THE ETHICAL AND LEGAL IMPLICATIONS OF PERFORMING INVOLUNTARY STERILIZATION ON MENTALLY INCOMPETENT ADOLESCENT WOMEN.

A DISSERTATION PRESENTED

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DECLARATION

I, **SERISHA BHAJAN**, declare that:

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SERISHA BHAJAN

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CHAPTER 1

1.1 INTRODUCTION

Sterilization is defined as "a procedure whereby a person could be permanently rendered incapable of fertilization or reproduction".[1] For many women sterilization is often the contraceptive method of choice.[2] For others, sterilization was the consequence of being dealt an unfortunate hand. It has been stated that "the right to bear a child is inviolable"[3] and yet thousands of women have been subjected to forced or coerced sterilization on account of poverty,[4] HIV status,[5] ethnicity,[6] and on the grounds of disability.[7]

Coerced sterilization refers to the sterilization of a woman on the grounds of misinformation, incentives or intimidation to compel the woman to undergo sterilization. Forced sterilization occurs when a woman is sterilized in the absence of both informed consent and knowledge thereof.[8] It has been stated that "forced and coerced sterilizations are grave violations of human rights and medical ethics and can be described as acts of torture and cruel, inhumane and degrading treatment."[9]

Women with disabilities, in particular, have been denied the opportunity to make decisions regarding their reproductive health and have been subjected to involuntary sterilization as a solution to the so called "problems" of menstrual management and the risk of conception.[10] The result being that whilst sterilization lessens the burden on the care giver charged with the

[1] Section 1 of the Sterilization Amendment Act 3 of 2005.
[2] Open Society Foundation, briefing paper: „Sterilization of Women and Girls with Disabilities", 10 November 2011 at 1 available at *http://www.opensocietyfoundations.org/publications/sterilization-women-and-girls-disabilities-0*, accessed on 21 May 2014.
[3] OI Paransky, RK Zurawin „Management of Menstrual problems and contraception in adolescents with Mental Retardation: A medical, Legal and Ethical Review with new suggested Guidelines" (2003) 16 *J Pedatr Adolesc Gynecol* 223:232.
[4] Open Society Foundation: „Against Her Will: Forced and Coerced Sterilization of Women Worldwide" 4 October 2011, at 4 available at *http://opensocietyfoundations.org/publications/against-her-will-forced-and-coerced-sterilization-women-worldwide*, accessed on 21 May 2014.
[5] Ibid 5.
[6] Note 4 above, 3.
[7] Note 4 above, 6.
[8] Note 2 above, 1.
[9] Note 4 above, 2.
[10] Note 2 above.

mentally incompetent patient‟s care, the patient herself is deprived of the ability to conceive a child and found a family of her own.[11]

The conventional justification for the involuntary sterilization of a mentally incompetent patient is that the procedure has to be performed on the basis that it is in the patient‟s best interests.[12] It has been submitted that instead of implementing measures to protect vulnerable mentally incompetent women against sexual abuse, instead of training and counseling incompetent women on how best to defend themselves against sexual predators and instead of providing access to education that encompasses personal hygiene during menstruation and family planning, sterilization is resorted to as an easy way out - effectively ridding the care giver of the inconvenience caused by menstruation and in addition, the patient‟s infertility means that there is one less thing to worry about.[13]

Whilst the involuntary sterilization of mentally incompetent women is acceptable provided that the procedure is performed on the basis that it is in the patient‟s best interests, the same will be looked at in light of the biomedical principles and ethical theories in order to determine the ethical implications of performing sterilization on mentally incompetent adolescent patients.

1.2 BACKGROUND

The Constitution of the Republic of South Africa (hereinafter referred to as "The Constitution") is founded on the principles of human dignity, the achievement of equality and the advancement of human rights and freedoms, guaranteeing the right to *inter alia* bodily and psychological integrity,[14] inclusive of the right to make decisions concerning reproduction[15] and to security in and control over the human body.[16] This dissertation aims to highlight the extent to which the aforementioned rights are protected in the context of the sterilization of mentally incompetent

[11] Note 2 above, 2.
[12] Note 2 above, 2.
[13] Note 2 above, 2.
[14] Section 12 (2) of the Constitution of the Republic of South Africa.
[15] Section 12 (2) (a) of the Constitution of the Republic of South Africa.
[16] Section (12) (2) (b) of the Constitution of the Republic of South Africa.

adolescent females in light of the Sterilization Act 44 of 1998 and analyze the ethical implications thereof.

