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**DOES THE MENTAL CAPACITY
ACT 2005 ADEQUATELY PROTECT
PERSONS WITH LEARNING
DIFFICULTIES AGAINST NEEDLESS
NON-CONSENSUAL STERILISATION?**

Jordane Watson¹

Abstract:

Non-consensual contraceptive sterilisation of people with learning difficulties is inherently controversial. As such any legal framework that provides for such a procedure needs to be rigorously scrutinised in terms of its adequacy to protect vulnerable people. This article aims to 'determine whether the post-MCA judicial approach adequately protects adults with learning difficulties against needless non-consensual contraceptive sterilisation'.² This will be achieved by assessing how the MCA has changed the judicial approach to non-consensual contraceptive sterilisation since the common law approach. Further comparisons will also be made between sterilisation and vasectomies. The capacity section will determine whether the judiciary are approaching the capacity assessment in a proactive way that aims to uphold autonomy where possible. The best interests section will determine whether the judiciary is adopting an approach that sincerely promotes the patient's best interests and genuinely upholds the least restrictive principle or whether their protection is undermined by a risk of prejudice, insincere motives and subjectivity. Finally, The human rights section will assess whether any Articles within the European Convention on Human Rights can offer patients reliable protection against needless sterilisation.

Keywords: contraceptive sterilisation, consent, Mental Capacity Act 2005

Introduction

Non-consensual sterilisation of people with learning difficulties is a controversial topic that requires strong legal protection. This controversy is largely due to the forced sterilisation of some 3.5million people under the Nazi regime and widespread

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² 'Sterilisation' within this article concerns any medical procedure intending to render a patient permanently infertile. 'Learning difficulty' is defined as 'delayed or incomplete intellectual development combined with some form of social malfunction. Martin, E., *Concise Medical Dictionary (Oxford Reference Paperback)* (2010) p.412.

eugenic policies across the USA and Europe during the twentieth century.³ Interestingly the domestic judiciary have consistently denied any eugenic influence⁴ and there has never been any domestic legislation specifically governing sterilisation in this context. Rather the issue became governed by a best interest assessment under common law as enshrined by the Mental Capacity Act 2005 (MCA). This article will assess the adequacy of the judiciary's approach in protecting people with learning difficulties against needless sterilisation. The judicial approach to assessing capacity and best interests will be scrutinised. This will be followed by an analysis of whether any European Convention on Human Rights (ECHR) Articles can reliably protect patients against needless sterilisation.

1 Capacity Assessments

Pre-Mental Capacity Act Capacity Assessment

The first step in determining the lawfulness of sterilisation is assessing the patient's capacity to consent. In order to uphold autonomy where possible the post-Mental Capacity Act 2005 (MCA) judicial approach should endorse a genuine assessment of capacity separate from best interest considerations. To assess this, it is first important to analyse the pre-MCA approach when determining capacity. The common law established a presumption of capacity to ensure autonomy was not arbitrarily disposed of. In *Re T Donaldson* LJ confirmed 'the right to decide one's own fate presupposes a capacity to do so'.⁵ The presumption theoretically protected a person's autonomy by requiring incapacity to be positively shown. Here, Donaldson LJ rebutted the presumption because T lacked capacity as she was in severe pain and disorientated at the time.⁶ Unfortunately no guidance was given on the presumption's conceptual basis. Pattinson argues the judiciary merely rubber-stamped medical opinion when rebutting the presumption.⁷ Arguably Donaldson LJ's findings were not based on objective principles that could be used in future cases. Rather his reasoning depended on fact-specific observations supplied by doctors. Although each case will differ, it is desirable to assess facts in the context of defined objective principles to encourage certainty. Consequently the protection of patient

³ Suter. S., 'A Brave New World for Designer Babies? (2007) 22(897) *BerkeleyTechnology Law Journal* 898, p.915.

⁴ *Re B (A Minor) (Wardship: Sterilisation)* [1988] AC 199 p.204 per Bridge LJ 'this case has nothing whatever to do with eugenic theory'.

⁵ *Re T (Adult: Refusal of Treatment)* [1993] Fam. 95 p.112.

⁶ *Ibid.*, p.111.

⁷ Pattinson, S., *Medical Law and Ethics*, (2011, Sweet & Maxwell, 3rd edn.) p.175.

autonomy was undermined because the presumption was open to subjective and arbitrary decisions.

Clear legal principle was needed to promote consistency. *Re C*⁸ involved a schizophrenic whose capacity was assessed after refusing an amputation. Thorpe LJ established a cumulative test to rebut the presumption of capacity. Regarding the relevant information, the patient must be unable to comprehend and retain it, believe it and weigh it in the balance to decide.⁹ The patient must also understand the 'nature, purpose and effects' of the treatment.¹⁰ Thus people with learning difficulties were not deemed incapacitated because of their condition. Instead a more principled approach was developed that could be consistently applied to any facts.

Interestingly, Ashton DJ points out that C recovered without the amputation.¹¹ This shows the importance of an accurate assessment of the need for treatment and capacity as a *preliminary* and separate step to avoid unwarranted paternalism. Indeed C had capacity¹² so any talk of his best interests was irrelevant. Therefore this shows the vital distinction between assessing capacity and assessing best interests. This ensures patients are not simply deemed incapable so assessors can impose their subjective opinion regarding the patient's sterilisation. The distinction was reaffirmed in *NHS v T*.¹³ where Charles J stressed that a capable patient's decision must be respected regardless of their medical best interests.¹⁴ Hence if the patient had capacity and decided against sterilisation, third party views to the contrary were irrelevant. Theoretically this endorsed autonomy whilst shielding against harmful paternalism. However, the principle was arguably counterintuitive, making it appealing to present a patient as unable to understand the information and hence incapacitated. Therefore, patients were still at risk of being deemed incapacitated so assessors could impose a best interest assessment satisfying their own subjective views.

⁸ *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.

⁹ *Ibid*, p.295 per Thorpe LJ.

¹⁰ *Ibid*.

¹¹ District Judge Aston, 'Justice and Incompetence', (2005) 73 *Medico-Legal Journal* Part 2.

¹² *Re C* p.295.

¹³ *The NHS Trust v Ms T (Adult Patient: Refusal of Medical Treatment)* [2004] EWHC 1279 (Fam).

¹⁴ *Ibid*, p.42.

Re C also gave guidance on the test's approach. Thorpe LJ held that C's schizophrenia did not deprive him of the capacity to make 'the decision in question'.¹⁵ Rather than determining C's capacity by his medical status, Thorpe LJ's assessment solely concerned the issue of amputation. This functional approach enhances autonomy by recognising that each decision requires a different formulation of factors to establish capacity. Moreover each patient has varying symptoms affecting their level of capacity. Brazier notes that in *Re P*,¹⁶ P, aged 17, had a mental age of 6 but good communication skills and could cope with her bodily needs. In *Re B*, B was also 17 yet could only communicate to the level of a 2 year-old and understand speech like a 6 year-old.¹⁷ Hence specific symptoms and abilities can vary greatly between patients despite equal diagnosis and chronological age. Furthermore, like B's communication and understanding skills, each patient will have varying abilities according to the specific skill needed for any decision. Accordingly a status, rather than issue specific assessment would yield discriminatory and illogical results. Therefore in theory this approach enabled patients to retain autonomy in the greatest amount of decisions possible.

Despite these principles the judiciary's explicit assessment of capacity was inconsistent. *Re S*¹⁸ involved the sterilisation of a woman with severe learning difficulties. Summing up Wall J's earlier ruling Butler-Sloss LJ noted 'common ground that S lacked capacity to consent to treatment of any kind'.¹⁹ She accepted that the court did not separately assess capacity and, since it not being a ground for appeal, did not assess it either. The perfunctory acceptance of incapacity is alarming. S was deemed incapacitated yet no explicit rebuttal of the presumption was given by either court. Herring contends that the courts were too readily deeming patients incapacitated in sterilisation cases.²⁰ Arguably 'severe learning difficulties' is adequate proof of incapacity. However, this argument is incorrect under the functional approach because it would lead to presuming incapacity based on a patient's diagnosed condition. Therefore common law sterilisation cases lacked proactive assessment regarding capacity. This undermined the patient's protection due to over-zealous medical professionals able to influence a judgment favouring

¹⁵ *Re C* p.295 per Thorpe LJ 'Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses'.

