated statutory age or above can consent. In the province of Quebec, articles 14-18 of the *Civil Code* deal with the rules governing consent of minors. A distinction is drawn between therapeutic and non-therapeutic treatments. Under article 14 of the Quebec Civil Code

> Consent to care required by the state of health of a minor is given by the person having parental authority or by his tutor.
> A minor fourteen years of age or over, however, may give his consent alone to such care.

Furthermore, article 21 C.C.Q. specifies that a minor can object to a life threatening experiment or consent to an experiment not likely to endanger his/her health if he is able to understand its nature and consequences. When a minor is confined to a health or social services facility for more than twelve hours his parents or tutor must however be informed. Moreover, the court or, in cases of emergency, where the minor's life is threatened, the parents can override a minor's consent.[202] A minor is unable to consent alone to any care not required by his/her state of health that could endanger his/her health, or cause grave and permanent defects (therefore to a purely contraceptive sterilization).[203]

In New Brunswick, the statutory age of consent to such care as surgical, dental treatment, diagnosis and preventive care, or any ancillary treatment, is 16.[204] However, a minor of 16 or above will only be legally competent to consent to a treatment that is considered by a medical practitioner or dentist to be in his/her best interests.[205] It would therefore seem that non-therapeutic sterilization could only in

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[202] Article 16 C.C.Q..
[203] Article 17 C.C.Q..
[204] See *Medical Consent of Minors Act*, S.N.B. 1976, c. M-6.1 [am. 1979, c.41, s.78] section 1 and section 2. This act was drafted in accordance with the recommendation of the Conference of Commissioners on Uniformity of Legislation Canada. In British Columbia, the statutory age of consent is also 16 years-old according to section 16 of the *Infants Act*, R.S.B.C. 1996, c. 223, section 16. On the relationship between section 16 of the Act and the common law "mature minor" rule, see *Van Mol v. Ashmore* (1999), 168 D.L.R. (4th) 637 (British Columbia Court of Appeal).
[205] *Ibid.* section 3(1) (b).

very limited circumstances be considered by a medical practitioner to be in the minor's best interests.[206]

ii. Common Law

In the absence of any legislation, the issue of competence is governed by the common law. No common law principle prevents a minor from consenting to a medical treatment; decisional capacity is not linked to a specific age.

Common law has lately developed a functional approach to the issue of minors' competence to consent to medical treatment. The courts moved from a test based on the emancipation of the minor from parental control, guidance and financial dependence[207] to a subjective test based on the ability of the minor to understand and appreciate the nature and the consequences of the proposed treatment: the so-called "mature minor" rule. This rule, which permits a case-by-case analysis of minors' decisional capacity, was first referred to in the case *Johnston* v. *Wellesley Hospital*[208], and definitively established by *C. (J.S.)* v. *Wren*[209]. In *Walker (Litigation Guardian of)* v. *Region 2 Hospital Corp.*[210]the court held that

> In Canada, the common law recognizes the doctrine of a mature minor, namely, one who is capable of understanding the nature and consequences of the proposed treatment. Accordingly, a minor, if mature, does have the legal capacity to consent to his or her own medical treatment...At common law, where a minor is mature, no parental consent is required.[211]

In determining whether a minor is mature, the courts will take into consideration such factors as the child's age, intellectual abilities, the child's independence from the parents' influence, the nature and beneficial aspect of the treatment.[212] The "mature minor" rule remains a discussed, complex and to some extent unsettled legal issue. The scope of the mature minor's decisional capacity remains unclear when the treatment is non-beneficial or non-therapeutic and can

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[206] It is difficult to imagine a situation where it would be beneficial for a minor, even though mature, to be deprived of his/her procreative abilities. We believe contraceptive sterilization to be an interference with bodily integrity to be left to the decision of competent adults. Indeed, it seems difficult to acknowledge the capacity for a minor to fully appreciate the consequences of sterilization. Children should be prevented from consenting to non-therapeutic acts which could have grave or permanent effects or could endanger life as is the case in Quebec.

[207] *Booth* v. *Toronto General Hospital* (1910), 17 O.W.R. 118 (H.C). This objective test was later rejected by the court, as independence from parents was thought not to always be equivalent to decisional capacity.

[208] *Johnston* v. *Wellesley Hospital*, [1971] 2 O.R. 103, 17 D.L.R. (3d) 139 (H.C.J.) [hereinafter *Johnston*].

[209] *C. (J.S.)* v. *Wren*, [1987] 2 W.W.R. 669 (Alberta Court of Appeal) [hereinafter *Wren*].

[210] *Walker (Litigation Guardian of)* v. *Region 2 Hospital Corp.* (1994), 116 D.L.R. (4th) 477.

[211] *Ibid.* at 487.

[212] See J. Wilson, *Wilson on Children and the Law* (Toronto: Butterworths, 1994) at para. 5.21.

severely or permanently injure the patient's health. Whereas the cases of *Johnston* and *Wren* did not expressly limit the minor's power to consent to medical care, in both the cases, the treatments were therapeutic[213]. Limiting only to beneficial treatments[214] the power of the mature minor to consent would have the effect of reducing his/her right to self-determination and autonomy.

The recent *Re Dueck*[215] case cast some doubts as to the sufficiency of factual competence in determining whether a minor can be considered mature. In this case, the Saskatchewan Queen's Bench Court placed Tyrell, a thirteen year old child suffering from osteosarcoma, in the care and control of the Minister of Social Services for the duration of his treatment, although the child and the parents had expressed their wishes that the cycle of chemotherapy be discontinued. In holding that Tyrell was not a mature minor, the court stated that "Tyrell does not **appreciate** and understand that if he discontinues his chemotherapy and refuses surgery, he will die within a year from the spreading cancer. [emphasis added]."[216] This case seems to require the additional necessity for the child to appreciate the information given in order to be able to consent to a treatment.[217] Although the issue of whether a mature minor can consent to a non-therapeutic act and that of the sufficiency of factual competence in determining minors' maturity remain yet to be settled by the courts, we are of the opinion that a protective attitude should be adopted when children are concerned. "While we should err on the side of respect for liberty when adults make decisions about medical treatment that seem to be clearly contrary to protecting their life or health, we should err on the side of protection when children make similar decisions for themselves."[218]

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[213] In the *Wren* case (*supra* note 209), the court considered the patient mature enough to consent to a therapeutic abortion. In the *Johnston* case (*supra* note 208), the treatment under the court's scrutiny was a cosmetic procedure which was sought to provide emotional and psychological benefits.

[214] This argument towards a limitation of minor decisional capacity has been labelled "welfare principle". See e.g. J. Costello, "If I Can Say Yes, Why Can't I Say No? Adolescents at Risk and the Right to Give or Withold Consent", in R.S. Humm, ed., *Child, Parent and State: Law and Policy Reader* (Philadelphia: Temple University Press, 1994) at 490-503.

[215] *Re Dueck*, [1997] 171 D.L.R. (4th) 761 (Saskatchewan Queen's Bench).

[216] *Ibid.* at 767.

[217] See more generally on this issue Margaret Somerville, *supra* note 138 at 187-189. The case could also be analysed as having been decided on the issue of voluntariness of Tyrell's consent. Indeed, the court analysed in details the influence of the parents' beliefs on Tyrell's decisions. The Bench held that "Tyrell has been given no real choice. Tyrell has been misguided by his father into placing his hope for recovery on a cure that does not exist. This is simply cruelty to Tyrell", *Re Dueck*, *supra* note 215 at 767.

[218] Margaret Somerville, *supra* note 138 at 189.

In conclusion, whether in Quebec or common law provinces, it seems safe to say that a minor cannot and should not consent to non-therapeutic sterilization.

4) Specificity

Under Canadian Law, the last requirement for a consent to be valid is its specificity to the particular medical procedure contemplated. Unless the situation is one of emergency[219], a physician cannot perform an act different from the one originally consented to. However, under certain circumstances, consent to an additional act, provided it is of minor importance and within the ambit of the procedure consented to, may reasonably be implied from the original consent. In *Brushett* v. *Cowan*[220], a patient had given his written consent to a muscular biopsy and to "such further and alternative measures as may be found to be necessary". Upon the discovery of an abnormal adjacent bone tissue in the course of the surgery, a bone biopsy was also performed. The court of appeal, reversing the findings of the trial judge, considered that in light of all the circumstances of the case, the initial consent was broad enough to cover an ongoing investigative process such as a bone biopsy.[221]

Although in most cases the existence of consent will be required by the law, in some cases, a physician will be allowed to proceed without his/her patient's consent or excused from not having provided sufficient information.

C. The exceptions to the need for a consent or an informed one

Under certain limited statutory or jurisprudential circumstances, a physician will not be legally required to secure the consent of a patient or will be excused from having withheld some information. Apart from mental or public health legislation[222], two situations deserve our attention.

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[219] Under, the emergency exception covered by article 13 C.C.Q. and established by the case *Marshall* v. *Curry*, [1993] 3 D.L.R. 260, 60 C.C.C. 136 (N.S. T.D.) (Nova Scotia Supreme Court), a physician is exempt from liability for the failure to obtain consent when the treatment performed was necessary to save the life of the patient or to prevent serious bodily injuries. This exception will be examined in greater detail in the following section of our paper.

[220] *Brushett* v. *Cowan* (1990), 69 D.L.R. (4th) 743 (Newfoundland Court of Appeal) rev'g in part (1987), 40 D.L.R. (4th) 488 (Nfld. T.D.).

[221] Consent to a particular procedure also covers usual and necessary minor sub-procedures. See e.g. *Taylor* v. *Hogan* (1994), 370 A.P.R. 375 (Newfoundland Court of Appeal), where a physician in the course of a laparoscopy removed adhesions. The court held that this additional act was required to enable the doctor to have a clear view of the abdomen.

[222] Mental Health legislation will be analysed in a later paragraph. Public Health Legislation will permit the performance of medical acts without consent in situations where the public interest outweighs

1) Medico-legal emergencies

Since the *Marshall* v. *Curry*[223] case and under article 13 C.C.Q.[224], when a patient is unable to give his/her consent due to unconsciousness, serious illness or severe intoxication, and consent from a legal representative is not reasonably possible, a physician is allowed to proceed with a life or health preserving treatment without that person's consent. Interpreted narrowly by the courts, this emergency exception, previously based on the rationale that the patient implicitly consented to the emergency treatment[225], is explained by the fact that in an emergency the doctor is privileged by reason of necessity. It only applies where the treatment cannot be delayed and has not been rejected prior to the emergency.[226]

Thus, as opposed to therapeutic sterilization,[227] a doctor will never be allowed to perform purely contraceptive sterilization without previously obtaining the patient's consent as elective procedures do not constitute emergencies.

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individual patients' autonomy. Such is the case when there is a risk of a spread of communicable diseases. Communicable diseases covered by such acts encompass cholera, leprosy, tuberculosis, and A.I.D.S.

Furthermore, it should be added that the *Criminal Code of Canada* contains provisions according to which a police officer will be allowed to proceed with a blood sample when he/she "has reasonable and probable grounds to believe that, by reason of any physical condition of the person,... the person may be incapable of providing a sample of his breath, or... it would be impracticable to obtain a sample of the person's breath", *Criminal Code*, *supra* note 53, section 254(3)(b) [am. S. 1(a), in force for this section; am. S. 1(b), s.18 (Sch. I, item 6(F), not in force].

[223] *Marshall* v. *Curry*, *supra* note 219.

[224] Article 13 C.C.Q. reads:

> Consent is not required in case of emergency. If the life of the person is in danger or his integrity is threatened and his consent cannot be obtained in due time.
>
> It is required, however, where the care is unusual or has become useless or where its consequences could be intolerable for the person.

[225] This explanation is in line with the civil law principle according to which every single person is required by the law to assist persons that are in danger. Such a principle is expressed, in Quebec, under the terms of article 2 of the *Quebec Charter of Rights and Freedoms*, *supra* note 11, which states

> Tout être humain dont la vie est en péril a droit au secours
>
> Toute personne doit porter secours à celui dont la vie est en péril, personnellement ou en obtenant du secours, en lui apportant l'aide physique nécessaire et immédiate, à moins d'un risqué pour elle ou pour les tiers ou d'un autre motif raisonnable.

[226] See e.g. *Malette* v. *Shulman*, *supra* note 123. In this case a doctor gave his unconscious patient a blood transfusion in spite of the presence in her purse of a Jehovah's Witness card refusing the performance of such medical procedure. The physician tried unsuccessfully to rely on the emergency exception established by the courts, arguing that not only was the treatment necessary to save her life but that there also existed some doubts as to the faith of the plaintiff. However the courts held that "in the circumstances of this case, the instructions in the Jehovah's Witness card imposed a valid restriction on the emergency treatment that could be provided to Mrs Malette and precluded blood transfusions", at 332.

[227] As shown by the case *Murray* v. *McMurphy*, [1949] 2 D.L.R. 442 (B.C.S.C.), courts are very careful in excusing a doctor from having sterilized a patient without his/her consent. In this case a surgeon sterilized his patient in the course of Caesarean section upon the discovery of tumours in the uterus. Although these tumours made further pregnancies dangerous, the performance of the medical act was only a matter of convenience and expediency and the doctor was found liable in battery.

2) Therapeutic privilege

Recognized implicitly by the Supreme Court of Canada in *Hopp* v. *Lepp*[228] and in Quebec by the case *Héritiers du Docteur Jean Sirois* v. *Brunelle*[229], the therapeutic privilege exception enables a physician to withhold information that he/she believed would lead to the harm or suffering of the patient.[230] It is based on the "assumption that the physician cares not only for the patient's psychological health but for his psychological and moral well-being"[231].Therapeutic privilege does not apply in Quebec when the care is not therapeutic[232] or in common law provinces where the treatment is elective.[233]. Furthermore, it is only admitted by the courts in extremely rare cases upon the clear proof that the disadvantages of disclosure outweigh the advantages.[234] The courts' narrow interpretation of this defence reveals the paramount importance of information in the patient-doctor relationship.[235]

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[228] See *supra* note 151.

[229] *Héritiers du Docteur Jean Sirois* v. *Brunelle*, [1975] C.A. 779.

[230] See E. Etchells, et al., "Bioethics for clinicians: 2 Disclosure" (1996) 155:4 Canadian Medical Association Journal 387 at 388.

The therapeutic privilege exception is different from the situation where a patient clearly indicates that he/she does not want to be told about specific things related to a given treatment. See e.g. *Pittman Estate* v. *Bain* (1994), 112 D.L.R. (4th) 257 (Ontario General Division). It should be noted that, in light of the non-therapeutic nature of contraceptive sterilization, the validity of a waiver in such situations seems doubtful. As already mentioned, the more elective the procedure, the more complete the information disclosed and the more narrowly the courts will interpret the exceptions to the doctrine of informed consent.

[231] B. Barber, *Informed Consent in Medical Therapy and Research* (New Brunswick, N.J., Rutgers University Press, 1980) at 37.

[232] Neither at common law nor at civil law can the therapeutic privilege exception be invoked by physicians carrying out research, whether or not therapeutic.

[233] See *Videto* v. *Kennedy* (1981), 125 D.L.R. (3d) 127.

[234] The status of therapeutic privilege is rather uncertain under Canadian law, mainly in light of the fear of its overuse. Indeed, in the case *Meyer Estate* v. *Rogers* (1991), 78 D.L.R. (4th) 307 (Ontario General Division), Maloney J., at 316, held that "the therapeutic privilege exception does not form part of the law of Canada and should not become a part thereof" as it is "an unwarranted extension of the privilege beyond its original scope which protected patients only from potential psychological harm" in the United Sates, and as the potential of the privilege "to override the requirement for informed consent" could ultimately lead to the irrelevance of the disclosure rule. However, this exception, although very narrowly defined, exists today under Canadian law. We believe that it should be subject to the same principles as those governing the exception to the general rule of access to medical records. Indeed, similarities exist between those two situations. The information which the patient desires to have access to is unavailable to the patient either because it is kept in records in possession of the doctor (exception to the rule of access to medical records), or because the information is part of the professional medical knowledge to which the patient is alien (therapeutic privilege). Furthermore, the patient's interest constitutes the underlying reason for the information not to be disclosed. The limits of the doctor's right to object to the patient's general right to access to medical records were established in *McInerney* v. *MacDonald* (1992), 93 D.L.R. (4th) 415 (Supreme Court of Canada). The courts held that the relationship between a patient and a medical practitioner is one of trust and confidence, one where the information shared is to be accessed by the patient in light of his/her interest in the information kept by the doctor. However, as with therapeutic privilege, in some limited circumstances, the doctor will be justified in refusing to disclose information contained in the patient's medical record. The court applied

Therefore, therapeutic privilege is irrelevant when the medical act performed is a non-therapeutic sterilization.

Our brief review of Canadian law on consent to treatment will be concluded by an overview of the liability that can arise from the failure by a doctor to secure consent or to adequately inform his/her patient.

D. The legal consequences of a lack of consent or an informed consent

Although, the physician's failure to obtain a consent might give rise to criminal liability[236] and a breach of the disclosure requirements to disciplinary actions[237], we will limit our study to the rules governing civil liability under the common and civil law of Canada.

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a reasonable physician test. Indeed the court stated, at 427, that

> the patient's right of access to his or her records is not absolute.(...) As part of the relationship of trust and confidence, the physician must act in the best interests of the patient. If the physician **reasonably believes** it is not in the patient's interests to inspect his or her medical records, the physician may consider it necessary to deny access to the information.(...) [t]he physician has a discretion to deny access to the information. But the patient is not left at the mercy of this discretion. When called upon, equity will intervene to protect the patient from an improper exercise of the physician's discretion. In other words, **the physician has a discretion to deny access, but it is circumscribed. It must be exercised on proper principles and not in an arbitrary fashion.**[emphasis added]

Furthermore, in Alberta, the *Health Information Act* (Bill 40, not yet proclaimed in force, c. H-48, assented to December 9, 1999 and mentioned in Gerald B. Robertson, "The Health Information Protection Act" (1997) 6:1 Health law Review 8) under section 11(1) provides that "A custodian may refuse to disclose health information to an applicant (a) if the disclosure could reasonably be expected (i) to result in immediate and grave harm to the applicant's mental or physical health or safety".

Enjoying the necessary insight of the patient's medical and psychological situation, physicians should be left the discretionary power to withhold the disclosure of certain information in extremely circumscribed situations where the doctor reasonably believes that in the patients' situation, the information will be seriously harmful.

One issue remains unsettled, whether or not a doctor is justified in withholding information relating to diagnosis.

[235] Margaret Somerville argues that in order to determine whether a doctor was privileged from withholding required information, the test should be what the "reasonable physician, in the same circumstances, would anticipate that the disclosure of information normally required would on the balance of probabilities in itself, mentally or physically, harm the particular patient in a serious way and to a significant degree." Margaret Somerville, "Therapeutic Privilege: Variation on the Theme of Informed Consent" (1984) 4 Law, Medicine and Health Care 4 at 4. The courts seem to apply this medical professional test as shown by the *Pittman Estate* v. *Bain, supra* note 230. In that case it was stated that if a doctor in the same circumstances would not have disclosed the particular information, proof being made by reference to the practice of a reasonable body of physicians, he/she would not be liable.

[236] See *Criminal Code, supra* note 53, part VIII, art. 264ff.

[237] Disciplinary actions can be undertaken by the medical profession itself because it is self-regulated. In such cases the professional body is given the power not only to control who enters the profession, but also to set the standards and discipline members will have to abide by. Failing to obtain consent or giving inadequate information could amount to unprofessional conduct, that is, a misconduct sanctioned

1) Common law: the distinction between battery and negligence actions affirmed

The two Supreme Court decisions *Hopp* v. *Lepp*[238] and *Reibl* v. *Hughes*[239] introduced a distinction between the consequences arising out of the physician's failure to obtain a consent at all, obtained as a result of fraud, threat or misrepresentation, or by a incompetent individual, and the failure to secure an informed consent. In *Reibl* v. *Hughes*[240], deploring the confusion existing in the case law between the actions of battery, an intentional tort, and that of negligence, Laskin C.J.C., speaking for the court, held that

> **actions of battery** in respect of surgical or other medical treatment **should be confined to cases where** surgery or treatment has been performed or given to which **there has been no consent at all, or where,** emergency situations aside, surgery or treatment has been **performed or given beyond that to which there was consent**. [Emphasis added][241]

Later he continues stating that "unless there has been misrepresentation or fraud to secure consent to the treatment, **a failure to disclose the attendant risks,** however serious, **should go to negligence rather than battery**. [Emphasis added]"[242]

Thus, a medical practitioner faces liability for battery in situations where the patient did not consent at all to the medical procedure, where his/her consent is vitiated by fraud, duress or misrepresentation, or where the treatment went beyond the consent that was given. An obstetrician performing a sterilization when the consent was only for a Caesarean operation would thus be liable in battery.[243] On the other hand, a negligence action will lie whenever the consent was not properly informed.[244]

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by the regulatory body. See for a more detailed discussion on this issue, Linette McNamara, Erin Nelson, "Regulation of Health Care Professionals", in Jocelyn Caulfied, Timothy Caulfield, eds., *supra* note 133, c.2 at 51.

[238] *Hopp* v. *Lepp*, *supra* note 151.

[239] *Reibl* v. *Hughes*, *supra* note 109.

[240] *Ibid.*

[241] *Ibid.* at 10.

[242] *Ibid.* at 11.

[243] *Murray* v. *McMurchy*, *supra* note 227.

[244] If the tort of negligence dominates the doctor-patient relationship and is the most common basis for a lawsuit, however, this is not to conclude that contract law is totally absent from this area. Historically, the doctors' duty to their patient arose from them being called. The medical profession was considered a "common calling". Doctors were required by law to act with care and skill when treating their patient, (see e.g. *Everard* v. *Hopkins* (1615), 2 Bulstrode 332, 80 E.R. 1164 (King's Bench)). The relationship between a patient and his/her doctor became contractual 300 years ago with the birth and development of contract law. Where no express terms existed, the law implied them and the consideration requirement was considered to be met by the patient' submission to treatment, (see e.g. *Branbury* v. *Bank of Montréal*, [1918] A.C. 626 (House of Lords) at 657).
Meanwhile, the doctrine of "common calling" had given birth to the notion "duty of care" and the tort of negligence, and the industrial environment gradually favoured it over contractual actions as it better

This distinction should not be overlooked, as an action in battery can sometimes be advantageous for a patient suing a doctor as far as the legal requirements are concerned. In a battery action, the burden of proof is on the physician, he must establish, on the balance of probabilities, the presence of a valid consent;[245] upon such proof, damages will be awarded even in the absence of physical injury for all the direct consequences of the medical intervention, whether or not foreseeable.[246]

2) Civil law: the preponderance of contractual liability

Until the beginning of the 1970's, in light of the difficulty of meeting the requirements of the civil law as far as the proof of a fault and the causal link were concerned, and due to the low damages awarded in court, only a few lawsuits were brought before the courts. The increasing expectations of patients in the outcomes of medical treatments[247], the appearance in the civil law of the concept of reasonable forseeability of damages, the facilitation of proving a physician's breach of duty of care[248], but most of all the introduction of the need for a doctor to obtain a free and enlightened consent[249], contributed to the development of the civil law on professional liability.

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covered most situations. (See, generally, Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 2nd ed. (Toronto: Carswell, 1984) c.2 at 26).

Thus, even though an action for breach of contract remains a possibility, it is an unlikely one. It is to be noted that, at common law, a contract can only be held to exist where there was an intention to create legal relations, the parties are competent, the terms are certain or at least ascertainable, and consideration has been provided for.

[245] *Kelly* v. *Hazlett*, *supra* note 142. It is noteworthy that the burden of proof being on the physician, in situation of doubt, the patient will be given the advantage.

[246] The defendant in a battery action is responsible for all the consequences of his wrongful act. The end result may seem harsh, given that a competent and prudent practitioner may be held legally responsible for an unforeseeable result. The result underlines the importance of consent and the value that the law attributes to the patient's right of self-determination.

B. Sneiderman, J.C. Irvine, P.H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses and Other Care Professionals*, 2nd ed. (Toronto: Carswell, 1995) at 25; see also Ellen I. Picard, G. B. Robertson, *supra* note 141 at 107; L. Klar, *Tort Law*, 2nd ed. (Toronto: Carswell, 1996) at 41.

[247] See e.g. J.L. Baudouin, "La Responsabilité Professionnelle Médicale: Pathologie et Thérapie", in J. L. Baudouin, *La Responsabilité Civile des Professionnels au Canada* (Cowansville: Ed. Yvon Blais, 1988) at 99 at 102ff.

It is interesting to not that originally patients turned to using a failure of informed consent as a basis for a claim because it was very difficult to get doctors to act as expert witnesses against other doctors and therefore difficult to prove medical negligence in carrying out the procedure. It was easier to prove a failure to disclose information i.e a failure to obtained informed consent.

[248] The case *X* v. *Mellen*, *supra* note 160, seems to be the decision that first found a physician liable upon the establishment of an ordinary fault assessed according to known norms.

[249] See e.g. Margaret A. Somerville, *supra* note 143.

The debate as to the nature of the relationship linking a patient with his/her medical practitioner,[250] though of importance when the Civil Code of Lower Canada was in force, has lost part of its practical significance as the differences between the two regimes of liability have been reduced.[251]

Today under the law of Quebec, the relationship between a doctor and his/her patient is primarily contractual.[252]

Margaret A. Somerville, commenting on the differences existing between the civil and common law wrote, in 1980,

> [A] claim based on a breach of duty in the physician-patient relationship is more likely to sound in contract in the civil law than it would at common law, and contrary to the civilian doctrine of cumul, which would allow a plaintiff to claim both delict or quasi-delict and contract in relation to the same facts which are alleged give rise to liability, there is a trend to exclude delictual or quasi-delictual liability to the extent that the obligation in issue has a contractual basis. Support for this trend depends on also excluding a doctrine of option, as argued by Professor P.A. Crépeau, ("La Responsabilité Médicale Hospitalière dans la Jurisprudence Québecoise récente, (1960) Revue du Barreau 434, at 470-472) but the doctrine of option was recently endorsed by a unanimous bench of the Supreme Court of Canada in Wabasso Ltd v. The General Drying Co (dated June 22 1981).[253]

The position advocated by the Supreme Court of Canada in the *Wabasso Ltd* v. *The General Drying Co* case was not followed by the Civil Code of Quebec as, by its article 1458, it rejects the doctrine of option.

> Under the terms of article 1458
>
> Every person has a duty to honour his contractual undertakings.
> Where he fails in this duty, he is liable for any bodily, moral or material injury he causes to the other contracting party and is liable to reparation for the injury; **neither he nor the other party may in such case avoid the rules governing contractual liability by opting for rules that be more favourable to them.** [Emphasis added][254]

As opposed to the common law, which distinguishes between actions in battery and negligence, the civil law applies the same liability regime in situations where no consent to a particular treatment or an uninformed one has been obtained.[255]

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[250] See our comments *supra* at 33-34.

[251] However, the distinction remains important as far as the hospital's liability for the wrongful act of one of the medical practitioners it employs is concerned. See, more generally, J.L.Baudouin, *La Responsabilité Civile*, 5th ed (Cowansville: Ed. Yvon Blais, 1998) at 634-635.

[252] "La responsabilité du médecin repose sur une base contractuelle ou consensuelle patient-médecin", *Lamarre* v. *Hospital du Sacré-Coeur*, [1996] R.R.A. 496 (Quebec Superior Court).

[253] Margaret A. Somerville, *supra* note 143 at 742 (note 5).

[254] Article 1458 C.C.Q.

[255] However, it is to be noted that when consent to the formation of the medical contract has not been obtained or is vitiated by error, fear or lesion, the liability will necessarily be extra-contractual.

A medical practitioner will be liable provided he/she committed a fault[256] in discharging his/her duty to disclose and obtain the patient's free and enlightened consent to treatment.

This chapter leads us to the conclusion that the legality of purely contraceptive sterilization is no longer in doubt, provided it is performed with skill and care after the obtaining of a free and enlightened consent by an individual both competent and adult. Voluntary non-therapeutic sterilization thus falls into the realm of self- determination. If, indeed, voluntary non-therapeutic sterilization does no longer constitute a legal issue, a problem arises when the operation is to be performed on a person who through age and/or disability is not factually or legally competent to provide a valid consent to the operation. Involuntary non-therapeutic sterilization is a complex and contemporary legal, ethical and moral issue, as it is a major and often irreversible non-medically necessary surgical operation depriving one, without his consent, of his/her capacity to procreate. Throughout the twentieth century, not only has it been promoted by the state as part of eugenic programs aiming at the improvement of the human gene pool, but it has also been requested by carers for the supposedly best interests of incompetent individuals on the basis of their inability to financially and emotionally cope with the responsibility of raising children, the possible psychological trauma of pregnancy and child-birth, or hygienic reasons.

The purpose of our second chapter is to determine, after a brief exposé of the Canadian eugenic past, the conditions under which involuntary non-therapeutic sterilization can be performed and whether or not the position adopted by the provinces ought to be reformed.

[256] Today, contractual and delictual faults that give rise to liability are similar in nature. See e.g. *X.* v. *Mellen*, *supra* note 142. On the notion of fault, see more generally J.L. Baudouin, *supra* note 251 at 642-643; A. Bernardot, R.P. Kouri, *La Responsabilité Civile Médicale* (Sherbrooke: Les Editions Revue de Droit, 1980) c.1.

Part two: Canadian law on involuntary non-therapeutic sterilization [257]

After reviewing the two eugenic sterilization laws that were enacted in Alberta and British Columbia, our discussion will lead us to examine the law on consent to treatment as far as incompetent individuals are concerned with a particular focus on the existence, if any, of statutory or common law authority allowing an alternate decision-maker to authorize non-therapeutic sterilization, and if not whether the courts have jurisdiction to allow such a procedure to be undertaken. Finally we question the need for a reform in this area of the law.

Chapter III: Involuntary sterilization: the shadow of a shameful eugenic past

Canadian law on non-voluntary sterilization cannot be fully understood without referring to its historical use in furtherance of public interests.

Historically, the first underlying rationale for the performance of involuntary sterilization, in Canada, was economic and eugenic.

The reception of eugenic theory, in Canada, was the result of the scientific developments outlining the importance of heredity in the transmission of certain traits, which occurred in the beginning of the twentieth century, and was part of a wider social reform movement aimed at the improvement of health, education and morality standards.

In the beginning of the twentieth century, in light of the large number of migrants settling in their territory, Canadian provinces witnessed a rapid urbanization and industrialization and, as a consequence, an increase in criminality, diseases and immorality rates. This, combined with the growth of the population of persons

[257] Whereas we are employing the term involuntary non-therapeutic sterilization, other equivalent terms are used in the literature: sterilization abuse, non-consensual sterilization, involuntary contraceptive sterilization, involuntary sterilization, compulsory sterilization, sterilization with third party consent.

labelled as mentally defective or feeble-minded, was believed to constitute a threat to Canadian society.

Eugenicists' belief in society's advancement through selective breeding policies appealed to Canadian social reformers[258] as it appeared to be a cost-efficient answer to overcrowded mental institutions and their under funding.[259] Influenced by the enactment, in the beginning of the twentieth century, of eugenic sterilization statutes in United States[260], two Canadian provinces adhered to the precepts of the Eugenic Movement, and, several other provinces discussed the opportunity of adopting negative eugenic breeding policies. In Ontario, in 1930, the Royal Commission on Public Welfare recommended the drafting of a piece of legislation permitting the coerced sterilization of immoral defectives and criminals; as for Manitoba, a provision to the same effect was proposed but, after much controversy, withheld from the legislative scheme.[261] Furthermore, the medical profession and the Federal Government favoured such initiatives. In 1925, the National Council of Women specifically expressed its support for policies legalizing the sterilization of the 'unfit'.[262]

In the following sections, we will concentrate on the two Canadian eugenic sterilization statutes that were in force for most of the twentieth century, their administration, the criticisms they engendered, and their late repeal.

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[258] Evidence of the interest engendered by eugenic doctrine can be found in the speech of the president of the United Farm Women of Alberta who stated in 1924

> [f]or ages, the iron rule of the survival of the fittest saw those qualities of strength, endurance, beauty, and intelligence, perpetuated in the race, while Mother Nature, inexorable to the individual, but with true racial beneficence, allowed the inferiors, the misfits, and the degenerates to be stamped out of existence. Today, we have complete reversal of this procedure. Science, medicine, and philanthropy enable many weaklings to reach maturity, preserve inferiors and degenerates, and take no measures to prevent continuous racial impoverishment.

Margaret Gunn, United Farm of Alberta, "Annual Address of the President of the U.F.W.A." (1924) *Minutes of the Annual Convention of the U.W.F.A.* at 69.

[259] Canadian provinces, influenced by European practices, began putting people with disabilities in institutions by the mid-1800's. These institutions soon became overcrowded with the development of systematic psychiatric and medical examinations in schools and the easy option it constituted for overburdened families. This trend was only reversed in the mid-1950's with the discovery of efficient medication, and the recognition of the rights of the mentally disabled.

[260] See introduction, *supra* pages 2-3. It is to be reminded that as early as 1907, the state of Indiana adopted a sterilization act. See e.g. Monroe E. Price, *supra* note 12.

[261] See B. Starkman, "The Control of Life: Unexamined Law and the Life Worth Living" (1973) 11 Osgoode Hall Law Journal 175 at 181 note 32.

[262] See more generally A. McLaren, *supra* note 6.

A. The eugenic sterilization acts of Alberta and British Columbia

As mentioned already, at the turn of the last century, two Canadian provinces adopted eugenic sterilization laws. Alberta passed the *Sexual Sterilization Act*[263] in 1928, and the *Sexual Sterilization Sterilization Act*[264] of British Columbia was enacted in 1933.

1) Alberta

Alberta was the first Canadian province to be endowed with a eugenic sterilization statute, the *Sexual Sterilization Act*[265] of 1928. Despite the common belief of widespread public support, this statute whose passing took the province ten years and gave rise to many debates, would not have come to existence without the constant lobbying of a few province's social, political and medical reformers from 1916 to 1928, such as the United Farm Women of Alberta[266].