A mentally incompetent individual has diminished autonomy and is accordingly unable to provide informed consent to medical procedures.[17] The decision to sterilize on her behalf is usually on the basis of menstrual management and personal care, pregnancy prevention as well as taking into account the individual"s ability in terms of motherhood and parenting.[18]

The primary justification for the involuntary sterilization of adolescent girls is that it is in their best interests.[19] Despite the justification for the choice of involuntary sterilization, and taking into account the degree of mental incompetence of the mentally incompetent adolescent concerned, there are psychological and physical effects that flow from the procedure.[20] Primarily that a female who is able to procreate and to have a family of her own is being denied the right to found and maintain a family and to retain her fertility on the basis of her disability.[21]

It is in light of the aforementioned that the ethical and legal implications of performing involuntary sterilization on mentally incompetent adolescents will be discussed, contrasting the legal position in South African law against that of the Australian states of Queensland, South Australia and New South Wales and finally, establishing whether a void exists in South African law and how best to address the void in order to afford maximum protection to the vulnerable group"s human rights.

Chapter two of this dissertation commences with a brief chapter on the history of sterilization in South Africa encompassing the historical eugenics program of the 1900s and the legal position prior to the commencement of the Sterilization Act.[22]

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[17] Note 2 above.
[18] Note 2 above.
[19] Note 2 above, 2.
[20] Note 2 above, 3.
[21] Article 23, UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly, 24 January 2007, A/RES/61/106 available at hhttp://www.un.org/disabilities/convention/conventionfull.shtml, accessed on the 4 August 2014.
[22] The Sterilization Act 44 of 1998.

Chapter three provides a discussion of the involuntary sterilization of women around the world in the past and in the present with the primary emphasis of the chapter being on the reasons for the sterilization of women and the complete disregard for autonomy, bodily integrity and human dignity.

Chapter four focuses on the Australian state of Queensland, and the current legal position regarding the sterilization of mentally incompetent adolescents. Australia has been chosen as part of the comparative analysis on the basis that Australia, like South Africa, is a former British colony and has a similar legal system.

Chapter five of this dissertation is dedicated to the legal position in South Africa and the International Human Rights Instruments that have been ratified by South Africa. Reference is made to the constitutional provisions pertaining to reproductive health and children, followed by a discussion of the relevant provisions of the Sterilization Act[23] and the Children‟s Act[24] as well as the International Covenant on the Rights of Persons with Disabilities[25] and The International Covenant on the Rights of the Child.[26]

In chapter six, the reasons for performing involuntary sterilization on mentally incompetent women will be discussed, as well as the alternatives to sterilization, and the benefits and risks thereof.

Chapter Seven is committed to a discussion of and the application of the biomedical principles to the issue at hand.

Chapter eight is committed to a discussion of and the application of the ethical theories to the issue at hand.

[23] Note 22 above.
[24] Note 23 above.
[25] UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution/adopted by the General Assembly, 24 January 2007, A/RES/61/106.
[26] United Nations Convention on the Rights of the child, 1989.

Chapter nine focuses on the standard of the best interests of the patient and how best the substitute decision-maker can make a determination as to whether sterilization truly is in the patient‟s best interests from an ethical point of view.

Chapter ten is the final chapter of this dissertation and brings the dissertation to a close with the writer‟s recommendations on the matter and concluding remarks.

1.3 RESEARCH METHODOLOGY

This dissertation is based purely on a literature review and is therefore desktop research. Relevant information has been sourced from the Constitution of the Republic of South Africa, The Sterilization Act[27] and the Children‟s Act,[28] International Human Rights Instruments such as the Convention on the Rights of People with Disabilities and the Convention on the Rights of the Child, the Health Professions Council ethical guidelines on Reproductive Health[29] and the Health Professions Council ethical guidelines on informed consent[30] as well as academic writing.

Reference is made to Australian law as part of the comparative study on how the sentiments enshrined in the Convention on the Rights of Persons with Disabilities have been given effect to within Australian law.