¹⁶ *Re P (A Minor) (Wardship: Sterilisation)* [1989] 1 FLR 182.

¹⁷ Brazier, M., Cave, E., *Medicine, Patients and the Law*, (2007, London: Penguin), p.285.

¹⁸ *SI (by her litigation friend, the Official Solicitor) v SI (her mother)* [2000] WL 571291.

¹⁹ *Ibid*, p.3.

²⁰ Herring, J., *Medical Law and Ethics*, (2012, Oxford University Press, 4th edn.), p.283.

sterilisation. Consequently the merits of the common law approach to assessing capacity lacked adequate practical protection.

Post-Mental Capacity Act Capacity Assessments

Section 1(2) MCA enshrined the common law presumption of capacity. Bartlett submits that the MCA does not overrule the preceding case law, but using common law precedent too prescriptively will undermine the statute.²¹ Accordingly, the judiciary might make detrimental use of precedent leading to little improvement under the MCA. Mackenzie argues that this 'key principle' provides important legislative rights.²² This indicates that the presumption's status is now more potent; enshrining the presumption should ensure it is adhered to and autonomy is retained where genuinely possible. However, the judiciary must employ genuine observation of the presumption. *Re K*²³ is the only post-MCA female contraceptive sterilisation case. Cobb J begins by committing paragraphs 23-25 to assessing capacity.²⁴ This starting point shows a promising post-MCA approach. It better protects patients against unwarranted paternalism because the judiciary is separately assessing capacity rather than just rubber-stamping medical opinions.

Section 1(3) MCA has added a new requirement that all practicable steps must be taken to help a person retain capacity before they can be deemed incapacitated. The MCA's accompanying Code of Practice states this aims to stop people being automatically labelled as incapacitated.²⁵ Whilst the common law presumption simply existed without clarification, the MCA's threshold of 'all practicable steps' provides patients with a standard of protection, thereby strengthening the presumption. Bartlett argues that s.1(3) is not window dressing, individuals should not be found incapable because it is inconvenient to help them work through information.²⁶ Unlike the common law, this principle requires assessors to provide evidence of efforts being made before a patient is deemed incapacitated. The judiciary must strictly interpret 'all practicable steps' to ensure *genuine* efforts have been made towards the patient

²¹ Bartlett, P., *Blackstone's Guide to the Mental Capacity Act 2005*, (2008, Oxford University Press), p.26.

²² Mackenzie, C., Rogers W., 'Autonomy, Vulnerability and Capacity: A Philosophical Appraisal of the Mental Capacity Act', (2013) 9(1) *International Journal of Law in Context* 37 at p.38.

²³ *A Local Authority v K (by the Official Solicitor) Mrs K and Mr K A NHS Trust* [2013] EWHC 242 (COP).

²⁴ *Ibid*, p.23.

²⁵ Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice*, (23 April 2007) para.2.6.

²⁶ Bartlett, *Blackstone's Guide to the Mental Capacity Act 2005*, p.47.

retaining autonomy. Otherwise carers might present facts as if s.1(3) has been satisfied without success in order to seek a best interests declaration that satisfies their own convenience.

The threshold of practicable steps creates a risk of an assessor conveniently deeming incapacity to impose a predetermined 'best interests' assessment. In *Re DE*, DE's capacity was assessed for sterilisation and sexual intercourse.²⁷ Initially a vasectomy was not in DE's best interests because he could not consent to sex. Accordingly 'considerable work' was carried out in which the effort spent 'could not be overstated'. Consequently, within two months DE could consent to sex.²⁸ Perhaps this signalled a genuinely proactive approach to assessing capacity. This is questionable. When DE originally lacked capacity regarding sex, action was hastily taken to keep him and PQ (his girlfriend²⁹) apart. Only after this separation caused DE to become withdrawn was it considered he might develop the capacity to consent to sex.³⁰ Bartlett points out that for DE to have lawful sex, only he could consent to it.³¹ There is no 'safety net' of a best interests assessment regarding sex. Hence limitless efforts were made only because there was no other way of DE resuming the relationship that was now considered as in his best interests. Thus instead of promoting the patient's autonomy regardless of their perceived interests, efforts are only made when there is no alternative way of assessors imposing their perception of the patient's interests. This is regardless of the patient's actual ability to develop capacity. Therefore this approach undermines the patient's protection by allowing assessors to circumvent s.1(3) so they can impose their own subjective beliefs regarding the patient's sterilisation.

In support of this argument, the approach to the vasectomy can be contrasted. Butler-Sloss LJ opined DE would not gain the capacity to consent to contraception 'no matter how dedicated the work carried out with DE is'.³² This is hardly on a par with the steps taken to help DE consent to sex. Against Bartlett's contention less than

²⁷ *A NHS Trust v DE (Appearing by his Litigation Friend the Official Solicitor)*, FG, JK, C Local Authority, B Partnership Trust [2013] EWHC 2562 (Fam) pp.18-19.

²⁸ *Ibid*, pp.27-32.

²⁹ *Ibid*, p.55 note the possibility of PQ receiving contraception was irrelevant. She was unreliable at taking oral contraceptives and had a needle phobia. King J also held that DE may form a new relationship, thus only his contraceptive status was relevant.

³⁰ *Ibid*, pp.24,27.

³¹ Bartlett, *Blackstone's Guide to the Mental Capacity Act 2005*, p.46; s.27(1)(b) MCA excludes consenting to sex.

³² *Re DE* p.35,52.

practicable steps were taken towards sterilisation³³. Non-consensual sterilisation falls under the MCA, hence the 'safety net' of a best interests assessment ensures it is lawful. Consequently perhaps there is no benefit in spending time and effort in helping patients to consent autonomously. Instead patients are conveniently deemed incapable to fit a predetermined best interest assessment. DE developed the capacity to consent to sex. Arguably he could also gain capacity to consent to the vasectomy. Thus out of respect for his dignity this potential should have genuinely been exhausted with efforts that matched consenting to sex. Therefore s.1(3) undermines the patient's protection against needless sterilisation because assessors can deem incapacity in order to impose their own subjective ideas.

To inform the analysis it is important to see whether a patient can have the capacity to consent to sex but not sterilisation after genuinely adhering to s.1(3). Regarding sex, in *LA v H* Hedley J held the information relevant to sex requires an understanding of the mechanics of the act; health risks; pregnancy risks; and that they have choice and can refuse.³⁴ In *Re K Cobb* J endorses Bodey J's test in *LA v A*.³⁵ The relevant information for contraception and sterilisation is the reasons for contraception; how each type is used; advantages and disadvantages of each type; possible side effects; how easily each type can be changed; and the generally accepted effectiveness of each.³⁶

Clearly, consenting to sterilisation involves a more technical understanding than sex. In *Re DE*, DE had severe learning difficulties.³⁷ Rightly or wrongly there is no duty to tirelessly help DE to understand sterilisation. Hence, perhaps his abilities fell within the less technical test for sex whereas taking practicable steps could not satisfy the more technical test for sterilisation. Nonetheless the absence of explicit reasoning is unjustified. Importantly 'practicable steps' opens up sterilisation to abuse in future cases. Therefore thorough reasoning would ensure genuine protection under s.1(3) whilst extinguishing the risk of blurring the lines between the best interests and capacity assessments.

³³ Bartlett, p.47.

³⁴ *A Local Authority v H* [2012] EWHC 49 (COP) pp.23-25..

³⁵ *A Local Authority v Mrs A, by her Litigation Friend, the Official Solicitor, Mr A* [2010] EWHC 1549 (Fam) p.64.

³⁶ *Re K* p.24.

³⁷ *Re DE*, p.2.