In 1917, the United Farm Women of Alberta (U.W.F.A.) articulated the first eugenic social reforms. They advocated segregation in mental institutions, and ultimately sterilization. Feeling threatened by the increase in number of mentally defective individuals and the correlative dissemination of diseases and violence, the U.F.W.A. declared, in the course of its annual meeting in 1917,

> "Whereas the problem of the feeble-minded is a continuous menace to society; and,
> Whereas the policy heretofore carried out in this Province deals only with the worst cases of mentally defective children, and,
> Whereas the real danger is constituted by the mentally defective adult,
> Therefore be it resolved that we urge upon the Government the necessity of putting into operation as speedily as possible a plan whereby the adult mental defectives of both sexes may be kept under custodial care during the entire period of reproduction. In this connection we would recommend that our

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[263] *Sexual Sterilization Act*, *supra* note 19.
[264] *Sexual Sterilization Act*, *supra* note 20.
[265] *Supra* note 19.
[266] The United Farm Women of Alberta, U.W.F.A., was created in 1916, as part of the United Farmers of Alberta. Composed of townswomen, this group pressured the government of Alberta to enact health reforms as the president of the group at that time (Margaret Gunn) believed that "with the restoration of physical health, mental health frequently follows" (M. Gunn, "The Farm's Women's Program for 1924", . (19 February 1924) The U.W.F.A 1).
For a more general account on the lobbying that took place in Aberta from 1916 to 1928 see e.g. P.V. Collins, *The Public Health Policies of the United Farmers of Alberta Government 1921-1935* (M.A. Thesis, University of Western Ontario, 1969) [unpublished] at 8-16, 80-85. See also A. McLaren, *supra* note 6 at 94-99; T.L. Chapman, "Early Eugenics Movement in Western Canada" (1977) 25:4 Alberta History 9 at 15.

> women make a wilful study of eugenics, with special reference to sterilization.[267]

The need for carrying out negative eugenic policies was also shared by the province's minister of Health and his predecessor, R.G. Reid, who said in 1923

> should we provide institutional care for all mental defectives, with all the cost which it entails, or should we not consider the possibility of dealing with the matter in a more drastic way? Sometimes it is necessary and just that we should sacrifice sentiment to the greater interests of humanity.[268]

The first draft of the *Sexual Sterilization Act* was introduced in March 1927, however its final version was not presented before the Parliament until 1928. This Bill was met with public, scientific and religious resistance and reserve[269]. Some citizens were concerned by the possibility that sterilization would be performed on wrongfully institutionalized patients, or as a condition of institutional release in breach of individuals' right to self-determination. The Canadian Medical Association Journal published an article in which, relying on new scientific studies, the concept of hereditary determinism was challenged, and the medical profession urged to undertake adequate studies on eugenics and sterilization.[270] The act was eventually adopted in 1928. It established a "Eugenic Board", composed of four members appointed by the Lieutenant-Governor in council. The Board's powers consisted of authorizing[271] sterilization of institutionalized individuals upon the establishment that

> the patient might safely be discharged if the danger of procreation with its attendant risk of multiplication of the evil by transmission of the disability to progeny were eliminated.[272]

Under the terms of section 7, 8 and 9 of the act, professionals and other individuals involved in the decision-making and in the performance of sterilization were protected from civil liability as long as they acted in good faith in furtherance of the statute's objectives. Consent of the individual was required or that of his/her spouse, parents, guardian or appointed provincial minister when the board considered him/her to be incapable of providing a valid consent.[273]

In 1937, the act was amended[274] extending the Board's powers over "mental

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[267] United Farmers of Alberta, *Annual Report and Yearbook* (1921) at 157.
[268] Deysne, B., *Welfare in Alberta* (M.A. Thesis, University of Alberta, 1966) [unpublished] at 99.
[269] See e.g. L.A. Giroux, "Sterilization Bill Given Second Reading; Opposition is Strong" *The Edmonton Journal* (25 February 1928) A3.
[270] See Editorial Comments (Nov. 1928) 19 Canadian Medical Association Journal 586.
[271] The decisions of the Eugenic Board had to be unanimous.
[272] *Sexual Sterilization Act*, *supra* note 19 section 4.
[273] *Ibid.* section 6.
[274] *Sexual Sterilization Act*, *supra* note 19.

defectives" whose consent to sterilization was not required as opposed to persons suffering from psychosis. "Mental defectives" were defined in the act as individuals

> suffering from a condition of arrested or incomplete development of mind existing before the age of 18 years, whether arising from inherent causes or induced by disease or injury.[275]

From 1937, the act found application not only in situations where mental disability or deficiency was likely transmissible to the progeny, but also in situations where mental injury was likely to result in the absence of sterilization. In 1942, a second amendment broadened the Board's jurisdiction to inmates affected by neurosyphilis, epilepsy with psychosis or mental deterioration, and Huttington Chorea.[276] Throughout its lifetime, approximately 2,822 sterilizations were performed under the act.[277]

2) British Columbia

Strongly influenced by the legislative campaign led by the Child Welfare Association, which claimed that "girls with mental disabilities presented a social and moral menace"[278], the *Sexual Sterilization Act*[279] was introduced in the law of British Columbia in 1933. Many provisions of this statute were similar to those contained in its Albertan counterpart, although the British Columbian Board's power and jurisdiction were much narrower. Under the provisions of the act, sterilization could only be performed when there was a likelihood that transmission of mental disability would occur. Its application was furthermore limited to institutionalized individuals and did not extend to patients of Hygienic Clinics. Under the terms of the British Columbia act, sterilization was a condition of institutional release as it applied to any inmates who

> if discharged therefrom without being subjected to an operation for sexual sterilization, would be likely to beget or bear children who, by reason of inheritance, would have a tendency to serious mental disease or mental deficiency.[280]

The Board established by the statute and whose decision to authorize sterilization had to be unanimous consisted of a psychiatrist, a judge and a social worker. Consent was required either from the patient, if he enjoyed the necessary

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[275] *Ibid.* section 3.
[276] *Sexual Sterilization Act*, S.A. 1942, c. 47, section 3.
[277] Gibson Davies, "Involuntary Sterilization or the Mentally Retarded: A Western Canadian Phenomenon" (1974) 1 Canadian Psychiatric Association Journal 1.
[278] A. McLaren, "The Creation of a Haven for 'Human Thoroughbreds': the Sterilization of the feeble-minded and the Mentally Ill in British Columbia" (1986) LXVII Canadian Historical Review 127.
[279] *Sexual Sterilization Act*, S.B.C. 1973, c. 79.
[280] *Ibid.* section 4(1).

capacity to consent to the procedure, or otherwise from a spouse, parent or appointed decision-maker. Provisions dealing with the protection from civil liability of professionals involved in the sterilization process were similar to the Alberta sterilization act. The British Columbia sterilization act remained unchanged until its repeal. Although no accurate account exists, the number of sterilizations performed under the statute is estimated not to have exceeded a few hundred.[281]

B. The discriminatory administration of the statutes and the criticisms voiced against them

In the end of the 1960'sand the beginning of the 1970's, the eugenic laws of British Columbia and Alberta were singled out by enlightened scholars and members of the medical profession as outdated, poorly drafted, and their application as violative of human rights, discriminatory and outrageous.[282]

1) the administration of the acts

The wording of the two aforementioned statutes did not discriminate against any particular category of Canadian's society, however their application did. Indeed, throughout the acts' lifetime, a disproportionately high number of women[283], American Indians[284], individuals of Eastern European descent, and those of Roman and Greek Catholic faith were referred to the Board, and ultimately sterilized.

Furthermore, in several cases, no medical or psychiatric grounds appeared to justify the authorization to sterilize provided by the Eugenic Board. In 1969, for instance, the Globe and Mail revealed the story of an Albertan teenage girl sterilized

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[281] LRCC WP N°24, *supra* note 10 at 27-28.

[282] See e.g. T. Christian, "The Mentally Ill and Human Rights in Alberta: a Study of the Alberta Sexual Sterilization Act" (1974) [unpublished] cited in LRCC WP N° 24, *supra* note 10 at 42-44; K.G. McWirther and J. Weijer, "The Alberta Sterilization Act: A Genetic Critique" (1969) 19 University of Toronto Law Journal 424.
Although most of the articles criticizing Canadian eugenics law related to the Alberta Sterilization statute, their criticisms could equally apply to the statute of British Columbia.

[283] "Of patients approved for sterilization [in Alberta] 35,3% were male and 64,7% were female. Thus, not only did the Eugenic Board approve the sterilization of more females, but a disproportionately high number of them were sterilized", LRCC WP N°24, *supra* note 10 at 42.

[284] "Although persons of Indian and Metis ancestry constituted a mere 3,4% of the Alberta population, they constituted 25,7% of those persons sterilized. It is incredible that between 1969 and 1972 more Indian and Metis persons were sterilized than British, especially when it is considered that Indians or Metis were the least significant racial group, statistically, and British were the most significant."(T. Christian, *supra* note 282 at 90).

on the basis of her mental deficiency. However, following the operation she successfully passed grade 12.[285]

2) Criticisms expressed against the statutes

The sterilization acts of Alberta and British Columbia have mainly been criticized for their biological and social erroneousness, and their biases against certain medical or psychiatric afflictions.

Promoted as an expression of the eugenic doctrine, they nevertheless equally applied to conditions arising out of injury[286], occurring late in life when reproductive years were over, or to diseases that could be prevented by adequate diets and medication. The acts were also pinpointed for their scientific inaccuracy. In the introduction, we have already mentioned the doubts expressed by scientists as to the explanation for mental disorders given by eugenicists. Indeed, the emphasis on heredity as the sole explanation for mental retardation, mental illnesses and other afflictions was denounced as fallacious when genetic research established the complexity of inheritance, the importance of the environment, and of the social and economic conditions in the development of individuals. Moreover, the determination of the disorders[287] listed in both statutes was mostly based on IQ tests. Those tests became controversial as a result of the differing interpretations to which their results could give rise depending on the cultural background of the person administrating the test.[288] Indeed, K.G. Whirter and J. Weijer[289], in their genetic critique of the Alberta sterilization act, noted that depending on the location of the taking of the test, a person enjoying an Intellectual Quotient of 60 would be sterilized in Alberta, the limit of

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[285] See *The Globe and Mail*, (12 April 1969) A6.

[286] *Supra* note 275 for a definition of mental defectives under the terms of the Alberta Sterilization Act.

[287] Furthermore, the deficiencies leading one to be proposed for sterilization did not amount to recognized medical syndromes.

[288] A. McLaren argues that

> given the Board of Eugenics ignorance of genetics, it is clear that it was the deviant behaviour of the patient_ as defined by middle class professionals_ and not any proof of genetic failure that led to sterilization. In place of medical diagnosis, the board relied heavily on the social criteria of what represented 'normality', morality, sexuality, and work habits to classify its charges. In so doing, the Board was reflecting the state of mind of that generation of Canadian progressives who embraced the dangerous notion_ a notion pushed to its logical conclusion in Nazi Germany_ that the social and economic challenges to the 20th century could be resolved by recourse to a biological solution

A. Mclaren, *supra* note 278 at 150.

At the time, many commentators shared the aforementioned exposed view. They deplored the absence of any geneticists in the Boards examining the files of people listed for sterilization.

[289] K.G. McWhirter and J. Weijer, *supra* note 282.

deficiency being 70, whereas in the United States he could be incorporated into the U.S. marines.[290]

Finally, the consent requirements were outlined as illusory. In the cases where it was required, it was considered as vitiated by coercion. Indeed, an inmate was given the choice either to be sterilized and discharged from the institution or to refuse to consent to the procedure and stay within the walls of the psychiatric establishment. Furthermore, in Alberta, when an individual was mentally disabled, the Board had the ability to override the necessity of obtaining consent, thus violating his/her rights to self-determination.

Summarizing the shortcomings of the Alberta sterilization act, K.G. McWhirter and J. Weijer wrote that

> Socially, the compulsory aspects of the act bear against persons and families who are likely to be young, poor, uninfluential, and certainly unlikely to resist personally the infliction of purportedly legalized mayhem. From the legal, social, and scientific standpoints the act is a disgrace to the whole Canada. Its legal defects, coupled with its scientific 'nonsense-clauses' should ensure that it, like some other Alberta acts, will be consigned to the rubbish heap. It is highly desirable that a politically independent body be formed in Alberta to clean up this and other abuses and to re-established respect for the rule of law.... This ignorant and perverted legislation poisons the atmosphere and holds up advances in modern preventive eugenics, which must be based on consent.[291]

C. The statutes' late repeal

Whereas the strength of the Eugenic Movement waned at the end of the Second World War with the discovery of the atrocities that took place under the Nazi regime, and despite their condemnation by scholars and public opinion, the repeal of the two Canadian eugenic sterilization acts only occurred in the 1970's: in 1972 for the Alberta act[292] and 1973 for the British Columbia[293] one.

When introducing the Bill abrogating the Alberta sterilization act, its sponsor, Mr. King, outlined the reasons underlying this repeal: the legal ambiguities of the sterilization act, its questionable scientific validity, and its violative nature as far as human rights were concerned.[294]

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[290] *Ibid.* at 426.
[291] *Ibid.* at 430
[292] *Sexual Sterilization Repeal Act*, S.A. 1972, c.87.
[293] *Sexual Sterilization Repeal Act*, S.B.C. 1973, c.79.
[294] Alberta, 17th Legislative Assembly, *Debates*, (31 May 1972) at 58-37 & 58-38 (Mr. King).

Ultimately, in 1996, in the case of *Muir* v. *Alberta*[295], the province of Alberta admitted its liability in an action in tort for wrongful sterilization and confinement brought before the Queen's Bench by Leilena Muir. An unwanted child, Ms Muir was admitted at the age of ten in the Provincial Training School for Mental Defectives in Red Deer Alberta upon the request of her mother. Although no proper medical or psychometric examination of the child was performed before or in the course of her institutionalization, she was surgically sterilized, in 1959, by way of salpingectomy. Neither her knowledge nor her consent had been sought or required by the Eugenic Sterilization Board, which gave its approval to the procedure on November 22, 1957. Unaware of her condition as far as reproduction capacities were concerned, she eventually left the school in 1965 against the advice of the medical staff. She later filed suit against the government of Alberta, claiming compensation for her wrongful sterilization and confinement. The government of Alberta admitted that its liability arose from the inadequate psychiatric testing of the plaintiff at the time, and in the course of her institutionalization, but limited this admission to the particular circumstances at stake. It left the court the task of determining the nature and amount of damages that should be awarded to the plaintiff. Holding Ms Muir entitled to a large pain and suffering award and to aggravated damages, Veit J., speaking for the court, stated that

> The circumstances of Ms. Muir's sterilization were so high-handed and so contemptuous of the statutory authority to effect sterilization, and were undertaken in an atmosphere that so little respected Ms. Muir's human dignity that the community and the court's, sense of decency is offended[296]

This case gave rise to many other claims based on similar grounds. In 1998, the Government of Alberta, fearing the proliferation of such claims, attempted to limit the damages recoverable by the victims of the abusive, outrageous and offensive behaviours that took place under the *Alberta Sterilization Act*. The proposed Bill, Bill n° 26, purported to rely on section 33 of the *Canadian Charter of Rights and*

Premier Lougheed also recognized the outrageous nature of the act and apologized on the behalf of the Alberta government to all the victims of its provisions. He stated

> I think the bill [the then still existing *Sexual Sterilization Act*] in its present form is most offensive with regard to the Bill of Rights and in fact, that is one of the reasons it was introduced early. It is a very disturbing bill as far as I am concerned personally and we feel strongly about it.(...)We feel, as I mentioned, very, very strongly that the bill is offensive and at odds with the proposed Bill of Rights

Ibid. at 58-39

[295] *Muir* v. *Alberta*, [1996] 179 A.R. 321 (Alta. Q.B.).

[296] *Ibid*, at 326.

Freedoms[297] dealing with constitutional override vis-à-vis the government. However, this scheme was withdrawn from the legislative schedule in light of the controversy it set into motion.

It is worth mentioning that Canada's eugenic past has influenced contemporary discussions on the subject of non-voluntary sterilization, an issue that will be examined in greater detail in the following paragraphs. Applied to, to determine whether the Court's inherent *parens patriae* jurisdiction extended to authorizing non-voluntary sterilization, LaForest J., speaking for the Supreme Court of Canada in the *Re Eve*[298] case declared

> [t]here are some other reasons for approaching an application for sterilization of a mentally incompetent person with the utmost caution. To begin with, the decision involves values in an area where our social history clouds our vision and encourages many to perceive the mentally handicapped as somewhat less than human. This attitude has been aided and abetted by now discredited eugenic theories whose influence was felt in this country as well as the United States[299]

[297] *Supra* note 111.
[298] *Re Eve*, *supra* note 89.
[299] *Ibid.* at 427.

Chapter IV: The legality of non-consensual non-therapeutic sterilization in Canadian Law

Before concentrating on the issue of involuntary non-therapeutic sterilization, it is primarily necessary to determine whether this surgical act, on people unable to consent for themselves, is illicit as far as the criminal law is concerned, or whether the provinces have been left with the task of delimitating its performance through public policy considerations. Once the legality of the operation is established, an overview will be undertaken of the rules governing the law on consent for those who through age and/or disability are incapable of providing a valid consent to medical treatment will be undertaken. Indeed, when a patient is not legally or factually mentally competent to make a treatment decision, physicians are not relieved from their duty to obtain an informed and enlightened consent and must therefore find a substitute source of authority empowered by statute or common law to decide on behalf of the incompetent. A distinction must be made between disabled adults and minors as different interests are at stake.

We will limit our study to situations where there is a need for consent, the principles concerning exceptions having been exposed earlier in the first part.

We will then determine whether under current Canadian law, authorization to a non-therapeutic sterilization can be given on behalf of incompetent individuals.

A. Involuntary non-therapeutic sterilization[300] and the criminal law

We have seen in the first part of our discussion that, although once questioned the legality *per se* of voluntary non-therapeutic sterilization is no longer in doubt. One might however wonder whether, in the absence of any guidance in the *Criminal Code*[301], the same conclusion can be reached as far as non-therapeutic sterilization is

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[300] The issue of non-therapeutic sterilization is primarily connected with women. Indeed, as noted by Margaret A. Shone

> The majority by far, of the reported cases brought to court in the United States, Canada and England involve the issue of the authority to sterilize incompetent females. Cases involving the sterilization of mentally incompetent males are extremely rare. This is not particularly surprising given that it is females who face the risks of pregnancy and delivery
> (Margaret A. Shone, "Sterilization of Mentally Retarded Persons-*Parens Patriae* power: *Re Eve*" (1987) 66 Canadian Bar Review 635 at 637)

[301] *Supra* note 53.

concerned, when performed on an individual lacking due to disability and/or minority the necessary capacity to consent.

The answer to this question essentially depends on the interpretation given to section 45 of the *Criminal Code*[302] and to the notion of benefit. Indeed, if as has been expressed by several authors[303], the scope of this section is to be limited to situations where the patient is unable to consent[304], and the notion of benefit to therapeutic advantage[305], then involuntary non-therapeutic sterilization is *prima facie* illegal, unless expressly permitted by the *Criminal Code.*[306] Under this analysis of the provisions of the *Criminal Code*, where one consents to a surgical operation, benefit to this person is *prima facie* presumed, whereas in the absence of such consent, benefit will have to be positively demonstrated. As expressed by Bernard Starkman[307] "when a person can consent then his decision-making process is the sole criterion of benefit."[308]

However interpreting section 45 in such a fashion does not seem to have been the path followed by Canadian courts and scholars, despite the holding of the majority in the case *Mortengaler* v. *The Queen*[309]. Due to a misinterpretation of section 45, the notions of consent and benefit have been considered as cumulative rather than

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[302] *Supra* note 55.

[303] See e.g. Robert P. Kouri, & Margaret A. Somerville, *supra* note 88.

[304] This seems to have been the primary intention of the *Criminal Code*'s draftsman. See Bernard Starkman, *supra* note 56. In this unpublished manuscript, Bernard Starkman outlines section 45 as based to a large extent upon article 205 of *Stephen's Digest* (Stephen, *A Digest of the Criminal Law*, 1st and 4th eds. (London: MacMillan and Co, 1877, 1887)), an article which was to be used as a defence to the performance of surgical operations on individuals unable to provide a valid consent due to unconsciousness, or unsoundness of mind caused by an accident . This historical approach to section 45 is reinforced by the absence in the text of any reference to the notion of consent, absence explained by Bernard Starkman by the self-evidentiary importance of self-determination and therefore consent felt by the writers of the Code. See more generally, *supra* note 56.

[305] For many years, scholars favoured a narrow interpretation of the notion of benefit. They considered that it should not extend beyond mental and physical health. For a more detailed review, see *supra* at 13-14, notes 61-64.

[306] This solution has been adopted by French law. Voluntary and involuntary non-therapeutic sterilizations are prohibited by criminal and civil law. It constitutes a mutilation illicit under the terms of article 222-9 N.C.pén. ("les violences ayant entraîné une mutilation ou une infirmité permanente sont punis de dix ans d'emprisonnement et de 10 000 francs d'amende"), and is prohibited by the civil law according to article 16-3 C. civ, which requires both consent and therapeutic benefit before any interference with bodily integrity can be carried out.("Il ne peut être porté atteinte à l'intégrité du corps humain qu'en cas de nécessité thérapeutique pour la personne. Le consentement de l'intéressé doit être recueilli préalablement hors le cas où son état rend nécessaire une intervention thérapeutique à laquelle il n'est pas à même de consentir").

[307] Benrard Starkman, *supra* note 56.

[308] *Ibid.* at 5.

[309] *Mortengaler* v. *The Queen*, *supra* note 65. It is to be remembered that the majority of the court held that the scope of section 45 should be limited to "a charge arising out of a surgical operation performed on a an unconscious patient." (*ibid.* at 646).

alternative criteria of the legality of surgical acts, and the notion of benefit extended to personal and socio-economic factors. Indeed, in the *Cataford*[310] case, Chief Justice Deschênes extended to personal and socio-economic factors, that is to say non medical elements, the factors to be taken into consideration when evaluating the beneficial nature of surgical acts.[311] Although this case, not binding on criminal courts, concerned voluntary non-therapeutic sterilization, it seems difficult to sustain the argument that purely contraceptive sterilization is solely beneficial when performed on a competent consenting adult.[312]

We believe that, legitimate under certain extremely limited circumstances, a point that will be developed later, involuntary non-therapeutic sterilization, in the absence of any positive criminal prohibition, should and will, in the course of our paper, be considered legal, the task of determining the boundaries within which allowing its performance being left to the provinces and their public policy considerations.

B. Consent to treatment for those who through age and/or disability are unable to consent for themselves[313]

When an individual is either a minor or has been found to be mentally incompetent, the law, whether by statute or at common law, has developed rules according to which treatment decisions can be made by a person authorized by law, appointed by the courts or, by the court itself, decisions which will be considered equivalent to a voluntary consent voiced by the patient. In this section, we will briefly

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[310] *Cataford*, *supra* note 59.

[311] For the holding of the court on this particular issue, see *supra* at 17 and note 75.

[312] It should be noted as outlined by Bernard Starkman (*supra* note 56) that section 45 was not meant to differentiate between therapeutic and non-therapeutic surgical acts. Such a distinction was indeed alien to the criminal law as most non-therapeutic acts only became available after the drafting of the code. Furthermore, in a society where many non-therapeutic acts such as cosmetic surgeries or non-therapeutic medical researches are carried out on a daily basis and widely accepted, it would seem awkward to consider all non-therapeutic acts as *prima facie* illegal. The case *Halushka* v. *University of Saskatchewan* (*supra* note 148) provides us with an example of a situation where a court did not question the legality of a non-therapeutic research. In this case, the plaintiff underwent anaesthetic tests as part of a non-therapeutic medical research on the comparative effect of anaesthetics conducted by two medical practitioners employed by the University of Saskatchewan. As a result of those testing, the plaintiff suffered both physical and mental damages and questioned the validity of the consent he had given. The court in solving the problems raised by this case did not consider whether such a research was in itself legal but rather concentrated on the sole issue of consent and adequate disclosure of information.

[313] We will assume in this section that there is no emergency and that nothing prevents a consent from being obtained by the alternate-consent giver.

review Canadian law, in order to determine who might be authorized to make treatment decisions on behalf of adults with a disability and minors lacking the capacity to do so, as well as the broad principles under which such decisions can be made. The *parens patriae* power of the courts will be examined in its own paragraph as it is used for the benefit of both mentally incompetent adults and minors. It is only after such a review that we will consider, in our next section, whether the power given to consent on behalf of another person extends to authorizing non-therapeutic sterilization.

1) Adults with a disability

At common law, legal representatives appointed by the courts or the superior courts themselves in the exercise of their *parens patriae* jurisdiction seem to be the only recognized sources of substitute decision-making. Provinces have however enacted legislative provisions or statutory regulations broadening the categories of individuals allowed to give authorization on behalf of mentally incompetent adults.

a) Common law

At common law, it appears that only a court-appointed guardian under provincial incompetency legislation or the court itself in the exercise of its *parens patriae* jurisdiction[314] can lawfully consent to medical treatments on behalf of an adult declared incompetent to make health care decisions.[315] It has been argued that in light of article 215(1) of the *Criminal Code*[316], which imposes a duty to provide one's spouse and others under one's charge with necessaries of life, it could be inferred that family members also enjoy the power to consent to medical treatment for those they have under their charge.[317] In the United States, several cases have embraced such a stance, recognizing parents or next of kin, even where not officially appointed legal guardian by the courts, as able to effectively give their consent to medical treatment

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[314] The *parens patriae* power of the courts will be examined in a later paragraph.

[315] See e.g. Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 3rd ed. (Toronto: Carswell, 1996) at 64; B. Dickens, "The Role of the Family in Surrogate Medical Consent" (1980) 1 Health Law in Canada 49. See also *Re S. (A.M.) (Gyardian ad litem of)* (1993), 49 E.T.R. 307 (Nfld. T.D.).
It should be reminded that in cases of emergency, that is to say when the treatment required is life or health preserving, a physician is allowed to proceed with the treatment without the patient's consent if the patient is both unable to give his/her consent, and consent from a legal representative is not reasonably possible. See *Marshall* v. *Curry*, *supra* note 219.

[316] *Criminal Code*, *supra* note 53.

[317] G. Robertson writes "[a]rguably, the *obligation* to provide health care [indeed, according to the *R.* v. *Tutton* (1989), 48 C.C.C. (3rd) 129 (S.C.C.), necessaries of life includes health care] implies a power to provide it, thereby empowering a spouse or other relative to provide substitute consent on behalf of a mentally incompetent patient." (G. Roberston, *supra* note 189 at 473).

for the incompetent individuals under their care. [318] Although, the issue has not yet been addressed by the courts, and in practice physicians often rely upon consents obtained from family members,[319] Canadian common law seems to theoretically abide by the rule according to which, in the absence of enabling legislation, family members do not enjoy any such authority.[320]

In fine, it should be added that common law courts have recently recognized the binding force of advance directives, that is to say wishes expressed in relation to specific treatments by an individual prior to his/her loss of legal competence. Indeed, in the *Fleming* v. *Reid*[321] case, Mr. Justice Robins, speaking for the court, held that

> A patient, in anticipation of circumstances wherein he or she may be unconscious or otherwise incapacitated and thus unable to contemporaneously express his or her wishes about a particular form of medical treatment, may specify in advance his or her refusal to consent to the proposed treatment. A doctor is not free to disregard such advance instructions, even in an emergency. The patient's right to forego treatment, in the absence of some overriding societal interest, is paramount to the doctor's obligation to provide medical care. This right must be honoured, even though the treatment may be beneficial or necessary to preserve the patient's life or health, and regardless of how ill-advised the patient's decision may appear to others.[322]

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[318] See e. g. *Farber* v. *Olkon*, 40 Cal. 2d 503, 524 P. 2d 520 (1953); *Ritz* v. *Florida Patient's Compensation Fund*, 436 So. 2d 987 (Fla. App., 1983). In the latter case, the Court of Appeal of Florida, fifth district, held that where no legal guardian is appointed by the courts, parents enjoy the authority to consent to necessary as well as urgent care on behalf of their incompetent adult children.

[319] As pointed out by B. Sneiderman, J.C. Irvine and P.H. Osborne, *supra* note 238, an "unwritten agreement between the law and medicine" (at 482) seems to exist as far as the role of family is concerned. The non-intervention of the law in that particular area induces an implicit legal ratification of the medical practice. This should only be permitted as long as family members do not disagree as to what treatment should be consented to, and act in the sole patient's best interests. The assumption according to which parents are the best judges of their children's interests (see e.g. *B. (R.)* v. *Children's Aid Society of Greater Metropoplitan Toronto*, [1995] 1 S.C.R. 315) should, in our opinion, be extended to close family members having under their charge an incompetent adult. In light of the length and costs of applications to courts, this solution would save money and time for family members, especially when the treatment is trivial. It would also warrant that treatments are not performed without any consent. As will be examined later when reviewing Mental Health legislation, some provinces have enacted provisions to that effect, empowering the nearest relatives to make treatment decisions on behalf of incompetent adults. See e.g., in Nova Scotia, the *Hospital Act*, R.S.N.S. 1989, c. 208, s. 54(2).

[320] Although, a common law custom has developed according to which next of kin, in the absence of a conflict of interest, can consent can consent to medical treatment on behalf of a person incompetent to consent, this practice is contested as far as legal theory is concerned and it appears that "the weight of authority supports the view that family members do not have the power at common law to consent to health care on behalf of an adult patient who is incapable of giving his personal consent."(G. Robertson, *supra* note 189 at 474).

[321] *Fleming* v. *Reid* (1991), 82 D.L.R. (4th) 298 (Ont. C.A.).

[322] *Ibid.* at 310. It should be noted that before both the decisions of *Fleming* v. *Reid* and *Malette* v. *Shulman*, *supra* note 123, the legality of such advance directives, in the absence of enabling legislation, was greatly doubted. Such legislative schemes were and still are in existence in a limited number of jurisdictions (see e.g. in Manitoba, section 7(1) of the *Health Care Directives Act*, S.M. 1992, c. 33). According to those schemes, an individual can express his wishes and preferences with respect to specific treatments, in an official written document, directives which will have to be respected by the appointed decision-maker and the physician should the individual become incompetent. While an

b) Legislation

i. Court appointed representatives

Before analyzing in greater details provincial legislation regulating alternate decision making, it is necessary to outline the unsatisfactory state of certain Canadian guardianship statutes. In an area where individuals, in light of their disability, should be protected from unduly intrusive interference with their right of autonomy and bodily integrity, [323]and thus be appointed a guardian for protective purposes, some provinces have adopted a highly criticisable all-or-nothing approach, [324] considering incompetent adults either globally unable to make any decision whether financial or personal, and thus rendering unlimited the scope of guardians' authority, or fully competent.[325] This approach mirrors the discrimination to which people with a disability have, historically and contemporaneously been subjected to, society's assumed concurrence of disability with dangerousness[326] and/or incompetence[327], the

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anticipated refusal of care has to be, in all circumstances, honoured, the indication of a preferred treatment would be subject to the same conditions of availability and clinical indications as exist for a competent individual.

[323] As noted by Mr. Justice Robins in *Fleming* v. *Reid*, *supra* note 321,

> Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, then that of competent persons suffering from physical ailments. (at 311)

[324] The approach to guardianship adopted by several provinces has been characterized as a all-or-nothing approach as the statutes not only do not distinguish between property and personal guardians, but also because guardians enjoy an unfettered authority to make decisions in all areas of the incompetent adult's lives.

[325] As written by P. McLaughlin

> [d]espite revolutionary advances in our knowledge about mental retardation, the law has generally retained the concepts that mental incompetency is an absolute reality, without degrees, changes over time or situationality, that a person may on medical grounds or some other form of professional evidence be determined by courts to be either wholly mentally competent, and not in need of a guardian, or wholly incompetent, and in need of a guardian.
> (P. McLaughlin, *Guardianship of the Person* (Downsview, Ontario: National Institute on Mental Retardation, 1970) at 70.)

[326] Indeed, the public at large, and a number of law-makers share the mistaken belief that the presence of a disability, in itself, renders dangerous an individual. As noted by Gerald B. Robertson, *supra* note 189, "there are certain widespread beliefs about the relationship between mental disorder and violence. One such belief frequently reported by the mass media is the notion that mentally disordered persons are dangerous and unpredictable in their behaviour and thus to be feared." (at 386). Amalgamating dangerousness and disability is not only an aberration as only a small proportion of people with a disability are dangerous to themselves or others, but is also dangerous as the elusive nature of the concept of "dangerousness" leaves room for interpretation and thus to intrusive intervention of the state and guardians in those persons' lives. "The malleability of this concept permits a wide latitude for statutory promulgation and interpretation." (B. Archibald Kaiser, "Mental Disability Law", in Jocelyn Downie & Tomothy Caulfield, eds., *supra* note 133 at 234).

[327] The presence of a disability alone is too readily and with no real justification associated with incompetence. As a result, many individuals are arbitrarily deprived of their right of autonomy and self-determination, society considering itself justified in intruding into every aspect of their lives. Such is the case with many guardianship statutes, which by adopting an all-or-nothing approach to capacity, suggest that people with a disability should be presumed globally and permanently incompetent. This is

public's fear of individuals who deviate from an established "normality" and whose disability, in its causes, effects and consequences, is not always fully understood. Outlining and condemning the inappropriate nature of the all-or-nothing approach adopted by the province of Nova Scotia, the Law Reform Commission of this jurisdiction[328] concluded that

> The assessment of "competency" under our law is an all-or-nothing approach. People are labelled as "competent" or "incompetent", without recognizing that people may be "incompetent" only some of the time. There are, of course, examples of people who are totally unable to make decisions, such as the person in a persistent vegetative state, but this is quite rare and most decision-making limitations are partial. In view of the principles of autonomy, [329]respect and equality, this all-or-nothing approach is inappropriate.

Another criticism voiced against some provincial incompetency legislations concerns the fact that although providing for both guardianship of the estate and of the person, they mainly deal with and focus on property management, an heritage from the historical origins of incompetency legislation.[330]

Although due to partial limits, a full review of guardianship legislations will not be undertaken, we will examine their general concepts as far as appointment and powers are concerned.

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highly unacceptable, as, as we have seen in our first chapter, adults are to be presumed for all purposes, competent. Except in extreme circumstances, where, for instance, a person is in a coma and therefore globally incompetent, decisional capacity should be carefully scrutinized, individually evaluated in relation to a specific time and a specific decision, and incompetence in one area should not be automatically conclusive of incompetence in any other area. Guardianship should remain the exception, the wishes of disabled people respected and taken into account, guardians' function aimed at ensuring that their interference is the least restrictive possible of their protégés' life. Guardianship , "a necessary and justifiable form of paternalism" in many circumstances, should "be viewed in terms of the individual's right to receive rather than the State's power to impose." (Gerald B. Robertson, *Mental Disability and the Law in Canada*, *supra* note 189 at 116-117). Over-protecting incompetent individuals by way of guardianship can disservice protected individuals, exposing them to exploitation. Guardians' powers have to be limited by the courts, if not under the terms of incompetency legislation.

[328] Law Reform Commission of Nova Scotia, *Final Report: Reform of the Laws Dealing with Adult Guardianship and Personal Health Care Directives* (Halifax: 1995).