[27] Note 22 above.
[28] The Children‟s Act 38 of 2005.
[29] The Health Professions Council of South Africa General Ethical Guidelines for Good practice in the Health Care Professions. Reproductive Health. Booklet 13.
[30] The Health Professions Council of South Africa General Ethical Guidelines for Good practice in the Health Care Professions. Seeking Patient‟s Informed Consent: The Ethical Considerations. Booklet 9.

CHAPTER 2
FAMILY PLANNING IN PRE AND POST APARTHEID SOUTH AFRICA

2.1 INTRODUCTION

Prior to the enactment of the Abortion and Sterilization Act,[31] the legal position concerning the issues of abortion and family planning in South Africa were governed by the common law.[32] In terms of the common law, an abortion was permitted only if the continued pregnancy would jeopardize the mother‟s life.[33] In the 1930s, so called "mother‟s clinics" were introduced for the purpose of providing economically disadvantaged, married white women with advice and effective methods of contraception.[34] The rationale behind the establishment of the clinics, according to the apartheid government, was that the quality of the white race would be improved if poor white women were provided with contraception as their ability to procreate would be limited.[35] Consequently, the white population experienced a drop in birth rate at the same time that there was an increase in the birth rate of the black population.[36] The growth of the black population sparked fear that the black population would over populate the country and the need to curb the rapid growth of the black population increased.[37] The attitude towards the black population is best summed up in the words of B. J. Vorster, the Prime Minister at the time, "we would like to reduce them, and we are doing our best to do so, but at all times we would not disrupt the South African economy".[38] Under the Apartheid regime, the white population was encouraged to procreate in order to maintain white supremacy over a growing black and coloured population.[39] Consequently, in an attempt to encourage procreation, white women were offered tax incentives and other benefits such as child benefit payments in order to increase the birth rate

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[31] Note 22 above.
[32] United Nations South Africa Abortion policy available at *www.un.org/esa/population/publications/abortion/doc/southafrica.doc* accessed on the 04 August 2014.
[33] Ibid
[34] National Department of Health, National Contraception Policy guidelines page 5 available at *http://www.kznhealth.gov.za/contraception.pdf* accesses on the 21 January 2015.
[35] Ibid.
[36] Note 28 above, 5 – 6.
[37] Note 28 above, 6.
[38] Ibid.
[39] S. Guttermacher, F. Kapadia , J. Te Water Naude, H. De Pinho „Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act" 1998 (24) 4 *International Family Planning Perspectives* 191:191

of the white population.[40] Whilst on the other hand, contraception was advocated for black and coloured women.[41]

Accordingly, family planning programmes that were implemented in the 1970s were directed at lowering the black population‟s birth rate and such was the determination to reduce the black population that in the 1980s at the government funded company Roodeplaat Research Laboratory, research was underway for the purpose of creating a means of not only ridding the country of black people as well as a vaccination that would be administered to black people in order to render them infertile.[42]

2.2 THE ABORTION AND STERILIZATION ACT 2 OF 1975

Legislation such as the Abortion and Sterilisation Act 2 of 1975 (hereinafter referred to as "The Abortion and Sterilisation Act") impacted on family planning services. The provisions of The Act were restrictive and made access to Abortion services difficult for most women.[43] In consequence thereof, many women sought backdoor abortions whilst others sought abortions overseas.[44]

Concerning the issue of sterilization of the mentally incompetent patient, the Abortion and Sterilization Act required that in the absence of their informed consent, two medical practitioners (one being a psychiatrist) had to certify in writing that the patient is fertile, that the patient‟s mental incompetence was hereditary in nature, and if the patient were to procreate, the child born of such a patient would be handicapped either physically or mentally.[45] Furthermore, the Act provided that if, on account of mental incompetence, the patient is not able to comprehend the consequences of procreation or bear the responsibilities flowing from being a parent, such a patient would be an eligible candidate for sterilization provided that consent was granted by the

[40] Ibid.
[41] Note 33 above.
[42] JA Singh „Project Coast: Eugenics in Apartheid South Africa‟ (2007) 32 *Endeavour* 1: 6
[43] Note 28 above, 7.
[44] Note 33 above.
[45] Nash ES, Navias M. „The therapeutic sterilisation of the mentally handicapped experiences with the Abortion and Sterilsation Act of 1975‟ (1992) 82 *SAMJ* 437:437.