To rebut the presumption of capacity s.2(1) MCA provides a two-part test. A *diagnostic* threshold of an impairment and a *functional* test that governs whether the patient is unable to make the decision because of the impairment. The Code of Practice gives an indicative list of conditions likely to satisfy s.2(1) including 'significant learning difficulties'.³⁸ Historically, cases have always involved learning difficulties that impair the patient's brain function.³⁹ Therefore although the Code has provided clarification, in practice the provision will not strengthen any protection due to the typical facts of sterilisation cases falling within the indicative list. Following the diagnostic threshold, the functional element must be satisfied. The MCA provides a cumulative test:

- s.3(1) A person is unable to make a decision for himself if he is unable to
- (a) Understand the information relevant to the decision;
 - (b) Retain that information;
 - (c) Use or weigh that information;
 - (d) Communicate his decision.

Jackson states that the inability to make a decision must be related to the impairment and the test is still issue-specific.⁴⁰ Thus the substantive requirements mirror the common law principles and any 'autonomy enhancing' value will depend on the judiciary's approach.

Explicit assessment of the functional requirement would improve the protection offered to patients. In *Re K*, Cobb J noted Dr D's claims that K lacked capacity to deal with the specific issues regarding sterilisation.⁴¹ However, unlike previous cases of passive agreement he holds that the relevant information regarding s.3(1) in sterilisation cases is Bodey J's test for contraception.⁴² He then concludes K lacks capacity because there was no doubt in his mind that K was unable to understand and weigh the information.⁴³ This is the first time greater depth has been given to assessing capacity in sterilisation judgments. Although improved, the approach remains unsatisfactory. Cobb J does not link the test to how he reached his conclusion by stating how the report illustrated K being unable to weigh the relevant information. Indeed for there to be 'no doubt' there must have been conclusive evidence. This lack of reasoning is unfortunate because we are left not knowing what

³⁸ The Code of Practice, p.4.12.

³⁹ *Re A (Medical Treatment: Male Sterilisation)* (2000) 53 BMLR 66 p.66 'A had Down Syndrome...impairment of intelligence'; *Re DE* p.9 DE 'suffers from life long learning disability, which is an impairment or disturbance of the functioning of his brain or mind' .

⁴⁰ Jackson, E., *Medical Law: Text, Cases and Materials*, (2013, OUP, 3rd edn.), pp.223-225.

⁴¹ *Re K* p.23.

⁴² *LV v A* p.64.

⁴³ *Re K* p.25.

constitutes lack of understanding when, for example, understanding the purpose of sterilisation. Moreover Lee argues that 'understanding' can be manipulated to facilitate a finding of incapacity.⁴⁴ Thus assessors could fallaciously present a patient as unable to 'understand' information. Considering this was the first post-MCA sterilisation case, full reasoning would have set a high standard that double-checked doctors were correct to find incapacity. Nonetheless, clarity was given by revealing the relevant information when assessing capacity in sterilisation cases. Therefore since the MCA we see a more principled approach specific to the issue of contraception.

Whether this test will be consistently applied in sterilisation cases is unknown. *Re DE* does not mention Bodey J's test or s.3(1). The only part of King J's judgment that resembles s.3(1) is 'DE lacks the capacity to weigh up the competing arguments for and against having a vasectomy'.⁴⁵ This reasoning fails to state why DE was unable to weigh the arguments. The judgment documents conversations with DE regarding his wishes.⁴⁶ Thus conversations must have been had with DE surrounding the issues. Hence it is questionable why examples were not given to illustrate her reasoning when declaring DE unable to weigh the information. Interestingly, Stauch argues that one aspect of weighing information is acting volitionally in light of information.⁴⁷ Arguably DE could act volitionally. King J states that when vasectomy is explained to DE as a foolproof method to contraception but condoms carry a risk, he chose the vasectomy.⁴⁸ Section 3(2) MCA provides a person is not to be regarded as unable to understand the information if he can understand an explanation appropriate to his circumstances. When vasectomy was explained to DE in understandable terms he did act volitionally, hence he potentially had the relevant capacity. Yet DE had already been deemed incapable by this point.⁴⁹ Therefore, King J's finding of incapacity because DE could not weigh the information is debatable. Accordingly the judiciary has some way to go in ensuring the functional element double-checks a correct assessment has been made. Instead they still seem hasty in deeming patients incapacitated to enforce a predetermined best interests assessment.

⁴⁴ Lee, S., 'Towards a Jurisprudence of Consent' in Eekelaar, J., *Oxford Essays in Jurisprudence*, (1987, Oxford: Clarendon Press) p.201.

⁴⁵ *Re DE* p.52.

⁴⁶ *Ibid.*, p.42-44.

⁴⁷ Stauch, M., Wheat, K., *Text, Cases and Materials on Medical Law and Ethics*, (2012, Routledge, 4th edn.) p.107.

⁴⁸ *Re DE*, p.52.

⁴⁹ *Ibid* p.53.

Issues surrounding a patient's parenting ability must also be considered. Section 3(4) states the information relevant to a decision includes the reasonable consequences of deciding either way. A patient must understand, retain and weigh the reasonably foreseeable consequences of taking or not taking contraception. This was explored in *LA v A* when the Local Authority argued that in contraceptive cases, s.3(4) includes a person being able to envisage how to care for a child. They claimed that to exclude this would be artificial.⁵⁰ Subsequently they relied on medical evidence that 'A lacks the intellectual ability to look after a child...independently'⁵¹ to show A's incapacity. Without contraception pregnancy is common. If a patient refuses contraception yet is not aware of the practicalities of childrearing, the child's removal would potentially be damaging. This likely damage could be negated by requiring a patient to understand parenting rather than just conception when determining capacity. Hence such a consideration is arguably sensible.

However this was not the outcome in the case. Bodey J concluded that the patient's understanding of bringing up a child was irrelevant. He argued that to avoid subjectivity and a paternalistic approach parenting abilities are best interests considerations and only relevant once a patient has been deemed incapacitated.⁵² 'Learning difficulties' encompasses a wide range of symptoms; hence some patients might be capable of parenting with support. Moreover Howard opines that parenthood is conceptually abstract.⁵³ Thus different people would measure the ability to parent differently. Allowing such a consideration in a capacity test would risk results depending on whether the assessor subjectively thought having a child was in the patient's or unborn child's interests based on their ability to parent. Also an assessor could be prejudiced and assume a disabled person cannot care for a child. Bodey J's approach provides strong protection by ensuring that patients are not deemed incapable due to subjective prejudice. Howard points out that if someone is not disabled, the decision to sterilise is not based on parenting abilities.⁵⁴ Hence it would be discriminatory to require a disabled person to show parenting abilities. Therefore the law correctly considers parenting ability only once the patient is deemed incapacitated to shield against subjective views tainting a genuine capacity assessment.

⁵⁰ *LA v A*, p.56.

⁵¹ *Ibid*, p.46.

⁵² *Ibid*, p.64.

⁵³ Howard, R., Hendy, S., 'The Sterilisation of Women with Learning Disabilities – Some Points for Consideration', (2004) 50 *BJDD* 133 p.135.

⁵⁴ *Ibid*, p.137.

2 Best Interests

If a person lacks capacity, the law must provide a mechanism for them to receive beneficial treatment in lieu of consent. This section will determine whether the judiciary is genuinely promoting the patient's best interests and investigate if the least restrictive principle is being upheld when sanctioning sterilisation.

Developing 'best interests'

*Re F*⁵⁵ concerned the sterilisation of a mentally handicapped woman and established the best interests principle as enshrined by the MCA. The House of Lords held that when making decisions for incapacitated patients, the treatment is lawful if it is in the patient's best interests.⁵⁶ The applicable standard was the *Bolam test*.⁵⁷ Brazier claims this medically focused approach provoked mere rubber-stamping of medical opinion.⁵⁸ Patients were at risk from over-zealous doctors cherry picking supportive medical opinion due to a lack of separate judicial assessment. Kennedy criticised that the principles amounting to best interests were left unarticulated by the court leaving no opportunity for scrutiny.⁵⁹ Thus the concept was at risk of arbitrary decisions with potentially damning effects in sterilisation cases due to historically detrimental attitudes towards the learning-disabled.