[329] *Ibid.* at 20. Also in the *Re Eve* case, *supra* note 89 at 16, the Supreme Court of Canada, quoting P. McLaughlin, *supra* note 325, characterized the law of guardianship as "pitifully unclear with respect to some basic issues."

[330] As noted by P. McLaughlin "[t]he property orientation affects practice as well. Courts are prepared to supervise the administration of estates and are familiar with the procedures in relation to such responsibility. However, they are unfamiliar with guardianship of the person." (P. McLaughlin, *supra* note 325 at 42). See, for more details, Gerald B. Roberston, *Mental Disability and the Law in Canada*, *supra* note 189 at 116-119.

- appointment

Various attitudes have been adopted by Canadian provinces in establishing the rules and circumstances under which a guardian can be appointed by court.[331] Whereas some provinces will permit the appointment of a guardian when a person whether or not mentally incompetent cannot manage his/her own affairs,[332] other jurisdictions have based their intervention upon the proof of a disability rendering the individual incapable of making his/her own decisions. Lately, the provinces of Alberta,[333] Ontario[334] and Saskatchewan[335] have adopted legislation which allows for the designation of a guardian in situations where not only the decisional capacity of the individual is impaired, but also where intervening is deemed to be substantially beneficial to him/her. These statutes have also introduced the concept of a limited guardianship.[336]

In Quebec, the civil code provides for three different protective regimes depending on the degree and permanence of the incapacity.[337] A curator will be appointed where the "incapacity to look after oneself and to administer one's own affairs is total and permanent"[338], a tutor[339] when the incapacity is only partial and temporary, and an

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[331] We will not review the conditions individuals must meet before being appointed guardians. It should be noted that courts, in selecting a representative, must consider which person will be the most suitable to serve the incompetent adult's best interests, a Public Trustee being a last resort solution. Preference will generally be given to family members. The courts will consider several factors such as the type of care required, the wishes of the patient, and the patient's residence.

[332] In New Brunswick, for instance, according to section 39(1) of the *Infirm Persons Act*, R.N.S.B. 1973, C.I-8, a guardian can be appointed whenever an individual whether or not "declared mentally incompetent" proves to be "through mental or physical infirmity arising from disease, age, or other cause, or by reason of habitual drunkenness or the use of drugs, (a) incapable of managing some or all of his or her affairs or providing for their management, or, (b) incapable of providing for some or all aspects of their personal care."

[333] See the *Dependant Adults Act*, R.S.A. 1980, c. D-32. This Act has been described as "one of the most significant attempts to rethink guardianship of the person" (P. McLaughlin, *supra* note 325 at 49). The major improvements of this new act consist of the introduction of limited or partial guardianship, the adoption of a functional approach in the determination of incompetency, the establishment of a possibility to circumscribe guardians' power and authority, the creation of the Public Trustee Guardian office, source of information, advice, control, review and in limited cases of guardianship itself. The new elements incorporated in the *Dependant Adult Act* render that act a model to be followed, or at least referred to (see, e.g. Gerald B. Robertson, *Mental Disability and the Law in Canada*, *supra* note 189 at 119-123.)

[334] See the *Substitute Decisions Act*, R.S.O. 1992, c.30.

[335] See the *Adult Guardianship and Co-Decision-Making Act*, S.S. 2001, being Chapter A.5.3 of *Statutes of Saskatchewan*, 2000, (effective July 15, 2001) as amended by the *Statutes of Saskatchewan*, 2001, c.20.

[336] See e.g. section 6 of the *Dependant Adults Act*, *supra* note 333.

[337] Indeed, according to article 259 C.C.Q., in selecting the form of supervision, consideration is to be given to the degree of the person's incapacity to care for himself or administer his/her property.

[338] Article 281 C.C.Q..

[339] Article 285 C.C.Q.

adviser of the person[340] when assistance is required although the individual is competent. The necessity to resort to a substitute decision-maker in the medical area is specifically provided for under the terms of article 11 C.C.Q. which states that "if the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation may do so in his place." Furthermore, representatives, sometimes in addition to the intervention of the courts, are the only persons allowed to make health-care decisions when the treatment is not required by the individual's state of health. Indeed, under the terms of article 18 C.C.Q.

> Where the person "..." is incapable of giving his consent, consent to care not required by the patient's state of health is given by "..." the mandatary, tutor or curator, the authorization of the court is also necessary if the care entails a serious risk for health or if it might cause grave or permanent effects.

- Powers

Only a limited number of provinces have provided the courts with the ability to decide from a list, ranging from legal proceedings to health care or residence, the powers to confer on a guardian.[341] In the absence of such guidance, the extent of guardians' authority remains uncertain, and dangerously wide. As far as medical treatments are concerned, when the authority to consent to treatment is not expressly conferred upon a guardian, it is understood that they derive their authority from being the custodian of their wards and therefore enjoying the same powers as parents over their children.

In making decisions in general and health care decisions in particular, the only restriction, common to all statutes, is that guardians must act in furtherance or the sole interest of the person they have under their charge,[342] interests which will always be respected when a sterilization is required for therapeutic reasons. Furthermore, in

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[340] *Ibid.*

[341] See e.g. *Dependant Adult Act*, *supra* note 333. Under the terms of section 10(1),

> When the court makes an order appointing a guardian, it shall grant to the guardian only the powers and authority referred to [in the Act] that are necessary for him to make or assist in making reasonable judgements in respect of matters relating to the person of the dependant adult.

The court has the ability to limit guardians' authority to what is in the best interests of the individual. A guardian will enjoy the authority to make treatment decisions only when specifically granted.

The Alberta act is worth mentioning as it recognizes the principle of the least restrictive alternative when intruding into an incapable individual's life.

[342] Therefore, as opposed to guardians of the estate, in making treatment decisions, a guardian is not allowed to take into account the interests of third parties such as those of the family. See e.g. *Re Leeming*, [1985] 1 W.W.R. 369 (B.C. S.C.).

Alberta, Saskatchewan and Ontario, the abovementioned statutes add the necessity to intervene in the least restrictive[343] or intrusive[344] manner possible,[345] whereas Quebec requires mandataries to assess the expected beneficial aspects of the care required in comparison with its advisability and anticipated risks, and to allow the procedure only where the latter are not disproportionate to the former.[346]

In common law jurisdictions, guardians' decisions can be overridden by superior courts in the exercise of their *parens patriae* jurisdiction, a power that will be examined later.

Sterilization can always be authorized by a legal representative, if it is undertaken in the patient's best interests, and is medically necessary. The extent of guardians' power as far as non-therapeutic medical acts are concerned cannot be given a straightforward answer as will be seen in our next part.

ii. Nearest relatives

A number of provinces, motivated by the desire to remedy common law deficiencies, and/or legalize what already happens in practice, have enacted legislation[347] or statutory regulations[348] providing for a list of persons, most

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[343] When assessing whether or not a given treatment is the least restrictive, reference is usually made to the environment. For instance, comparison will be made between the degree of restrictiveness of confinement in opposition to a medical therapy or narcoleptics.

[344] Intrusiveness is understood as intrusiveness of the patient's personality (safety, and well-being). In determining which treatment is the least intrusive, M.H. Shapiro suggests that consideration should be given to "the reversibility of effects, the foreignness of the state after the treatment, the speed of the treatment" amongst others (M.H. Shapiro, "Legislating the Behaviour Control, Autonomy and Coercive Use of Organic Therapies" (1974) 47 Southern California Law Review 237, at 262. Determining intrusiveness can be hard as it is a highly subjective concept. See J. Arboleda-Flórez, & M. Copithorne, *Mental Health Law and Practice* (Toronto: Carswell, 1994) at 5.47. As far as sterilization is concerned, hysterectomy constitutes the most intrusive means of sterilization as it consists of removing the uterus.

[345] The principle of the least restrictive alternative originates from the United States and was used in interpreting constitutional rights. It was indeed held that "in pursuing legitimate state interests, the government had to use means that least restrict fundamental personal liberties." (see R.M. Levy, & L.S. Rubenstein, *The Right of People with Mental Disabilities: the Authoritative ACLU Guide to the Right of People with Mental Illness and Mental Retardation* (Carbondale and Edwardsville: Southern Illinois University Press, 1996) at 32). The principle of the least restrictive and intrusive alternative, offering greater autonomy and protection to individuals with mental disabilities, seems to have been accepted by the Canadian Supreme court in the Charter case *R.* v. *Oakes*, [1986] 1 S.C.R. 103, 65 N.R. 87, 24 C.C.C. (3d) 321, 50 C.R. (3d) 1, 26 D.L.R. (4th) 200; 14 O.A.C. 335 S.C.C, where it was held that even though in violation of section 7 of the *Canadian Charter*, restrictions to an individual's liberty and autonomy proportionate to the interests and aim at stake could amount to a justification under section 1 of the *Canadian Charter.*

[346] Article 12 C.C.Q. states that

> If he [the person who gives consent for another person] gives his consent, he shall ensure that the care is beneficial notwithstanding the gravity and permanence of certain of its effects, that it is advisable in the circumstances and that the risks incurred are not disproportionate to the anticipated benefits.

[347] See e.g. section 20(1) of the *Health care Consent Act*, *supra* note 134. In Quebec, according to article 15 C.C.Q., where an adult lacks the necessary capacity to provide a valid consent to a

commonly the nearest relatives, legally authorized to make treatment decisions on behalf of a mentally incompetent individual when no mandatary has been appointed by the courts. Without the need for the intervention of a court, should an individual be found incompetent, the first person listed will enjoy the power to make treatment decisions, provided certain required conditions are met.[349] The passing of those provisions was felt adequate and necessary as relatives, as parents for their children, are believed to be in the best position to assess the incompetent adult's interests, being in contact with him/her and thus aware of his/her wishes, interests, desires. Furthermore, in certain provinces, for example Quebec or Nova Scotia[350], an individual is recognized as having the ability, while competent, to appoint a person who will have full authority to make treatment decisions in case of loss of mental competence, or to express his/her wishes in a written form with respect to a specific type of care.[351] For instance, in Quebec, under the terms of article 11 C.C.Q.

> If the person is incapable of giving or refusing his consent to care, a person authorized "..." by mandate given in anticipation of his incapacity may do so in his place.

Alternate decision-makers do not enjoy an unfettered discretion when making decisions in general and treatment decisions in particular. Provinces have selected various bases upon which decisions can be made. Traditionally, they have used a best interests test[352], however, lately, with the growing legal recognition of the

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therapeutic treatment "consent is given by his spouse, or if he has no spouse, or his spouse is prevented form giving consent, it is given by a close relative, or a person who shows a special interest in the person of full age".

[348] See e.g. the *Infirm Person Act*, R.R.P.E.I. 1981, c. H-10 [made pursuant to the *Hospital Act*, R.S.P.E.I. 1988, c. H-10].

[349] For instance, under the terms of section 28(1) & (2) of the *Dependent Adults Act*, *supra* note 333, in Alberta, the nearest relative must, in order to enjoy the authority to make health care decisions on behalf of an incompetent individual,

(a) be apparently mentally competent,
(b) have been in personal contact with the formal patient over the preceding 12 months period
(c) be willing to assume the responsibility of making treatment decisions
(d) be available
(e) and make a statement in writing certifying his or her relationship to the formal patient and the facts respecting personal contact and willingness to assume responsibility.

[350] See *Medical Consent Act*, R.S.N.S. 1989, c. 279.

[351] See our comments *supra* note 322.

[352] See e.g. section 28(3) & (4) of the Alberta *Dependent Adults Act*, *supra* note 333. It is to be noted that the notion of best interests is subject to various interpretations. Indeed, in England, the House of Lords, when adopting this test in determining whether a given treatment should be administered, defined best interests as equating best medical interests, with reference being made to professional standards. In *F.* v. *West Berkshire Health Authority*, [1989] 2 All E.R. 545 (H.L.) and subsequently in *Airedale N.H.S. Trust* v. *Bland*, [1993] 1 All E.R. 821, the House of Lords held that the best interests of a patient are met when the treatment decided upon is one a reasonable physician, in similar circumstances and taking into consideration any expressed wishes of the patient, would have

fundamental importance of respecting patients' anticipated wishes in the health care context,[353] several jurisdictions have moved towards a substitute-judgement test, whereby decisions must be based on what the decision-maker believes the patient, if competent, would have made. In Quebec, article 12 C.C.Q. not only requires alternate decision-makers to act "in the sole interests of the patient", but also to take into consideration "as far as possible any wishes" the person "may have expressed". Therefore a subjective best interests test has been enacted in Quebec. Often leading to similar practical solutions, choosing between a best interests standard and a substitute judgement test remains of symbolic importance.

> The distinction is perhaps, likely to be more of ethos and emphasis: thinking oneself into the shoes of the persons concerned and recognizing the values placed on personal preferences (not all decisions are, or should be taken on reasonable grounds) is a mark of respect for human which may have a value greater than its practical effect.[354]

When an alternate decision-maker refuses to authorize a given procedure, his/her refusal can be overridden by superior courts themselves in the exercise of their *parens patriae* jurisdiction, in common law jurisdiction, or in application of legislative provisions.[355] It seems however, in light of the *Fleming* v. *Reid*[356] decision that a refusal can only be overturned when it does not concur with the patient's anticipated wishes. Speaking for the court, Justice Robins, holding that a legislative scheme permitting, even in furtherance of the patient's best interests, non-consensual

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administered. In Alberta, on the other hand, the best interests of an incompetent patient are assessed according to several factors: whether the treatment agreed upon (is likely to or) improves the health and well-being of the patient, even though the patient has not been cured as a result of its administration (the same solution was adopted in Ontario, see e.g. *Fleming* v. *Reid*, *supra* note 321), whether non-therapeutic treatment would (likely) lead to the deterioration of the patient's condition, whether the anticipated benefits of the treatment outweigh its risks, and whether the treatment constitutes the least restrictive or intrusive alternative. It should be noted that, as opposed to other statutes, no consideration is given to the patient's wishes. In light of the *Fleming* v. *Reid*, (*supra* note 321) in situations where the decision is contrary to the wishes of the patient, expressed while competent, the act could be in violation of the *Canadian Charter* (*supra* note 111). However, it could be argued that as the persons falling under the scope of the act, which according to section 1(1) are individuals representing a danger to themselves or others, are in a different position than that of the individuals considered in the *Fleming* case, the failure to take into consideration the patient's wishes could be justified under section 1 of the *Canadian Charter* for treatments administered to decrease dangerousness.

[353] See *Fleming* v. *Reid*, *supra* note 321.

[354] U.K., Law Commission, *Mentally Incapacitated Adults and Decision-Making: An Overview,* Consultation Paper No. 119 (London: Her Majesty's Stationery Office, 1991) at 108.In our opinion, while a substituted judgement test might prevail should there be any known wishes or relevant information concerning the patient, applying this test when no such elements are present is hypocritical and constitutes a legal fiction as the decision-maker will be guessing, relying on his own subjective values, what the patient would have wanted, and will thus be given too much discretion.

[355] See e.g. section 17 of the *Health Care Directives Act*, *supra* note 322, in Manitoba which permits a Review Board to override a decision when the refused treatment is in the patient' best interests.

[356] *Fleming* v. *Reid*, *supra* note 321.

treatment without consideration of the patient's prior wishes violates section 7 of the *Canadian Charter*[357] unless justified under section 1, concluded that

> A Legislative scheme that permits the competent wishes of a psychiatric patient to be overridden, and which allows a patient's right to personal autonomy and self-determination, to be defeated, without affording a hearing as to why the substitute consent giver's decision to refuse consent based on the patient's wishes should not be honoured, in my opinion, violates the principles of fundamental justice.[358]

3) Parental Consent

Except in those situations where a minor is deemed competent to consent to medical treatment by provincial legislation or through the application of the "mature minor" rule, parents[359], or guardians, when this is someone other than a parent, are invested with the legal authority and duty[360] to make treatment decisions for their children. This principle has not only been formulated at common law but has also

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[357] *Canadian Charter*, *supra* note 111.

[358] *Fleming* v. *Reid*, *supra* note 321 at 317-318.

[359] Unless otherwise decided by the courts, or in situations where parents have implicitly or expressly delegated their power to a third party, treatment decisions have to be consented to by both parents, or at least both parents have to be informed by the medical practitioner of the intended treatment, its risks and consequences. This principle derives from the fact that parents enjoy the joint guardianship of their children (see e.g. section 20 of the Ontario *Children's Law Reform Act*, R.S.O. 1990, c. C.12). Some temperaments to this rule exist in situations where the care is of trivial importance or where the treatment has to be undertaken in an emergency situation. The consent of one parent is then deemed to have been provided by both parents.
In Quebec, according to article 600 C.C.Q. the father and mother exercise parental authority together. Before 1977 and the enactment of *An Act to Amend the Civil Code*, L.Q. 1977, c.72; which came into force the 17th of November 1977, the civil code talked about paternal rather that parental authority. The concept of paternal authority (at common law, children were also under the yoke of their fathers' authority, considered as their chattels), adopted by Quebec civil law in 1866 derives from the Roman law notion of *patria potestas*. Although theoretically belonging to both parents according to article 174 C.C.L.C., married mothers could only exercise paternal authority upon the absence or incapacity of their husbands. The 1977 amendments to the civil code not only instituted equality in the family but also introduced the notion of best interests of the child. Therefore, whereas prior to 1977 children were subject to the arbitrary and sometimes abusive will of their fathers, as from that year children's best interests, whose respect came under the control of the courts, became the main limit of parent' parental authority. For a more detailed review of the origins of paternal authority and the changes that the 1977 amendment to the civil code brought about, see F. S. Freedman, "The Status, Right and protection of the Child in Quebec" (1978) 38 Canadian Bar Review 715; see also M. Rivet, J.F. Neault, "De la Puissance Paternelle à l'Autorité Parentale: Une Institution en Train de Trouver sa vraie Finalité" (1974) 15 Cahiers de Droit 779.

[360] This duty finds expression under the terms of section 215(1) of the *Criminal Code*, *supra* note 53, which states that parents are legally obliged to provide necessaries of life for their children:

> Everyone is under a legal duty
> (a) as a parent, foster parent, guardian or head of family, to provide necessaries of life for a child under the age of 16 years.

Although not defined in the code, necessaries have been interpreted as covering not only food, shelter and clothes, but also necessary and beneficial health care (see e.g. *R.* v. *Brooks* (1902), 5 C.C.C. 372 (British Columbia Supreme Court)). According to section 215(3), parents' failure to fulfill their duty can constitute a criminal offence when it is likely to endanger permanently the health of their children.

been in several provincial statutes[361], and been recognized as a liberty interest protected under section 7 of the *Canadian Charter*[362]. In Quebec, under the terms of article 14 C.C.Q.,

> Consent to care required by the state of health of a minor is given by the person having parental authority or by his tutor.[363]

As for care not required by the minor's state of health, article 18 C.C.Q. states that

> **Where the person is under 14 years of age** or is incapable of giving his consent, consent to care not required by his state of health **is given by the person having parental authority** or the mandatary, tutor or curator [emphasis added].[364]

At common law, La Forest J. in the case *B. (R.)* v. *Children' Aid Society of Metropolitan Toronto*[365] noted that "the common law has always, **in the absence of demonstrated neglect or unsuitability**, presumed that parents should make all significant choices affecting their children, and has afforded them a general liberty to do as they choose.[emphasis added]"[366]

Parents' prerogative to consent on behalf of their offspring is predicated upon the assumption that they are the best judges of their children's interests, preferences, welfare, and that in most cases the state does not enjoy the necessary means to apprehend those interests.[367]

The standard for parental decision-making in the health care context is solely the best interests of the infant. The risks, alternatives, and benefits of a given treatment must therefore be assessed in each situation in order to choose the medical

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[361] See e.g. section 39 of the Manitoba *Family Maintenance Act*, R.S.M. 1987, c. F-20.

[362] Under the terms of section 7 of the *Canadian Charter*, *supra* note 111,

> 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 principle of fundamental justice.

The Supreme Court of Canada held that section 7 of the *Canadian Charter* encompassed parental right to take decisions for their children free from state intervention stating that "[t]he parental interest in bringing up, nurturing and caring for a child, including medical care and moral upbringing, is an individual interest of fundamental importance to our society." *B.(R.)* v. *Children's Aid Society of Metropolitan Toronto*, *supra* note at 319. The Supreme Court however added that parents' power to consent to their children's medical treatment is not absolute, the state being justified in intervening to protect children's health or life. See for more details Joan M. Gilmour, "Minors", in Jocelyn Downie & Thimothy Caulfield, eds., *supra* note 133 at 196-202.

[363] According to *Re Goyette* v. *Centre Des Services Sociaux du Montréal Métropolitain*, [1983] C.S. 429, parents' duty to consent to their children's treatment is incumbent on the parents even though they do not wish to be burdened by such a responsibility.

[364] Furthermore, when the treatment considered presents serious risks and a high probability of grave and permanent consequences, the authorization of the court, alongside the consent provided by the parents, becomes necessary. Under the terms of article 18 C.C.Q. *in fine*

> the authorization of the court is also necessary if the care entails a serious risk for health or if it might cause grave and permanent effects.

[365] *B.(R.)* v. *Children's Aid Society of Metropolitan Toronto*, *supra* note 319.

[366] *Ibid.* at 372.

[367] *Ibid.*

treatment that best secures the child's health and well-being.[368] However, although bound to act in the child's best interests when determining what type of care to consent to, parents are given a certain discretion, and enjoy in limited circumstances the authority to allow certain medical acts to take place, even though they are not recommended by the medical profession. As held by La Forest J. in *B. (R.)* v. *Children's Aid Society of Metropolitan Toronto*[369] "we must accept that parents can, at times, make decisions contrary to their children's wishes and rights as long as they do not exceed the threshold dictated by public policy, in its broad conception."[370] This explains why parental authority extends beyond purely therapeutic acts to cover non-therapeutic care, notably trivial medical acts such as orthodontic treatments or blood testing.[371] Whether non-therapeutic sterilizations are amongst the medical acts to which parents can safely consent to will be examined in our next part.

Even though parents are invested with the authority to consent to their children's medical treatment, this power is not absolute and the state will be allowed to intervene when necessary.[372] Canadian provinces have implemented subsidiary rules applying to situations where, even when acting in good faith, according to moral, ethical or religious beliefs, parents refuse to consent to, or fail to seek medical treatment deemed in their children's best interests.[373] Under the terms of those various

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[368] In Quebec the standard of alternate decision-making is encompassed within the terms of article 12 C.C.Q. which states that

> A person who gives his consent to or refuses care for another person is bound to act in the sole interest of that person, taking into account any wishes the latter may have expressed.

Furthermore, the Civil Code provides an alternate decision-maker with a series of elements that need to be taken into account when assessing what constitutes the most beneficial type of care. Indeed, in the second paragraph of article 12 C.C.Q., the civil code specifies that

> If he gives his consent, he shall 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 benefits.

[369] *B.(R.)* v. *Children's Aid Society of Metropolitan Toronto*, *supra* note 319.

[370] *Ibid.* at 373.

[371] See B. Sneiderman, J. Irvine, & P. Osborne, *supra* note 246 at 42.

[372] It is not until the beginning of the nineteenth century that children came to be considered as human beings and that the state established its right to intervene in order to protect their best interests. The first statutes, which influenced the western world, were enacted in England.

[373] The *parens patriae* jurisdiction constitutes the second mechanism through which the state intervenes to protect children from the harmful repercussions of parental refusal to consent to treatment. Lately it has increasingly been used by Canadian courts as an alternative to child welfare legislation, as it appears less judgemental of parents' behaviour. Indeed, the application of child welfare legislation presupposes the characterization of a child as 'in need of protection' or 'neglected'. This often leads parents to feel guilty, judged or pointed out by society as bad parents, when their decisions are, in most cases, driven by religious beliefs, or by the desire to do, in extremely distressing or traumatic situations, what is, in their opinion, the best for their child.

The *parens patriae* jurisdiction will be examined in our next paragraph as it is used for the benefit of both adult and minors.

statutes, a child, once found in need of protection, will be temporarily removed from his/her parent's authority and care to be placed under the custody of a welfare or government agent who will thus be empowered to make the appropriate decision. A child in need of protection is traditionally defined as

> A child in the care of a person who neglects or refuses to provide or obtain proper medical, or other remedial care or treatment necessary for the health or well-being of the child or refuses such care or treatment to be supplied to the child when it is recommended by a duly qualified practitioner.[374]

The Supreme Court of Canada, in the *B. (R.)* v. *Children's Aid of Society of Metropolitan Toronto*[375] case held that a child will legally be declared 'in need of protection' not only where the refused treatment is life-saving but also when it is aimed at the preservation of the child's well-being.[376] In that particular case, the parents of Sheena B., a prematurely born child, contested the two wardship orders granted by the Provincial Court of Ontario to the Children's Aid Society following their refusal to consent, based on their religious faith, to a potentially life-saving blood transfusion. They argued that section 9(1)(b)(ix) of the *Child Welfare Act*[377] was in violation of the *Canadian Charter,* as it prevented them from freely exercising their right to liberty and freedom of conscience protected by section 7 and 2(a)[378] of the *Canadian Charter.* The Supreme Court of Canada, although establishing that the right for parents to make treatment decisions for their children was protected under section 7 of the *Charter*,[379] concluded that the alleged section of the Ontario *Child Welfare*

In fine, it can be added that careless parents could face criminal charges in light of section 215(3) of the *Criminal Code*, *supra* note 53, when their refusal of necessary medical care is unjustified; the more severe the damage to the child's health, the more serious the charges they will have to answer to.

[374] *Child and Family Services Act*, S.M. 1985-1986, c. 8 [as am. C.C.S.M., c. 80] section 17(b)(iii) (am. 1986-1987, c. 19, s.8, s. 17(b)(iii) re-en 1989-1990, c.3; s.3]. In Quebec, the province will intervene whenever the security and development of a child is in danger, i.e., according to section 38(b)(c) of the *Youth Protection Act*, R.S.Q.c.P-34.1, as amended to 22 December 1992, s.38,39, when parents do not provide him with adequate medical care. Furthermore according to article 16 C.C.Q., the court is required to intervene when parents refuse, without any justifications, to consent to therapeutic treatments.

[375] *B.(R.)* v. *Children's Aid Society of Metropolitan Toronto*, *supra* note 319.

[376] Commenting on section 19(1)(b)(ix) of the Ontario *Child Welfare Act*, R.S.O. 1980, c.66 [rep. S.O. 1984, c.55, s.208], La Forest J. interpreted the notion of a 'child in need of protection' as encompassing "situations where treatment might be warranted to ensure his or her health or well-being." He also stated that "although broad in scope, the section is compatible with a modern conception of life that embodies the notion of quality of life."(*B.(R.)* v. *Children's Aid Society of Metropolitan Toronto*, *supra* note 319 at 375).

[377] See *supra* note 376.

[378] According to section 2(a) of the *Canadian Charter*, *supra* note 111,

> Everyone has the fundamental freedoms:
> (a) freedom of conscience and religion;

[379] Indeed La Forest J. noted that "[i]t seems to me that the right of parents to rear their children according to their religious beliefs, including that of choosing medical or other treatments, is an equally fundamental aspect of freedom of religion" (*B.(R.)* v. *Children's Aid Society of Metropolitan Toronto*,

Act accorded both procedurally and substantially with the principles of fundamental justice and therefore did not violate section 7 of the *Canadian Charter*: "[t]he protection of a child's right to life and to health is a basic tenet of our legal system, and legislation to that end accords with the principles of fundamental justice, so long as it respects the requirements of a fair procedure."[380] As a result the treatment at stake was ordered to take place. Section 7 of the *Canadian Charter* therefore not only secures parents in their right to educate their offspring according to the tenets of their faith but also protects children's right to receive proper medical care. Should a conflict of interests arise, the interests of children will prevail. It is no excuse for parents to rely on their religious beliefs to evade the application of the child welfare legislations' provisions whenever a treatment is in the best interests of the child.[381]

In fine, we would like to add that the situations where parents are to be superseded in their rights to consent to their children's medical treatment by a government agent or by the court should remain exceptional, especially in the case of terminally ill or dying children where medicine is sometimes unable to provide any remedy against death. Furthermore when overriding parental decisions, the treatment least harmful to the parents' beliefs of the parents but that will protect the child's health and well-being should be the one performed.[382] Although protecting children's life and health constitutes one of society's paramount duties, this duty should not be discharged to the detriment of their well-being: unnecessary suffering when the promise of beneficial outcomes is low is unacceptable.

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supra note 319 at 382). However it should be noted that no consensus was reached amongst judges as to whether superseding parents in their right to consent to medical treatment was violative of the *Canadian Charter*'s provisions. Some of the judges however held that freedom of religion equally apply to the child, and it included the right to stay alive until being able to make a reasoned choice as to whether or not to follow the tenets of a particular faith. If parents see their right to security, liberty and integrity protected under the *Canadian Charter*, so do children. Should a conflict of the right to liberty and that of freedom of religion arise, the former would prevail.

[380] *B.(R.)* v. *Children's Aid Society of Metropolitan Toronto*, *supra* note 319 at 374.

[381] It is necessary to add that although in the cases exposed in our discussion, the best interests of the child was clearly lying in following the medical profession's decision, in many other situations what actually is in the child's best interests is less than clear. Parents and the courts must therefore be extremely careful in assessing the various elements pertaining to the particular situation.

[382] As written by Margaret Somerville (M.A. Somerville, *The Ethical Canary*, *supra* note 138 at 179): "even when we are justified in intervening, we have ethical obligations to do the least harm possible, especially in circumstances that are already very traumatic, as is always the true in situations that involve seriously ill children."

4) Parens Patriae[383] Jurisdiction

In situations where the law, common or statutory, has failed or has been inadequate in protecting minors or incompetent adults, superior common law courts may intervene, using their *parens patriae* power to make orders in the individual's best interests as parents would for their children. This paternalistic power, exercisable only in the absence of a specific statutory provision,[384] has different origins whether exercised for the benefit of mentally incompetent adults or children.

a) historical origins of the jurisdiction

The *parens patriae* power over adults, only exercisable by superior courts for the benefit of an individual found legally incompetent, by due legal proceedings,[385] constitutes a remnant of the historical jurisdiction of the English sovereign over vulnerable individuals incapable of looking after themselves.[386] Indeed, in 1610, *The Tounson's Case*[387] held that the King is the custodian of individuals unable to care for themselves or manage their own affairs (*jure protectionis suae regiae*). Transferred from the royal household to the Court of Ward and Liveries[388] and then to the Crown through the Lord Chancellor,[389] the *parens patriae* jurisdiction was later received by Canadian superior courts by legislation. As an example, in Manitoba, as of 1902, section 3 of the *Lunacy Act*[390] conferred on the superior court the jurisdiction for

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[383] The notion of *parens patriae* comes from Latin, and the concept was used by Roman Law as early as the 5th century B.C.. *Parens* means father, and *patriae* homeland.

[384] See *Beson* v. *Director of Child Welfare (Nfld)*, [1982] 2 S.C.R. 716 at 724ff.

[385] The legal finding of incompetence appears to have always been a precondition of the exercise of the *parens patriae* jurisdiction. Even when exercised by the king, "[t]he Inquisition "..." was the condition precedent to the exercise of the Royal Prerogative" (Sir W. Staunford, *An Exposition of the King's Prerogative* (London: Hand and Sharre, 1607) at 3.); this statement is confirmed by several cases: see e.g. the *Touson's Case* (1611), 8 Co. Rep. 170; 77 E.R. 730, or the *Beverley's Case* (1603), 4 Co. Rep. 123; 76 E.R. 1118 (K.B.).

[386] It is interesting to note that the exact date of the creation of such a jurisdiction in England is unknown and is as written by Sir Theobald "lost in the midst of antiquity." (Sir H.S. Theobald, *The Law Relating to Lunacy*, (London: Stevens and Sons Ltd., 1924) at 1.). Although its existence was recognized in an early 14th century English statute *De Prerogative Regis* (17 Edw. II. Ch. 9.), its creation seems to result either from general assent or the enactment of a lost statute of Edward I. that took from "the feudal lords, who would naturally take possession of the land of a tenant unable to perform his feudal duties" "the care of persons of unsound mind." (Sir H.S. Theobald, *ibid.* At 1).

[387] *The Tounson's Case*, *supra* note 385.

[388] This court was created during the reign of Henry the VIII, at a time where, for tax purposes, the King decided to abolish the system of fiduciary rights.

[389] "It was not, however, as head of the Court of Chancery that the Lord Chancellor exercised this jurisdiction, but as the representative and delegate of the Crown under the sign manual." (*Re Bulger* (1911), 1 W.W.R. 574 at 576).

[390] *Lunacy Act*, ch. 103, R.S.M. 1902.

"those matters which in England are conferred upon the Lord Chancellor by commission from the Crown under the sign manual."[391]

The jurisdiction of the courts over children has a different origin. Indeed, as opposed to adults, presumed competent unless otherwise declared by due process of law, children are inherently in need of protection and automatically assigned by law an alternate decision-maker. Thus, it is only where the authority responsible for taking

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[391] In the jurisdiction of Prince Edward Island, the *parens patriae* prerogative was transferred to the Supreme Court of Prince Edward Island by section 2 of the *Chancery Jurisdiction Transfer Act*, S.P.E.I. 1974, c. 65.

English law: it is interesting to note that in English law, the inherent jurisdiction of the courts for the benefit of mentally incompetent adults has been wholly incorporated into statutory provisions, leaving the courts with no authority to act as corrective decision-makers. As mentioned by Lord Brandon in the case *In Re F., F.* v. *West Berkshire Health Authority*, [1989] 2 W.L.R. 1025 (C.A.), 1063 (H.L.), [1989] 2 All E.R. 545 (House of Lords) [hereinafter *Re F.*],

> The *parens patriae* jurisdiction as related of persons of unsound mind no longer exists. It ceased to exist as a result of two events both of which took place on November 1st 1960. The first event was the coming into force of the *Mental Health Act*, 1959 "..."The second event was the revocation by Warrant under the Sign Manual of the last Warrant dated 10 April 1956, by which the jurisdiction of the Crown over the persons and property of those found to be unsound of mind by inquisition had been assigned to the Lord Chancellor and the judges of the High Court, Chancery Division. (*Re F.*, 2 W.L.R. 1025 at 1031.)