patient‟s surrogate decision maker[46] as well as in writing from the Minister of Health and Population Development.[47]

In order for a request for involuntary sterilization to be considered, the patient had to be assessed by a clinical psychologist. The role of the clinical psychologist was to conduct social and psychometric assessments on the patient.[48] Beneficial information pertaining to the patient‟s ability or inability to adapt to changing situations as well as information pertaining to *inter alia* sexual abuse and the patient‟s reaction to stressful situations were elicited from a relative close to the patient in order to make a determination regarding the degree of the patient‟s mental incompetence and whether the patient was in fact eligible for sterilisation.[49] In addition, an experienced psychiatric social worker was required to interview both the patient and her family and take into consideration the patient‟s circumstances and the will of the family.[50]

A consultant psychiatrist was required to interview the patient and her family and after considering all relevant information previously elicited, the psychiatrist would then determine whether it is advisable for the patient to be sterilized.[51] Thereafter, if written consent to the sterilization procedure was granted by the Minister of Health and Population Development, the patient was referred to a hospital for sterilization.[52]

The Act provided that in instances where the patient had not reached puberty, sterilization would not be granted. In addition, where alternate contraceptive methods had not been used or even considered and where the family expressed reservations regarding the procedure, sterilization was not be granted.[53] On the other hand, patients who were incompetent to the extent that they were rendered incapable of self-care and personal hygiene, were incapable of communicating on

[46] Ibid; Section 4 of the Abortion and Sterilization Act 2 of 1975.
[47] Note 39 above.
[48] Note 39 above.
[49] Note 39 above.
[50] Note 39 above, 438.
[51] Ibid.
[52] Note 44 above.
[53] Note 44 above.

a meaningful level and were immobile, were sterilized particularly in order to relieve the family of the burden of menstrual management.[54]

In all instances, the patients were incapable of consenting to sterilization on account of their mental incompetence, the nature of which deprived the patient of understanding the consequences flowing from *inter alia* procreation.[55] The decision was taken in order to ease the burden on the patient‟s family who were tasked not only with ensuring the welfare of a mentally incompetent individual but were also required to exercise a higher degree of supervision in order to ensure that the individual in their care was protected against sexual abuse and unwanted pregnancy.[56]

2.3 CONCLUSION

The provisions of the Abortion[57] and Sterilization Act pertaining to Sterilization were abolished by the Sterilization Act.[58] The Sterilization Act allows for sterilization of a mentally competent patient provided that the patient is over the age of eighteen (18) years old, is capable of giving informed consent and has furnished consent to the procedure. The relevant provisions of the Sterilization Act will be discussed in greater detail in chapter five below.

Essentially, in repealing the Abortion and Sterilization Act, the provisions of the Choice on Termination of Pregnancy Act[59] and the Sterilization Act have ensured that the state no longer has such stringent control over access to abortions and sterilizations and the issue of family planning vests in the hands of individual.

[54] Note 44 above.
[55] Note 44 above.
[56] Note 44 above.
[57] The provisions pertaining to abortion were repealed by the Choice on Termination of Pregnancy Act 92 of 1996.
[58] Note 22 above, note 28 at page 15.
[59] Choice on Termination of Pregnancy Act 92 of 1996

CHAPTER 3
INVOLUNTARY STERILIZATION WORLDWIDE PAST AND PRESENT

3.1 INTRODUCTION

Thomas Malthus cautioned in 1798 that population control was essential on the basis that human beings have the ability to bear many children and a rapidly growing population would impact negatively upon the environment.[60] Food and other resources would become scarce and in time, epidemics would be rife and social issues caused by overcrowding would result in the overpopulated region crumbling under the pressure of a demanding and increasingly growing population.[61] Despite his warning, Malthus was not in favor of programmes aimed at controlling population growth.[62] Malthus believed that moral restraint was all that was required to prevent over population.[63] According to Battin, early population control was achieved through sterilization and later progressed to reversible methods of contraception.[64]

From 1948 when the apartheid regime was in power, sterilization was used as a tool to achieve in some instances, racial hygiene[65] and in other instances, racial supremacy.[66] This chapter focuses on the abuse of sterilization by various states during the 1990s and to date.