To some extent the inadequacy of *Re F* was rectified a decade later. *Re A* involved the vasectomy of a man with learning difficulties.⁶⁰ Butler-Sloss LJ clarified that 'best interests' encompasses medical, emotional and welfare issues rather than solely medical considerations.⁶¹ Only to consider medical factors was flawed because contraceptive sterilisation is not a medical necessity. Considering wider factors is more realistic and patient-friendly because it recognises the broader repercussions. Additionally, Thorpe LJ endorsed a balance sheet approach to the assessment, similar to the checklist suggested by the Law Commission.⁶² This involved drawing up the treatment's actual benefits and dis-benefits and the likelihood of the potential

⁵⁵ *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1.

⁵⁶ *Ibid.*, p.83.

⁵⁷ *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. In other words the treatment was in the patient's best interests if the relevant doctor's view was consistent with a responsible body of medical opinion.

⁵⁸ Brazier, M., *Medicine, Patients and the Law*, p.132.

⁵⁹ Kennedy, I., 'Patients, Doctors and Human Rights' In Blackburn R., Taylor, J., *Human Rights for the 1990s*, (1991), p.90.

⁶⁰ *Re A*, pp.77-78.

⁶¹ *Ibid.*, p.72.

⁶² Law Commission, *Report on Mental Incapacity*, (15 January 1995, EWLC No. 231) para.3.28.

losses and gains.⁶³ Donnelly argues although this approach was more sophisticated,⁶⁴ its mechanist nature was inadequate because it made the test open to judicial subjectivity.⁶⁵ If the assessment requires weighing up two lists, this hardly incentivises in-depth and explicit analysis of a complex issue like non-consensual sterilisation. Consequently disguised subjective views could undermine the patient's protection. Therefore although unsatisfactory, the Law Commission's proposals did encourage the judiciary to pre-emptively develop a more principled and MCA-compatible approach.

Section 1(5) MCA enshrined the best interests assessment. Although the principle mirrors the common law, the supporting framework might change the treatment of patients. Section 4(2) gives general guidance that assessors must consider all the relevant circumstances. Hence the MCA specifically prescribes considerations, but does not limit the assessment to those considerations. This flexibility complements the issue-specific approach and protects patients against needless sterilisation because different cases will require different considerations to make a rounded assessment.

Patient participation

The common law approach lacked enthusiasm towards patient participation. The Law Commission's checklist approach included the patient's participation and his view on the proposed treatment.⁶⁶ However in *Re A Butler-Sloss* LJ perfunctorily held 'A had indicated no...but it was not an informed no since he could not understand the reason for the operation'.⁶⁷ Subsequently A's view and participation in the assessment was dismissed. Donnelly claims this approach created a major flaw in the common law.⁶⁸ A's opinion was sought, but if his participation was disregarded because of his incapacity then seeking his view was pointless. The judiciary were merely paying lip-service to good practice. Moreover, Donnelly argues, decision-makers lack fundamental knowledge of what it feels like to be the patient.⁶⁹ Accordingly, notwithstanding a person's incapacity, a fully informed assessment

⁶³ *Re A*, p.77.

⁶⁴ Donnelly, M., 'Best Interests, Patient Participation and the Mental Capacity Act 2005', (2009) 17 *Medical Law Review* p.4.

⁶⁵ Donnelly, M., 'Decision-making for Mentally Incompetent People: The Empty Formula of Best Interests?' (2001) 20 *Medical Law Review* 405, p.411.

⁶⁶ Law Commission, *Report on Mental Incapacity*, para.3.28.

⁶⁷ *Re A*, p.69.

⁶⁸ Donnelly, 'Decision-making for Mentally Incompetent People', p.411.

⁶⁹ Donnelly, 'Best Interests, Patient Participation and the Mental Capacity Act 2005', p.28.

hinges on this vital information. Thus the common law was inadequate towards endorsing a patient's participation and views.

Section 4(4) MCA states that decision-makers 'must, so far as reasonably practicable, permit and encourage the person to participate.' Donnelly notes the provisions recognise the valuable contributions a learning-disabled person can provide.⁷⁰ This requirement provides better balance between capable and incapable people through having partial influence regarding their sterilisation. However, Donnelly argues that participation must be reinforced to be genuinely inclusive⁷¹. Therefore unless the judiciary is proactive, the patient's views will have no more respect than under the common law approach. In *Re G*⁷² Morgan J disregarded s.4(4) 'by reason of her condition it is not reasonably practicable to involve G'.⁷³ Notwithstanding the assessment's potential accuracy, Donnelly claims Morgan J's brash dismissal illustrates the risk the 'reasonable practicable' standard creates.⁷⁴ In sterilisation cases patients often have conditions that inhibit communication. Therefore the MCA allows dismissive attitudes to deny patients participation due to inconvenience rather than impracticability. This is especially applicable where an assessor has preconceived ideas about the patient's best interests. Lee notes interested parties can be selective when presenting facts in support of arguments to the judge.⁷⁵ Hence, assessors could tailor facts to show participation is impracticable in order to silence a patient's conflicting view. Therefore the judiciary must take a stricter approach to ensure genuine endorsement of participation to guard against distorted assessments.

Re K was the first post-MCA female sterilisation case. K had mild to moderate learning difficulties.⁷⁶ Unfortunately Cobb J does not mention K's participation or her condition's practical consequences. Surely 'mild to moderate' learning difficulties do not prevent participation completely? The lack of effort towards K's participation becomes apparent when compared with *Re DE* (the first post-MCA male sterilisation

⁷⁰ *Ibid*, p.11.

⁷¹ Donnelly, M., 'Determining Best Interests under the Mental Capacity Act 2005', (2011) 19 *Medical Law Review* 304 p.308.

⁷² *In the Matter of G (TJ)* [2010] EWHC 3005 (COP).

⁷³ *Ibid*, p.2.6

⁷⁴ Donnelly, 'Determining Best Interests under the Mental Capacity Act 2005', p.307.

⁷⁵ Lee, R., Morgan, D., 'Sterilisation and Mental Handicap: Sapping the Strength of the State?' (1988) 15(3) *Journal of Law and Society* 229 p.235.

⁷⁶ *Re K*, p.2.

case). King J stated that despite DE's considerable communication difficulties, his carers determined his wishes through doing all that was reasonably practicable to facilitate participation.⁷⁷ Despite his condition, efforts were possible within 'reasonableness' to ensure his participation. Whilst each patient's condition is unique, the only apparent difference between these cases was that DE had a devoted team who were happy to promote his participation. This is concerning because not every patient will have the same chance to participate. Considerable room for inconsistency remains post-MCA because an assessment can be based on convenience rather than practicability.

Section 4(6) MCA requires consideration of a patient's wishes. Assessors must consider, so far as is reasonably ascertainable a person's present wishes and feelings and the other factors that he would be likely to consider if he were able to. In *Re DE* King J considered DE's wishes that were not directly related to the vasectomy. She held that if DE had capacity he would consider the benefits to his parents of the vasectomy.⁷⁸ Sterilisation cases involve congenital conditions. The assessor cannot interpret the patient's past capacitated views. Donnelly claims that assessors may invent patient wishes that accord with their own views.⁷⁹ Thus an assessor could merely say a patient would hold certain views to justify sterilisation. This risk is heightened where a third party would benefit from the sterilisation. Secondly all parties were confident that DE did not want more children.⁸⁰ This consideration enabled King J to build a full picture of DE's wishes regarding the consequences of sterilisation. Seeking a patient's wishes on having children endorses a patient friendly approach because it does not consider sterilisation in a vacuum. However, the judiciary must remain vigilant to avoid considering 'wishes' that are merely assumptions made about the patient.

King J also sought DE's view regarding the vasectomy. DE was 'broadly in favour' of vasectomy yet recently expressed he wanted to use condoms. However, the doctors felt this should be disregarded because he had recently been warned of the pain risks involved.⁸¹ Alarmingly the doctors proactively found excuses to dismiss DE's views that differed from their own but endorsed the views that fitted. Additionally the Official Solicitor opined 'DE ... parrots the views of his parents', hence King J

⁷⁷ *Re DE*, p.92.

⁷⁸ *Ibid.*

⁷⁹ Donnelly, 'Best Interests, Patient Participation and the Mental Capacity Act 2005', p.19.