The role of English courts is therefore limited to determine whether or not a given decision, act, or procedure is in the best interests of the person whose situation is under scrutiny. In the medical area, as expressed by Lord Brandon "part VII of the Mental Health Act 1983 does not confer on a judge nominated under section 93(1) any jurisdiction to decide questions relating to medical treatment", therefore "involvement of the court is not strictly necessary as a matter of law" even though "it is nevertheless highly desirable as a matter of good practice (*Re F.*, 2 All E.R. 545 at 554-556). In our opinion, the absence of any residual *parens patriae* power in English law, creates a less than satisfactory system. When a situation not covered by any statutory provision arises, as is the case in England with the question of involuntary non-therapeutic sterilization, the court's intervention, not mandatory, is left to the discretion of the medical profession or alternate decision-makers. Involuntary non-therapeutic sterilization is a delicate ethical and legal issue, with many social implications. The possibility of abuses is so numerous, and the cloud of eugenics so dense that it should always be carefully approached, whether it is allowed or prohibited. The safeguards in existence in English law are not protective enough, and the mentally incompetent adult's right to integrity is put in jeopardy.

In English law, no one is legally empowered to make sterilization decisions on behalf of a mentally incompetent adult. As a result "doctors make decisions about medical treatment and the incompetent, purely on the basis of what they, the doctors, believe to be best for the patient. The great majority of these decisions will be uncontroversial, but some can have huge ethical significance, and in those circumstances, although doctors would be wise to seek the appropriate declaration from the court, they are under no obligation to do so." (Marc Stauch, Kay Wheat, & John Tingle *Sourcebook on Medical Law*, 1st ed. (London: Cavendish Publishing Limited, 1998) at 181. An incompetent adult can be sterilized without any control if no one brings the matter before the court. Even if the a court of law intervenes, it will be limited to declaring the operation contemplated in the patient's best interests; no order preventing the taking place of a sterilization can be voiced. Many scholars and judges are displeased with the limited role English law courts enjoy with regards to the mentally incompetent adult's medical care. The unsatisfactory protection of mentally disabled individuals prompted the Law Commission to draft a series of recommendations expressly dealing with medical care. See, U.K., Law Commission, *Report on Mental Incapacity*, Report No 231 (London: Her Majesty's Stationery Office, 1995).

It should be added that in Canadian law, superior courts have a residual *parens patriae* power even where there is a statute governing decision-making for incompetent people; See e.g. *Re Superintendent of Family & Child Services and Dawson* (1983), 145 D.L.R. (3d) 610 (B.C.S.C.); revg (*sub nom. Re D.(S.)*) (1983), 42 B.C.L.R. 173 (Prov. Ct.).

decisions on their behalf refuses, negligently fails to fulfill his/her duty or is lacking that the court will intervene making the child its ward and taking the necessary steps to protect him/her. The wardship jurisdiction or *parens patriae* jurisdiction of the courts over children, never specifically granted to the courts, was created in England at a time where children were considered as chattels and where guardians needed the intervention of the law in order to be protected in their rights.[392] The jurisdiction so created was enjoyed until the middle of the seventeenth century by the Court of Ward and Liveries, and upon its disappearance "by the Court of Chancery, which justified it as an aspect of its *parens patriae* jurisdiction."[393] The wardship jurisdiction, an aspect of the wider *parens patriae* prerogative, is today protective in nature, the feudal system of tenures having been abolished. The distinctive feature of this jurisdiction is that children, unlike adults, can be made wards of the court.

b) scope of the jurisdiction

i. Rationale personae

If the *parens patriae* power of the courts has always been exercised for the benefit of mentally incompetent individuals and born children, its *rationale personae* scope came under scrutiny in the case *Winnipeg Child and Family Services* v. *G. (D.F.)*[394] where the Supreme Court of Canada was asked to determine whether a foetus was entitled to protection under that residual common law jurisdiction. This case concerned a pregnant glue-sniffing addict mother, who had already given birth to two children suffering from brain damage, was still sniffing glue and had been refused access to all the treatment facilities she had applied to in order to get treatment for her

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[392] In the Middle Ages, in England, custody was deferred to the Lord when the person inheriting a military tenure was a minor and thus unable to fulfill his duty to fight. The Lord enjoyed the power to marry the child, which in practice consisted of selling the heir to another family.

[393] *Re Eve*, *supra* note 89 at 408. It is noteworthy that the Court of Chancery, on its own will, in the absence of any precedent, decided to extend its exercise of its *parens patriae* jurisdiction to the benefit of children. Its origin is believed to date form the seventeenth century, the case *Falkland* v. *Bertie* ((1696), 2 Vern. 342, as cited by W.S. Holdsworth, *A History of English Law* (London: Methuen & Co. 1979) Vol. Vi at 648) being cited as authority. In this case, it was held that

> In this court there were several things that belonged to the king as *pater patriae*, and fell under the care and direction of this court, as charities, infants, idiots, lunatics, etc. Afterwards such of them as were of profit and advantage to the king were removed to the court of Wards by the statute; but upon the dissolution of that court, came back again to the Chancery.

However, the first recorded case in which the Court of Chancery, using its *parens patriae* power, made a child its ward was *Eyre* v. *Shaftsbury*, 2 P.W.M.S. 103, 24 E.R. 659, [1558-1774] All E.R. 129 (Ch. 1722). In that case a mother had conferred custody of her child on a person judged inadequate by the court. It is not until the enactment of the *Guardianship of Infants Act, 1866* (U.K.) c. 27, that children's welfare became one of the paramount concerns of the Court of Chancery, thus officially conferring the Court the exercise of the jurisdiction for the benefit of children.

[394] *Winnipeg Child and Family Services* v. *G. (D.F.)* (1996), 138 D.L.R. (4th) 238 (Man. Q.B.); rev'd (1996), 138 D.L.R. (4th) 254 (C.A.); aff'd [1997] 3 S.C.R. 925 [hereinafter *Winnipeg* cited to S.C.R.].

addiction. Legal proceedings were launched by the child welfare authorities asking for the court to issue an order in order for Mrs G. to be compulsorily hospitalized. McLaughlin J., writing for the majority of the court, held that the *parens patriae* jurisdiction of the court could not sustain an order of involuntary treatment and detention, as Mrs G. was not an incompetent adult, nor her foetus an individual enjoying legal rights. She felt that, by allowing such an order to stand, and therefore implicitly recognizing foetal legal rights before birth, and particularly the right to sue their mother, a dangerous door would be left open, as it would introduce "introduce a radically new conception into the law; the unborn child and his mother as separate juristic persons in a mutually separable and antagonistic relation"[395] and, as a result, "seriously intrude on the right of women"[396].[397] The exercise of the *parens patriae* jurisdiction is therefore limited to the benefit of incompetent adults and born minors.[398]

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[395] *Ibid.* at 945.

[396] *Ibid.* at 960. It would indeed "interfere with the pregnant woman's ability to choose where to live and what medical treatment to undergo." (*ibid.* at 960).

[397] McLaghlin J. left to the legislator, the task, if wished, to modify the current state of the law as such change "would not be an incremental change "..." but a generic change of major impact and consequence" therefore "if anything is to be done, the legislature is in a much better position to weigh the competing interests and arrive at a solution that is principled and minimally intrusive to pregnant women." (*ibid.* at 961). For an analysis of the decision and its implications as well as an overview of the criticisms addressed by the minority opinion of Justice Major, see Sandra Rodgers, "State Intervention in the Lives of Pregnant Women" in Jocelyn Downie & Timothy Caulfield, eds., *supra* note 133 at 127ff. See also Margaret Somerville, *The Ethical Canary, supra* note 138 at 180-182. Recognizing foetal legal rights to life would dangerously permit some sort of discrimination against women to take place. Pregnant women's lives, decisions, and rights should not be subject to unjustifiable restrictions or violation in order to protect unborn children, and the *Winnipeg* decision should therefore be welcomed. A woman should not be put in a situation where she has to choose between aborting her child, an option not always open to her, and an involuntary hospitalization, or commitment.

In Quebec, the law recognizes the unborn conceived children as enjoying certain rights. However, the personality they possess is conditional upon their birth and mainly enables the protection of their patrimonial rights (see article 192 al.2 C.C.Q. and following). In the health care area, pregnant women are recognized as having the right to refuse treatment, even though that refusal might lead to their death and ultimately that of their unborn child (see *Nancy B.* v. *Hôtel-Dieu du Québec*, *supra* note 125). If certain scholars believe that a court could order a pregnant woman to undergo treatment (e.g. a detoxification treatment) in the interest of the foetus (see, e.g. P.A. Crépeau, "Le Consentement en Matière de Soins et de Traitements Médicaux ou Chirurgicaux selon le Droit Civil Québécois" (1974) 52 Canadian Bar Review 247 at 251.), it would seem, and we support this stand, that only a clear legislative scheme could create such an exception to the right of autonomy inherent to any human being.

[398] Prior to the *Winnipeg* decision, *supra* note 394, several jurisdictions, Canadian and foreign, had limited to born children and adults the ambit of the *parens patriae* jurisdiction. See e.g., in New Brunswick, *New Brunswick (Minister of Health and Community Services)* v. *Hickey*, N.B.Q.B. (Fam. Div.), November 4, 1996, unreported; *Re A.* (1990), 28 R.F.L. (3d) 288 (Ont. U.F.C.) where Steinberg U.F.C.J. wrote of the foetus living in a woman's womb "[i]t is, therefore, impossible in this case to protect the child without ultimately forcing the mother, under restraint if necessary, to undergo medical treatment and other processes against her will. I believe that the *parens patriae* jurisdiction is not broad enough to envisage the forcible confinement of a parent as a necessary incident of its exercise." In

ii. Rationale materiae

Protective in nature, this power permits and requires[399] the courts to intervene in order to prevent or protect the person for whose benefit it is exercised from actual or potential harm,[400] whether physical, material or psychological. Although historically solely exercised in dealing with the management of estates, the *parens patriae* jurisdiction was never limited to such situations, and was extended, over the times, to cover personal situations. In the *Berverley's Case*[401] Sir Edward Coke stated that "the King shall have as well the custody of the body"[402]. In England as well as in Canada, the courts have lately made use of their prerogative in cases concerned with necessary medical treatments.[403] "In other words, the categories under

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England, May L.J. of the English Court of Appeal held in *Re F. (in Utero)*, [1988] 2 All E.R. 193 (C.A.) that "[u]ntil the child is actually born there must necessarily be an inherent incompatibility between any projected exercise of wardship jurisdiction and welfare of the mother."
It is to be noted that recent Canadian cases have reached a similar conclusion when asked to determine whether a foetus could be considered as a child in need of protection as far as child welfare legislation was concerned. See e.g. *Re Baby R.*. (1988), 15 R.F.L. (3d) 225 (B.C. S.C.). Child welfare legislation that would provide for the protection of a foetus as of a child would be subject to the *Canadian Charter* as happened in the case *Joe* v. *Yukon (Director of Family and Children's Services)* (1986), 5 BC.L.R. (2d) 267 (Y.T. S.C.), where a legislative provision to this effect was declared in violation of the charter and its removal ordered from the statute. A similar fate seems to await section 1(g) of the New Brunswick *Family Services Act*, S.N.B. 1980, c. F-22, which includes foetuses in the definition of children.

[399] Indeed, as mentioned by Robins J.A. "[o]ur society recognizes that the state **has an obligation** "..." to provide care for the mentally disabled and to act in its role as *parens patriae* for the protection and benefit of those who, through mental disability, are unable to take care of themselves." (*Fleming* v. *Reid*, *supra* note 321 at 311.).

[400] Indeed, "the Court will intervene not merely on grounds of an injury actually done, or attempted against "..." the person or property, but also if there be any likelihood of such an occurrence, or even an apprehension or suspicion of it." (cited in *Re Eve*, *supra* note 89 at 412-413).

[401] *Beverley's Case*, *supra* note 385.

[402] *Ibid.* 4 Co. Rep. 123 b. at 126 b.. In the *Wellesley* v. *Duke of Beaufort* (1827), 2 Russ. 1, 38 E.R. 236, Lord Eldon, then Lord Chancellor, explained the reasons underlying the confinement of the exercise of the equitable powers to the sole management of estates stating at that "the jurisdiction has been exercised for the maintenance of children solely when there was property, not because of any rule of law, but for the practical reason that the courts obviously had no means of acting unless there was property available."

[403] For instance, it has been used in Canada to override parental refusal to blood transfusion based on their religious beliefs. In the case *Re D. (S.)*, [1983] 3 W.W.R. 618 (B.C. S.C.), the British Columbia Court of Appeal exercised its *parens patriae* jurisdiction to authorize, despite the parents' refusal, the replacement of a block shunt to drain fluid from the brain of a seven-year-old hydrocephalic boy. The case was a difficult one as the threat to the child's life was not immediate, although he would ultimately be likely to die should the shunt not be replaced, and the child had undergone many treatments in the past years.
When used to override parents' refusal to consent to a beneficial treatment, the jurisdiction is used parsimoniously by the courts, as they are willing to preserve parental discretion in raising children. Only where the refusal is clearly detrimental to the child's health will the court intervene and override the initial decision.

which the jurisdiction can be exercised are never closed"[404], the *parens patriae* power of superior courts is "of undefined and undefinable breadth."[405] Reaffirmed by the Supreme Court of Canada in *Re Eve*[406], the *parens patriae* jurisdiction, unlimited in scope, must however be exercised in accordance with its underlying guiding principles. The paramount principle is that this power must be exercised according to "[w]hat is most for the benefit of the unhappy subject of the application"[407], as it is based upon the principle of necessity. Furthermore, the more sensitive the issue and serious the area of intervention, the more careful the courts must be in exercising their discretion. As held by Mr Justice La Forest "[i]t is a discretion, too, that must at all times be exercised with great caution, a caution that must be redoubled as the seriousness of the matter increases."[408] Its subject matter being unlimited, we will later determine whether non-therapeutic sterilization can be ordered by superior courts in the exercise of their *parens patriae* jurisdiction, that is to say whether such an operation can be considered in an individual's best interests.

c) the parens patriae jurisdiction: a common law prerogative?

The *parens patriae* jurisdiction is a common law prerogative unshared by the civil law. Although referred to in several cases,[409] it cannot be exercised by the Superior Court of Quebec as this court was never recognized as enjoying the same power and authority as the English Court of Chancery.[410] Those powers were exclusively vested

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[404] *Re Eve*, *supra* note 89 at 426 where La Forest J. held that "the jurisdiction is very broad in nature, and "..." can be invoked in such matters as custody, protection of property, health problems, religious upbringing and protection against harmful associations. This list "...", is not exhaustive."

[405] *Winnipeg*, *supra* note 394 at 971.

[406] *Re Eve*, *supra* note 89 at 411 where La Forest J. held that "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."

[407] *In Re John McMaughlin*, [1905] A.C. 343 at 347. This principle was adopted by the Supreme Court of Canada in *Wright* v. *Wright*, [1951] S.C.R. 728.

[408] *Re Eve*, *supra* note 89 at 427.

[409] Some Quebec cases have relied on the *parens patriae* jurisdiction in order to justify their conclusions. In the *Re Goyette* case, *supra* note 363, Reeves J. when overriding parent's refusal to consent to a life-saving surgical operation for their 26-month-old child suffering from Down syndrome not only relied on article 42 of the *Loi sur la Protection de la Santé Publique* but also upon "the inherent common law jurisdiction to protect those who cannot protect themselves." (J. Magnet, "Withholding Treatment form Defective Newborns: Legal Aspects" (1982) 42 Revue du Barreau 187 cited by P. Kouri, "L'Arrêt Eve et le Droit Québécois" (1987) 18 Revue Générale de Droit 643 at 646. In *Institut Pinel de Montréal* v. *Dionet al.*, *supra* note 193, Durand J. held that the *parens patriae* jurisdiction of the court was transferred to the Quebec Superior Court by virtue of article 31 C.C.P.. See more generally P. Kouri, *ibid.*.

[410] In the case *Valois* v. *De Boucherville*, [1929] R.C.S. 234, Judge Mignault held that "La Cour Supèrieure n' a pas la juridiction des cours de chancellerie en Angleterre." (at 242). As a result the *parens patriae* jurisdiction could only be lawfully exercised by the Superior Court of Quebec if a legislative scheme to that end was to be enacted.

in the Queen's representative, the Lieutenant Governor.[411] Furthermore, the *parens patriae* power being a residual prerogative enjoyed by superior courts only where no statutory provision provides for adequate rule, its existence seems unnecessary in Quebec, a province where the interests of children and mentally incompetent individuals are well-protected through the application of its protective regimes and where article 46 C.C.P.[412] is believed to have conferred on Quebec courts similar powers to those enjoyed by superior courts under their *parens patriae* equitable power.

Having examined the law on consent to treatment applicable in situations where an individual is incompetent through disability and/or age, we will now determine whether guardians or alternate decision-makers, in application of specific statutory provisions, common law principles or superior courts' *parens patriae* prerogative enjoy the authority to consent to involuntary non-therapeutic sterilization and whether the law in this area needs to be reformed.

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[411] For a more detailed historical review, see Robert P. Kouri, *supra* note 409 at 648-649. Professor Michel Morin is of the opinion that the civil law does not need to resort to the *parens patriae* jurisdiction as "[translation] civil law judgments have been able to take the child's interest into account without having to borrow from a foreign system of law." (Michel Morin, "La Compétence Parens Patriae et le Droit Civil Québécois: un Emprunt Inutile, un Affront à l'Histoire" (1990) 50 Revue du Barreau 827 at 901). He further writes

> En se tournant plutôt vers le doit civil, les tribunaux québécois éviteront au moins trois écueils. Ils ne se croiront pas autorisés à contourner les lois, une proposition qui est majoritairement rejetée dans les autres provinces. Ils ne s'attribueront moins souvent une compétence lorsqu'un tribunal étranger est parfaitement en mesure de protéger les intérêts de l'enfant, une attitude extrêmement néfaste qui découle directement de l'exercice de la compétence *parens patriae*. Enfin, le droit civil ne sera pas perçu comme un système sclérosé qui ne peut s'adapter à la réalité contemporaine sans recourir aux concepts de la common law. (*ibid.*at 831.)

[412] Under the terms of article 46 C.C.P.

> The courts and the judges have all the powers necessary for the exercise of their jurisdiction. They may in the cases brought before them, even of their own motion, pronounce orders or reprimands, suppress writings or declare them libellous, and make such order as are appropriate to cover cases where no specific remedy is provided by law.

C. Involuntary non-therapeutic sterilization and Canadian Provincial Law

The repeal of the two Canadian eugenic sterilization statutes sounded the death knell of eugenic beliefs, and coincided with an accrued emphasis on the principle of "normalization"[413], principle which promoted deinstitutionalization. As a result, many individuals who, previously, would have been locked up and segregated behind the doors of mental institutions, were to live in the community raised and cared for by family members or private care-givers. Disabled individuals, subject to a looser supervision, were finally able to express their sexuality.

Caregivers and family members became aware of the increased possibility that their disabled protégés not only indulge in activities of a sexual nature but also become parents. Fearing the consequences of such occurrences, they tried to find adequate means of contraception. Sterilization, which, the birth control restrictions having been relaxed, became one of the most popular means of contraception in Canada, was seen, in some circumstances, as a solution. The "normalization" principle provided a basis upon which access to sterilization was requested as it entitled mentally disabled individuals to be granted the same opportunities in controlling procreation as any other Canadian citizen. However, lacking the necessary competence to consent to medical decisions, the availability of non-consensual non-therapeutic sterilization was questioned.

In the following part, we will turn to the law developed by Canadian common and civil law provinces to examine the answer given by provinces to the delicate issue of non-consensual non-therapeutic sterilization. Whereas the civil code of Quebec modified its provisions over time, rendering involuntary non-therapeutic sterilization

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[413] The concept of "normalization" was defined by W. Wolfenberger (Wolf Wolfenberger, and al., *The Principle of Normalization in Human Services* (Toronto: National Institute on Mental Retardation, 1972) at 28 as " "..." [t]he utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible.". This principle emphasizes the need to provide individuals with mental disability with an environment as close to what is considered by society as "normal" as possible, in order to restore their dignity and promote their rehabilitation and development (physical, moral and social). Proponents of this doctrine fought against the presumptions which disabled individuals were the victims of, and urged society to grant them, as far as possible, the same opportunities as any other citizens such as the possibility to marry, become parents, or vote. As expressed by the Alberta Institute of Law and Reform, (Alberta Institute of Law and Reform, *Sterilization Decisions: Minors and Mentally Incompetent Adults* (Report for Discussion No 6) (Edmonton: 1988) at 31) "[t]he normalization concept emphasizes the similarities, rather than the differences, between disabled persons and other persons."

in turns legal and illegal, the law in common law provinces remained uncertain until the holding of the Supreme Court of Canada in the *Re Eve*[414] case.

1) Involuntary non-therapeutic sterilization and Quebec: the theoretical legality

As discussed in our first chapter, since the *Cataford*[415] case, non-therapeutic sterilization or purely contraceptive sterilization is not *per se* contrary to public policy. Even though on the specific facts of the *Cataford* case, the woman had voluntarily consented to the operation, the holding of the case was interpreted as extending to all non-therapeutic sterilizations. One question however remains, whether parents, the courts, or a legally appointed representative could approve of the operation in situations where the patient was incapable of consenting to it.

In the absence of any specific statutory provision dealing with sterilization, the answer to that question has varied, in Quebec, according to the amendments made to its civil code over the years. The provisions of the Civil Code of Lower Canada, then the changes brought by its amendments in 1990, and finally the dispositions of the new Civil Code of Quebec will in turn be examined.

a) The Civil Code of Lower Canada

i. Adults

Under the terms of the unrefined article 325 C.C.L.C.,[416] incompetent individuals, even though lucid at times, were interdicted by an order of the courts. Prohibited by law from exercising any of their civil rights, and their wishes disregarded, interdicted mentally disabled adults were appointed a curator legally authorized to enter into any medical or hospital contract that was aimed at the protection and furtherance of their best interests.[417] By virtue of art 7 of the Public Curatorship Act The Public Curator

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[414] *Re Eve*, *supra* note 89.

[415] *Cataford* v. *Moreau*, *supra* note 59.

[416] Under the terms of article 325 C.C.L.C.

> A person of full age, or an emancipated minor who is in an habitual state of imbecility, insanity or madness, must be interdicted, even though he has lucid intervals.

This article was highly criticized as it was modelled on the French Civil Code of 1866 and had remained untouched ever since despite the use of a rather shocking and limited vocabulary as far as its description of the persons subject to interdiction was concerned. Indeed, the words used were not only disrespectful of mentally disabled individuals but also did not correspond to any scientific or medical definitions of known mental disabilities. Over the years, the scope of this article, due to the generous interpretation of the courts and the doctrine, was to be extended to cover any individual unable to manage his/her own affairs and/or take care of his/her person (see L.P. Sirois, *Tutelles et Curatelles* (Québec: Imprimeries de l'Action Sociale Ltée, 1911) at 392, No 504).

[417] Curator's power to consent to medical treatment was concealed in article 343 C.C.L.C. which reads

enjoyed similar authority over uninterdicted mentally incompetent individuals hospitalized in an institution.[418]

Whether non-therapeutic sterilization could be consented to by a curator or by the Public Curator thus depended on the interpretation given to the notion of best interests. Whereas authorizing the procedure to relieve the family or the institution of the inconvenience or burden of the taking care of the disabled individual and/or a pregnancy, or the resulting child was clearly forbidden as serving the interests of a third party, the law did not seem to imply that all non therapeutic sterilization were to be regarded as non-beneficial. In one unreported decision, a Quebec court in the district of Drummond held that a curator could authorize a tubal ligation for a retarded female;[419] non-therapeutic sterilization was thus amongst the non-therapeutic acts which curators and the Public Curator could theoretically authorize. However, the decision remained in the hands of the individual empowered to authorize the operation and subject to his/her standpoint on the issue of the status of purely contraceptive sterilization. One of the Public Curators of Quebec of the time, Mtre Rémi Lussier, expressed his reluctance towards the recognition of the existence of such a power. Considering non-therapeutic sterilization as amounting a mutilation, he always refused

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> The curator to a person interdicted for imbecility, insanity or madness has over such person and his property all the powers of a tutor over the person and the property of a minor; and he is bound towards him in the same manner as the tutor is towards his pupil

It is to be noted that curators, as well as the Public Curator (an office that will be discussed, were the only individuals legally allowed by civil law to consent to treatment on behalf of the persons they had under their charge. Where a person was factually incompetent to consent to a specific treatment, but not represented by a curator, the law remained silent as to who could consent on his/her behalf to medical treatment. For instance, a judicial advisor's role (see article 349 C.C.L.C. which stated that "[a] judicial advisor is given to those who, without being absolutely insane or prodigal, are nevertheless of weak intellect, or so inclined to prodigality as to give reason to fear that they will dissipate their property or seriously impair their fortune") was limited, according to article 351 C.C.L.C., to assisting individuals in patrimonial matters. Additionally the code did not consider the possibility of an interdicted individual being competent to make certain specific decisions..

[418] According to article 7 of the *Public Curatorship Act (Loi sur la Curatelle Publique)*, L.R.Q. 1977, c. C-80,

> The public curator shall have over the person and property of the patient, or if a curator to the person is appointed, over the property of the patient only, the powers, and obligations of a tutor, but he shall not have custody of the person.

[419] In this case, *In Re D* (District of Drummond, no 451-TC dated the 20th of September 1973) it was held that "le curateur est autorisé à prendre les mesures requises afin que sa pupuille N, puisse subir une ligature des trompes." This case was criticized as it seemed to imply, by homologating the authorization provided by the family council, that a curator needed the support of the family council in order to be able to consent to a non-therapeutic medical act. This seemed patently wrong as unless specified by the civil code, a curator did not need to follow any formality in order to consent to a medical act, therapeutic or non-therapeutic. As written by J.Pineau, "[n]otre code a parfaitement défini les attributions du tuteur [a statement equally applicable to curators] , du conseil de famille et du juge, et nous concluons "..." que, hors les cas où le code exige l'intervention du juge sur avis du conseil de famille, le juge ne peut pas intervenir pour imposer des conditions ou des restrictions à l'action du tuteur" (L.P.Sirois, *Tutelles et Curatelles, supra* note 416 at 125).

to accede to the plea of families in that matter stating that "procéder à une stérilisation uniquement parcequ'une personne est atteinte de troubles mentaux constitue une mutilation car cette personne n'en tire aucun bénéfice physique et mental"[420].

ii. Minors

Until the beginning of the 1970's, decisions concerned with a minor's health were left to the discretion and arbitrariness of the recipient of paternal authority. For fear of disrupting the family unit, courts were extremely cautious when intervening to protect children.[421] Wishing to incorporate in the civil code the growing legal recognition of the concept of children's best interests, which became over time the paramount consideration of the courts, as well as the right for a child considered mature enough to consent to his/her own medical treatment, the Quebec legislator passed the *Public Health Protection Act*[422] that came into force as of February 1973, and which specifically dealt with health care issues. According to its section 42[423], whereas a minor of fourteen years or above (this age was chosen arbitrarily) could consent alone to therapeutic treatments, an *infans* was subject to the beneficial will of his/her father[424], or upon his failure or unavailability, to the neutral supervision of the courts.[425] However, although expressly granting the courts the power to override

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[420] Letter from Me R. Lussier to Robert Kouri, dated 9th of March 1979.

[421] At that time "the rights of parents over their children was considered to be sacred, natural and of public order [footnotes omitted]" (Bartha, M., Knoppers, "From Parental Authority to Judicial Interventionism: The New Family Law of Quebec", K. Connell-Thouez & B. Knoppers, eds., *Contemporary Trends in Family Law: A National Perspective* (Toronto:Carswell, 1984) at 215). For instance, in a custody case (the same could have been held in a case where consent to medical treatment deemed beneficial by the medical profession had been refused by the father), *Affaire X*, [1972] R.L. 379, the court declared that "[l]e père, et à défaut du père, la mère a un droit naturel à la garde de ses enfants, ce droit est sacré et le tribunal doit le respecter. **Son intervention ne peut être justifiée que dans les cas extrêmes**. [emphasis added]" (at 384)

[422] *Public Health Protection Act,* S.Q. 1977, c. P-35. This statute enacted to provide more clarity on the issue of minority and consent to treatment came into force the 28th of February 1973 by proclamation of the Lieutenant-Governor, (G.O.Q. 1973, part 2, vol 105, at 503).

[423] Originally section 36. The first version of the article created a limited number of instances where medical practitioners or institutions were able to rely on the sole consent of the minor, namely, in the case of pregnancy, of the presence of one of the diseases listed in the act, or in situations where the minor was under the influence of drugs or alcohol. This attempt was met by numerous criticisms, as it not only reaffirmed minors' submission to paternal authority but for a few instances, but also distinguished arbitrarily between various medical conditions. The second draft of the article proclaimed minors' ability to consent to all treatment required by their health. This article deprived parents of their right to decide for their children's health care, and did not provide the necessary safeguards to ensure that the child's interests would be protected from his/her unreasonable decisions or from the over-or mal-treatment of the medical profession.

[424] As noted beforehand parental authority was substituted to the principle of paternal authority with the introduction of article 244 of the Code Civil which came into force the 17th of November 1977.

[425] Under the terms of section 42 of the Act, *supra* note 422,

> An establishment or a physician may provide the care and treatment required by the state of health **of a minor fourteen years of age or older** with his consent **without being required to obtain the consent of the person having parental authority**;

parental refusal of a treatment potentially life-saving or beneficial,[426] the statute only concentrated on care required by the minor's state of health. Purely contraceptive sterilization, being by definition non-therapeutic, not medically necessary, remained therefore outside of the scope of the statute, and governed by the general rules ("droit commun") of the Civil Code.[427] Under those rules, the person holding parental authority was able to take any decisions based on children's best interests, thus could theoretically consent to a contraceptive sterilization if in the sole best interests of the child.

b) The 1990 amendments to the Civil Code

In 1990, the Civil Code of Lower Canada was modified with the coming into force of the *Loi sur le Curateur Public et Modifiant le Code Civil et d'autres Dispositions Législatives*[428]. Reaffirming the paramount importance of the principle of inviolability of the person, and the collateral necessity for a consent when interfering with a person's bodily integrity, the amendments identified, under article 19.1 to 19.4, the circumstances under which a mandatary, tutor or curator could authorize the performance of a medical act on behalf of individuals unable to care for themselves. Article 19.2 and 19.3 limited those situations to the authorization of therapeutic

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"..."

Where **a minor is under fourteen** years of age, the **consent of the person having paternal authority** must be obtained; however if that **consent cannot be obtained or where refusal** by the person having parental authority **is not justified in the child's best interest, a judge of the Superior Court** may authorize the care or treatment.

[426] Before the enactment of the Act, in several instances, the Superior Court of Québec, in the absence of any legislative provisions, overrode parental refusal to consent to a potentially life-saving treatment relying on the doctrine of emergency and necessity.

[427] As noted by Albert Mayrand "[l]es interventions chirurgicales pour rendre stérile un mineur de quatorze ans dont la santé n'est pas mise en cause ne tombent pas sous la protection de l'article 36 "..."; le titulaire de l'autorité paternelle pourrait donc s'y opposer." (Albert Mayrand, *L'Inviolabilité de la Personne Humaine*, *supra* note 93, at 66 n°52.)

[428] *Loi sur le Curateur Public et Modifiant le Code Civil et d'autres Dispositions Législatives,* L.Q. 1989, c.54, enacted the 15 April 1990, (1990) 122 G.O. II 939. Amongst the changes that were inserted in the Civil Code, two deserve our attention. Firstly, two distinctive protective regimes were established with the creation of tutorship (article 333 C.C.L.C.). Awarded by the courts, the supervision of a person of full age became dependent upon the degree of incapacity. Under article 328 C.C.L.C. "in selecting the form of protective supervision, consideration is given to the degree of the person's inability to care for himself or to administer his property". Secondly, according to article 331 and 331.1 C.C.C.Q., custody of the incapable was removed from the hands of the Public Curator unless no other person able to assume such responsibility was available. Therefore, the person to whom custody was entrusted retained the ability and duty to consent to therapeutic care.

331.1 The Public Curator does not have the custody of the protected person of full age to whom he is appointed tutor or curator unless, where no other person can assume it, the court entrusts it to him. He remains nevertheless responsible for protection of the person where the latter is entrusted to the custody of another person. The other person, however, shall exercise the power of a tutor or curator to give consent to the care required by the state of health of the person of full age, except the care which the Public Curator indicates he will provide.)

medical acts. Unless considered medically necessary, and therefore beneficial, sterilization when sought for purely contraceptive reasons could not legally be performed on an incompetent patient (minor and or mentally incapable), as no one had the authority to give a valid consent.

c) The Civil Code of Quebec

A major revision of the civil code occurred in January 1993. Reorganized and updated, the civil code of Quebec contains under its title II entitled "Certain personality rights" chapter I "Integrity of the Person", a section entirely devoted to provisions dealing with health care. Article 11 C.C.Q. extends alternate decision makers' authority in the health care context not only to care required by the patient's state of health but also to non-therapeutic medical acts.

Under the terms of article 18 C.C.Q., which specifically deals with care not required by the patient's state of health and therefore with non-therapeutic sterilization, and applies to both minors and mentally incompetent adults

> Where the person is under fourteen years of age or is incapable of giving his consent, consent to care not required by his state of health is given by the person having parental authority or the mandatary, tutor or curator; the authorization of the court is also necessary if the care entails a serious risk for health or if it might cause grave and permanent effects.

Thus according to that article, non-therapeutic sterilization when performed on an incompetent individual or a minor is not prohibited; however both the authorization of the court and that of the substitute decision-maker are needed, as non-therapeutic sterilization is not only a treatment not required by the person's state of health but is also a type of care which has permanent effects, depriving the person of his/her ability to procreate. The introduction of the courts' supervision, a necessary safeguard for the gravest interference with bodily integrity, was advocated and supported by many commentators. As expressed by F. Fournier, president of the "Commission des Droits de la Personne du Québec" in the end of the seventies

> En ce qui concerne la stérilisation et l'expérimentation, la commission approuve sans réserve l'article 20 du projet qui exige l'autorisation du tribunal quand un examen, traitement ou intervention non requis par l'état de santé présente un caractère permanent ou irréversible ou un risque sérieux pour le mineur ou le majeur non doué de discernement. Cette disposition n'empêche pas la stérilisation des personnes handicapées mais elle garantit que le tribunal puisse s'opposer à une demande de stérilisation qui ne serait pas faite dans l'intérêt véritable de la personne.[429]

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[429] Québec, Assemblée nationale, Commission permanente de la justice. Auditions de personnes et d'organismes en regard des projets de loi n°s 106 "Loi portant réforme du Code Civil du Québec du

The standard by which mandataries, tutors or curators must abide by when consenting to or refusing to authorize the performance of non-therapeutic sterilization is contained under the terms of article 12 C.C.Q.