3.2 STERILIZATION IN THE UNITED STATES OF AMERICA

Whilst sterilization policies in South Africa in the 1900s were directed at preventing the growth of the black population, sterilization in Europe and the United States of America was justified on the basis of eugenics[67]. The belief was that traits such as intellect were hereditary[68] and as stated

[60] MP Battin 'Population Issues' in H Kuhse & P Singer (ed) *A Companion to Bioethics* (1998): 149.
[61] Ibid.
[62] Note 53 above.
[63] Note 53 above.
[64] Note 53 above.
[65] Note 39 above, 440.
[66] Note 28 above, 6.
[67] J. Watson „Does the Mental Capacity Act 2005 adequately protect persons with learning difficulties against needless non-consensual sterilisation?" (2015) 1 *Plymouth Law and Criminal Justice Review* 167:167.
[68] ES Scott „Sterilization of Mentally Retarded Persons: Reproductive Rights and Family Privacy" (1986) *Duke Law Journal* 806:809 footnote 12.

by the court in the case of *Buck v Bell*[69] "it is better …if instead of waiting to execute degenerate offspring for crime, or …let them starve for their imbecility, society can prevent those …manifestly unfit from continuing their kind. …three generations of imbeciles is enough"[70] Eugenic policy was based on Mendel"s theory that certain character traits are hereditary.[71] It was accordingly argued that character traits such as criminal tendencies and mental incompetence were hereditary and as a means of controlling the spread of such undesirable traits, mentally incompetent, criminal and epileptic people were targeted by sterilization laws.[72] The idea was that the bearers of the aforementioned "undesirable traits" were procreating rapidly and therefore posed a threat to the "normal" members of society.[73] Social Darwinists were anxious to improve the species and socialists endeavored to use sterilization as a tool to achieve the goal of small families which would result in an improved quality of living for the working class.[74]

According to Scott, "involuntary sterilization was used as a weapon of the state in the war against mental deficiency".[75] Eugenic policy required that those targeted by eugenic laws were sterilized in the absence of both their knowledge and informed consent to the procedure.[76] The evils of the eugenic sterilization policy of the United States of America in the early 1900s ranged from sterilizing mentally incompetent patients in order to prevent them from procreating, to using sterilization as a method of punishing rapists.[77] Sterilization was also used as a method of reducing public welfare expenditure on the basis that sterilization would prevent the birth of children who would have to be supported by the state as their parents were incapable of supporting them financially or otherwise.[78] However, the United States Supreme Court declared in 1942, that procreation is a fundamental human right, making authorization for the sterilization of mentally incompetent patients difficult to obtain.[79]

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[69] 274 US 200 (1927)
[70] Ibid.
[71] Note 61 above.
[72] Note 61 above footnote 11.
[73] Note 61 above, 809 – 810 footnote 12.
[74] Note 61 above, 806.
[75] Note 61 above, 806.
[76] Note 61 above, 806.
[77] Note 61 above, footnote 11
[78] Note 61 above, footnote 11
[79] American Academy of Pediatrics „Sterilization of minors with disabilities" Committee on bioethics (1999) 104 *Pediatrics* 331: 331

3.3 STERILIZATION IN NAZI GERMANY

In Europe during the period of 1933 – 1939, Germany enacted and implemented a series of laws with the sole purpose of the attainment of "Nazi racial hygiene".[80] The Nazi regime aimed to purge Germany of people deemed to be genetically defective alternatively, "racially foreign"[81] and advocated the "Nordic race"[82] as the supreme race to inhabit Germany.[83]

The Nazi regime seized control over the media and all educational and cultural institutions in Germany and ensured that eugenics began to infiltrate every institution and Jews (who were believed to be an alien race) were forced to leave all institutions including universities, hospitals and public healthcare institutions.[84]

In 1935, the Nazi regime passed the Marital Health Law of October 1935.[85] The main objective of the Act was to prohibit marriage between genetically fit and genetically defective individuals.[86] A national duty imposed upon the genetically fit was for them to get married and procreate and in doing so, ensure the growth of a superior, genetically sound race.[87]

The Reich Central Office for Combatting Homosexuality and Abortion was established in 1936 with the purpose of removing all obstacles to reproduction for genetically fit people.[88]