⁸⁰ *Re DE*, p.44.

⁸¹ *Ibid.*, p.52.

accepted that DE's parents heavily influenced him.⁸² Donnelly suggests that assessors might lead patients by focusing on their preferences.⁸³ Arguably DE's extracted views were merely views that were heavily influenced by his parents who endorsed the vasectomy. Thus interested parties can manipulate information to influence the patient with their own views. Consequently, the judiciary must remain vigilant towards ensuring the authenticity of the patient's views

Following their questionable authenticity, we must assess if DE's view influenced the assessment. King J submits that attaching weight to a view is issue-specific⁸⁴ but arguably her claim is unconvincing:

I approach DE's wishes ... to a vasectomy with the utmost caution ... DE does not have the capacity to consent to contraception; it is therefore for the court to consider ... his best interests taking into account his wishes in respect of not having a baby.⁸⁵

Accordingly DE's wishes on vasectomy were disregarded. Despite King J endorsing an issue specific-approach she dismisses DE's view based on his incapacity (status). This is unfortunate because as discussed previously, anything but an issue specific approach can create illogical results. Donnelly suggests that without enough weight being attached to the patient's views, the MCA will have little effect.⁸⁶ Arguably where the issue is vasectomy, the patient's view on vasectomy itself is vital to make an informed assessment. However, if DE's confused views were heavily influenced, attaching weight to them would have distorted the assessment. Hence King J was right to be cautious. In any case, no matter how much assessors facilitate s.4(6), difficulties will always arise because by the nature of sterilisation cases most patients will have communication issues. Therefore the judiciary must endorse taking the patient's views into account but equally ensure they are undoubtedly the patient's.

Third party views

Considering views of others within an assessment is controversial because self-serving views might distort the perceived patient's interests. Under the common law approach, in *Re B*, Oliver LJ reassured that the carer's convenience was irrelevant to the assessment; when considering the contraceptive pill he took into account the

⁸² *Ibid*, p. 39.

⁸³ Donnelly, 'Best Interests, Patient Participation and the Mental Capacity Act 2005', pp.18-19.

⁸⁴ *Re DE*, p.88 per King J citing *Munby J in ITW v Z* [2009] EWHC 2525 (Fam).

⁸⁵ *Ibid*, p.53.

⁸⁶ Donnelly, 'Best Interests, Patient Participation and the Mental Capacity Act 2005', p.19.

carer's concerns that administering contraceptives would be difficult.⁸⁷ Lee cynically opines he authorised sterilisation for the carer's convenience rather than B's best interests.⁸⁸ If B had a child she could not look after, her carers would have had to assist in the child's care. However this does not justify sterilisation. The carers should have accepted the 'inconvenience' of administering contraceptives to avoid a pregnancy in B's interests. This would have incidentally alleviated the risk of them having to care for any future child. Interestingly, administering other medication was unproblematic, what would be difficult about contraception is unknown. Ultimately, matters of third party convenience were considered under the guise of the patient's best interests. This distorted the assessment and undermined the patient's integrity through insincere motives.

Third party considerations were revisited in *Re A*. Arguments surrounding protection of vulnerable women were submitted as relevant to A's best interests assessment⁸⁹ but Butler-Sloss LJ dismissed this by citing *Re Y*.⁹⁰ Here it was established that third party benefits were only acceptable if they were incidental to serving the patient's interests.⁹¹ Indeed sterilising A would not protect vulnerable women from other men. Consequently their protection was too remote and should be considered separately. Thus the common law refused to allow considerations that purely benefitted a third party. This protected patients to an extent from self-fulfilling intentions. However Butler-Sloss LJ stated 'whether third party interests should ever be considered [is]... left open'.⁹² Bartlett argues that this left the issue unclear.⁹³ Therefore patients were at risk from subjective and insincere motives impinging on their best interest assessment.

Section 4(7) MCA governs the current approach to third party views. Assessors must take into account the views of anyone engaged in caring for the person or interested in his welfare. Furthermore Code of Practice 5.48 clarifies that the MCA allows actions that benefit other people, as long as they are in the best interests of the person who lacks capacity. Hence the Code affirms *Re Y* regarding third party benefits clearing up the uncertainty. The wide scope of views that can be considered facilitates a balanced assessment albeit the provision's practical effectiveness hinges

⁸⁷ *Re B*, pp.212.209.

⁸⁸ Lee, 'Sterilisation and Mental Handicap', p.239.

⁸⁹ *Re A*, p.69.

⁹⁰ *Re Y (Mental Incapacity: Bone Marrow Transplant)* [1996] 2 FLR 797.

⁹¹ *Re A*, p.73.

⁹² *Ibid.*

⁹³ Bartlett, *Blackstones Guide*, p.55.

on the judiciary's approach. In *Re K*, K's parents thought sterilisation was the least restrictive option whereas the Authority thought an IUS was.⁹⁴ Cobb J paid significant attention to K's parents' view but agreed with Doctor Rowland's that less invasive contraceptives were available.⁹⁵ Herring states that doctors have expertise but unlike relatives may not know the patient's ethical views. Contrastingly relatives may have conflicting interests.⁹⁶ Thus differing views are not necessarily insincere; they can be merely from a different perspective and hence deserve consideration. Therefore s.4(7) facilitates an all-encompassing approach by recognising each person will have a unique relationship with the patient. Consequently the patient's genuine best interests are more likely to be ascertained.

Further guidance is given in *Re DE*. DE's parents believed vasectomy was in his best interests to restore his independence and because DE did not want another child their reasons seem altruistic.⁹⁷ King J presents that *another* child would gravely upset and impact the family. Hence vasectomy would relieve their anxiety.⁹⁸ Accordingly this might have tainted DE's parents' views of his best interests. Realistically impartiality would be difficult when another pregnancy would be terrible for them. King J cites 5.48 of the Code as relevant and states that she is not concerned with the parent's interests but how their distress would considerably impact on DE's welfare.⁹⁹ Lee suggests that the parties' benefits are not always mutually exclusive.¹⁰⁰ Indeed sometimes patient and third party benefits are intertwined. It would be senseless to withhold patient benefits by being overly cautious towards benefitting others. Hence King J employs a pragmatic approach to s.4(7). However, Herring argues that s.4(7) allows people to present a patient in a way that will promote the order they are seeking.¹⁰¹ Therefore considering DE's parents' anxiety opens up potential for people to exaggerate matters in order to secure sterilisation for convenience under the guise of incidental benefits. Thus self-fulfilling views can operate under s.4(7). Consequently the judiciary must remain vigilant when considering views of persons who might have an insincere pro-sterilisation motive.

⁹⁴ *Re K*, pp.13, 21.

⁹⁵ *Ibid.*, pp.27,33 'In particular, I have noted, and understand, Mrs K's plea ... be fairer to K for her to be sterilised ... resolved 'once and for all''.

⁹⁶ Herring, *Medical Law and Ethics*, p.209.

⁹⁷ *Re DE*, p.4.

⁹⁸ *Ibid.*, p.92.

⁹⁹ *Ibid.*, p.63.

¹⁰⁰ Lee, 'Sterilisation and Mental Handicap', p.239.

¹⁰¹ Herring, *Medical Law and Ethics*, p.281.

Other relevant factors

The common law recognised the detrimental effects a patient may suffer from pregnancy or from a child being removed as a relevant factor. In *Re X Holman LJ* considered evidence that X could not look after a child and that its removal would be damaging for her concluding contraception was needed¹⁰². Herring claims the approach focused on the patient's interests rather than the unborn child's.¹⁰³ Although this patient-centric approach may disadvantage any child conceived by a patient, we do see rightful consideration of the emotional consequences of pregnancy. Furthermore the patient was protected from needless sterilisation by detrimental effects only justifying 'some form' of contraception. The common law approach to detrimental effects was adequate by not justifying needless sterilisation and holding the patient's interests as paramount.