> A person who gives his consent to or refuses care for another person is bound to act **in the sole interest of that person, taking into account, as far as possible, any wishes the latter may have expressed.**[430] If he gives his consent, he shall ensure that the care is **beneficial** notwithstanding the gravity and permanence of certain of its effects, that it is advisable in the circumstances and that the **risks incurred are not disproportionate to the anticipated benefit.** [Emphasis added]

In the province of Quebec purely contraceptive sterilization can legally be performed on an individual lacking the necessary ability to consent. This was confirmed by the Superior Court of Quebec in the *T.(N.)* v. *N.-T. (C.)*[431] case in 1999, although on the specific facts the court refused to give its authorization to the procedure. In that case, a tutor had requested the Superior Court of Quebec to authorize the tubal ligation of the mentally disabled nineteen-year-old girl she had under her care pursuant to article 18 C.C.Q.. In support of her application, the tutor argued that such a medical act would be beneficial to the girl as should she give birth to a child, not only would that infant likely be handicapped, but the girl would not be able to cope with the responsibilities involved in raising the child. The Public Curator opposed the request relying on the right to procreate, as a component of the wider right to bodily integrity. The Superior Court of Quebec in reaching its conclusion not only reviewed the appropriate provisions of the Civil Code but also referred to the Supreme Court of Canada holding in the *Re Eve*[432] case, which although not binding in Quebec was however felt to be a wise source of inspiration.[433] The court weighed

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droit des personnes et 107 Loi portant réforme au Code civil du Québec du droit des successions" dans *Journal des débats: Commission parlementaires* 4ème session, 32ème législation at B-1683 (28 avril 1983).

[430] It should be added that contrary to therapeutic procedures, the court must respect the incompetent patient's refusal to undergo a non-therapeutic procedure; see art. 23 C.C.Q.

[431] *T. (N.)* v. *N.-T. (C.)*, [1999] R.J.Q. 223 (Superior Court of Quebec).

[432] *Re Eve*, *supra* note 89.

[433] The Court held that "Bien que ces principes doctrinaux [les principes relatifs à l'exercice de la prérogative *parens patriae*] ne s'appliquent pas au Québec parce que la compétence des tribunaux, dans ces cas, relève d'une législation spécifique, il n'en demeure pas moins que l'exercice de la discrétion qui en découle peut s'inspirer des principes retenus par la Cour suprême [footnotes omitted]" (*T. (N.)* v. *N.-T. (C.)*, *supra* note 431 at 226).
Reference to the principles established by the Supreme Court of Canada in the *Re Eve* case was made in an earlier case, decided in Montreal. In March 1987, in the case *In Re X. et Bouchard et le Curateur Public et le Ministre des Affaires Sociales*, (Montréal, 500-24-00008-86), Mayrand J. relying on the findings of the *Re Eve* case declared a young teenager ward of the Social Services of Ville-Marie and

the grave interference of the girl's bodily integrity, the deprivation of her fundamental right to procreate, as an inevitable consequence of non-therapeutic sterilization, against the medical and psychological advantages that the respondent would gain from the procedure. Although expressing its sympathy and understanding of the difficulties involved in taking care of a mentally disabled person, the court concluded that on the specific facts of the case, the applicants had failed to demonstrate that the sterilization considered would further the sole interests of the girl.[434] It stated that

> La position à adopter en l'instance ne peut que se calquer sur celle retenue par la Cour suprême du Canada. Elle paraît d'autant plus justifiée qu'il existe, selon le mis en cause, au moins deux moyens de contraception qui pourraient convenir à la condition de l'intimée et qui ne présenteraient pas les mêmes caractéristiques de gravité et d'irréversibilité que la ligature tubaire.[435]

From the holding of the Superior Court it seems that only where the sole interest of the incompetent person and/or minor is at stake, for instance, where although not medically necessary, sterilization would improve the person's physical or mental health or well-being, will a Quebec Court homologate the decision to authorize a non-therapeutic sterilization. The cautious attitude of the court in analysing the interests of incompetent patients, and determining of incompetency of patients,[436] is to be welcome, in light of the wide and invasive powers conferred by the civil code on an alternate decision maker.

As a final comment, we cannot but regret that the Supreme Court of Canada in the *Re Eve*[437] case only examined the legality of this medical act in relation with the *parens patriae* power of common law superior court, a jurisdiction unshared by Quebec superior court, and did not extend its analysis to *Charter*[438] issues, and more

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authorized and homologated their decision to sterilize the girl stating that

> on a, du côté médical, des rapports à l'effet que ça ne peut qu'améliorer sa situation, au niveau de l'épilepsie. Egalement, on a une certitude que ça va détériorer sa situation au niveau de son développement mental, si l'opération n'est pas autorisée et effectuée. De sorte que, **ayant à l'esprit les grands principes de la Cour suprême**, à l'effet qu'on doit se montrer exigeant, on doit s'assurer que l'enfant était bien représentée (elle est bien représentée), qu'on doit faire preuve de précaution et qu'on doit exiger une preuve correspondant à la gravité de l'opération qui est irréversible, la Cour se déclare satisfaite que la preuve l'a convaincue d'une façon prépondérante et concluante. [emphasis added] (at 3).

[434] Indeed, from the evidence brought before the court, amongst the reasons underlying the request, the concerns of the mother seemed to be predominant. However, there was no evidence that a pregnancy would affect the health or mental condition of the girl.

[435] *Supra* note 433 at 227.

[436] Indeed, the Superior Court, before reaching its conclusion, examined the incapacity of the patient in consenting to the particular medical procedure, characterized as non-therapeutic the act contemplated, restated the relevant civil code provisions, and scrutinized all the evidence to determine whether the conditions set by the code had been fulfilled.

[437] *Re Eve, supra* note 89.

[438] *Canadian Charter, supra* note 111.

specifically its sections 7 (liberty and integrity of the person) and 15(1) (equality rights). Indeed, although both parties in the *Re Eve* case made references to the *Canadian Charter*, these arguments were dismissed hastily by La Forest J. Whereas the decision was held to fall outside the scope of section 7 limited to "protect individuals against laws or other state action that deprive them of liberty"[439], arguments based on section 15 of the *Canadian Charter* were dismissed as that section "was not in force when these proceedings commenced."[440]

2) Involuntary non-therapeutic sterilization and Common law provinces: the proclaimed prohibition, the uncertain reality

In common law provinces, in the absence of a clear statutory or jurisdictional prohibition or recognizance, the uncertainty surrounding the legality of non-consensual non-therapeutic sterilization left the medical professional with the hard task of deciding whether or not to respond to the requests of family members, care-givers and alternate decision-makers. According to various surveys, obstetricians did perform such medical acts. Ultimately, the Supreme Court of Canada, in 1986, in the *Re Eve* case banned such a practice holding that non-therapeutic sterilization could never be for the best interest of incompetent individuals. However it left the door opened for legislative intervention, and room for the interpretation of the courts.

a) The pre-Eve era: the uncertainty

i. The medical profession: the practice of contraceptive sterilization

Before the Supreme Court's intervention in the *Re Eve* case, the medical profession when requested by alternate decision-makers (parents, guardians) to sterilize an incompetent individual for non-therapeutic motives had to decide whether to accede to their demands and face the wrath of the law should the consent-giver be held not to enjoy such an authority, or refuse to act upon any substitute consent and leave incompetent individuals, care-givers and institutions in delicate situations. Whereas the Canadian Medical Protective Association urged medical practitioners to

[439] *Re Eve*, *supra* note 89 at 436.
[440] *Ibid.* at 437. The Supreme Court of Canada might have been reluctant to open up *Charter* issues in the transitional period, not only in this specific cases but also in all other cases.

only perform non-therapeutic sterilization on patients 16 years of age or older after the obtaining of a court order homologating the "substitute decision-maker"'s decision, various studies have shown that, in practice, non-therapeutic sterilization were undertaken. As noted by B. Sneiderman, J.C. Irvine and P.H. Osborne[441], "[i]n Ontario, nearly 300 "mentally retarded" minors were sterilized in 1976, according to a Community and Social Services Ministry study that examined health insurance billings"[442], sterilizations whose purpose were mainly contraceptive. This practice was criticized by many associations involved in the lives of mentally disabled individuals. Members of those associations feared that the lack of supervision and control was leaving the door wide open for abuses, and were of the opinion that in many cases the sterilizations performed were both "unwanted or unwarranted"[443].

ii. Provincial legislation, the theoretical availability of sterilization in some provinces.

- Eugenic sterilization statutes

As abovementioned, in the beginning of the last century, two Canadian common law provinces, embracing the theories developed by eugenicists, implemented sterilization statutes whereby many institutionalized inmates, affected with mental disabilities or diseases, were sterilized with or without the obtaining of a prior consent or the taking into account of their expressed wishes. These two infamous and discriminatorily administered statutes were repealed in the beginning of the seventies, and eugenicist ideas thereby abandoned.

- Adults

Apart from those shameful acts, certain provincial incompetency statutes appeared to implicitly confer, or were unclear on whether they conferred on guardians the power to consent to purely contraceptive sterilization. Section 9 (1) of the *Dependant Adults Act*[444] of Alberta bestowed plenary guardians with "the power and authority "..."to consent to any health care that is in the best interests of the dependant adult", "health"

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[441] B. Sneiderman, J.C. Irvine and P.H. Osborne, *supra* note 246.
[442] *Ibid.* at 300.
[443] LRRC WP n°24, *supra* note 10, at 11, "because of their dependence on others, minors and mentally disabled persons (minors or adult) are in a vulnerable position and relatively powerless to protect themselves from sterilizations that are either unwanted or unwarranted".
The same occurred in other provinces such as Alberta. Under Alberta's insurance plan, based on retardation and birth defects, "[i]n the period 1976-1978 inclusive, a total of seventy-eight hysterectomies were performed, eleven other sterilizations on girls and eight on boys."(W.F.Bowker, *supra* note 149 at 975).
[444] *Dependant Adults Act*, S.A. 1976, c. 63.

being defined under the terms of section 1(h) as "any examination, diagnosis, or ailment, "...", and any procedure undertaken for the purpose of preventing pregnancy, [and] any medical, surgical, obstetrical medical act or dental treatment". A guardian of the person, in the province of Alberta, empowered to consent to health care decisions was thus theoretically able to authorize non-therapeutic sterilization if believed to be in the person's best interests as the purpose of purely contraceptive sterilization is to eliminate the capacity to procreate and *a fortiori* to prevent pregnancies. Some judges, interpreting the provisions of the act in such an extensive manner, expressly granted guardians the authority to consent to the performance of sterilization for menstrual management, whereas other refused to do so or remained silent. In any case, the Public Guardian, unsettled by the doubts surrounding the act, had developed the habit of requesting the court for assistance whenever faced with sterilization cases, even though in most cases the court refused to answer preferring to let the guardian decide.[445]

It could be and has been argued that interpreting the Alberta act as empowering guardians to consent to non-therapeutic sterilization was not the intention of the legislature. Preceding the statute's enactment, the *Alberta Sterilization Act 1928* had recently been repealed, and with the new act the province desired to start anew and try to forget its highly criticized eugenic past. Furthermore the legislature expressly stated that the new act was not supposed to cover sterilization.[446]

Certain provincial mental health acts, evasive in their description of the treatments that could be administered on involuntarily institutionalized individuals dangerous to themselves or others seemed to leave room for the unlikely but possible performance of non-therapeutic sterilization. In Ontario, for instance, in furtherance of article 31 (a) (2) of the *Mental Health Act*[447], such was arguable, provided sterilization would

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[445] See Alberta Institute of Law and Reform, *supra* 413 at 60-62.

[446] See, e.g. W.F. Bowker, *supra* note 149 at 974-975. He noted that "[i]t would be odd to find that a legislature which repealed the *Sexual Sterilization Act* out of solicitude for the fundamental right to procreate had by a side-wind conferred on the guardian of a dependant adult the power to authorize sterilization in the name of contraception." (at 975).

[447] *Mental Health Act*, R.S.O. 1970, c.269 as amended by 1978, c.50, section 1(f). According to section 31 a(2)

> Psychiatric treatment shall not be given to an involuntary patient without the consent of the patient, or, where the patient has not reached the age of majority or is not mentally competent, the consent of the nearest relative of the patient except under the authority of an order of a regional board made on the application of the officer in charge.

This article permitted the involuntary treatment of a patient when the order to treat originated from the regional board.

qualify as a psychiatric treatment, one that would enhance the patient's state of health, or prevent its deterioration[448].

From this brief review it can be concluded that provincial legislations, inadequately drafted, were unable to provide clear answers as to the authority of alternate decision-makers to consent on behalf of mentally incompetent individuals to sterilization.

- Minors

The question of non-therapeutic sterilization when sought for minors was posed under different terms as as opposed to guardians who derive their prerogatives from specific statutory provisions, parents' authority in the health care context is inherent and limited to what is in the child's best interests. Whereas therapeutic sterilization never raised any legal issue, many advocated the adoption of a cautious attitude when dealing with non-therapeutic sterilization. It was argued that due to the likeliness of conflict between children's and parents' interests, non-therapeutic sterilization could never safely be said not to have been consented to in furtherance of the parents' own interests, (the fear of having to raise a child should the disabled infant become pregnant).[449] Unless medically necessary, beneficial, non-therapeutic sterilization as far as minors were concerned was thought to be "illegal in common law Canada"[450].

iii. <u>The jurisprudence: the availability of non-therapeutic sterilization through the exercise of the court's *parens patriae* jurisdiction</u>

In the absence of clear statutory provisions empowering alternate decision-makers to consent to non-therapeutic sterilization, the courts were left wondering whether the scope of their *parens patriae* power included non-therapeutic sterilization orders.

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[448] Although a far-fetched extension of what constitutes a psychiatric treatment, sterilization aimed at the prevention of the occurrence of a trauma linked to childbirth could have been argued to fall under the category of psychiatric treatments. However, such an interpretation was unlikely to stand. It is to be noted that, as for minors under 16 years old, the Minister of Health ordered in 1978 the drafting of a moratorium according to which sterilization, except when medically necessary, could not be performed. This disposition lately found expression under section 52 of the Regulation 865 (R.R.O. 1980, Reg. 865 (under the *Public Hospital Act*)), still in force today:

(1) "..." no surgical operation for the purpose of rendering a patient or outpatient incapable of insemination or of becoming pregnant shall be performed where the patient or out patient is under the age of 16 years

(2) Subsection (1) does not apply where the surgeon or the attending physician believes the operation is medically necessary for the protection of the physical health of the patient or outpatient.

[449] But then, many parental decisions are flavoured by the fulfillment of their own interests. Choosing a specific school, or a given medical treatment could also be said to only further parents' own interests.

[450] M. A. Somerville &, P. Kouri, "Comments on the Sterilization of Mental Incompetents in Canadian Civil and Common Law", *supra* note 88 at 625.

Whether the purpose of sterilization, medically necessary or purely contraceptive, is relevant in considering its legal status, and if so whether social considerations enter in the definition of what is therapeutic, has received varied answers by Canadian provincial courts.

Whereas in the *Re K.*[451] case, the Court of Appeal of British Columbia rebutted such consideration relying primarily on a best interests test, the Supreme Court of Canada, in the *Re Eve*[452] decision, as we shall see later, differentiated therapeutic from non-therapeutic sterilization in discussing its legality. The *Re K.*[453] case provides us with a sample of the reasoning judges were adopting prior to the intervention of the Supreme Court of Canada, and suggests that provincial courts were ready to extend the exercise of their equitable prerogative to sterilization orders, in situations where it was sought, if not for pure contraception, at least for reasons beyond pure medical necessity.

K. was a ten-year-old girl enrolled in a special education programme. She was affected by tuberous sclerosis, a medical condition that impaired her brain functioning due to the growth of tumours on her brain. She not only enjoyed the mental capacities of a 26 month old girl, capacities which in the best case scenario would only reach that of a 3 and a ½ year old, but also suffered from epilepsy causing her mild to severe seizures. As a result of her condition she required constant supervision and needed assistance in most daily tasks, including her washing and dressing. Capable of understanding many things, she was however unable to communicate well. When advised by doctors that her menstruation, whose early onset constituted a feature of her malady, would soon start, her parents petitioned the court in order to obtain the authorization to consent to her sterilization. Although they were believed to enjoy, as parents, the right to consent to that particular operation, acting for their daughter's best interests, recourse to judicial homologation was required by the concerned medical practitioner, hesitant to act upon the sole will of the parents. The case was asked to be proceeded on an expedient basis. In support of their application, the applicants outlined the aversion to blood to which K. was subject, a fear that they believed would reach tremendous height once her menses started, and that would probably lead to K.'s institutionalization. Her phobic aversion to blood had surfaced on many occasions. In situations where she was wounded or had blood samples taken,

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[451] *Re K.*, [1985] 4 W.W.R. 727 (British Columbia Court of Appeal).
[452] *Re Eve*, *supra* note 89.
[453] *Re K.*, *supra* note 451.

she would become hysterical, agitated, and would either pick at her punctures or else smear blood on her face. They also feared the sexual abuses of which K. could potentially be the victim. Alternative methods to sterilization, such as a desensitization programme, were considered but rejected as either likely to fail in resolving K.'s aversion or creating a serious medical risk to her health such as the lowering of her seizure threshold.

Opposing the request, the counsel for the Public Trustee, representing K., expressed the concern that a hysterectomy, a non-therapeutic surgery, could only be performed as a last resort, and not as a preventive solution, and proposed instead to enrol K. in a desensitization programme.

In a three step argumentation, Wood J., trial judge of the Supreme Court of British Columbia was led to conclude that a hysterectomy would not be in K.'s best interests.[454] He firstly stressed the importance of K's right to integrity and equal protection (protected by section 7 and 15 of the *Canadian Charter*[455] respectively) and to reproduction. Notwithstanding the possibility that K. would probably never procreate or understand what a uterus was, Wood J. however concluded that holding "that the operation would be of less significance" to her "must of necessity be founded on the belief that the mentally handicapped in our society are not entitled to the same rights of either sexual identity or childbearing that those of us, who are not so disabled, enjoy."[456] He then qualified the contemplated sterilization as non-therapeutic surgery as it was sought not for medical reasons but as a means to prevent a reaction to blood that was only anticipated.[457] He finally relied on the *parens patriae* jurisdiction of the court, a prerogative, which according to him, was exercisable in situations where the risks and advantages of a medical act were of equal or close weight, that is to say when the act was non-therapeutic.[458] He concluded, adopting a

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[454] *Re K.*, [1985] 3 W.W.R. 204, 60 B.C.L.R. 209.
[455] *Canadian Charter*, *supra* note 111.
[456] *Re K.*, *supra* note 454 at 221.
[457] Wood J. thus established a distinction between therapeutic sterilization, remedy to a clearly demonstrated medical condition, and non-therapeutic sterilization, whose legality could only be discussed when not consented to.
[458] He indeed stated that "the benefits to her of non-therapeutic surgery which threatens those rights [the personal rights of K. as pointed out earlier] are at best anticipatory and perhaps non-existent. In such a case, the exclusive judgment of the parents, even loving, caring, exemplary parents such as K. is privileged to have, cannot be presumed to be free from subjective considerations which may be at odds with the legal rights of the child", *Re K.*, *supra* note 454 at 222.

"clear and convincing evidence" standard[459], that K.'s parents had failed to demonstrate the proposed hysterectomy to be in K.'s best interests[460], and that the desensitization programme would not be successful. To reach such a conclusion he established a set of criteria to be met before a non-therapeutic sterilization could be approved by the courts, criteria listed after an exhaustive review of Canadian and American jurisprudence and of the working paper prepared by the Law Reform Commission of Canada in 1979[461]. Wood J's decision was clearly establishing a distinction based on the aim of sterilization. He did not dismiss non-therapeutic sterilization as non-performable when its subject was an incompetent individual but rather recognized the right for parents to consent to it with adequate supervision from the court in its exercise of *parens patriae*. He indeed wrote that

> parents have the right to provide substituted consent for the sterilization of their infant child, but that where such an operation would amount to a non-therapeutic procedure, such consent must be the subject of the review by this court to ensure that the best interests of the child are reflected by that decision.[462]

On appeal, the British Columbia Supreme Court of Appeal overturned the lower court's decision, granting the order for K.'s sterilization.[463] K. was subsequently sterilized by way of hysterectomy and the application to the Supreme Court of Canada dismissed for lack of standing.[464]

Craig J.A., Anderson J.A concurring, reviewing Wood J.'s holding, mainly criticized his adoption of a "clear and convincing evidence" standard in contradiction with all relevant Canadian authorities on the issue. He concluded that such a standard would not only constitute too harsh a burden of proof for parents, but would also set a twofold standard. He preferred to recourse to the traditional "balance of probabilities" standard used in civil actions and defined by Cartwright J. in *Smith* v. *Smith*[465].

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[459] This standard of proof, according to which the onus of proof must be discharged by clear and convincing evidence, is borrowed from American law and more particularly from the case *Addington* v. *Texas*, (441 U.S. 418, 60 L. Ed. 2d 323, 99 S. Ct. 1804 (1979)) and constitutes a departure from the traditional balance of probabilities standard generally applied in Canadian civil actions.

[460] "The benefits of K. having non-therapeutic sterilization performed are at best anticipatory and perhaps non-existent", *Re K., supra* note 454 at 224.

[461] LRCC WP n°24, *supra* note 10.

[462] *Ibid.* at 226-227.

[463] *Re K.*, *supra* note 451.

[464] The Supreme Court of Canada denied leave to appeal on technical grounds ([1985] 4 W.W.R. 757 (S.C.C.)). It is interesting to note that the members of the British Columbia Court of Appeal, sure of the rightness of their holding, did not allow their decision to be stayed pending the edition of their written reasons.

[465] *Smith* v. *Smith*, [1952] 2 S.C.R. 312, [1952] 3 D.L.R. 449.

Cartwright J. noted that

> proof of a fact must be proven to the reasonable satisfaction of the tribunal, satisfaction depending upon the totality of the circumstances on which its judgement is formed including the gravity of the consequences of the finding,[466] the seriousness of the allegations made, the unlikelihood of an occurrence of a given description.[467]

Craig J., Anderson J.A. concurring also believed Wood J. to have wrongfully declined the application based on a consideration of mentally disabled individuals as a class rather than on the unique facts pertaining to K.'s particular situation. He also deplored the conclusion that the desensitization programme could constitute a viable alternative to sterilization in preventing K.'s aversion of blood, when all expert evidence pointed to the contrary.

The most interesting conclusion, however lies between the lines of Anderson J.A.'s statement. He indeed not only rejected the distinction between therapeutic and non-therapeutic sterilization, although opining K.'s surgery to be therapeutic, but also relied exclusively on a subjective best interests' test to resolve the issue. The objective criteria set by Wood J. were deemed by him inappropriate. Concluding that K., due to her disability and collateral inability to understand what was happening and what changes a hysterectomy would bring upon her, "would not suffer any loss of her right to reproduce"[468]. In light of the compelling evidential force of expert and parental arguments,[469] especially of those enjoying a close relationship with K., K's sterilization had been established, to the reasonable satisfaction of the court, to be in her best interests.[470] He further stated that the matter should never have been brought before a court, as a court should not intervene, as a matter of principle, in cases where loss of rights were not involved. Parents should not, in such situations, incur the

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[466] *Ibid.* at 331-332.

[467] *Ibid.* at 331. Cartwright J. was citing Dixon J. in *Briginshaw* v. *Briginshaw* (1938), 60 C.L.R. 336.

[468] *Re K., supra* 451 at 748.

[469] Most of the evidence purporting to demonstrate K.'s phobic aversion to blood was brought by her parents, the medical professionals in charge of K. having only witnessed mild reaction when subjecting her to blood sampling procedures. Should a court, under such circumstances give full credential to that kind of second-hand evidence? On this particular point, see Carol Anne Polowich Finch-Noyes, *supra* note 56 at 288 footnote 75.

[470] The hysterectomy was thought to be in K's best interests for several reasons:

- Its non performance would likely cause her parents additional anxiety and possibly lead to an institutionalization contrary to her well-being (but then isn't the court taking into consideration interests external to K.'s?), and would probably hinder her learning process, and possibly affect her seizure threshold.
- The desensitization programme would most likely fail to fulfill its purpose and sterilization would have to be performed anyway.
- K. would not suffer from a loss of gender identity as she is not able to grasp such concepts.

additional expenses, anxiety, and loss of time linked to legal proceedings, when they were needed alongside their offspring.

> It is my opinion that, except in exceptional cases, where important legal rights are involved, the decision in these cases should be left to the parents and the physicians consulted by them. While in all cases involving children the welfare of the child is the paramount consideration, taking prevalence over all other rights of the parents to make decisions on behalf of their children, it has not been demonstrated that to refer cases like the present to the courts is in the best interests of children.[471]

From this decision, it could be inferred that courts were likely to adopt a non-interventionist attitude, only encroaching on parental rights to consent for their children's medical treatment when satisfied on the balance of probabilities that the child's best interests had not been adequately protected, and that the *parens patriae* jurisdiction was likely to extend to orders of sterilization, whether or not therapeutic when thought to be in the best interests of the child.

Although the facts of the case could justify the decision taken by the British Columbia Court of Appeal, the judgement is not free from criticisms. We cannot but be appalled by some of the comments made by Anderson J.A. in his dealings with K.'s rights. In a shocking paragraph, he stated that individuals lacking the necessary mental capacity to comprehend the meaning and purpose of contraception or reproduction should be deprived from their right to reproduce or such right should be overlooked when considering their best interests. He indeed wrote that "the loss of the right to reproduce was, therefore not a matter open for consideration"[472] and further that "the loss of rights of reproduction was not a loss in any real sense."[473] This is a shocking conclusion, the exercise of rights and their protection from any violation cannot depend upon their comprehension, upon competency.[474] In a society fighting

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[471] *Supra* note 451 at 749.
[472] *Ibid.* at 744.
[473] *Ibid.* at 747.
[474] Many writers have defended the theory according to which possession of a right was dependent upon it being understood as a concept and being desired. Rights would thus be linked to interests. According to this theory, certain classes of people are denied rights by virtue of their inability to understand their meaning or desiring them. Pushed forward, this argument leads to rather shocking conclusions. In *Causing Death and Saving Lives*, Glover, an author, writes

> Desires do not presuppose words, but they do presuppose concepts. A baby can want to be fed, or be changed, or go to his mother, although he does not speak. Innumerable signs of recognition and pleasure show us that that he has concepts. But a baby cannot want to escape from death any more than he can want to escape the fate of being a chartered accountant when grown up. He has no idea of either.
>
> (Cited in Marc Stauch, Kay Wheat & John Tingle, *Sourcebook on Medical Law*, 1st ed. (London: Cavendish Publishing Limited, 1998) at 72).

Thus, a new-born child, unable to conceptualize life and desire it (is that really so anyway?), would be deprived of a right to life. We cannot but strongly disagree with this interest approach of rights, and

for a more widespread recognition of the rights of mentally disabled individuals, and equality, such comments should have no standing in a court of law. Such attitude towards mentally disabled individuals is furthermore prohibited by the *Canadian Charter*[475]. Further criticisms of the judgement are related to its treatment of the evidence presented.[476]

However, despite those criticisms, this case shows the disagreement concerning the legal status of sterilization that was taking place between judges before the *Re Eve*[477] case. Several questions were raised: whether it was at all illegal, whether its legality should depend upon its characterization as therapeutic, or upon a best interests test, whether social considerations had any relevance.

b) The Re Eve case

The Supreme Court of Canada in the *Re Eve*[478] case addressed and resolved, once and for all, or so it thought, the issue of non-therapeutic sterilization of minors and mentally incompetent adults in Common Law provinces. The judges were unanimous in holding that, absent enabling legislation, neither a guardian, parents or other alternate-decision maker nor the court in the exercise of its *parens patriae* jurisdiction enjoy the power to authorize a sterilization that is non-therapeutic, that is to say whose aim is not targeted at the enhancement of the physical or mental health of the patient.[479]

The legal proceedings were started by the mother of Eve (named by McQuaid J. of the Supreme Court of Prince Edward Island), a 24-year-old girl, living in a training school during the week and with her mother on week-ends, who petitioned the Prince Edward Island Supreme Court, following her daughter's involvement with a young male, in order to be appointed guardian of her daughter and obtain the authorization to consent to her sterilization. Eve, whose mental capacity to consent was never questioned, not only was moderately mentally disabled but also suffered from what is called an extreme expressive aphasia, a condition, whose causes and remedy are unknown,

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prefer a natural rights understanding of rights whereby individuals enjoy rights by virtue of their humanity. "It may be difficult, "...", to exercise a right if one is unaware of its existence or one lacks the concepts or the desire, but this cannot mean that one lacks the rights in question." (*ibid.* at 72)

[475] *Canadian Charter, supra* note 111.

[476] See *supra* footnote 470. As previously outlined, the phobic aversion to blood, described by the parents, uncontested but un-witnessed, or not to the same extent, by any member of the medical profession, was given great emphasis and was strongly relied upon by Anderson J.A..

[477] *Re Eve, supra* note 89.

[478] *Ibid.*

[479] Therapeutic sterilization, whether or not voluntary, and voluntary non-therapeutic sterilization are legal.

impairs the patient's communication skills. Although psychiatrists agreed that such a malady rendered Eve unable to express her emotions or formulate her perception of them, they were uncertain of the extent of her ability to form thoughts, or understand what she perceived. In light of her sexual awakening, her talk of marriage and the relationship she started with a young male, her mother set her mind on sterilizing her by way of an hysterectomy as she believed her to be incapable of coping with pregnancy, childbirth or the raising of a child. Approaching 60 years of age, she was also worried about the burden which would fall upon her should her daughter give birth to a child.

The Court was presented with three requests: that Eve be declared mentally incompetent, that her mother be appointed committee of the person and that she be given the authority to consent to Eve's sterilization. Concentrating on the last claim, McQuaid J. of the Family Division of the Supreme Court of Prince Edward Island, justifying the exercise of the *parens patriae* prerogative of the court by the purely contraceptive purpose of the proposed medical act, concluded that in the absence of "clear and unequivocal statutory authority"[480], the court could and should not allow the procedure pursuant its *parens patriae* jurisdiction. Establishing the fundamental character of the right to inviolability and the higher protection to which incompetent individuals were entitled, he concluded that

> The court had no authority or jurisdiction to authorize a surgical procedure on a mentally retarded person, the intent and purpose of which was solely contraceptive. It followed that, except for clinically therapeutic reasons, parents or others similarly situated could not give a valid consent to such a surgical procedure either, at least in the absence of clear and unequivocal statutory authority[481]

On appeal, launched in *in banco*, the three judges of the Prince Edward Island's Supreme Court reversed McQuaid J.'s holding, the majority finding the evidence brought before them compelling enough to warrant Eve's sterilization.[482]

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[480] *Re E.* (1979), 10 R.F.L. (2d) 317 (P.E.I.S.C. Fam. Div.) at 319.

[481] *Re Eve*, *supra* note 89 at 396.

[482] Although agreeing with Large J. and Campbell J. that Eve's sterilization be allowed, McDonald J. however believed the *Mental Health Act* (R.S.P.E.I. 1974, c. M-9 as amended by the *Chancery Jurisdiction Transfer Act*, S.P.E.I. 1974, c.65) to provide no legal basis for the present claim, but stated that the question not having been answered by McQuaid J., it was not to be treated on appeal. He also deplored the absence of Eve's independent representation. In his conclusions he urged the courts to approach the issue of non-therapeutic sterilization with utmost caution, declaring that such operations should remain exceptional and setting a number of criteria to which the courts should refer to when determining whether a sterilization was for the best interests of the patient. Campbell J. and Large J. adopted a broader approach to the issue of purely contraceptive sterilization. Unlike McDonald J., uneasy about opening the door of the *parens patriae* of the Court to non-therapeutic sterilization, and

In reaching their order they stated that

> we are unanimously of the opinion that the Court has, in proper circumstances, the authority and jurisdiction to authorize the sterilization of a mentally incompetent person for non-therapeutic reasons. The jurisdiction of the Court originates from its *parens patriae* powers towards individuals who are unable to care for themselves and gives the Court authority to make the individual a ward of the Court[483]

Leave to appeal to the Supreme Court of Canada was subsequently granted to Eve's guardian *ad litem*. The *parens patriae* doctrine constituted the unique ground on which the appeal was allowed.[484] La Forest J. delivered the unanimous judgement of the Court, adopting a rights-based approach to the issue. He firstly examined Prince Edward Island's statutory provisions to determine whether they provided guardians or the court jurisdiction to order the proposed non-therapeutic sterilization. He decided that even though section 30 of Prince Edward Island's *Mental Health Act*[485], regulating the appointment and powers granted to committees of the person , could be read as permitting a committee to consent to medical treatments, an assertion which he greatly doubted,[486] it could never be interpreted as extending to non-therapeutic acts and could not therefore be used in support of the applicant's case. Indeed, article 30 A. (2) referred to "such allowance to be made out of the estate for the maintenance and

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doing so mainly on the basis of the inappropriateness of a complete ban, they were of the opinion that social considerations should have their place amongst the factors to take into consideration when weighing the merits of a non-sterilization order.

[483] *Re Eve, supra* note 89 at 396.

[484] By choosing to allow the appeal on the basis of its *parens patriae* jurisdiction, the Supreme Court of Canada was expressing its will to resolve an issue that had remained uncertain for years. Indeed, as expressed by Anne Bolton (M. Anne Bolton, "Whatever Happened to Eve? A Comment" (1987-1988) 17 Manitoba Law Journal 219), the absence of procedural safeguards provided to Eve at trial, no *guardian ad litem* had been appointed to protect Eve's interests, as well the applicant's failure to satisfy the onus of proving the inadequateness of any other means of dealing with Eve's sexuality and fertility constituted sufficient grounds for appeal: "any one of these evidentiary or procedural failures would have provided the Court with sufficient grounds to allow the appeal. However, the Court did not allow the appeal on any of those grounds, but rather chose to decide the matter on the basis of the *parens patriae* doctrine."(at 221).

[485] *Mental Health Act, supra* note 482.

[486] From the language of section 30 of the Act (*supra* note 482) it could indeed be inferred that its ambit was limited to persons in need of guardianship but also in possession of property, which was not the case for Eve. Its first line read

> 30 A. (1) When a person in need of guardianship **is possessed of goods and chattels, lands and tenements or rights or credits**, the Supreme Court may on petition, "...", order that person "..." to be examined by two medical men, to ascertain his state of mind and capability of managing his affairs "..." [emphasis added].