The following conditions: "feeblemindedness, schizophrenia, manic-depressive disorder, genetic epilepsy, Huntington‟s Chorea, genetic blindness, genetic deafness, severe physical deformity and chronic alcoholism" were believed to be hereditary.[89] The Law for the Prevention of Genetically Diseased Offspring was enacted on the 14 July 1933 and was applicable to all men

[80] United States Holocaust Memorial Museum, Washington, DC Holocaust Encyclopedia available at *http://www.ushmm.org/wlc/en/article.php?Moduleld=10007057*, accessed on 29 September 2014.
[81] Ibid.
[82] Note 73 above.
[83] Note 73 above.
[84] Note 73 above.
[85] Note 73 above.
[86] Note 73 above.
[87]Note 73 above.
[88] Note 73 above.
[89] Note 73 above.

and women with any of the aforementioned conditions, men being sterilized by vasectomy and women by tubal ligation.[90]

On the 15 September 1935, the Blood Protection Law was enacted. The Act made marriage and sexual relations between the genetically fit German race and Jews a criminal offence.[91] The ultimate step in order to attain complete segregation was the forced emigration of Jews.[92] Similarly, in South Africa under the apartheid government, legislation was enacted prohibiting inter-racial marriages and ensuring racial segregation.

As has previously been stated, the involuntary sterilization of mentally incompetent women has been practiced worldwide historically, based on eugenics polices[93] in order to maintain "racial hygiene"[94] and to date for reasons such as relieving family members or care givers of the burden of menstrual management in adolescent females and as a preventative measure against unwanted pregnancies arising from sexual abuse.[95] In instances where an individual is deprived of the ability to consent to medical procedures on account of mental incompetence, sterilization is referred to as involuntary sterilization.[96] However, despite the grave injustice, involuntary sterilization is not a thing of the past. To date, even mentally competent women are sterilized in the absence of informed consent.

3.4 PRESENT DAY STERILIZATION WORLDWIDE

One of the categories of women that have been sterilized in the absence of knowledge and consent are women belonging to racial and ethnic minorities. Such was the case in the Czech Republic, Hungary and Slovakia.[97] In this context, sterilization occurred after delivering a baby by caesarian section alternatively, whilst a woman is labour she would be told that sterilization has to be performed immediately. The consent form handed to her for signing (whilst she was in

[90] Note 73 above.
[91] Note 73 above.
[92] Note 73 above.
[93] Note 31 above, 440.
[94] Note 31 above, 440.
[95] Note 31 above, 439.
[96] Note 4 above, 3.
[97] Note 4 above, 3.

labour) was either written in illegible hand writing, was in a language unfamiliar to the woman, or in Latin terms.[98]

Poor women often fall victim to involuntary sterilization. For instance, in Uttar Pradesh, India poor, illiterate women had been sterilized involuntarily in so called "sterilization camps".[99] The procedure to be employed in the sterilization process, the available alternatives and the consequences flowing from the procedure were never explained to the women. They were requested to sign the consent form by way of a thumb print and sterilization was performed unbeknown to them.[100]

In 2010, it came to light that in Uzbekistan, women were being forced to undergo sterilization in order to secure employment as part of the government"s family planning program.[101] The pre-requisite for eligibility for employment was a so called "sterilization certificate".[102]

Cases of HIV positive women being forced to undergo sterilization have been recorded in Chile[103], the Dominican Republic[104], Mexico[105], Namibia[106], South Africa[107], and Venezuela.[108] Women who are ignorant of the available medical treatment to prevent mother to child transmission of HIV are told that if they continue with the pregnancy, HIV will be transmitted to the unborn child.[109] Alternatively, medical services are denied to women who do not consent to sterilization.[110]

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[98] Note 4 above, 3.
[99] Note 4 above, 4.
[100] Note 4 above, 4.
[101] Note 4 above, 4.
[102] Note 4 above, 4.
[103] Centre for Reproductive Rights and VIVO POSITIVO, *Dignity Denied: Violations of the Rights of HIV-Positive Women in Chilean Health Facilities* (2010).
[104] Human Rights Watch, A Test of Inequality: Discrimination against Women Living with HIV in the Dominican Republic (2004), 41 – 43.
[105] Tamil Kendall*, 'Reproductive Rights Violations Reported by Mexican Women with HIV,'* Health and Human Rights in Practice 11 (2) 79 – 84.
[106] J. Gatsi, J. Kehler, T. Crone, *Make it Everybody's business: Lessons Learned from Addressing the Coerced Sterilization of Women Living with HIV in Namibia* (2010).
[107] Anna-Maria Lombard, '*South Africa: HIV-Positive Women Sterilized Against the Will*' City Press, June 7, 2010
[108] Note 4 above, 5.
[109] Note 4 above, 5. Of further relevance in this regard are the provisions of The National Health Act 61 of 2003; Sexual Offences Act 32 of 2007; Mental Health Care Act 17 of 2002; Choice on Termination of Pregnancy Act 92