As noted under s.4(2) the Act is flexible in allowing un-prescribed relevant factors to be considered. Section 4(11) defines relevant factors as those which the assessor is aware of and those that are reasonable to regard as relevant. Thus the assessor is able to make a rounded assessment by having enough freedom to incorporate any issues the facts produce. The detrimental effects to any unborn child are also disregarded under the MCA approach as seen in *LA v A*.¹⁰⁴ This article only concerns the patient's interests so it is important to focus on potential detrimental effects to the patient. This raises the question of whether a mentally disabled person's best interests can ever be served by having a child they cannot look after. In *LA v A*, A already had two children removed from her but refused contraception, yet Bodey J refused to impose contraception holding there was no risk to A's mental health through pregnancy or the removal of a child.¹⁰⁵ Herring argues 'it is hard to believe the removal of a child would not cause A grave emotional harm'.¹⁰⁶ A wanted another child. Arguably she must have felt some loss from the removal of her existing children. It is unrealistic to believe anyone could be so detached from their child to be unaffected by its removal. If A keeps having children removed, in practice the line will have to be drawn somewhere before she is damaged and arguably her interests were not served by being left open to the risk of pregnancy.

¹⁰² *Re X (adult patient: sterilisation)* [1999] 3 FCR 426 p.427,430.

¹⁰³ Herring, *Medical Law and Ethics*, p.283.

¹⁰⁴ *LA v A*, p.78 'such arguments were too speculative because A's future parenting abilities were unpredictable ... if she were to become pregnant, so be it.'

¹⁰⁵ *Ibid*, p.75.

¹⁰⁶ Herring, J., 'Family: The Right to Choose', (2010) 160 *New Law Journal* 1066 p.1067.

Re DE adopted a more desirable approach. DE could not look after his child (XY). XY was subject to care proceedings and placed with PQ's mother.¹⁰⁷ Following the pregnancy's grave consequences on DE's wellbeing, King J concluded it was 'in DE's best interests to resume the life he had before PQ's pregnancy'.¹⁰⁸ This ultimately meant a vasectomy, as it was clear DE's interests were not served by having a child he could not care for. Importantly each case is fact-specific. Herring submits it is easy to take the moral high ground but this may leave the patient suffering from a distressing pregnancy.¹⁰⁹ Imposing contraception must be balanced against the detrimental effects of having a child the patient cannot look after. Imposing contraception is realistically the 'lesser of two evils' in the likely situation a patient will suffer from the pregnancy. In such situations non-consensual contraception is justified to circumvent this damage. Notably though this consideration will only justify sterilisation once less invasive contraceptives prove unsuitable.

Least restrictive

Under the common law in *Re B*, Oliver LJ held that contraceptive sterilisation would only be approved as a last resort.¹¹⁰ This would require evidence that other contraceptives were incompatible with the patient's existing medication. Thus theoretically patients were protected against needless sterilisation. However, even *Re B* (as discussed above) saw a half-hearted attempt at exhausting other methods where the carer's convenience was concerned. Hence the principle was built on weak foundations that were easily circumvented.

The MCA had some way to go to ensure sterilisation was not a convenient method of non-consensual contraception. Section 1(6) requires the purpose for which the treatment is needed to be achieved in a way that is least restrictive of the person's rights and freedom: sterilisation will be unlawful unless all less restrictive contraceptives are unsuitable. In *Re K* there was no risk of pregnancy hence the least restrictive option was to do nothing.¹¹¹ This approach is an improvement from the common law cases such as *Re P* where despite there being no risk of pregnancy,

¹⁰⁷ *Re DE*, p.13.

¹⁰⁸ *Ibid*, p.65 'It is in DE's best interests for him to resume the life he had before PQ's pregnancy'.

¹⁰⁹ Herring, *Medical Law and Ethics*, p.285.

¹¹⁰ *Re B*, p.210.

¹¹¹ *Re K*, p.19.

sterilisation was still sanctioned.¹¹² Mullender argues the least restrictive principle obliges assessors to treat patients respectfully and only override their liberty where it is necessary in their interests.¹¹³ Thus s.1(6) provides vital protection against needless sterilisation by requiring an initial assessment of whether any intervention is needed at all.

Re K also indicates how the judiciary will uphold the principle when females are actually at risk of pregnancy. A speculative declaration was sought that should K's interests require contraception, sterilisation was not the least restrictive option.¹¹⁴ Cobb J submitted that the seriousness of sterilisation could not be doubted so less restrictive methods should be tried first.¹¹⁵ Although K had tried the implant, other less restrictive methods were available so sterilisation was not necessary should contraception be in her best interests. Unlike the last resort principle, the least restrictive principle ensures the pregnancy risk is first assessed and if this risk exists, sterilisation is not conveniently favoured. With advancements in contraceptive technology, sterilisation should be the least restrictive contraceptive method in only exceptional cases. Therefore s.1(6) offers indispensable protection against sterilisation.

Male cases may provide different results. In *Re DE*, contraception was in DE's best interest. King J applied s.1(6) by considering the range of male contraceptives; ultimately these were vasectomy and condoms. DE received 12 weeks training on using condoms yet his technique remained questionable.¹¹⁶ King J concluded that the likelihood of pregnancy using condoms was far greater than vasectomy.¹¹⁷ Importantly, restricting DE's freedom would be highly detrimental, as past evidence showed. Hence vasectomy was rightly the least restrictive method to secure his interests. This presents a desirable approach because all other methods were genuinely exhausted before sanctioning vasectomy. Section 1(6) presents an interesting result that reverses the common law position where only females had been sterilised. There being fewer contraceptive methods for men, sterilisation will become the least restrictive method more frequently than in female cases. In practice the provision will produce different results according to gender. Nevertheless, if the

¹¹² *Re P (A Minor) (Wardship: Sterilisation)* [1989] 1 FLR 182 p.189.

¹¹³ Mullender, R., 'Involuntary Medical Treatment, Incapacity, and Respect', (2011) 127(Apr) *Law Quarterly Review* 167 p.170.

¹¹⁴ *Re K*, p.20.

¹¹⁵ *Ibid*, p.33.

¹¹⁶ *Re DE*, pp.57-59.

¹¹⁷ *Ibid*, pp. 59,93.

judiciary genuinely exhausts all other contraceptives, sterilisation should still only be lawful in exceptional cases.

3 Human Rights

Due to the lack of consent in sterilisation cases, human rights considerations must form part of a best interests assessment. This section will assess whether any ECHR Articles can offer patients adequate protection against needless sterilisation.

Pre-Human Rights Act 1998

Before the Human Rights Act 1998 (HRA), sterilisation cases mentioned some vague right to reproduce. *Re D*¹¹⁸ involved a ward suffering from 'impaired mental functioning'. Her mother sought sterilisation because D could not look after a child. Heilbron J refused sterilisation stating it would violate her basic human right to reproduce.¹¹⁹ This shows a high value being attached to reproductive rights regardless of mental disability. Dimopoulos contends that at this point rights were dominated by emotion, rather than legally based reasoning.¹²⁰ Unfortunately there was no elaboration on the right's conceptual basis. It appeared the judiciary saw the right as so basic that no further explanation was needed. Although the recognition offered welcome protection in this case, without clear legal principles the right was open to emotion led subjectivity making the protection offered to subsequent patients uncertain.

The lack of principle caused the status of the right to change shortly after. In *Re B*, the House of Lords authorised contraceptive sterilisation and confined *Re D* to its facts because unlike B, D could potentially gain the capacity to marry.¹²¹ Lord Hailsham confirmed the right to reproduce but stated that to talk of a right to reproduce regarding an individual who has no maternal instincts 'parts company with reality'.¹²² Lord Oliver held the right was of no value if B was unable to appreciate the choice.¹²³ Stauch argues their reasons are unjustified because they lead to the dangerous argument that a disabled person has no rights because they are incapable of operating them in their own best interests.¹²⁴ Arguably many patients are

¹¹⁸ *Re D (A Minor) (Wardship: Sterilisation)* [1976] Fam 185.

¹¹⁹ *Ibid*, p.193.

¹²⁰ Dimopoulos, A., *Issues in Human Rights Protection of Intellectually Disabled Persons*, (2010, Ashgate), p.126.

¹²¹ *Re B*, p.211.

¹²² *Ibid*, p.204.

¹²³ *Ibid*, p.211.