Furthermore the powers granted to the committee seemed to be limited to the deciding of allowances directed towards the maintenance and medical treatment of the incompetent person and not to extend to the taking of the medical decisions themselves. Section 30 A (2) indeed stated that

> 30 A. (2) "..." the Supreme Court may make an order appointing some fit and proper person to be a committee of the person and estate of the person in need of guardianship and if necessary direct such **allowance** to be made out of the estate for the maintenance and medical treatment of the person in need of guardianship as it deems proper "..." [emphasis added].

medical treatment of the person in need of guardianship"[487]. Clearly, a non-therapeutic procedure, not medically necessary by definition, could not be characterized as a medical treatment as understood by section 30 of the act. La Forest J. also rejected section 48 of the *Hospital Management Regulations*[488] as inappropriate and unhelpful in the matter at hand as they by no means regulated the legality of alternate decision-makers' consent but the governance of hospitals. From that analysis of Prince Edward Island's statutory provision, Mr. Justice La Forest was expressing the view that, absent clear and strong language, guardians' power could not be extended to the authorization of non-therapeutic sterilization, a conclusion we agree with, non-therapeutic sterilization constituting a major interference with bodily integrity.

In the absence of applicable statutory provisions and before concentrating on the specific facts of the case, Mr. Justice La Forest spent some time setting the legal background of the issue at stake: determining whether a Court could and should order non-therapeutic sterilization pursuant its *parens patriae* jurisdiction, the sole remaining legal basis for such an order. He reviewed, at length, the origins, birth, development and reception by Canadian Superior Courts of that peculiar and particular power, focusing especially on its theoretically unlimited scope, which had extended over time to cover cases involving medical procedures[489], and its paramount underlying principle: the best interests of the subject of the application. He also examined the law on non-therapeutic sterilization in the United States, the early adoption of eugenicist theory by way of sterilization statutes and ratified by the courts as constitutional,[490] the criticisms voiced against such acts, and the present use of the *parens patriae* power to allow non-therapeutic sterilization despite the absence of enabling legislation, a trend he disagreed with.[491]

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[487] *Ibid.*

[488] *Hospital Management Regulations*, R.R.P.E.I., c. H-11 adopted pursuant to section 16 of the *Hospital Act*, R.R.P.E.I. 1974, c. H-11.

[489] He indeed stated "I have no doubt that the jurisdiction may be used to authorize the performance of a surgical operation that is necessary for the health of the person" (*Re Eve*, *supra* note 89 at 427). He further wrote that "the *parens patriae* jurisdiction has on several occasions been exercised to authorize the giving of a blood transfusion to save a child's life over its religious objection." (at 418).

[490] See *Buck* v. *Bell*, *supra* note 16.

[491] In 1978, in the case *Stump* v. *Sparkman*, 435 U.S. 349, 98 S. Ct. 1099, 55 L. Ed. 2d 331 (1978), an Indiana Court relied, for the first time, on the equitable jurisdiction bestowed by statute to the court to hold that a judge, who allowed the non-therapeutic sterilization of a child supposedly retarded, could not be liable for having made such an order. The girl had filed suit against the judge upon the discovery that the procedure, presented by her mother as an appendectomy, was in fact a sterilization. A lower court had found the judge liable, as he was thought to have been acting without jurisdiction.

It is only upon such a review that La Forest J. answered in the negative the question of whether the Supreme Court could and should make use of its equitable jurisdiction to order the sterilization of Eve in particular and incompetent individuals in general. He drew a distinction between therapeutic and non-therapeutic sterilization, holding that although legal when "necessary as an adjunct to treatment of a serious malady"[492], the "procedure should never be authorized for non therapeutic purposes under the *parens patriae* jurisdiction"[493]as it can never be said to be in the best interests of the subject of the application.[494] La Forest J. stated the various reasons explaining his reaching of such a conclusion. He restated the fundamental informing principle pertaining to the exercise of the *parens patriae* jurisdiction (the furtherance of the best interests of the incompetent individual), outlined the delicacy of the issue referring to Canada's shameful eugenic past,[495] stressing the danger of letting such theories enter through the back door by way of abuse if a lenient attitude was to be adopted by the court in dealing with the issue. He then referred to the particular features of the surgery contemplated, its seriousness in terms of interference with the right to bodily integrity,

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Since the decision *Stump* v. *Sparkman*, and despite its doubted legal validity, nine other states have followed the same path, their courts recognizing an inherent power to authorize non-therapeutic sterilization of mentally incompetent individuals. It is noteworthy that a consensus has not been reached amongst those states as to the standard to use when considering the merits of a case. Whereas in five states the best interests test combined with guidelines (similar to those enacted by McDonald J., in *Re E.* (1981), 115 D.L.R. (3d) 283 at 307-309) prevails (see e.g. in New Hampshire *In Re Penny N.*, 414 A. 2d 541 (N.H. 1981)), the other four have preferred the substituted judgement standard, first adopted by the new Jersey Supreme Court in *In Re Grady*, 426 A. 2d 467 (N.J. 1981). This latter test leads judges to consider the issue through the hypothetically competent eyes of the patient, taking into consideration the mental handicap. It is interesting to note that the court, in the *In Re Grady* case, analysed the matter in terms of a choice between two rights: the right to control contraception and therefore to voluntarily choose to be sterilized, and the right to bodily integrity, such a choice falling in the hands of the judges, in the absence of competence. This conclusion makes us wonder how one can talk about choice, when such choice cannot be exercised by the patient, who it should be recalled is incompetent to consent to the contemplated sterilization. This approach has not only been criticized, criticisms that we share, by La Forest J. who characterized it as fictional, but also by fellow U.S. courts. Accusing the Court in the *Re Grady* case of not calling a spade a spade, a Wisconsin court in *In Matter of Eberhardy*, (307 N.W. 2d 881 (Wis. 1981)) concluded that

> the question is not choice because it is sophistry to refer to it as such, but rather the question is whether there is a method by which others, acting in behalf of the person's best interests and in the interests, such as they may be, of the state, can exercise the decisions. "..." Any governmentally sanctioned (or ordered) procedure to sterilize a person must be denominated for what it is, the state's intrusion into the determination of whether or not a person who makes a choice shall be able to procreate.

[492] *Re Eve, supra* note 89 at 434.

[493] *Ibid.* at 431.

[494] Reviewing the possible tests that could be used by superior courts in deciding whether or not to allow involuntary non-therapeutic sterilization, La Forest J. rejected both the best interests and the substituted judgment tests, the former for its discretion and the latter for its fictional nature.

[495] "To begin with, the decision involves values in an area where our social history clouds our vision and encourages many to perceive the mentally handicapped as somewhat less than human. This attitude has been aided and abetted by now discredited eugenic theories whose influence was felt in this country as well as the United States." (*Re Eve, supra* note 89 at 427-428).

non-therapeutic nature, almost certain irreversibility and possible negative psychological impacts. He drew on the report prepared by the Law Reform Commission of Canada[496] which described purely contraceptive sterilization as not only elective in its purpose but also almost irremediable in its consequences.[497] He then focused on the particular features of the case at hand, analysing the arguments brought in support of the application as lacking evidential force. In his opinion, the applicants failed to convince him not only of the detrimental consequences that the non-performance of the hysterectomy would have on Eve's health, but also of the beneficial nature of the procedure. The reasons underlying the application should here be recalled. It was first argued that Eve's sterilization would permit her mother to avoid the possibility of having to take care of and raise a child her daughter be impregnated, a task she felt was beyond her strength. However, as we have seen before, when reviewing the *parens patriae* jurisdiction of common law Superior Courts, this power can only be exercised for the sole benefit of the subject of the application, that is to say, in the present case, Eve; Eve's mother's fears and anxiety were alien considerations. Although "it is easy to understand the natural feelings of a parent's heart, "..." the *parens patriae* power of the court cannot be used for her benefit"[498] [the benefit of Eve's mother] and a court "must exercise great caution to avoid being misled by this all too human mixture of emotions and motives"[499]. Eve's mother also brought to the court's attention the psychological trauma that a pregnancy would cause Eve, her potential unfitness as parent as well as the hygienic problems linked to menstruation that Eve would experience. Strongly relying on the Law Reform Commission report[500], La Forest J. dismissed all those arguments as not compelling enough to outweigh the detrimental and violative nature of the hysterectomy.[501]

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[496] LRCC WP N°24, *supra* note 10.

[497] The Law Reform Commission of Canada indeed provided a definition of sterilization in its report. It wrote that

> [s]terilization, as a medical procedure is distinct because, except in rare cases, "...", if the operation is performed, the physical health of the person is not in danger, necessity or emergency not being factors in the decision to undertake the procedure. In addition to its being elective, it is for all intents and purposes irreversible. (at 3).

[498] *Re Eve*, *supra* note 89 at 421

[499] *Ibid.*

[500] LRCC WP N°24 *supra* note 10.

[501] The Supreme Court of Canada stated:

> The justifications advanced are the ones commonly proposed in support of non-therapeutic sterilization "...". Many are demonstrably weak.

All those considerations led him to favour the preservation of Eve's and all mentally incompetent individuals' reproductive capacity over the non-therapeutic interference with their bodily integrity: "The irreversible and serious intrusion on the basic rights of the individual is simply too great to allow a court to act on the basis of possible advantages which, from the standpoint of the individual, are highly debatable."[502]

In fine, Mr. Justice La Forest concluded specifying that compulsory intervention of the courts was required in cases where doubts existed as to the nature of the sterilization requested, the onus of proof lying with the party seeking the order. In such occurrences, independent representation of the subject of the application was to be ensured.[503]

In the absence of any specific sterilization statute the holding of the *Re Eve* case applies not only to superior courts in the exercise of their *parens patriae* jurisdiction over adults as well as children, but also to guardians, or parents. Indeed, stating that purely contraceptive sterilization can never be beneficial when performed on an incompetent individual, Mr. Justice La Forest implicitly extended the scope of its holding beyond the circumstances before him as parents and guardians as the courts in exercising their prerogative power over infants have the responsibility to act in the best interests of the incompetent individual.[504] Furthermore, although providing no definition of what should be comprised under the term "non-therapeutic"[505], by

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The Commission dismisses the argument about the trauma of birth by observing at p.60

> For this argument to be held would require that it could be demonstrated that the stress of delivery was greater in the case of mentally handicapped persons than it is for others. Considering the generally known wide range of post-partum response would likely render this a difficult to prove.

The argument relating to fitness as a parent involves many value-loaded questions. Studies conclude that mentally incompetent parents show as much fondness and concern for their children as other people; "..."

As far as the hygienic problems are concerned, the following view of the Law Reform Commission (at p.34) is obviously sound:

> ...if a person requires a great deal of assistance in managing their own menstruation, they are also likely to require assistance with urinary and fecal control, problems which are much more troublesome in terms of personal hygiene.

Apart from this, the drastic measure of subjecting a person to a hysterectomy for this purpose is clearly excessive.

(*Re Eve*, *supra* note 89 at 430-431)

[502] *Re Eve*, *supra* note 89 at 431.

[503] *Ibid.* at 438

[504] "[W]hat the superior courts ...[can] not do in the exercise of their broad discretionary protective jurisdiction, parents and guardians...[can]not do." Alberta Institute of Law Research and Reform, *supra* note 401 at 12.

[505] He only stated that "the foregoing [his conclusions], of course, leaves out of consideration therapeutic sterilization [a therapeutic sterilization, in his opinion, is one that enhance the patient's health, health being defined as "mental as well as physical health" (*ibid.* at 427).] and where the line is to be drawn between therapeutic and non-therapeutic sterilization. On this issue, I simply repeat that

qualifying the situation existing in the *Re K.*[506] case as "at best dangerously close to the limits of the permissible"[507], La Forest J. seems to have adopted a rather narrow interpretation of what should be understood by "therapeutic", social considerations having no standing in that definition.

However, although banning the performance of such procedures, the Supreme Court of Canada left the door open for legislative intervention.

> judges are generally ill-informed about many of the factors relevant to a wise decision on this difficult area. They generally know little of mental illness, of techniques of contraception and their efficacy. And however well presented a case, it can only partially inform. If sterilization of the mentally incompetent is to be adopted as desirable for social purposes, the legislature is the appropriate body to do so.[508]

c) The post-Eve era

Criticisms and departure from the *Re Eve* holding are not only to be found, as will be examined later, in scholars' comments but also in subsequent court decisions and to some uncertain extent in subsequent provincial legislations.

i. Courts' interpretations

Although bound to respect the Supreme Court's decision, lower courts have tried to moderate its harshness. Several cases have shown the ability of judges to either rely on the protection of the parties' privacy to omit revealing the relevant facts and reasons on which they based their decree authorizing the perpetration of non-therapeutic sterilization,[509] or to interpret extensively what is to be understood by "therapeutic". In the *Re H. (E.M.)*[510] the Saskatchewan Court of Queen's Bench urged judges to construe the Supreme Court's sentence "sterilization as an adjunct to treatment of a serious malady"[511] used by the Supreme Court in the *Re Eve* case as follows: "In my opinion, the words "malady" and "condition" should be given a broad meaning rather than restricting them to a disease or physical ailment"[512].

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utmost caution must be exercised, commensurate with the seriousness of the operation."(*ibid.* at 433). No further guidance was provided.

[506] *Re K.*, *supra* note 451.

[507] *Re Eve*, *supra* note 89 at 434. The adamant disapproval of the Supreme Court of Canada towards the holding of the British Columbia Court of Appeal is rather surprising when one remembers that leave to appeal had been refused just a few months before.

[508] *Re Eve*, *supra* note 89 at 432

[509] In the Saskatchewan *Re R. (S.L.)* (1992), 104 Sask. R. 6 case, Harbinski J., Judge of the Saskatchewan Court of Queen's Bench, alleging the autistic 11-year-old girl's right to be protected in her privacy, closed all files after his ruling to authorize the exercise of an obstetrical operation.

[510] *Re H. (E.M.)* (1995), 130 Sask. R. 281.

[511] *Re Eve*, *supra* note 89 at 431 (cited to S.C.R.)

[512] *Re H. (E.M.)*, *supra* note 510 at 284.

In the *Re H. (E.M.),* the patient, subject of the application, was affected by a sided hemapharesis, seizure disorder and mental disability; her mental abilities were that of a 12 ½-year-old child. She lived in an institution and despite her mental disability was well-integrated and had learnt some living skills. Her parents became anxious when her menses appeared as it caused her such emotional distress that, as a result, she was losing bladder control and was therefore prevented, during those periods, from intermingling with others and participating in the daily activities of the centre. Furthermore, her parents outlined her lack of understanding of the situation, and the emotional distress her monthly loss of blood had and a possible pregnancy would have on her, a situation unlikely to evolve according to the medical professionals in charge of her care. The parents, supported by the institution's medical staff, thus applied to the Saskatchewan court to obtain its approval for a planned endometrical ablation that would almost certainly cause the disruption of fertility, as well as for her sterilization. Gerein J. refused to homologate the decision to ligate her fallopian tubes as sterilization would then constitute the sole purpose of the operation, an operation thus proscribed by the Supreme Court of Canada, but approved of the ablation.

Recognizing the difference between the situation at stake and the facts in the *Re K.*[513]case (Gerein J. noted that "the child will not have the dramatic physical reaction to menstruation as would the child in the *Re K.* case"[514] and also stated that "I am also aware that in the instant case the reaction of the child does not have the same element of physical violence as in the *Re K.* case"[515]), the Court of Queen's Bench however qualified the detrimental consequences of not intervening as extremely serious and "fall[ing] on the "correct side of the permissible"[516]. It seemed that by stressing the importance of the child's emotional and psychological well-being, and taking into consideration the result that non-intervention would have on her social life, the inability of the child to take part in the social activities of the group, the court was ready to consider social factors. The judges of the Saskatchewan Court of Queen's Bench, disliking the solution enacted by the *Re Eve* case, cast some doubts on its supposedly rigidity. From this case, it can be inferred that the Supreme Court of Canada failed to enact a clear rule and in light of its evasiveness in characterizing what was meant by "therapeutic" left the door open for subsequent courts'

[513] *Re K., supra* note 451.
[514] *Re H. (E.M.), supra* note 510 at 284.
[515] *Ibid.*at 285.
[516] *Ibid.*

interpretation. This case makes us wonder at the decision a common law court would arrive at should it be faced with a sterilization request. It leaves out the possibility for a court to characterize a sterilization as therapeutic when its true purpose is non-therapeutic. The answer to that questioning depends on each judge's beliefs and opinions, a situation less than satisfactory in an area where individuals rights are at stake.

ii. Post-Eve legislation

Two provincial legislatures, Ontario and Saskatchewan, have enacted post-Eve provisions that deal with non-therapeutic sterilization. However, although the Ontario *Substitute Decisions Act 1992*[517] codifies the *Eve* decision, the *Adult Guardianship and Co-Decision-making Act*[518] could be read as overriding the holding of the Supreme Court of Canada.

Initially, in Ontario, the Legislature was presented with a bill, Bill 108, *Substitute Decisions Act, 1991*[519], which not only prohibited alternate decision-makers from giving their consent to the performance of non-therapeutic sterilization as held in the *Re Eve* case but also to any "sterilization that is not necessary for the performance of the person's physical health"[520]. This bill was therefore going further than the Supreme Court which had defined therapeutic purposes as encompassing physical and mental health considerations. The proposed section was amended and the statute enacted left untouched the law concerning "sterilization that is not medically necessary for the protection of the person's health"[521]. Ontario has thus codified *Re Eve*.

The Saskatchewan statute, the *Adult and Co-Decision-Making Act*,[522] which scope is limited to adults of 16 years of age and above, is rather unclear. On the one hand it permits the courts to confer on guardians the authority to make health care

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[517] *Substitute Decisions Act, supra* note 334.

[518] *Adult Guardianship and Co-Decision-Making Act, supra* note 335. This statute replaced the *Dependent Adults Act*, S.S. 1989-1990, c. D-25.1.

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

[520] *Ibid.* section 47(7)(a) and 56(5)(a).

[521] *Supra* note 334 section 66(14). Under the terms of that section:

> 66.(14)Nothing in this Act affects the law relating to giving or refusing consent on another person's behalf to one of the following procedures:
>
> 1. Sterilization that is not medically necessary for the protection of the person's health.

[522] *Adult Guardianship and Co-Decision-Making Act, supra* note 335.

decisions[523] with the exception of "a procedure, the sole purpose of which is sterilization"[524], and on the other hand it states under section 25 that

> A decision-maker shall exercise the duties and powers assigned by the court diligently, in good faith, in the best interests of the adult and, in a manner so as to
>
> (a) ensure that the adult's civil and human rights are protected;
> (b) encourage the adult to
> (i)) participate to the maximum extent in all decisions affecting the adult;
> (ii) act independently in all matters in which the adult is able; and
> (c) limit the decision-maker's interference in the life of the adult to the greatest extent possible[525]

We can only but regret the awkward use of the words "sole purpose", which in our opinion are synonymous with "unique", as it has the consequence of allowing decision-makers to decide about the sterilization of an incompetent adult without any further procedural safeguard, as long as another reason, beyond contraception, is invoked. Such motives are legion, most of the times non-therapeutic sterilization being required on grounds such as menstrual management. Furthermore, there is the problem of how to reconcile section 25 of the Saskatchewan act which requires decision-makers to act in the best interest of the adult, one of the stated paramount principles of the act[526], and the Supreme Court holding which clearly stated that non-therapeutic sterilization can never be for the best interest of the incompetent patient, other than by concluding that *Re Eve* was overridden by the Saskatchewan legislature only as far as mentally incompetent adults are concerned.

In our opinion, even though, as will be revealed later, we advocate the initiation of a reform in the area of non-consensual non-therapeutic sterilization, reform which effect would be to recognize that on an individual basis, some limited

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[523] According to section 15 of the Act, *supra* note 335,

> 15. Where the court makes an order pursuant to section 14, the court shall specify which of the following matters are to be subject to the authority of the personal co-decision-maker or guardian:
>
> (h) "..." decisions respecting the adult's health care, including decisions respecting admission to a health care facility or respecting treatment of the adult.

[524] *Ibid.* section 22(4),

> No authority granted pursuant to clause 14(1)(b) or section 19 includes authority to
>
> (c) consent on behalf of the adult to a procedure, the sole purpose of which is sterilization.

[525] *Ibid.* section 25.

[526] It is to be noted that amongst the stated principles according to which the act must be administered and interpreted we find that under section 3 of the *Adult Guardianship and Co-Decision-Making Act*, *supra* note 335,

> (a) adults are entitled to have their best interests given paramount consideration.

circumstances can justify the performance of a non-therapeutic sterilization. We think that not only adequate procedural safeguards must then be enacted, and thus the decision not left in the sole hands of the alternate decision-maker, but also legislation to that effect must be clearly and cautiously drafted so as to leave no room for uncertainty. The Saskatchewan act fails in doing so and as written by Dwight Newman, "does not go very far in terms of eliminating confusion"[527].

The law regarding involuntary non-therapeutic sterilization in common law provinces is not as straightforward as one may think when reading the conclusions reached by the Supreme Court in the *Re Eve* case. Despite the holding that non-therapeutic sterilization can never be in the best interests of an incompetent individual, uncertainty remains and criticisms can be expressed. In Quebec, the permissive approach adopted by the civil code can to some extent be worrisome. In light of those concerns, one might wonder whether a reform in this area should be enacted.

[527] Dwight Newman, "An Examination of Saskatchewan Law on Sterilization of Persons with Mental Disabilities" (1999) Saskatchewan Law Review 329 at 343.

Chapter V: The law on involuntary non-therapeutic sterilization: the need for a reform?

The state of the law as far as non-consensual non-therapeutic sterilization is concerned is less than satisfactory. The law of the province of Quebec, by theoretically allowing guardians to consent to non-therapeutic sterilization, the courts' intervention constituting the unique limit to the width of their powers and the law of common law provinces, by prohibiting, in the absence of unequivocal legislation, the performance of sterilization when non-consensual and non-therapeutic, but failing to clearly explain where the line should be drawn between therapeutic and non-therapeutic sterilization, are subject to criticism.

Although, extremely small and reduced in number, some circumstances, a combination of physical, psychological and social considerations, may warrant the legal recognizance of non-consensual non-therapeutic sterilization. A reform of the current state of Canadian law, desired and proposed by many, seems therefore advisable and will be advocated by the author. The law of foreign jurisdictions as well as provincial and national reports of law reform commissions provide us with a number of propositions and references. In light of the delicacy of the deeply value-laden issue discussed, the possibility of abuses that the absence of safeguards could generate, a reform, which should be undertaken by way of legislation, should be carefully drafted so as to leave as little room for unwarranted interpretation and uncertainty as possible and ensure that eugenics does not find its way back into Canadian law.

It should indeed be remembered that the principle of inviolability of the person is of utmost importance, and increased caution must be exercised when interfering with the bodily integrity of mentally incompetent individuals and/or minors in light of their incapacity to consent, an incompetence which necessitates that decisions concerning their lives be taken by a substitute consent giver, a third party to the medical act, and in light of the abuses of which they have been, in the past and to some extent contemporaneously, the victims. Therefore, in the absence of unequivocal legislation, no one should be authorized to consent to non-therapeutic sterilization on behalf of an incompetent individual, whether minor and/or mentally disabled.

A. Reflections on Canadian current law on involuntary non-therapeutic sterilization

Common law and Quebec provinces are in turn to be scrutinized and reflected upon, the deficiencies or potential dangers of their legislation outlined. Whereas the common law provinces' prohibition is to be criticized for its harshness, Quebec civil code provisions, too permissive, could have dangerous consequences were they to be interpreted and applied carelessly as will be shown by the study of the law of foreign jurisdictions.

1) Common law provinces: Re Eve under scrutiny

Although the *Re Eve* case purported to clarify, once and for all, common law position on non-therapeutic sterilization, its holding engendered a controversy. Following the delivery of the Supreme Court of Canada's conclusions, praise and criticisms were soon to be voiced not only by Canadian scholars but also by the media and the judiciary. Although we share some of the criticisms, we cannot but acknowledge the merits of the Supreme Court's decision.

a) Re Eve praised

For many rights advocates, the decision of the Supreme Court was to be acclaimed as constituting "a turning point in the fight for the recognition of the rights of the mentally handicapped."[528] The mentally incompetent person's right to bodily integrity as far as their capacity to procreate is concerned was assured the utmost protection as involuntary non-therapeutic sterilization was prohibited, and no exception to the so proclaimed rule enjoying any stand. Associations and groups involved in the furtherance of the quality of life and rights recognition of mentally disabled individuals praised the *Re Eve* decision for its reaffirmed condemnation of eugenic theories and saw in the holding of the court the end of the performance of unwarranted sterilization, authorized under doubtful justifications.

Other supporters of the decision welcomed the recognition by the Supreme Court of the gravity of sterilization when non-medically necessary, as well as the existence of negative psychological consequences when performed on a mentally disabled individual. They emphasized the rightness of Mr. Justice la Forest's affirmation that "proposed non-therapeutic treatments such as contraceptive sterilization must be

[528] P. Poirier, "Groups for Mentally Handicapped hail ruling banning compulsory sterilization" *The Globe and Mail* (24 October 1986) A3.

approached by the courts as procedures done **to** dependent persons, and not procedures to be done **for** them. [emphasis added]"[529] considering that it reflected what has happened in practice.

An interesting argument expressed in support of the Supreme Court's decision was raised by Professor Robertson[530]. He believed that the result of the *Re Eve* blanket prohibition was to affirmatively discriminate against individuals with a disability. Noting that denial of access to as well as provision of health care could potentially be discriminatory, he argued that in the former case it could become an "affirmative discrimination"[531] when aimed at the improvement of the conditions of an already disadvantaged class. He stated that eugenic sterilization statutes and the abuses that took place in their name permanently marked involuntary non-therapeutic sterilization; as a result of the association between non-therapeutic sterilization and eugenics, allowing the performance of involuntary non-therapeutic sterilization would heighten society's belief that mentally disabled individuals are less than human, and not worthy of protection. Only by way of a blanket prohibition could such an attitude change and the collective interests of mentally disabled individuals be protected and improved.

> All mentally disabled people have an interest in the demise of procedures, such as involuntary non-therapeutic sterilization, which symbolize the discrimination which they have endured in the past and which they continue to endure. All mentally disabled people stand to benefit from a change in society's attitude towards the handicapped; in my opinion the rejection in Eve of non-therapeutic sterilization represents an important step towards that change of attitude[532]

However, if praise was expressed towards the *Re Eve* holding, it was outweighed by its criticisms.

b) Re Eve criticized

First and foremost, *Re Eve*'s deficiencies were declared to lie within the blanket prohibition established by the Supreme Court preventing the individual assessment of individuals' situation, essence of the *parens patriae* jurisdiction; and within the vagueness of the distinction between therapeutic and non-therapeutic sterilization procedures. Furthermore, the decision to leave provincial legislation to

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[529] *Re Eve*, *supra* note 89 at 410.
[530] G. Roberston, "Mental Disability, and *Re Eve*: Affirmative Discrimination?", in Tarnopolsky, W.S., Whitman, Joyce, & Ouellette, Monique, eds., *Discrimination in the Law and the Administration of Justice* (Montréal: Editions Thémis, 1993) at 448.
[531] *Ibid.* at 450.
[532] *Ibid.* at 456.

deal with the issue if need be, was felt if not criticisable at least unlikely to take place. Finally, commentators deplored the absence of consideration by La Forest J. of certain issues such as competence, *Charter* issues and other intrusive means of contraception.

i. The blanket prohibition: an inflexible stance adopted by the Supreme Court

The major criticism expressed against the *Re Eve* holding is the fact that it enacted a blanket prohibition preventing the formulation of any exception to the rule based on the particular circumstances of a case. The stance taken by the Supreme Court according to which non-therapeutic sterilization can never safely be said to be in the best interests of an incompetent individual was felt too extreme, inflexible and discriminatory. Furthermore the complete ban established by the Court reflected its emphasis on the class to which Eve belonged rather than on the particular situation of Eve.[533] Adopting a right-based analysis in which sterilization and its justifications were examined generally in an abstract fashion, the Supreme Court was said to have denied a whole class access to a procedure characterized as "the leading means of birth control chosen by Canadian women aged eighteen to forty-nine."[534] And to have, as a result, "done a disservice to mentally incompetent persons and their care-giver."[535]

> By discussing the issue as an abstract problem of justice and rights, Mr. Justice La Forest failed to apply the criterion in an individualized manner. Instead of a jurisdiction existing for the benefit of the particular individual, it became a jurisdiction which emphasized disembodied concerns about liberty interests.[536]

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[533] M.A. Bolton, *supra* note 484, also observed that

> 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 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.
>
> (M.A. Bolton, "Whatever Happened to Eve? A Comment" (1988) 17 Manitoba Law Journal 219 at 226.)

[534] M.A. Shone, *supra* note 290 at 635, citing K. Krotki, Canadian Fertility Study, 1984.
The reference made to statistics must be moderated. Indeed, whereas contraceptive sterilization is a widespread means of contraception, it is mainly chosen by women in their late thirties who have already given birth to several offspring. When requested on behalf of mentally handicapped individuals, the subjects of the applications are generally in their early twenties, have not had any children, and sometimes have not even started menstruating (see e.g. *K.* subject of the application in *Re K.*, *supra* note 86). In order for the comparison to be meaningful the same characteristics of age; situation (...) must be shared by the two groups being compared. See for more details on this particular point B.M. Dickens, "Reproduction Law and Medical Consent" (1985) 35 University of Toronto Law Journal 255 at 265-266.

[535] *Ibid.* at 646.

[536] Patricia Peppin, "Justice and Care: Mental Disability and Sterilization Decisions" (1989-1990) 6 Canadian Human Rights Year Book 65 at 67.

Examples of La Forest J.'s abstract analysis of the issue at stake can be found in its consideration of the purposes for which sterilization was sought. Instead of focusing on whether Eve, and Eve solely, would be psychologically wounded by childbirth, unable to cope with parenthood or hygienic problems, he examined those questions by referring to mentally disabled individuals in general.

Finally, the attitude of the Supreme Court of Canada was considered to be in complete contradiction with the fundamentals principles pertaining to the exercise of the *parens patriae* jurisdiction of the court, a prerogative based on the assessment of the sole best interests of the individual subject of the application, and to lead to the curtailment of a jurisdiction proclaimed to be limitless.[537]

ii. The distinction between therapeutic and non-therapeutic sterilization: a disturbing lack of clarity

The second criticism expressed concerned Mr. La Forest's distinction between therapeutic and non-therapeutic sterilization, the cornerstone of the Supreme Court's judgement. This distinction was characterized as unclear and artificial, and guidance provided by the Mr. Justice La Forest as extremely vague. As noted by M.A. Shone, the Court gave only "limited guidance on the placement of the line"[538]. Indeed, whereas therapeutic sterilization was defined as necessary for physical and/or mental health, non-therapeutic sterilization simply was described as a procedure whose purpose is purely social, but what exactly was to be considered as such was left unrevealed.

The distinction drawn by the Supreme Court was also characterized as being "in contradiction with the definition of health provided by the World Health Organization which states that health must be understood as "a state of complete physical, mental and **social well-being**"[539] and not merely an absence of disease or infirmity[emphasis

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She also noted that

> The Court has lost sight of the individual "Eve" in its concern about the social problem. This judgement fails to conform to the normative basis of the *parens patriae* jurisdiction. Its individualized focus is lost and its beneficial thrust is overridden. In this part of the judgement, Eve has become an abstraction, a representative of a class. The individual subject of the application has virtually disappeared. (*ibid.* at 66.)

And concluded by writing that "[i]n short, even the Court's right analysis was truncated and unimaginative." (*ibid.* at 64).

[537] M. Anne Bolton indeed stated that "[t]o argue that there is a distinction between limiting a jurisdiction *per se*, and limiting its exercise, is mere sophistry."(M.A Bolton, *supra* note 472 at 222).

[538] M.A. Shone, *supra* note 300 at 638.

[539] Preamble to the World Health Organization (WHO) Constitution adopted by the International Health Conference held in New York in 1946 and ratified by Canada on August 29 of the same year. WHO., "The First Few years of the World Health Organization" (1958) at 459.

added]."[540] By overlooking social considerations in assessing an individual's best interests, the Supreme Court was said to have fragmented the person,[541] the influence of his/her environment and social well-being on the state of his health (mental as much as physical) totally ignored. Commentators criticizing the Supreme Court in such a fashion were of the opinion that sterilization, even though non-therapeutic, could be beneficial, permitting mentally disabled individuals to lead a life less supervised, to express their sexuality without the collateral risk of impregnating or being impregnated. Foreign courts also commented on the distinction adopted by the Supreme Court of Canada. In the United Kingdom, the Supreme Court of Canada's focus on the distinction between therapeutic and non-therapeutic purposes in debating the possibility for an alternate decision-maker or the court to lawfully authorize non-voluntary sterilization was believed to be irrelevant by the British House of Lords. In the *Re B. (A Minor) (Wardhsip: Sterilization)*[542] case, decided shortly after *Re Eve*, the House of Lords favoured the use of a best interests test stating that

> I find, with great respect, their conclusion [the conclusion of the Supreme Court of Canada in the *Re Eve* case] that the procedure of sterilization should *never* be authorised for non-therapeutic purposes **totally unconvincing and in startling contradiction** to the welfare principle which should be the first and paramount consideration in wardship cases. Moreover, "..." I find the distinction they purport to draw between "therapeutic" and "non-therapeutic" purposes of this operation in relation to the facts of the present case above as totally meaningless, and, if meaningful, quite irrelevant to the correct application of the welfare principle. [emphasis added][543]

iii. Legislative intervention: the undesirability and un-likeliness

Some authors also disapproved of the Supreme Court's conclusion that if the performance of non-consensual non-therapeutic sterilization was to be authorized, the legislature constituted the only appropriate body to do so. Mr. Justice La Forest was accused of "passing the buck."[544] His attitude was seen as paradoxical. Indeed, after reviewing at length the eugenic statutes enacted by past legislatures, in foreign as well as Canadian jurisdictions, and warning of the dangers of allowing the performance of non-therapeutic sterilization for mentally handicapped persons, a slippery slope that could ultimately lead to covert eugenics, he nevertheless concluded that members of

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[540] M.A. Shone, *supra* note 300 at 638.
[541] *Ibid.* at 639.
[542] *Re B.(A Minor) (Wardship:Sterilization)*, [1987] 2 W.L.R. 1213; [1988] 1 A.C. 199 (House of Lords) [hereinafter *Re B.*]. This case as well as English law on the question of non-consensual non-therapeutic sterilization will be examined in greater detail below.
[543] *Ibid.* cited to W.L.R. at 1216, per Lord Hailsham.
[544] M.A. Bolton, *supra* note 484 at 224.

the legislature were in a better position than the judiciary to adequately assess whether social purposes should have any bearing in non-consensual sterilization decisions.