It has been reported by women in Namibia and South Africa, that whilst in labour and *en route* to the operating theatre, women have been rushed to sign consent forms for sterilization to be performed on them.[111] The consent forms were forced upon the women and the content of which was never explained to them.[112] In Chile, on the other hand, women have reported being sterilized in the absence of their consent. In such cases, sterilization was performed during a cesarean section.[113]

Recent events in India best illustrate the evils of coerced sterilization and the risks women face in undergoing the procedure in less than favorable conditions. India‟s family planning programme dates back to 1951 when the first five year plan was implemented.[114] The five year plan aimed to reduce the country‟s birth rate as the economy was taking strain under the rapidly growing population.[115] A department of family planning was established in 1966 to address the issue of family planning in India.[116] However, the country‟s birth rate continued to climb and impacted negatively on the family planning programme.[117] In an attempt to make a success of its family planning programme, the department of family planning began to offer financial incentives to women to encourage sterilization and sterilization targets were implemented.[118]

In the 1970s, sterilization camps were established for the purpose of sterilizing men by performing vasectomies.[119] Whilst the vasectomy is a simple and cost effective method of family planning, the vasectomy began to decline in popularity on account of the unsavory treatment of the young men who had been coerced into sterilization camps which resulted in the

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of 1996; as well as the matter of Minister of Health v Treatment Action Campaign (Case No 2) 2002 (5) SA 721 (CC).

[110] Note 4 above, 5.

[111] Note 4 above, 5.

[112] Note 4 above, 5.

[113] Note 4 above, 5.

[114] S. Venkatram „India‟s sterilization camps must give way to proper family planning‟ available at: *http://www.theguardian.com/global-development/poverty-matters/2014/nov/22/india-sterilization-camps-family-planning-tragedy*, accessed on the 24 November 2014.

[115] Ibid.

[116] Note 114 above.

[117] Note 114 above.

[118] Note 114 above.

[119] Note 114 above.

family planning programme coming to a close.[120] In 1977, the department of family planning under the new name of the department of family welfare proceeded to revive India‟s family planning programme.[121] The attempt however, was unsuccessful.[122]

In 2000, India‟s population policy moved away from a target based approach to family planning.[123] It was acknowledged that sterilization was not the answer to solving the problem of India‟s rapidly growing population. What was required was for the women of India to be empowered through education and employment.[124]

The move away from a sterilization target was replaced with what was termed the "expected level of achievement". Health care workers were motivated to meet the expected level of achievement by being offered incentives.[125]

The Indian government‟s obsession with lowering India‟s birth rate continues and free sterilization is promoted.[126] To date, India‟s family planning programme has shifted its focus from the sterilization of men to the sterilization of women. Poor women are lured into sterilization camps where they are coerced into sterilization in exchange for as little as Rs 1400-00[127] (approximately 10 US Dollars).

On the 12 November 2014, after undergoing free sterilization procedures, eleven women died and twenty remained in critical condition.[128] It came to light that the deaths occurred in consequence of contaminated antibiotics that had been administered to the women who underwent sterilization at the sterilization camp in Bilaspur district of Chhattisgarh state,

[120] Note 102 above.
[121] Note 102 above.
[122] Note 102 above.
[123] Note 102 above.
[124] Note 102 above.
[125] Note 102 above.
[126] K. Daigle „At least 11 women die after sterilization in India‟ available at: http://za.news.yahoo.com/2-india-women-die-27-ill-sterilization-061843655.html accessed on the 24 November 2014.
[127] Note 102 above.
[128] Note 102 above.