¹²⁴ Stauch, *Text, Cases and Materials on Medical Law and Ethics*, p.193.

unaware of their rights. Nevertheless, to take them away because someone has deemed them unable to exercise the right in a 'preferable' way discriminatorily lowers the person's status - rights are not dependent on a desire to use them. A non-disabled person may never want a child yet their reproductive rights are not interfered with. Hence to deny a right ultimately based on disability attaches less worth to disabled people and defines rights by capacity rather than by being human. Consequently the basic right to reproduce inadequately protected patients from needless sterilisation.

Post Human Rights Act 1998

At present there is no guidance on the European Court of Human Rights (ECtHR's) approach in this context. There was a brief possibility of clarification in 2012. *Gauer v France* concerned five intellectually disabled women who were sterilised without their informed consent.¹²⁵ They submitted that this violated their rights under Articles 3, 8 and 12. The application was procedurally inadmissible. Despite the opportunity to clarify the human rights position regarding non-consensual sterilisation; the ECtHR stated it was unnecessary to examine the further possible inadmissibility.¹²⁶ Whilst *Gauer* was pending, the European Parliament reported that the case illustrates how a legal system might appear fair but is nevertheless unable to deal with cases of severe abuse.¹²⁷ Thus domestic law might be implemented with good intentions of providing ways to allow non-consensual sterilisation, for example the MCA's best interest test. However, this does not necessarily mean sterilisation under the MCA is not an abuse of human rights.

Article 3

Article 3 ECHR may apply in this context; it states that no one shall be subjected to torture or to inhumane or degrading treatment. Interestingly Dimopoulos submits that interpreting sterilisation into Article 3 is problematic because during the consultative stages of the ECHR a UK representative proposed to explicitly include sterilisation within Article 3.¹²⁸ After reservations from other states the amendment was rejected because it might have unbalanced the text. Therefore perhaps if sterilisation was

¹²⁵ *Gauer and Others v France* (dec.) (App No 61521/08) ECHR 23 October 2012.

¹²⁶ *Ibid.*, p. 2

¹²⁷ Policy Department C: Citizens' Rights and Constitutional Affairs, *Discrimination Generated by the Intersection of Gender and Disability*, Directorate General for International Policies, (May 2013, European Parliament, PE 493.006)
[http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/493006/IPOL-FEMM_ET\(2013\)493006_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/493006/IPOL-FEMM_ET(2013)493006_EN.pdf), para.4.2.3.

¹²⁸ Dimopoulos, *Issues in Human Rights*, p.181.

intended to be strictly prohibited by Article 3, it would have been included at the consultative stage.

Guidance can be sought from indirectly linked ECtHR decisions. *Herczegfalvy v Austria*¹²⁹ concerned force-feeding: the Grand Chamber held that a measure which is a therapeutic necessity (as decided by medical consensus) cannot be regarded as inhumane or degrading'.¹³⁰ Dimopoulos argues that if Article 3 is applicable for our purposes it would offer little protection because sterilisation is generally sanctioned with unanimous medical opinion that it is necessary in the patient's best interests.¹³¹ However, any applicability at all is doubtful. Unlike treating a medical condition that incidentally sterilises a patient, contraceptive sterilisation is not therapeutic. Domestically, contraceptive sterilisation may be deemed in a patient's best interests without being a *therapeutic* necessity. Consequently contraceptive sterilisation arguably falls outside *Herczegfalvy's* exception to Article 3. Therefore the court could sanction a domestically lawful contraceptive sterilisation that was not a therapeutic necessity thereby violating Article 3. This illustrates the lack of clarity in this area.

If Article 3 was applied to incapacitated patients, the repercussions could be counter-intuitive. In *Re DE* there was a high risk of pregnancy without contraception. If a child was born it would have been taken away and PQ would have left DE, causing him immeasurable stress.¹³² King J had no doubt that after DE's struggle with condoms, vasectomy was the only option to secure his best interests.¹³³ DE was apparently unable to consent and his vasectomy was not a medical necessity. Accordingly, if sterilisation fell under Article 3 purely due to lack of consent, then as an absolute right DE's vasectomy would have violated Article 3. Instead of protecting DE, the restrictions on his freedom would have caused him more distress than the vasectomy. In cases where no matter how much the patient is supported to give informed consent, if he still lacks capacity, sterilisation would be unlawful regardless of the potential benefit. Hence the wider repercussions of a blanket prohibition would be detrimental. Therefore Article 3 is undesirable in the context of incapacitated patients.

¹²⁹ *Herczegfalvy v Austria* (1992) (App No 10533/83) 18 BMLR 48.

¹³⁰ *Ibid*, p.82.

¹³¹ Dimopoulos, *Issues in Human Rights*, p.182.

¹³² *Re DE*, p.63.

¹³³ *Ibid*, pp.93-94.

Article 8

Article 8 (the right to respect for private and family life) might be more appropriate. *Storck v Germany*¹³⁴ involved a '100% disabled' woman who claimed receiving non-consensual treatment violated Article 8. The ECtHR held even a minor non-consensual interference with physical integrity violates Article 8.¹³⁵ Hence under *Storck*, because non-consensual sterilisation constitutes an interference with physical integrity, Article 8 may apply. Donnelly submits this is so regardless of incapacity.¹³⁶ Thus patients who are deemed incapacitated but do not wish to be sterilised could seek protection under Article 8 as it has the potential to protect patients against needless contraceptive sterilisation.

Article 8 is qualified; paragraph 2 states a public authority can interfere with Article 8 in accordance with law and where it is *necessary* in a democratic society in the interests of for example protection of health. The sterilisation must be *proportionate* to a *legitimate aim* to be in accordance with the law. Here the aim is contraception. Arguably this is legitimate where there is an actual risk of pregnancy that would detrimentally affect a patient. Regarding proportionality, in *VC v Slovakia* the ECtHR found a violation of Article 8 and ruled the supposed risks 'could also have been prevented by means of alternative, less intrusive methods'.¹³⁷ Presumably regardless of capacity, the ECtHR would endorse contraception according to the less intrusive method to avoiding discrimination. Although cases are fact-dependent, there are many less invasive contraceptives than sterilisation. Hence sterilisation would be disproportionate until all lesser methods are *genuinely* exhausted. As such this requirement and the MCA's least restrictive principle are mutually complementary. The qualifications offer controlled flexibility that ensures sterilisation can be carried out where it is genuinely in a patient's best interests.

To satisfy 'necessity', assessors could argue sterilisation is in the interests of protecting health. Although much is fact dependent, it is likely the proposed sterilisation would be in the interest of the patient's psychological health due to the effects of pregnancy. Therefore sterilisation is potentially justifiable under paragraph 2 but Dimopoulos argues that Article 8 is undesirable because the margin of appreciation would be too wide given the lack of consensus among member

¹³⁴ *Storck v Germany* (App No 61603/00) ECHR 16 September 2005.

¹³⁵ *Ibid*, p.143.

¹³⁶ Donnelly, 'Best Interests, Patient Participation and the Mental Capacity Act 2005', p.14.

¹³⁷ *VC v Slovakia*, p.113.

states.¹³⁸ Although conceivable, Dimopoulos advocates total prohibition of non-consensual sterilisation.¹³⁹ Here I am arguing for a genuine approach to assessing capacity and best interests whilst exhausting lesser methods first, after all a total prohibition might be more detrimental to a patient than sterilisation. Hence despite a wide margin, proportionality as complemented by adherence to the least restrictive principle would endorse adequate protection for patients. Therefore Article 8 is the most desirable article in this context.