> The Learned Justice, who expressed concerns about courts hearing applications at the "behest of a third party", suggests that the Legislature considers "the feelings of the public in this area". Who is the public here? It is obviously not persons who could be affected by this legislation, since persons lacking the capacity to consent to surgical procedures for themselves would hardly be drafting letters to their MLAs."[545]

Furthermore, it was contended that the argued lack of information of judges about mental illnesses, contraception or procreation should not prevent them from deciding the issue before them.

> The observation that a case can only "partially inform" is obviously not limited to non-therapeutic cases. It is true of any case that comes before the court. And yet the courts daily make decisions that affect individual citizens collectively or that are commercially important. "..."The lack of complete information is not offered as a reason for shrinking jurisdiction.[546]

Finally commentators outlined the fact that even if legislation was the appropriate channel to be used to legalize involuntary non-therapeutic sterilization, by rejecting both the "best interests" and "substitute judgement" tests, by failing to discuss Charter issues, and by emphasizing the sensitivity of the issue, the Supreme Court "created a climate that would make it very difficult for any government to proceed in this area"[547]

iv. *Re Eve*, the absence of consideration of major issues

Some issues, of great importance, were either discarded by the Supreme Court of Canada as irrelevant, their implications failing to be recognized, or left untouched: such is the case with the issue of competence, charter matters and the consideration of other intrusive means of contraception.

- Competence

It was argued that by failing to discuss Eve's competence and assuming it had been clearly established and declared, the Supreme Court "overlooked the significance of the fundamental right to be presumed competent."[548] As already outlined, one of the underlying principles of the *parens patriae* jurisdiction, when exercised for the benefit of an incompetent adult, is that it can only be exercised once the person has

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[545] M.A. Bolton, *ibid.* at 224.
[546] M.A. Shone, *supra* note 300 at 642.
[547] G. Sharpe, " "Eve" v. Mrs. "E", and the Canadian Mental Health Association, the Canadian Association for the Mentally Retarded, the Public Trustee of Manitoba, and the Attorney General of Canada (intervenors)" (1987) 7 Health Law in Canada 90 at 91.
[548] P. Peppin, *supra* note 536 at 81.

been legally, by due process of law upon sufficient evidence, found mentally incompetent, factual incompetence being insufficient. This rule stems from the common law principle that adults are to be presumed competent unless proven otherwise.[549] In the *Re Eve* case, no finding of incompetence had ever been made. The trial judge, although convinced of Eve's incompetence, failed to mention it in his order. On appeal, McDonald J. doubted the adequacy of the trial judge's assessment of Eve's incompetence, based on the absence of representation and his analysis of the Mental Health provisions. However, despite the central importance of this criticism, he was unable to dwell on this point, limited as he was to the examination of the sole grounds of appeal as drafted by counsel. Mr. Justice La Forest acknowledged the trial judge's oversight but stated that "these questions of possible statutory power only amounted to a preliminary skirmish."[550] Patricia Peppin criticized the fact that, even though Eve's competence was not in doubt, the Supreme Court did not question the legality of exercising their *parens patriae* power in the absence of a formal finding of incompetence. "The failure to recognize the implications of the lack of a mental incompetency finding is a serious flaw in the case."[551]

- Charter issues

Many commentators outline the brief and non-conclusive attention paid by the Supreme Court of Canada to the *Canadian Charter*'s[552] issues.

> In a decision which uses rights language and deals with important questions about values, we might have expected the Court to look to the *Charter of Rights and Freedoms* or guidance. Although section 7 and 15 arguments were made by counsel for "Eve", the analysis in the judgement of the relationship between the *Charter* and the *parens patriae* jurisdiction is brief and unenlightening.[553]

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[549] This principle is codified under section 16(2) of the *Criminal Code* (*supra* note 53) which states that
> Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities.

It has also been codified in several provinces. See e.g. *Adult Guardianship and Co-Decision-Making Act*, *supra* note 335 section 3(b).

[550] *Re Eve*, *supra* note 89 at 406. La Forest J. firstly admitted McDonald J.'s concerns stating that "In summary, MacDonald J. appears to have been right in doubting that the trial judge had properly addressed the threshold question".

[551] P. Peppin, *supra* note 536 at 93. P. Peppin was also of the opinion that in the territory of Prince Edward Island, legislation had embraced the whole extent of the ancient *parens patriae* power and that no residual power remained in the hands of the court.

[552] *Canadian Charter of Rights and Freedoms*, *supra* note at 111.

[553] P. Peppin, *supra* note 536 at 99.

Both section 7 and 15 of the *Charter* were dismissed, and as a result, many questions left untouched and unresolved: whether the enactment of the *Charter* had any effect on the scope of the inherent equitable power of the Superior courts; whether its exercise would be affected or its scope reduced, its protective basis modified to include a right-based analysis; whether section 7 guaranteed a right to procreative choice, or whether section 15(1) was violated when individuals were denied access to a procedure based on their disability.[554]

- Other contraceptive means

Other comments concerned the fact that although emphasizing the importance of the privilege of giving birth, the Supreme Court did not discuss other methods of contraception, which, even though reversible, are clearly intrusive and entail serious risks if used in the long run. Were contraceptive means such as Depro-provera to be prescribed to mentally incompetent individuals even in situations where the reason for their use was of a purely social character? And if so, who was allowed to consent? What about abortion or *in-vitro* fertilization?

c) Re Eve praiseworthiness

Although we advocate a reform in the area of non-therapeutic sterilization, agreeing with some of the criticisms expressed, we cannot but recognize the merits of the Supreme Court holding in the *Re Eve* case.

This case should be acclaimed in that it underscores the gravity of sterilization, stresses the situations where, in light of its pure social undertone, non-therapeutic sterilization should never be performed, outlines the delicacy and sensitivity of the issues involved in performing non-therapeutic sterilization on individuals lacking the necessary capacity to do so, and condemns once and for all eugenics.

i. Sterilization: a grave medical act

One of the commendable effects of the *Re Eve* case is to affirm the right to physical inviolability to which mentally incompetent individuals are entitled, and to ensure that any interference with their bodily integrity be scrutinized, considered with utmost caution. Proponents of the legality of non-therapeutic sterilization discard too readily the intrusive and often irreversible nature of sterilization, as well as the possible

[554] As already mentioned, *supra* note 440, the Supreme Court might have been worried to touch upon and open up non-argued *Charter* issues in the transitional period. As for section 7 of the *Canadian Charter*, it might a negative content right.

negative psychological consequences that can arise following its performance.[555] It should be remembered that its result is to deprive disabled women of an essential element of their womanhood. Furthermore, sterilization, especially when performed by way of hysterectomy (which remains the exception), is performed surgically, with all the risks attendant upon any other surgical acts.

Affirming that involuntary non-therapeutic sterilization should be approached as a procedure done to dependant individuals is also to be acclaimed. It is not to be forgotten that the cases in which the courts are involved deal with individuals declared mentally incompetent or considered as such in light of their minority. They cannot voice a valid consent. Therefore if involuntary non-therapeutic sterilization is to be allowed on an individual basis it should be viewed as amounting to interfering with an individual's bodily integrity when it is thought to be in the best interests of this person as defined by society and the state.

ii. Sterilization: a medical act that should not be performed under certain circumstances

As outlined by La Forest J, sterilization should never be performed when sought to benefit the sole best interests of a third party to the act, nor can it be chosen for its technical availability or financial attractiveness. Over the years, Canadian courts have been presented with requests emanating from parents or carers experiencing difficulties in the raising, caring and supervision of mentally disabled individuals, and for whom the slightest evidence of sexual awareness was felt as a threat to a stability hardly acquired. Fearing the additional responsibility of having to take care of another child should their protégé become parent, they were seeing in sterilization the answer to many of their problems. This means of contraception was privileged in light of its reduced costs and the absence of supervision following its performance. Oral contraceptives, for instance, not only have adverse effects, such as weight gain or the lowering of seizure threshold when the individual is also affected by epilepsy, but its administration also needs to be constantly monitored, and oral contraceptives have to be taken over a long period of time. Although, as did Mr. Justice La Forest, we understand the problems experienced by parents and carers, we cannot but oppose the performance of sterilization for their benefit or convenience.

[555] See LRCC WP N°24, *supra* note 10 at 50 where the Law Commission states that "In a study by Sabagh and Edgerton, it was found that sterilized mentally retarded persons tend to perceive sterilization as a symbol of reduced or degraded status. Their attempts to pass for normal were hindered by negative self perceptions and resulted in withdrawal and isolation rather than striving to conform."

This is not to conclude that a parent's or carer's situation should always be discarded as irrelevant. Mentally disabled individuals' interests also comprise their relationship with the social environment. "While it is important to acknowledge the potential for conflict of interest between care-giver and dependant adult, it is also important for courts making determinations of their best interests to consider individuals within their own social context."[556]

La Forest J. also opposed sterilization when performed for the sole reason of relieving the incompetent individual of the trauma associated with childbirth or childbearing, or for fear of the person not being able to cope with parenting. If those reasons might, sometimes, lead to the conclusion that a mentally incompetent woman needs to be guarded against the occurrence of pregnancy, this is not to conclude that they constitute, in themselves, medical justifications for the girl to be sterilized. Sterilization should remain a last resort option and not be chosen in light of its advantages over other means of contraception. When not medically necessary, the main purpose sterilization serves is to prevent the occurrence of pregnancy, it thus cannot be used as a means to deny women with disabilities their right to a 'normal' sexual life, or to disregard the existence of sexual exploitation.

iii. therapeutic/non-therapeutic distinction

Rightly outlined by the detractors of the *Re Eve* decision, the distinction established by the Supreme Court is rather vague. It can seem strange to see that such an important element, at the heart of the decision, was not given more careful consideration. How can a holding be followed by lower courts if one of its essential elements is overcast by uncertainty? This is even more appalling a flaw in a decision where concerns were expressed about the best interests and the substituted judgement tests. Indeed, although envisioning situations where non-therapeutic sterilization could be beneficial, he refused to solely rely on those standards, both considered unsatisfactory either in light of their uncertainty[557] or their fictional nature.

It is to be recognized that in many instances, it is difficult to classify sterilization as either therapeutic or non-therapeutic. As noted by Edward W. Keyserlingk "the line between therapeutic and non-therapeutic is not hard and fast, and probably never can

[556] P. Peppin, *supra* note 536 at 80.

[557] "the best interest test is simply not a sufficiently precise or workable tool to be used in situations like the present" (*Re Eve, supra* note 89 at 432).

be."[558] Whereas a sterilization performed to cure a person of a diseased uterus clearly is therapeutic as is non-therapeutic a sterilization sought for purely hygienic purposes, management of menstruation can not be given such a straightforward answer, as various problems (menstrual pain, phobic aversion of blood) are encompassed under this term. Many have advocated the creation of a specific category of sterilization when intended for menstrual management[559], or that it be considered therapeutic. Labelling sterilization for menstruation management as therapeutic is dangerous as more often than not the problems encompassed under this term are not the result of a medical condition, and only cause distress to mentally disabled women, distress which does not always endanger mental health. Cases have shown that in many situations, such sterilization is sought to relieve carers or the family of the embarrassing behaviour of the incompetent woman. The behaviour referred to can range from the smearing of blood to the eating of sanitary towels. Education and behavioural therapy might constitute a more appropriate answer to those hygienic problems. As outlined by Susan and Robert Hayes "no reasonable medical practitioner would undertake an operation for colostomy because the patient smears faeces- why is the smearing of menstrual blood so much more abhorrent and untreatable by education, conditioning and behaviour modifying techniques."[560] A further element might explain our reluctance to classify sterilization for menstrual management as therapeutic, the fact that it is performed by way of hysterectomy, as in order for a woman to be relieved of her menses, her uterus must be removed. The intrusive nature of this surgical operation combined with our previous comments lead us to favour the consideration of sterilization for menstrual management as *a priori* non-therapeutic.

Although we do not advocate the distinction established by La Forest J. for the purpose that it serves we however believe that distinguishing therapeutic from non-therapeutic sterilization is neither meaningless nor irrelevant when approaching the

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[558] E. W. Keyserlingk, "The Eve Decision-A Common Law Perspective" (1987) 18 Revue Générale de Droit 657 at 670.

[559] See, e.g., in England, the Law Commission which in its report on mental incapacity purported to distinguish between sterilization whose purpose is to cure a disease of the reproduction organs, sterilization intended for menstrual management and, contraceptive sterilization. According to the Commission, only the latter category should require the intervention of the court. Provided an independent medical practitioner issues a document certifying that the patient has menstruation management problems, that is to say suffers a phobic aversion to blood, or, shows an inability to cope with the hygienic aspects of menstruation, no further authorization should be necessary for a sterilization procedure to take place. See, U.K., Law Commission, *supra* note 391 at para. 6.8..

[560] Susan Hayes, Robert Hayes, *Mental Retardation: Law, Policy and Administration* (Sydney: Law Book, 1982) at 180.

issue of involuntary non-therapeutic sterilization and could be used as an indicia of the need for higher scrutiny. Indeed, the distinction is based on the principle that some procedures, therapeutic medical acts, are *a priori* considered legitimate and admissible by society, and can be performed or authorized on the sole basis of the alternate decision-maker's authority, whereas others, in light of their lack of medical necessity (non-therapeutic procedures do not constitute medical acts in the pure sense of the terms, nor can the persons concerned be defined as patients) should be approached with more caution. "The value of the distinction between therapeutic and non-therapeutic interventions is that ordinarily, *ex hypothesi*, the court will regard therapeutic intervention as legitimate. By contrast the court will need to be persuaded that an intervention which has no therapeutic purpose is legitimate."[561]

The distinction is therefore to be retained as a means to determine in which situations an alternate decision-maker cannot authorize involuntary sterilization without the intervention of an appropriate body. A narrow definition of therapeutic sterilization should be prevalent: it should only refer to sterilization aimed at curing or preventing a recognized medical condition.

iv. Eugenics

Finally, another merit of the *Re Eve* decision lies in its emphasis on Canada's eugenic past as something which not only must be acknowledged but should also not be forgotten when considering the issue of involuntary non-therapeutic sterilization. Eugenic purposes must clearly be made illegal should provincial legislators reform the law on involuntary non-therapeutic sterilization.

2) Quebec: the latent uncertainty

As outlined previously, in Quebec an alternate-decision maker or the person enjoying parental authority can authorize, with the homologation of the court, the performance of non-therapeutic sterilization provided its risks are outweighed by its benefits. In applying the test set forth under the terms of article 12 C.C.Q., Quebec courts, influenced by the holding of the Supreme Court of Canada in *Re Eve*, seem to be extremely cautious in determining the merits of an application for a non-therapeutic sterilization order, making sure that only the interests of the mentally incompetent patient will be served by the medical procedure. Quebec's judiciary thus appears to approach involuntary non-therapeutic sterilization in a similar way as La Forest J. in

[561] I. Kennedy, A. Grubb, *Medical Law*, 2nd ed. (London: Butterworths, 1994) at 316-317.

Re Eve. However, the provisions of the civil code contain the seed for wider interpretation, and abuse. Article 12 C.C.Q. states that when determining whether a non-therapeutic treatment should be consented to, the best interests of the incompetent must be clearly demonstrated; in assessing such interests the benefits of the medical act contemplated must be weighed against its risks, and the wishes of the incompetent individual, as far as possible, given consideration. Such a test which could be defined as a subjective best interests test could permit due to its malleability the imposition of the decision-maker's values, which may vary from one another.[562] Relying on the law of another jurisdiction, even though of common law tradition, namely England, we will demonstrate that there is room for uncertainty, and that the safeguards are not sufficient to prevent Quebec courts from extending the circumstances that may warrant non-therapeutic sterilization.

a) England: "judges rule not OK"[563]

Many of the authors who opposed the conclusions of the Learned Justice La Forest in the *Re Eve* case, referred to its English counterpart, the *Re B.*[564] case in which the House of Lords rejected the vague therapeutic/non-therapeutic distinction to embrace a best interests test and allow the non-therapeutic sterilization of a teenage girl. This case was characterized by some Canadian commentators as demonstrating "an understanding that best interests can include a person's emotional, social, economic and psychological needs, the fulfillment of which is crucial to promoting quality of life."[565] We strongly object to this praise[566] and will show that the decision

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[562] It should be noted that under the realm of the Civil Code of Lower Canada, the curator could authorize involuntary non-therapeutic sterilization without further formalities. There existed no *a priori* control of the courts, or the family council, and the possibility to apply to the courts after the performance of the sterilization in order to obtain damages was insufficient a safeguard. As written by Robert P. Kouri (Robert P. Kouri, "L'Arrêt *Eve* et le Droit Québécois", *supra* note 411 at 651)

> un système où la décision de stériliser pourrait être prise par le curateur seul, comporterait d'énormes dangers car il n'y aurait aucun contrôle préalable efficace de la décision du curateur. Un recours *a posteriori* en indemnisation s'avèrerait un remède peu satisfaisant car il est toujours plus souhaitable de protéger les droits d'une personne contre toute atteinte que de compenser cet individu après la violation de ses droits.

[563] Reference is here made to an article written by Josephine Shaw and entitled "Sterilisation of Mentally Handicapped People: Judges Rule OK?" (Josephine Shaw, "Sterilisation of the Mentally Handicapped People: Judges Rule OK?" (1990) 53 Modern Law Review 91).

[564] *Re B.*, *supra* note 542.

[565] M.A. Boulton, *supra* note 484 at 225.

[566] As noted by Gerald Robertson, "[i]t is ironic that, while Canadian academic writing has been critical of the *Eve* decision, and supportive of the House of Lords' decision in *Re B.*, in England the reverse has generally been true."(G. Robertson, "Sterilization, Mental Disability, and re Eve: Affirmative Discrimination?", *supra* note 509 at 453). In England, the *Re B.* case was not only criticized but also led calls for statutory reform and regulation of substituted decision-making in this area and generally. In 1995, the Law Commission issued recommendations embodying the creation of adult guardianship and

as well as the ones that followed are highly criticisable in light of the vagueness of the principles on which they are based, and the wide discretion with which they warrant medical practitioners.

The facts of the case are as follows: Jeanette, a 17-year-old girl, a voluntary patient in a local authority residential unit since 1973, was moderately disabled, the suggested cause being an abnormality of the brain. She was described as experiencing difficulties in understanding speech and expressing herself, unable to care for herself, prone to mood swings and violence (for which she was medicated), as well as highly tolerant to pain. Due to her inability to care for herself beyond the simplest tasks such as bathing, dressing, finding her way in limited localities, she was closely supervised. Showing signs of sexual awakening, and having approached members of the opposite sex, her mother together with the persons responsible for her care became worried that she might become pregnant. Sterilization seeming to be the only adequate means of contraception (oral contraceptives were rejected as she was overweight and prone to suffer many side-effects should they be administered), legal proceedings were started by the council in order for Jeanette to be made a ward of the court, and leave be given for the sterilization. The House of Lords, in an expedient way, granted leave and dismissed the Solicitor's appeal. Concluding that Jeanette did not enjoy a right to procreate, as she did not possess the mental capacities to make choices with regards to contraception.[567] The House of Lords in only 28 days[568] held that the sterilization sought was lawful as it was beneficial in light of Jeanette's incompetence, inability to cope with parenthood,[569] the trauma that childbirth would cause her[570], the physical

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court-appointed managers empowered to manage their personal welfare and make decisions with respect to health-care; see U.K., Law Commission, *supra* note 391.

[567] In a similar argumentation as the one used in by the British Columbia Court of Appeal in the *Re K.* case, *supra* note 451, the Law Lords held that "But the right to reproduce is of value if accompanied by the ability to make a choice and in the instant case there is no question of the minor to make such a choice or indeed to appreciate the need to make one." (*Re B.*, *supra* note 542, Lord Oliver at 207). The Law Lords' conclusion that Jeanette would never further develop, nor be able one day to exercise her procreative choice seems to be unfounded as her mental capacities had improved since her birth. From a 'wild' child unable to undertake the simplest tasks, she became a teenager able to perform certain tasks and live in a training centre. As rightly pointed out by MMr. Morgan and Freeman "[t]o arrest Jeanette's metamorphosis at the age of 17 and to treat her as though she will never become 27, 37, or 40 abandons 25 years of potential reproductive capacity, affinitive development, and emotional maturing to expert evidence which is necessarily speculative in nature and highly opinionated." (R., Lee, D., Morgan, "Sterilizing the mentally handicapped: sapping the strength of the state?" (1988) 15 Journal of Law and Society 229 at 241).

[568] The expediency with which the Law Lords solved this case can be explained by the fact that Jeanette was soon to turn 18, the date as from which the welfare jurisdiction could not be used for her benefit.

[569] "If she gives birth to a child it would be essential that it be taken from her for fostering or adoption although her attitude towards children is such that this would not cause her distress." *Re B.*, *supra* note 542, Lord Oliver at 207.

and psychological risks that a pregnancy would create, and her lack of maternal feelings.

Closely scrutinizing the argumentation and conclusions reached by the House of Lords, its holding seems questionable and mainly based on speculative assertions. The evidence relied upon is rather inconsistent. Whereas on the one hand, the Law Lords outlined the girl's inability to cope with contraception, or to understand the link between intercourse and pregnancy, on the other hand however they stressed her ability to manage menstruation, and to understand the relationship between pregnancy and the giving of birth. If Jeanette's carers medicated her for epilepsy, administering oral contraceptives was felt to be beyond the same carers' capacities.[571] Furthermore, the evidence relied upon fails to explain Lord Oliver's conclusion that there existed an "obvious risk of pregnancy"[572]. Nothing in the evidence provided establishes the fact that she was either sexually active or even fertile and thus likely to become pregnant. The only activities of a sexual nature that Jeanette seems to have had indulged in were provocative gesturing and masturbation, and if any danger there was, it resided in Jeanette being the prey of sexual abuses, which sterilization could not constitute an answer to.

The principles on which the best interests test was based left undisclosed, the conclusion drawn by the Law Lords from the evidence provided seems to have been reached hastily, and to have led to Jeanette being discriminated against on the basis of her mental impairment.

The *Re B.* decision was followed two years later by the case *In Re F.*, *F.* v. *West Berkshire Health Authority*[573] where the non-therapeutic sterilization of a 36-year-old woman, severely disabled, and involved in a relationship with a man, was held to be in her best interests. As in *Re B.*, the judges failed to define what was encompassed under the term 'best interests' and demonstrated "a tendency to deviate opinions and

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[570] "The process of delivery would be likely to be traumatic and would cause her to panic." (*ibid.*).

[571] "It would not be possible in light of her swings of mood and considerable physical strength to ensure the administration of the necessary daily dose." (*Re B.*, *supra* note 542 , *per* Lord Hailsham at 212.) Reviewing the statement written by Lord Oliver, we can read that Jeanette's medication included Danazol, a drug which has many side-effects such as weight gain and fluid retention especially when the patient also suffers from epilepsy. Weight gain and side effects combined with the difficulty of medicating Jeanette were the factors on which the conclusion that oral contraceptives were an unworkable option was based. It is rather difficult to reconcile the facts with the finding of the Law Lords.

[572] *Ibid.* "Note that in the judgement of Lord Oliver, he moves from reference to "provocative gestures" to the "risk of pregnancy" without pausing to consider that there is no inevitable progression from one to the other." (Stauch, M., Wheat, K., & Tingle John, *supra* note 391 at 206).

[573] *Re F.*, *supra* note 391.

assertions of the medical profession to the status of 'fact' and to use these as a basis for decision. As in *Re B.* there is some space for an 'alternative fact analysis'."[574] If the Supreme Court of Canada with the *Re Eve* has been accused of doing a disservice to mentally disabled individuals by over protecting them, The House of Lords, not protective enough of the rights of mentally incompetent individuals to bodily integrity, seems to have done a rather worse disservice to mentally disabled individuals. If the Supreme court of Canada lost sight of the individual *Eve* to focus on the class of individuals to which she belongs, the House of Lords, concentrating on the sole best medical interests of Jeanette, lost sight of the wider issues involved with non-therapeutic sterilization, and overlooked the implications that their decision would have.

b) A comparison with Quebec law

The *Re B.*[575] and the *Re F.*[576] cases demonstrate that inappropriate analysis can be made by the courts when a best interests test, whose guiding principles remain to some extent undisclosed, is relied upon. The law on involuntary non-therapeutic sterilization in England is informative in that a best interests test, although to some extent different from the one in existence in Quebec,[577] is used to determine whether or not to allow the procedure. Although it shows the deficiencies of leaving the judiciary the task of determining what is meant by best interests in sterilization decisions, more particularly in borderline cases, the possibility of best interests arguments "degenerat[ing] into social convenience"[578] and the danger that vagueness could engender, English law is not to be equated with the law in Quebec. This is not only so because Quebec is a civil law and not a common law jurisdiction, but also because its legal system is far more protective of mentally incompetent adults than English law. In England, since the disappearance of the protective equitable jurisdiction for adults, no one is empowered to make health care decisions on behalf

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[574] Josephine Shaw, *supra* note 563 at 92.
[575] *Re B.*, *supra* note 542.
[576] *Re F.*, *supra* note 391.
[577] It is to be reminded that English law is more paternalistic than Quebec law in that medical practitioners are given more discretion in providing medical treatments. Judges are more reluctant to intervene in the medical area, as they believe that rendering physicians more accountable for their acts would likely result in defensive practices. See Sheila MacLean, "Negligence- a Dagger in the Doctor's Back", in P. Robson and P. Watchman, eds., *Justice, Lord Denning and the Constitution* (Farnborough: Gower, 1981). Therefore the comparison between English and Quebec law is relevant to the extent to which it demonstrates the deficiencies of using a standard not stringent enough.
[578] Josephine Shaw, *supra* note 563 at 98.

of adults, there is no equivalent to the wardship jurisdiction for minors; moreover, in involuntary non-therapeutic cases, if the intervention of the courts is strongly advised, it is not compulsory. Furthermore, their decisions are limited to a declaration of lawfulness of the procedure. In Quebec, however, not only has guardianship of adults been enacted, but the court's intervention is also required in the case of involuntary non-therapeutic sterilization according to article 18 C.C.Q..

The law in both common law and civil law provinces is deficient in some way or another which lead us to question the opportunity of a reform in the area of involuntary non-therapeutic sterilization.

B. The need for a reform: "[d]iscussion on this matter is not closed nor should it be"[579]

Even though the Supreme Court forbade the performance of non-consensual sterilization, the issue has not and will not disappear. Not only are parents and carers still seeking to limit mentally incompetent individuals' ability to procreate[580], a situation that can become delicate should all other methods of contraception prove to be unsuccessful[581] but subsequent cases have also shown that the debate is not closed,

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[579] Dwight Newman, "An Examination of Saskatchewan Law on the Sterilization of Persons with Mental Disabilities" (1999) 62 Saskatchewan Law Review 329.

[580] Can we then be certain that involuntary non-therapeutic sterilization is not "undertaken in the shadow of the law."(Josephine Shaw, *supra* note 563 at 93.). Recently, in the province of British Columbia, a mother consented to the castration of her son, who had become disabled as a result of brain damage suffered after a heart failure that occurred when he was only six weeks old. Unable to learn to read or write, the child had also developed an aggressive behaviour which increased as he became older; while the mother retained the power to make decisions in the medical area, the Office of the public trustee was conferred the management of the boy's financial and legal rights. The castration, performed by an urologist was designed not only to curb the aggressiveness of the young boy but also to ensure that he would never father a child who he would be unable to care for. The performance of the castration revealed, the medical practitioner was reprimanded and fined by the B.C. College of Physicians and Surgeons, and the issue brought before the British Columbia Supreme Court. See, Jane Armstrong, "Woman embroiled in legal battle for having disabled son castrated" *The Globe and Mail* (28 May 2002) A1 & A7. This recent occurrence confirms the standpoint according to which despite the Supreme Court's decision in *Re Eve*, parents of mentally disabled children are still concerned about the fact that their offspring might become parents, and are seeking means to prevent such an occurrence. Although the primary purpose of the castration, different from a sterilization in the pure sense of the term, was to remedy aggressiveness, the other purpose consisted in preventing the child from having to face the 'burden' of parenthood, which his mother felt to be unmanageable by her son.

[581] It is noteworthy that since the *Re Eve* decision, sterilization demands have decreased; although it can not be clearly quantified. Nevertheless, as pointed out by the Law Reform Commission of Manitoba, statistical data cannot be used as an argument to support a *status quo* as "[t]here can be a small demand for a just law; the size of the demand would not justify a failure to recommend law reform." (Manitoba Law Reform Commission, *supra* note 566 at 24.)

courts being ready to interpret the therapeutic/non-therapeutic distinction loosely. In Quebec, discussion on the matter should not be closed as the provisions of the civil code might prove too permissive were they to be handled by a careless judiciary.

The state of the current Canadian law on involuntary non-therapeutic sterilization being unsatisfactory, the question of a reform is then posed, reform which should underscore sterilization as a "special form of treatment requiring extraordinary safeguards."[582] A few remarks are to be made prior to the consideration of the nature and form of a reform.

Although Canadian eugenics must not be forgotten, disallowing non-consensual non-therapeutic sterilization cannot be based on the fear of letting eugenics re-enter Canadian Law, as religion cannot be made illegal in light of the increasing number of extremist groups. What Canada's eugenic past must teach us is the exercise of great caution when determining the principles that should guide a reform, and to make sure that adequate safeguards are enacted to enable the protection of mentally individuals' interests.

Disallowing involuntary non-therapeutic sterilization cannot be made on a collective basis, or upon the reliance of abstract principles. An individual approach must be undertaken, otherwise it could be thought to be inconsistent with the *Charter.*

Finally, should a reform as advocated by us not take place, a situation which would be unfortunate, the deficiencies of the current law still need to be addressed and a unique stance be adopted by all Canadian provinces.

A reform however recommended, we must consider the way by which it should be enacted, whether the right to reproduce should be emphasized, as well as whether the *Criminal Code* should be amended in order to include a provision on sterilization.

1) Reform: the legislative path recommended

Advocating the enactment of a reform, the means by which it should be implemented is to be decided upon. Favour is given to legislation in light of the human rights implications, the complexity of the issue as well as the failure by the courts to provide a comprehensive and satisfactory answer to the problem.

a) Most of the debate surrounding the legality of involuntary non therapeutic sterilization and whether a legal mechanism should exist to permit the giving of a substitute consent for non-therapeutic medical acts have been human-rights oriented.

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[582] Kirsty Keywood, "Sterilising the Woman with Learning Difficulties" in Jo Bridgeman, ed., *Law and Body Politics_Regulating the Female Body* (Dartmouth: Aldershot, 1995) at 142.

While advocates of the legality rely on the right of equality of access (the argument is therefore one of benefit) protected under section 15(1) of the *Canadian Charter*, arguing that the right of the individual must prevail over those of the community to which he/she belongs as "doing justice to the individual cannot result in injustice on the collective scale"[583], opponents of the existence of substituted-consent frames consider the issue to be: whether the state should be allowed to interfere with a person's bodily integrity for contraceptive sterilization purposes; reliance is thus on both section 7 of the *Canadian Charter*[584] which protects individual's right to security of their person and on section 1 which only save legislative provisions that accord with the principles of fundamental justice. Protecting the group in order to protect each of its members, this side considers that "doing justice to the collectivity cannot result in injustice on an individual scale"[585]. As a result, depending on the stance adopted, whether on the one hand denying mentally disabled individuals the benefit of a widespread means of contraception could constitute a breach of equality rights, it could also on the other hand positively discriminate the individual and enhance the group's equality rights. As noted by one author

> 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 abridgement of human rights, regardless of the good that may issue from it.[586]

Any legislation that will be enacted with regards to sterilization will have to comply with the provisions of the *Canadian Charter*. Once again, the constitutionality of a sterilization statute, whether or not a violation of section 15(1)[587] will ensue, will ultimately depend on the ideological and philosophical stance adopted . Not a 'legal' problem in the strict sense of the term, but rather an ideological one, the reform that we advocate will be best handled by legislators, elected representatives of Canadian citizens.

> Such a fundamental question of ideology that carries profound human rights implications is "..." best handled directly by, and addressed in the first

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[583] Manitoba Law Reform Committee, *supra* note 566 at 20.
[584] *Canadian Charter*, *supra* note 111.
[585] *Ibid.* at 20.
[586] R. Macklin and W. Gaylin (eds.), *Mental Retardation and Sterilization: A Problem of Competency and Paternalism* (New York: Plenum Press, 1981) 117-118
[587] It is to be reminded that differences in treatment of two different groups can, depending on the underlying purpose, amount to a beneficial or detrimental discrimination, enhance or impair the group's equality. See *Andrews* v. *Law Society of British Columbia*, (1989) 56 D.L.R. (4th) 1 (S.C.C.).

> instance by, the government and the Legislature composed, as they are, of elected members representative of the entire population.[588]

The delimitation of the circumstances where non-therapeutic sterilization could be consented to must therefore be decided by the provincial legislators.

b) A reform by way of legislation is necessary to ensure that not only non-therapeutic sterilization be available when for the benefit of the disabled individual, but also that the necessary safeguards are enacted, to prevent abuses and discrimination. Determining whether involuntary non-therapeutic sterilization is acceptable and should be allowed to take place cannot be summed up as a simple choice between the right to bodily integrity and the right for the state, in certain limited circumstances, to interfere with that integrity; sterilization is only one element of a web of issues such as mental health care and its funding, the law on consent, the rationale behind the various protected regimes enacted, the protection of mentally disabled individuals in their rights, lives, their status in the community. We believe that Parliaments are in a better position to address, in a non-partisan way, and to gather the scientific, and statistical information necessary to provide an adequate answer to those issues than courts of law, limited to the examination of the facts of the various cases, and more than often unable to find an adequate answer which will properly assess all the underlying forces, conflicts surrounding a particular decision.

> Parliament, of course, are notoriously unwilling to legislate in the field of medical law, for there are few votes to be gained and many to be lost amid the ethical minefields of medicine and psychiatry. Moreover there is always the danger that legislative measures, if they are forthcoming, may be more the result of pressure group politics than the considered analysis of the issues involved. That is in the nature of parliamentary democracy. It is preferable surely to judicial autocracy."..." Most importantly, it is less likely to be blinded by the imperatives of rule-making in the context of hard cases and provides an opportunity to take a long hard look at the wider context of the sterilisation debate[589]

The legislative path has not only received support from Canadian scholars[590] but has also been characterized by Canadian Law Reform commissions and foreign jurisdictions as appropriate.

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[588] Manitoba Law Reform Commission, *supra* note 566 at 24.

[589] Josephine Shaw, *supra* note 563 at 97.