Post-MCA cases illuminate the domestic approach towards Article 8. *Re DE* explicitly examines Article 8.¹⁴⁰ Unlike *Storck*, although non-consensual DE was 'broadly in favour of the idea.'¹⁴¹ Nevertheless, King J held the vasectomy engaged Article 8 due to *Evans v UK* where the Grand Chamber held reproductive rights derive from the respect to private life because private life 'incorporates the right to respect for both the decisions to become and not become a parent'.¹⁴² Since the MCA, the court must consider the patient's wishes. DE's wish to not have any more children ultimately required a vasectomy. Subsequently King J concluded that DE had competing rights under Article 8. Namely that a vasectomy would prevent a future choice to become a parent contrasted with a right to respect for autonomy regarding his present wish not to have more children.¹⁴³ Clearly in-depth consideration was given to DE's Article 8 rights based on his specific circumstances. It would be interesting here if the facts were different and DE wanted more children. Perhaps if this were so the right to *choose* to reproduce would have had more bearing in the assessment. Harwood points out that King J's analysis illustrates that Article 8 points that arise in the context of best interests can be considered under s.4.¹⁴⁴ Although much is unclear, Article 8 is positively implicated in sterilisation cases under the right to *choose* to become a genetic parent. As is desirable this right is not absolute, it is flexible enough to take into account the whole picture when determining a patient's genuine best interests.

¹³⁸ Dimopoulos, *Issues in Human Rights*, p.180.

¹³⁹ Dimopoulos, A., 'Some Contrarian Thoughts on *Re DE* [2013] EWHC 2562 (Fam)', 17 August 2013, <http://andreasdimopoulos.wordpress.com/2013/08/17/some-contrarian-thoughts-on-re-de-2013-ewhc-2562-fam/> 20 March 2014

¹⁴⁰ *Re DE*, pp.72-76.

¹⁴¹ *Ibid*, p.52.

¹⁴² *Evans v UK* (App No. 6339/05) ECHR 10 April 2007, p.71.

¹⁴³ *Re DE*, p.77.

¹⁴⁴ Harwood, V., 'Non-therapeutic Sterilisation', (2013) *P.I Comp* 3 p.4.

Article 12

Article 12 states that men and women of marriageable age have the right to marry and to found a family according to national laws. Looking at ECtHR trends towards Article 12 will illuminate the question of its applicability. Eriksson suggests that Article 12 was a reaction against racist Nazi reproductive policies and European eugenics.¹⁴⁵ Thus it would be logical for patients to be protected under Article 12, considering its establishment was directly related to non-consensual sterilisation. In *X and Y v UK* the ECtHR held 'it is implicit in Article 12 that it guarantees a right to procreate'.¹⁴⁶ Eijkholt notes this shows early case law was favourable in interpreting the right to found a family as a right to procreate.¹⁴⁷ Hence there is a strong argument in turning to Article 12 when asserting reproductive rights. Despite this historical recognition the ECtHR has recently shown disfavour towards Article 12. In *SH v Austria* the ECtHR held Article 12 does not guarantee a right to conceive.¹⁴⁸ This confirmed the earlier ruling in *Sijakova* where despite having already declared the claim inadmissible the ECtHR explicitly stated 'Article 12 of the Convention does not guarantee a right to procreation'.¹⁴⁹ Eijkholt argues this convincingly signals that Article 12 does not offer any legal foundation for the right to procreate.¹⁵⁰ Hence if the ECtHR is currently approaching reproductive rights through other articles, the domestic approach should follow. This may explain why King J did not mention Article 12 in *Re DE*. Therefore Article 12 is potentially no longer appropriate when asserting reproductive rights.

Even if the ECtHR reverted back to Article 12, in practice it might not offer any protection for our purposes. Dimopoulos claimed that reproduction does not fall under Article 12 unless it is within marriage.¹⁵¹ In the history of sterilisation cases a patient has never been married so Dimopoulos' Article 12 submission would be obsolete in offering protection in this context. The Commission argued that even if the right to reproduce can exist without marriage, Article 12 recognises the existence of a couple as fundamental to its exercise.¹⁵² Thus Liu doubts whether a single

¹⁴⁵ Eriksson, M., *The Right to Marry and to Found a Family: A World-Wide Human Right*, (1990), p.29.

¹⁴⁶ *X and Y v United Kingdom* (App No 7229/75) (1977) 12 DR 32 (EComHR) p.33.

¹⁴⁷ Eijkholt, M., 'The Right to Found a Family a Stillborn Right to Procreate?', (2010) 18 *Medical Law Review* p.133.

¹⁴⁸ *SH and Others v Austria* (App No 57813/00) ECHR 03 November 2011 p.2.

¹⁴⁹ *Šjakova v Former Yugoslav Republic of Macedonia* (App No 67914/01) ECHR 06 March 2003 p.3.

¹⁵⁰ Eijkholt, 'The Right to Found a Family', p.136.

¹⁵¹ Dimopoulos, *Issues in Human Rights*, p.183.

¹⁵² *X v Belgium and Netherlands* (App No 6482/74) (1975) 7 DR 75 (EComHR) p.77.

individual can assert any reproductive rights under Article 12.¹⁵³ This is vital for sterilisation cases because most patients in this context are single. Hence its application is too restrictive to have any consistent value in sterilisation cases. Contrastingly, Eijkholt states Article 8 is facilitative regarding reproductive rights because it applies to everyone.¹⁵⁴ Therefore Article 12 is not desirable due to its restrictive scope and the current ECtHR approach.

Conclusion

The post-MCA approach to capacity has improved since the common law which ultimately denied patients a thorough capacity assessment. Capacity is now recognised as a genuine starting point and clarification has been given regarding the relevant information in sterilisation cases. The exclusion of parenting abilities within the assessment continues to be a valuable tool against detrimental third party views. However there is ample chance for detrimental subjectivity and prejudicial views to covertly operate under the 'practicable steps' standard. Furthermore the judiciary is still not explicitly and thoroughly analysing the patient's abilities within the functional test, hence the approach harbours a risk of covert subjectivity. Consequently these weaknesses allow for capacity to be judged on convenience. This risks defeating contraceptive autonomy in favour of a predetermined best interests assessment. Therefore the judicial approach, although improved, still inadequately protects patients against needless sterilisation.

A best interests assessment must genuinely promote the patient's interests and strictly adhere to the least restrictive principle to adequately protect a patient. The common law assessment lacked thorough analysis, denied patients participation and was uncertain regarding third party views thereby risking the assessment's accuracy. The approach has improved post-MCA by endorsing patient involvement in some cases, considering a wide range of views and providing clarity that the patient's interests are paramount. Furthermore under the post-MCA judicial approach and due to contraceptive advances, sterilisation should be a true exception. Interestingly this research has provided a significant finding that in practice, unlike the common law, the least restrictive principle will result in male vasectomy being the less restrictive option more frequently than female sterilisation. Unfortunately the research has discovered that participation can still be completely excluded without justification or

¹⁵³ Liu, A., *Artificial Reproduction and Reproductive Rights*, (1991, Aldershot: Dartmouth Publishing), pp. 131-132.

¹⁵⁴ Eijkholt, 'The Right to Found a Family', p.141.

tenuously circumvented. This risks an uninformed assessment. Additionally assessors can choose only to consider views that fit their own idea of the patient's best interests. Moreover third parties with insincere intentions can promote their own interests under the guise of promoting the patient's interests. Thus a best interest test can be distorted in a number of ways to fallaciously justify sterilisation.

The basic right to reproduce was weak and easily defeated offering little protection to patients. Although there is a lack of certainty in this context, it is concluded that contrary to Dimopoulos' view but supportive of recent ECtHR and domestic trends, Article 8 ECHR is most appropriate to offer protection in sterilisation cases. Article 8 is complementary to the least restrictive principle. It is flexible enough to protect patients against needless sterilisation but allows sterilisation where it truly serves the patient's best interests. Therefore each section has determined that although the protection against needless sterilisation has improved, it is still inadequate because the current approach indicates future cases are still open to uncertainty and distorted assessments.

The MCA's facilitative framework provides the tools for patients to be adequately protected but the judiciary must set clear precedent for the MCA's protection to become reality. Accordingly the following courses of action are needed. The judiciary must genuinely take all practicable steps to endorse autonomy. They must thoroughly and explicitly assess capacity to avoid an assessment based on subjectivity, prejudice or convenience. In addition the best interests assessment must be approached with caution to ensure the 'patient's views' are indeed their true and full views. Additionally when the judiciary considers third party views they must ensure these views truly promote the patient's interests. Furthermore the judiciary must continue to reinforce the least restrictive principle. Finally future analysis of cases involving females who are at risk of pregnancy would give a more direct analysis of any improvement in protection since the MCA.