[590] As written by W. F. Keyserlingk legislation is "the road we should have taken long ago, even before *Eve*, both to protect mentally disabled from having sterilization *imposed* on them, and to provide them *access* to contraceptive sterilization when it is sought for their benefit." (W.F. Keyserlingk, *supra* note 558 at 672).

i. As early as 1979, before the *Re Eve* holding, the Law Reform Commission of Canada published a working paper on sterilization.[591] Referred to by courts, scholars, and law reform institutes as a reliable and invaluable source of information, the report purported to determine whether a reform of the law on involuntary non-therapeutic was needed. Concluding that "objective, determinable standards"[592] be developed by legislators in the area, it recommended the implementation of two processes to determine competence on the one hand and make non-therapeutic sterilization orders on the other hand.[593] A governmentally appointed special tribunal responsible for the making of such orders would "evaluate the medical, social and psychological benefits"[594] of the person in order to determine whether there is "any compelling interest to justify the operation."[595]

In the province of Alberta, the Institute of Law and Reform issued a report in 1988[596] which promoted the passing of legislation which would allow involuntary non-therapeutic sterilization[597] to be performed in extremely circumscribed circumstances. The need for a reform was explained by the unfairness and discriminatory nature of the Supreme Court's prohibition in the *Re Eve* case[598], and by reference to the 'normalization' principle which required sterilization for contraceptive purposes to be accessible to mentally impaired individuals. Legislation was favoured as it would "assist in better balancing the competing values relating to preservation of or interference with the capacity to reproduce"[599]. Its scope extending to elective sterilization and hysterectomy for menstrual management, the proposed statute empowered the Court of Queen's Bench to make decisions related to both the mental competence of the subject of the application and upon the finding of incompetence the desirability of performing a sterilization. Guiding principles for the decision-making

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[591] LRCC WP N°24, *supra* note 10.
[592] *Ibid.* at 107.
[593] The only procedures left out of the scope of the reform would be therapeutic sterilization understood as "any procedure carried out for the purpose of ameliorating, remedying, or reducing the effect of disease, illness, disability, or disorder of the genito-urinary system."(*Ibid.* at 106).
[594] *Ibid.* at 112.
[595] *Ibid.* at 112.
[596] Alberta Institute of Law and Reform, *supra* note 413.
[597] Non-therapeutic sterilization is understood as "any procedure that is not medically necessary for the protection of the physical health of the person." (*Ibid.* at 109).
[598] The Institute compared the shortcomings of the holding of the Supreme Court of Canada in the *Re Eve* case to the supposed merits of the conclusions reached by the House of Lords in the *Re B.* case (*supra* note 542). Indeed, unlike the author, the Institute of Law and Reform considered *Re B.* to demonstrate "the possibility that a sterilization may be 'in the best interests' of a mentally incompetent person notwithstanding that it lies outside the therapeutic limit imposed by the Supreme Court of Canada." (*ibid.* at 83).
[599] *Ibid.* at 2.

process were stated and procedural protections such as the legal representation of the incompetent individual provided for.

ii. As in Canada, foreign jurisdictions have proposed and/or enacted legislative reforms in order to adequately provide for the delicate issue of involuntary non-therapeutic sterilization. Due to spatial limits, we will only mention two jurisdictions, Germany whose legal system has specifically addressed the issue since the beginning of the 1990's,[600] and France where the National Ethics Committee issued a report,[601] in 1996, urging the legislators to legalize non-therapeutic sterilization of mentally disabled individuals in certain limited circumstances.[602]

c) Furthermore, with regards to Canadian law, the legislative mechanism should be opted for as not only in common law provinces have other pathways been closed by the Supreme Court of Canada and attempts to moderate the harshness of the *Re Eve* decision by the courts have proven unsatisfactory, but also because we have shown, through the study of the law of other jurisdictions, that letting the judiciary handle the matter through the use of a best interests test could engender more uncertainty.

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[600] In September 12th 1990, the *Betreuungsgesetz* was enacted, it came into force on January 1st 1992. This act of Parliament operated a reform of the law on guardianship instituting a single protective regime, *Betreeuung* (this term could be translated in English as "assistance" or "guardianship", but we prefer using the German name as it is primarily a German legal concept.), for mentally disabled and elderly adults incapable of managing their own affairs, and containing provisions specifically dealing with non-therapeutic sterilization. This legislative scheme was drafted in order to address and answer the criticisms directed towards prior guardianship statutes. Previous provisions were accused of being discriminatory, the language used was considered inadequate, many outlined the fact that mentally disabled individuals were treated as objects, the concentration being on the loss of capacity, the management of the estate, whereas their wishes or desires were not taken into account, and provisions dealing with personal matters were if not nonexistent, at least less than satisfactory. With regards to sterilization, the provisions whose scope extends to both incompetent adult women and men are meant to curtail the practice of involuntary non-therapeutic sterilization to situations of danger to the physical or mental health of the incompetent. Consent to the procedure necessitates the intervention of a special assistant and the court, and procedural safeguards are provided for. If sterilization is permitted, a delay of two weeks must be respected before the procedure can be carried out. A thorough study of the act can be found in *Das Betreuungsgesetz, eine Information des Bunderministers des Justiz* and in *Die Sorge für die Person und das Vermögen Volljähriger nach deutschem Recht* cited in Thierry Verheyde, "La Nouvelle Loi Allemande en Matière de Tutelle des Majeurs: un Modèle pour une Eventuelle Réforme du Droit Français?" J.C.P. N. 1993.I.2461.

[601] France, Comité Consultatif National d'Ethique, *supra* note 49.

[602] In France , in the absence of any provisions in the law dealing with sterilization, reliance is made on article 16-3 C.civ. which prohibits the performance of any medical act which is not cumulatively consented to and therapeutic. However, in light of the illegal practice of sterilization, the recognizance of women's sexuality and their need for contraception, the National Ethics Committee urged legislators to address the issue and create a legal frame within which involuntary non-therapeutic sterilization could be performed in limited circumstances, according to specific rules. The Committee also recommended that "des services compétents d'assistance pour parents handicappés mentaux ayant des enfants à charge" "soient corrélativement développés." (*ibid.* at 17).

2) A reform: the right-based approach analyzed

As noted beforehand, more than often, the question of rights constitutes the starting point in the debate surrounding involuntary non-therapeutic sterilization. Human rights and more particularly procreative rights are relied upon by both proponents and opponents of the legality of such a procedure. However, we do not believe that the issue should be solved with reference to the right to reproduce not only because no consensus has been reached as to the exact scope of this right but also because it has never been officially granted *Charter* protection in Canada.

a) As with any other rights, the right to procreate or reproduce, encompassed by the wider right to privacy, can be understood both as a positive right[603], i.e., the right to have access to assisted reproduction, and a negative right[604], i.e., the right not to be deprived of one's reproductive capacities. In the debate which is the object of our discussion, the argument according to which the right to reproduce is violated when incompetent individuals are sterilized for non-therapeutic reasons is countered by claims that denying those persons the benefit of the procedure infringes their converse right to be sterilized.[605] A conflict of rights therefore arises, the clash which results in an impasse.

Furthermore, there is no real consensus as to what is encompassed by the right to reproduce or where its theoretical foundation lies. The right to reproduce could be limited to the right to bear a child or extended to a wider right to social parenting[606] (as opposed to biological parenting), its enjoyment dependent upon capacity or humanity. Douglas Gillian argues that the central element in parenting is not the genetic or gestational part, but lies in the desire to fulfill a parental role. In his opinion, limiting the right to procreate to the bearing of a child would exclude men from its ambit. This analysis leads to the consequence that infertile couples or homosexuals would enjoy a positive right to have children that is to say a right to

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[603] Positive rights are defined by Laura Shanner (Laura Shanner, "The Right to Reproduce: When Right Claims have Gone Wrong" (1995) 40 McGill Law Journal 823 at 840) as "Rights of assistance, resources, or (in certain conditions) entitlement."

[604] Negative rights are characterized as "rights of forbearance entailing an obligation upon others to leave the claimant alone." (*ibid.* at 839).

[605] This line of argument was used in the *Re Grady* case (*Re Grady*, (1981) 85 N.J. 235, 426 A. 2d 467) where the New Jersey Supreme Court concluded that if non-therapeutic sterilization in theory violates the right to reproduce, a right held not to depend on the capacity to choose to exercise it, there existed a corresponding right not to reproduce, to be sterilized.

[606] Douglas Gillian, *Law, Fertility and Reproduction* (London: Sweet &Maxwell, 1991).

assisted conception (in vitro fertilization and new reproductive technologies).[607] Other scholars, adopting an interests' approach to rights, have deemed insufficient the intention to assume the responsibilities of parenthood insisting on the need to insert a further condition of capacity to assume responsibilities, excluding *de facto* mentally incompetent individuals from the enjoyment of any right to reproduce.[608] Both the Canadian case *Re K*[609] and the English *Re B.* case[610] adopted this approach of the right to reproduce claiming that disabled women, unable to choose whether or not to exercise this right, or to take responsibilities for the consequences of its exercise (that is to say fulfilling their parental role), should be denied its enjoyment . Advocating this doctrine, D. Feldman argues that "asserting rights against individuals involves "..." reciprocal responsibilities towards state and society"[611]; he further notes that

> If people want such a right, they must be willing and able to take responsibility for bringing up their offspring. If they are not, the right to reproduce is no more than a right to impose unquantified burdens on other members of society, present and future, for the sake of personal gratification."[612]

The last approach is a natural rights approach according to which all individuals, in light of their humanity, enjoy a right to reproduce, a view that we favour.[613]

Finally, it should be remembered that deciding upon the legality of involuntary non-therapeutic sterilization cannot be seen as a simple choice between two competing rights; wider moral political and social issues are involved with sterilization.[614]

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[607] This qualified reproductive right was examined by Laura Shanner, *supra* note 603. She argues that establishing such a right would be dangerous as seekers going unscreened, the future of children conceived through assisted reproduction could be in jeopardy. She believes that the issue of assisted reproduction should not be solve in terms of rights are their handling is problematic, and inappropriate.

[608] For a criticism of this interests approach to rights see *supra* note 474 where it is argued that such a doctrine would lead the 'normal' 'dominant' individuals of the society to make decisions for all other members.

[609] *Re K., supra* note 451.

[610] *Re B., supra* note 542.

[611] D. Feldman, "Rights, Capacity and Social Responsibility" (1987) 16 Anglo-American Law Review 97 at 102.

[612] *Ibid.* at 113.

[613] See *supra* note 474 where we support a natural rights approach. See, R.G.Lee, D. Morgan, "Sterilization and Mental Handicap: Sapping the Strength of the State?", *supra* note 567, who advocate a natural rights approach to the issue of reproduction.

[614] If the problem was resolved by the making of a choice between the right to have access to sterilization and the right not to be sterilized, the clarity believed to have been achieved could be a sham. For instance, if the right to reproduce was to be established, disabled individuals could still be discriminated against, their physical and sexual freedom unrecognized, their children taken away from them. Alternatively, recognizing the right to be sterilized would not ensure that eugenic sterilization does not take place, or that individuals are not sterilized in a discriminatory fashion.

b) In the *Re Eve* case, the applicants argued that section 7 of the *Canadian Charter*[615] guaranteed all individuals the right to procreate. Although the wording of that section does not refer to such a right, it could be read and interpreted as encompassing such a right. In the case *R.* v. *Mortengaler*[616] Parker J. referring to the U.S. case *Griswold* v. *Connecticut*[617], which confirmed the existence of a right to procreate under the wider right to privacy[618], outlined that

> [Section 7 may be seen] as providing broad protections for the individual against government interference, protection which permit substantive review of a wide variety of laws that purport to infringe or breach the privacy of the individual. Under this model, the word "liberty" would include reproductive liberty.[619]

Under such an analysis of section 7 of the *Canadian Charter*, section 15 of the *Canadian Charter* prohibiting discrimination based on disability (or incompetence) could provide the necessary support to the claim for access to non-medically necessary sterilization. Indeed, offered to capable individuals as a contraceptive option, it could not be denied to citizens in light of their mental impairment. However, the right to procreate has never been officially granted constitutional protection, Canadian jurisdictions being reticent to establish the existence of such a right, favouring the concept of bodily integrity.[620] La Forest J. in the *Re Eve* case only referred to the "great privilege of giving birth"[621], and although no conclusion was reached as to the existence of a right to procreate it was nevertheless stated that it could not be encompassed by the terms of section 7.[622] "[I]n Canada, the Supreme Court has refrained from explicitly identifying the existence of such a right. Rather, the Court has identified a right to "physical integrity" as it affects the "privilege of

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[615] *Canadian Charter*, *supra* note 111.

[616] *R.* v. *Mortengaler* (1984) 47 O.R. (2d) 353, 12 D.L.R. (4th) 502 (H.C.J.) [hereinafter *Mortengaler* cited to O.R.] appeal quashed on procedural grounds (1984) 48 O.R. (2d) 319, 14 D.L.R. 184 (C.A.).

[617] *Griswold* v. *Connecticut*, 381 U.S. 479, 85 S. Ct. 1678 (1965). In the United States, the existence of a right to procreate was first established by the Supreme Court in the case *Skinner* v. *Oklahoma*, 316 U.S. 535 (1942) where it was held that "Marriage and procreation are fundamental to the very existence and survival of the race." (at 541).

[618] It should be noted that in that case, the right to privacy in relation to sexuality and reproduction was only meant to be enjoyed within marital ties. Following this case, a discussion ensued as to whether such a limitation should survive.

[619] *Mortengaler, supra* note 616 at 394-395.

[620] See e.g. article 10 C.C.Q., *supra* note 121.

[621] *Re Eve*, *supra* note 89 at 428.

[622] Furthermore, in 1985, the Ontario Law Reform Commission concluded that it could not decide whether the *Canadian Charter* could be broadly interpreted as conferring individuals a right to procreate.(Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters* (Toronto: Ministry of Attorney General, 1985).

giving life."[623] Furthermore, recognizing the existence of a right to procreate is opposed by many such as Laura Shanner who claims that analysing procreation in terms of rights mainly focuses on the parent overshadowing the interests of others, such as the future children, medical practitioner or society.[624]

3) A reform: the amendment of the Criminal Code

One question remains, should the *Criminal Code* contain a provision specifically dealing with involuntary non-therapeutic sterilization, or should the matter be solely handled by provincial legislators? The author argues that should the *Criminal Code* be amended to support a sterilization clause it should be limited to rendering criminally reprehensible the performance of non-therapeutic sterilization for eugenic purposes, that is to say sterilization aimed at the improvement of the human gene pool.

Recommending the passing of similar provincial legislations reforming the law on non-therapeutic sterilization, their nature and form, and guiding principles remain to be stated.

C. A reform: guiding principles

Due to spatial limits, we will conclude our discussion by broadly exposing the framework and some of the guiding principles we believe a legislation in the area discussed should state, respect and protect.

Enabling legislation should deal with two issues: that of competence and the determination of the mechanisms and criteria according to which the appropriate body should authorize or refuse the performance of involuntary non-therapeutic sterilization. Following the proposal of the Law Reform Commission we would recommend that the former matter be decided by the courts, while the latter would be resolved by a special tribunal presided over by a learned judge,[625] a multidisciplinary body composed of experts and laypersons (physicians, psychiatrists, social workers).

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[623] Bernadette McCherry & Margaret A. Somerville, "Sexual Activity Among Institutionalized Persons in Need of Special Care" (1998) 16 Windsor Year Book Access Justice 90 at 105.

[624] Laura Shanner, *supra* note 603. She writes: "Above all, I think it a profound mistake to affirm a right to procreate. "..." Both a specific affirmation of a right to reproduce and a casual derivation of procreative rights from other reproductive rights would have the same effect, which is likely to lead to dangerous outcomes for many children conceived both with or without assistance." (at 872).

[625] Some authors have rejected the idea of a special tribunal arguing that it might "authorize a certain number of these procedures in order to justify its own continued existence." Manitoba Law Reform Commission, *supra* note 566 at 30. We however like the idea of a multidisciplinary body as we believe this constitutes a further guarantee that the best interests of the individual will be assessed satisfactorily. However, a special tribunal presents the advantage of being impartial, flexible procedurally speaking and better able to assess the benefits of an individual in light of the varied background of its members.

This body should be as far as possible neutral and independent from families, staff members and guardians, although their concerns and arguments should be heard.

If competence is to be decided upon by the courts as is traditionally the case, the test for competence must however be modified, not only in the specific area of sterilization but also on a more general basis. First and foremost, the presumption of competence should by all means and in all circumstances be respected and a mental incompetence declaration be made before guardians may intervene to consent to therapeutic or non-therapeutic sterilization. The all-or-nothing approach of certain common law incompetency legislations must be abandoned as it not only fails to acknowledge the different degrees of incompetence, and the fact that it can vary in time and from one area to another area of the person's life, but also because it is in violation of the *Canadian Charter* and more particularly its section 1.[626] Indeed, such an approach to competence fails to satisfy the proportionality test as set out in *R.* v. *Oakes*[627]. Secondly, the test for competence must not be based on the degree of handicap or on the criteria of mental age as it is uninformative of the capacities of the person.[628] Many times, medical practitioners assign a mental age to their disabled patients to permit people to better grasp the extent of the disability referred to. If that mental age, a way to describe an individuals in terms of his/her pathology, can be informative, it can in no way be conclusive. A 17-year-old disabled individual ascribed a mental age of five cannot be considered in the same way as a child of that age as emotionally and socially he/she has developed skills a 5-year-old child does not possess. Thirdly and finally, sterilization should only be considered as an option if the person is permanently incompetent. The individual must not only be incapable of understanding reproduction or contraception but that inability must be in all likeliness permanent. In relation to children, sterilization should only be carried out on an

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[626] *The Canadian Charter of Rights and Freedoms*, *supra* note 111, guarantees certain rights and freedoms subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[627] *R.* v. *Oakes*, *supra* note 345. In this case, the challenged section 8 of the *Narcotic Control Act* (R.S.C. 1970, c. N-1-1) was held to be in violation of section 11(d) of the *Canadian Charter* protecting the presumption of innocence, as it required the accused individuals to disprove the fact that they intended to do trafficking with the narcotics they were found in possession of. The Supreme Court further established that, in order for a statutory provision violating the *Canadian Charter* to be saved under its section 1, a proportionality test had to be discharged: the measure challenged had to be fair and not-arbitrary, proportionate to the goal to be attained and constitute the least restrictive measure possible.

[628] "Intelligence testing "..." in so far as it leads to labels such as 'mental age of five' "..." misdiscribes the mentally handicapped person in a discriminatory fashion." R.G.Lee and D. Morgan, *supra* note 567 at 235.

exceptional basis, principally when their psychological or physical health is threatened.

Once a declaration of incompetence has been made, and independent representation provided to the incompetent individual, the special tribunal must intervene to determine whether a sterilization is to be consented to.[629] Its intervention would be limited to non-therapeutic procedures. As mentioned above, the term therapeutic should limitedly refer to the treatment of some present or inevitable disease such as the removal of a diseased ovary or uterus.

It is necessary to determine the test to be used by the body empowered to determine whether a non-therapeutic sterilization, as defined earlier, should be performed. In doing so, three tests need our consideration, the substituted-judgement or "in the shoes" test, the best interests standards and the medical practitioner's standing.

According to this latter test, the performance of an act of a medical nature is acceptable and in the best interests of a person whenever there exists a 'body of opinion', a faction of physicians, that would support the decision made by the medical practitioner, best interests are therefore understood as best 'medical' interests. This paternalistic standard, traditionally used in the area of consent to determine under what circumstances a medical practitioner would be guilty of negligence has been repudiated in Canada in the beginning of the 1980's with the rise of a more patient-centred approach to medical law.[630]

This test should be rejected as it is not stringent enough to safeguard the interests at stake and leads to "abstentionism, leaving the standard of care to be set exclusively by a single faction within the medical profession"[631] . As expressed by Margaret Brazier, a best medical interests tests would only protect mentally incompetent individuals from the "complete maverick whom not one of his colleagues would back in his decision to sterilize."[632] Furthermore it would seem odd to leave in the sole hands of medical practitioners the decision to authorize an act, which, in light of its non-therapeutic nature, is not considered *per se* a medical act.[633] The interests of the

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[629] Provisions concerning the designation of the members of the tribunal, the possibility of appeal, the question of costs would also have to be provided for.

[630] Such a test is still used in English law. Its principles were set down in the case *Bolam* v. *Frien Hospital Management Committee*, [1957] 1 W.L.R. 582.

[631] Marc Stauch, Kay Wheat, & John Tingle, *supra* note 412 at 192.

[632] Margaret Brazier, "Down the Slippery Slope", (1990) 6 Professional Negligence 25 at 27.

[633] Josephine Shaw further rightly noted that "[i]t cannot be correct entirely to equate the standard of care to which a doctor must adhere if he or she is not to run the risk of paying compensation for damage caused and the standard which governs the application of a strictly limited exception to the consent

medical profession are alien to the issue of non-therapeutic sterilization, concentration must be on the interests of the subject of the application.

The substituted judgement test is used in many states in the United States[634] and consists of determining what decision the individual would have made "if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.[635] Advocates of this test underscore the consideration of subjective criteria and the positioning of the decision-maker in the shoes of the individual as permitting a better assessment of the person's situation. Although interesting in its subjectivity, this test however constitutes a legal fiction and should only be used in situations where the individual subject of the application was once competent. It would result in mere speculation, and endow the judiciary with too much discretion when used for the benefit of a person who never enjoyed the capacity to consent.

The last test is the best interests test. Previously referred to, this test directs the decision-maker to weigh and take into consideration several elements in order to determine the most beneficial course of action to be taken. However, in light of its objectivity and discretional nature,[636] we believe that a combined best interests/substituted judgement test should be adopted. It would combine "the objectivity of a reasonable person with the subjectivity of the circumstances of the particular individual for whom the decision is being made."[637] In light of the danger its use can engender, it can only be adopted if its principles are clearly outlined, permitting scrutiny over its use.

Guidelines must undoubtedly be part of the legislative reform to ensure that the benefit and dignity of the incompetent individual remain paramount.

- The special tribunal must meet

and inform the subject of the application of the nature of the procedure, its risks and consequences outlined as well as that of not carrying out sterilization, and must take into consideration the individual's wishes, beliefs, background, age and environment:

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principle encapsulating a fundamental right to self-determination." Josephine Shaw, *supra* note 563 at 104.

[634] It was defined in *Superintendent of Belchertown State School* v. *Saibewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977).

[635] *Ibid*, 373 Mass. 728, at 752-753.

[636] See our comment *supra* at 129-133.

[637] Alberta Institute of Law and Reform, *supra* note 413 at 113.

it is indeed necessary to "seek answers from those who are most affected"[638] and to afford "as much decision-making authority as is consistent with the individual's functional abilities."[639] Efforts should therefore be made to offer mentally disabled individuals socio-education and training programmes, to encourage them to express their wishes and adopt an assertive behaviour, exercise active control over their lives. In order to do so, society must acknowledge and accept the reality of mentally disabled individuals' sexuality. Contrary to mythical beliefs, beliefs which have entered the courtrooms,[640] their sexual desires are not uncontrollable[641] and do not pose a sexual threat to the rest of the community nor are they inherently vulnerable. Giving disabled individuals the possibility of being informed about and expressing their sexuality would change the focus. This might however prove to be difficult in the institutional setting.[642]

Furthermore, the issue of contraception should not remain a female issue. In all the cases studied in the course of our discussion whereas Canadian, English or Australian, the subjects of the applications were women. This is explained by the fact that men cannot become pregnant and purely contraceptive sterilization can hardly be found in their best interests.

As outlined by Christopher Heginbotham

> whilst it is a truism that it is women who become pregnant, nonetheless much of the recent debate has been sexist. The simple assumption has been made that it is the woman's problem and there is nothing men can do either to ease the problem, or to see it as affecting both sexes.[643]

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[638] Janice J. Tait, "Reproductive Technology and the Right of Disabled Persons" (1986) 1 C.J.W.L. 446 at 455.

[639] P. Peppin, *supra* note 536 at 108.

[640] Indeed, in many cases women are considered promiscuous and signs of sexual awareness presumed to always lead to sexual intercourse and pregnancies.

[641] The slightest sign of sexual desire or gesture is often interpreted as a problem, as if disabled individuals were unable to control their desire. As noted by Michael and Ann Craft (Michael and Ann Craft, *Sex and the Mentally Handicapped* (London: Routledge, 1978)) at 41 "Some Parents are afraid that their mentally handicapped offspring will not be able to control their sexual impulses...Consequently any obvious manifestation of interest is seen in terms of "a problem", something to be stopped."

[642] For a discussion on sexual activity in institutions see Bernadette McSherry, Margaret Somerville, *supra* note 623. The authors analyse, through three different perspectives, the conflict existing between institutionalized individuals who express and request a recognizance of their right to sexual privacy and the staff members and families who oppose such a claim fearing harmful consequences. They also expose the ethical and legal undertone of the debate and scrutinize the attempts made by various institutions to remedy this issue.

[643] Christopher Heginbotham, "Sterilising People with Mental Handicap" in S. McLean, ed., *Legal Issues in Human Reproduction* (Aldershot:Gower, 1989) at 134.

Efforts should be made to render mentally disabled men as aware, as conscious and as responsible as women of the consequences that sexual relationships can engender and of the necessity to resort to contraception to avoid pregnancies as well as sexually transmitted diseases.

Finally, the decision to approve the sterilization of an individual cannot be based on an unfounded presumption of inadequacy for parenthood,[644] but must be backed up by clear and convincing evidence. Many arguments supporting the non-therapeutic sterilization of disabled individuals have been based on their assumed unfitness for parenthood. Such an argument is dangerous as it is difficult to assess fitness and competent individuals might as well be terrible parents, but society would not sterilize them on that ground. It is to be remembered that "a parent's intelligence is not necessarily correlated to child-rearing ability, and that retarded parents can provide adequate child care."[645] Disabled individuals may express the desire to have children and may provide love and affection and intellectual stimulation to their offspring. In accordance with the 'least restrictive alternative' principle rehabilitative services should be afforded to disabled parents before their children be taken away from them.

- The psychological, social and physical effects of authorizing or not authorizing the sterilization should be assessed together with the risks involved with one decision or the other. Moreover, once a decision has been reached, its reasons should be clearly stated to permit scrutiny and possibly an appeal.

- Sterilization should remain a last resort option: there should be no other alternative or less intrusive means with regards to the most up to date medical knowledge in accordance with the least restrictive alternative principle. This should be so in light of the intrusive and sometimes irreversible nature of sterilization. Even if sterilization was to become, in all instances, reversible, its performance for non-therapeutic reasons should remain exceptional as "resources for non-urgent gynaecological surgery are scarce."[646] The alternative methods that should receive examination are not only other contraceptive means but also sexual training and education, the focus being on the pathology as much as the environment. It should only be performed in limited cases when proof has

[644] Nor should it be solely be based on the sole ground that child birth would likely be traumatic.
[645] Randy A. Hertz, "Retarded Parents in Neglect Proceedings: The Erroneous Assumption of Parental Inadequacy" (1979) 31 Stanford Law Review 785 at 797.
[646] A. Adamson, *supra* note 15 at 18.

been made of the individual's fertility and involvement in activities of a sexual nature of the individual . In the past, courts have relied too hastily on doctors' and parents' evidence or drawn conclusion from vague descriptions. If sterilization is decided upon the method least likely to be irreversible must be chosen.

- Sterilization should never be

performed for the benefit of others, for convenience, eugenics reasons, or budgetary constraints: Sterilization cannot be dependent upon the quality of care, and supervision that the individual receive. As outlined by Mr. Freeman[647] discussing the *Re B.*[648] case

> the danger with decisions like that in Jeanette is that it is so much easier to avert the supposed danger by sterilisation than to put time, effort, and commitment into education, training counselling and assistance of the mentally handicapped. Their sexual needs and sexual rights are easily steamrolled in the name of convenience[649]

Thus, efforts, time and money should be spent to ensure that disabled individuals are better cared for and educated. Their freedom cannot be conditional upon the avoidance of conception.

In fine, we would like to underscore the necessity, in combination with the reform proposed by us, to improve the quality of life of mentally impaired individuals and their families: for instance by psychologically supporting families, by providing them information about alternative contraceptive means, by allocating more resources to the care of mentally disabled individuals whether or not institutionalized, by ensuring that sexual exploitation is fought against,[650] by educating the general population about the legal rules in existence, the right and needs of people with disabilities.

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[647] M.D. Freeman, "Sterilising the Mentally Handicapped" in M.D. Freeman, ed., *Medicine, Ethics and the Law* (London: Stevens,1988) at 55.

[648] *Re B.*, *supra* note 542.

[649] M.D. Freeman, *supra* note 646 at 67

[650] Sterilization cannot be used as a mean to overlook the abusive relationships that sometimes are perpetrated against mentally impaired individuals and to permit those crimes to go unpunished in light of the disappearance of their physical manifestation (pregnancies). It is noteworthy that the focus when considering the sexuality of disabled individuals is expressed in terms of the likeliness of their becoming parents, the danger of sexual exploitation is often overlooked. Logically, however, if a person cannot understand the link between sexual intercourse and pregnancy, it is likely that she/he is incapable of consenting to sexual intercourse.

Conclusion

Since time immemorial, individuals have tried to limit the size of their families. In the last century, they have seen their efforts facilitated with the improvement of birth control methods. Canadian citizens, prevented from being informed about and having access to contraception for most of the twentieth century, are now offered a wide range of contraceptive means, sterilization being only one of them. In light of its past eugenic use, and its often irreversible nature, sterilization has always enjoyed a particular status and its use and legal status engendered debate, discussion and controversy.

To be fully understood, the law on sterilization cannot be studied as an isolated issue. The decision of whether or not to allow the performance of sterilization, and more particularly non-therapeutic sterilization, constitutes a means by which Canadian society expresses its policy in the area of medical and mental health law, its position in the recognition of the rights to autonomy, self-determination, bodily integrity and equality, and its duty to protect its citizens in certain given circumstances.

The legality of voluntary sterilization, whether or not therapeutic, and, provided its performance is undertaken with due care and skill upon the obtaining of a free, enlightened consent given by a legally competent individual, demonstrates society's acknowledgement of an individual's right to self- determination in the medical area in general and in a matter as private as their sexuality in particular. The legality of voluntary sterilization was rendered necessary in a society which moved away from conservatism and paternalism, and gradually recognized patients quasi-equality in their relationship with medical practitioners bound to share their knowledge and information and take the appropriate precautions when interfering with bodily integrity. Furthermore, the public, professional and private acceptance of birth control in general and sterilization in particular, its technical availability due to the improvement of surgical techniques, its widespread practice if not in the shadows at least despite its uncertain legality, led the various Canadian provinces to reassess their consideration of public policy and officially recognize what was unofficially accepted and practised. The evolution of the law on voluntary sterilization mirrors the evolution of Canadian society.

The law on non-voluntary non-therapeutic sterilization constitutes a more complex moral, ethical and legal issue as not only the procedure is grave and intrusive, and

consent to it is to be provided by a party external to the patient-doctor relationship, but also because it is an emotionally charged issue in light of the many examples of ill-treatment of its most vulnerable citizens Canadian history contains. Over the centuries, mentally disabled individuals have been neglected, abused, and maltreated, segregated in often shameful and understaffed institutions, considered undesirable by eugenicists and arbitrarily sterilized as a result, the victims of myths, misconceptions and inappropriate labelling, the innocent prey of baldly drafted estate-oriented guardianship legislations. It is only in the past decades that efforts have been made to confer upon mentally disabled individuals, both internationally and nationally (especially since the enactment of the *Canadian*[651] and *Quebec Charter of Rights and Freedoms*[652]), the protection and enjoyment of rights, and that provincial legislators have attempted to rethink the concept of guardianship, competence, powers and to provide for the management of the estate as well as for the care of the person. Unable to erase its past, Canada must approach the issue of involuntary non-therapeutic sterilization with utmost caution, addressing it with regards to the way it wishes to treat its most defenceless citizens. Society owes mentally disabled individuals a duty: the duty to treat them in a non-discriminatory fashion, to recognize and respect their rights (notably to autonomy, bodily integrity and equality), to provide them with consistent care and supervision, and to permit them to live a respectful life where their needs are addressed, their concerns, wishes and desires taken into consideration, their protection against abuses ensured, where they can develop to their fullest. This duty transcends the institutional walls. In order to do so, a balance must be struck between autonomy and protection or paternalism. Whereas on the one hand mentally disabled individuals must be warranted the enjoyment of the same right as any other citizen, and be afforded as much autonomy (however greater freedom must not be synonymous with less care) and competence as feasible, on the other hand due to their vulnerability they must be protected by adequately drafted mental health legislations, decisions concerning their lives taken by supervised alternate decision-makers whose powers must be specifically circumscribed and whose intervention limited to the least intrusive means possible. As a result it is necessary to allocate resources to their care (medical and psychological to ensure that consistent care and supervision is provided for), to develop training and education programmes both inside and outside the

[651] *Canadian Charter*, *supra* note 111.
[652] *Quebec Charter of Rights and Freedoms*, *supra* note 111.

institutional setting, to support their families, to rethink and upgrade the concept of guardianship, legal competence, to fight misconceptions, abuses, to inform the general public. Non-therapeutic sterilization is only one element for which Canadian provinces have to find an adequate answer, and in doing so sight of the wider issues must not be lost. We believe that the current law on involuntary non-therapeutic sterilization is less than satisfactory and the debate surrounding its legality is not and should not be closed, as uncertainty is still rampant. If non-therapeutic sterilization is to be allowed in circumscribed circumstances, it should be done by way of legislation, safeguards would have to be enacted, and collaterally efforts be made to remedy the deficiencies of the current system of health care and of mental health law in order for mentally disabled individuals to acquire wider autonomy and be afforded comprehensive protection.

We realize that the proposition exposed within the lines of our discussion is not perfect, and might seem unlikely to occur but it nevertheless has the merits of addressing the various problems and attempting to provide a solution to them. We also acknowledge the fact that involuntary non-therapeutic sterilization has been and still is in the centre of a passionate, polarized and ideological debate, and that any solution proposed leads to the making of a subjective choice based on a particular social philosophy. Indeed, both the legality and the unlawfulness of involuntary sterilization could be defended by equally compelling legal arguments. However, whatever the stance adopted with regards to its legality, the law on involuntary non-therapeutic sterilization has to be clearly expressed, and a uniform national standard adopted.

In fine, we would like to add that scientific researches in the area of contraception[653], and in the treatment of mental disability might in a near future change the parameters of the discussion on the specific issue of sterilization. However, this is not to say that the duty that Canadian society owes to its most vulnerable citizens does not have to be addressed.

[653] Soon, irreversible methods of sterilization will become a fixture of the past, and less intrusive methods of contraception carrying few side-effects and being administered once and for all will probably be created. However, the issue of consent to a procedure that is non-therapeutic will not disappear. Furthermore, it can be remembered that even if all sterilization procedure were reversible, the likeliness that reversal would be performed would be slight.

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