India.[129] The antibiotics were said to have been contaminated with Zinc Phosphide.[130] An investigation as to why the antibiotics were purchased locally from Mahawar Pharmaceuticals, a company that was previously barred (in 2012) from producing drugs in account of having produced drugs of inferior quality is in progress.[131]

In all of the aforementioned instances, the determination to perform sterilization has been made by the medical practitioner in the absence of informed consent and without having due regard not only in respect of the risk of performing such a procedure but also in respect of the far reaching consequences of rendering a woman infertile. Sadly, such medical practitioners are not held accountable for their actions.[132] Their lives continue and it is the sterilized woman who has to live with the far reaching consequences of being rendered infertile. A woman may be abandoned by her spouse due to her inability to procreate, she may lose trust in medical professionals and the realization that she cannot have children of her own. The fact that the ability to found a family has been taken away from her, will no doubt have adverse psychological effects and have aptly been described as "acts of torture and cruel, inhumane and degrading treatment".[133]

[129] Kalra A. & Shah A. 'Rat poison chemical found in pills linked to India sterilization deaths' 15 November 2014 available at *http://www.reuters.com/article/2014/11/15/us-india-health-sterilisation-idUSKCN0IZ06520141115* accessed on the 21 January 2015.
[130] Ibid.
[131] Note 117 above.
[132] Note 4 above, 2.
[133] Note 4 above, 2.

CHAPTER 4

THE INVOLUNTARY STERILIZATION OF MENTALLY INCOMPETENT WOMEN AND GIRLS IN AUSTRALIA

4.1 INTRODUCTION

Australia, like South Africa is a former British colony.[134] Having adopted a federal constitutional system, Australia‟s legislative, judicial and executive powers are shared between Australia‟s six states and the federal government.[135] Matters pertaining to the protection of children in Australia are governed by states and territories.[136] Of the six Australian states, the states of New South Wales, South Australia and Queensland have enacted legislation that deal with the issue of sterilization of children.[137]

However, prior to the 1980s, involuntary sterilization of mentally incompetent girls and women was rife in Australia.[138] A hysterectomy was performed on young girls prior to the onset of puberty on the basis that sterilization was a prerequisite to obtaining admission at an institution in which mentally incompetent women would be cared for.[139]

In the 1980s it came to light that mentally incompetent women were being subjected to involuntary sterilization.[140] Consent to the sterilization procedure could not be sought from the

[134] The official website of the British Monarchy available at *http://www.royal.gov.uk/MonarchAndCommonwealth/Australia/Historyandpresentgovernment.aspx* accessed on the 21 January 2015.
[135] Childrens rights: Australia available at *htttp://www.loc.gov/law/help/child-rights/Australia.php*, accessed on 12 September 2014.
[136] T. Boezaart „Protecting the reproductive rights of children and young adults with disabilities: the roles and responsibilities of the family, the state and judicial decision-making‟ (2012) 26 *Emory International Law Review* 69:82
[137] Ibid.
[138] L. Hallahan „Time to stop the forced sterilization of girls and women with disability‟ available at *http://www.abc.net.au/rampup/articles/2012/10/05/3604907.htm,* accessed on 6 November 2014.
[139] Ibid.
[140] C. Frohmader „Dehumanized. The forced Sterilization of Women and Girls with Disabilities in Australia‟ WWDA submission to the Senate Inquiry into the involuntary or coerced sterilization of people with disabilities in Australia March 2013 at page 26 available at http://wwda.org.au/wp-content/uploads/2013/12/WWDA_Sub_SenateInquiry_Sterilisation_March2013.pdf accessed on the 6 November 2014.

patient on account of her mental incompetence and was obtained from the patient‟s doctor, family or care giver.[141] The patient was ignorant of the purpose of the procedure.[142]

In 1992, the Australian High Court held that consent for the sterilization of a mentally incompetent young girl for non-therapeutic purposes must be obtained from the court.[143] The matter before the court was the case of Department of Health and Community Services V JWB and SMB (Marion‟s case).[144] The application was made to the Australian High Court for the sterilization of a young woman on the basis of menstrual management and the prevention of conception.[145] The court *a quo* held that that "the function of [the] court when asked to authorize sterilization is to decide whether, in the circumstances of the case, that is in the best interests of the child".[146]

As has previously been stated, the Australian states of New South Wales, South Australia and Queensland have enacted legislation that deal with the issue of sterilization of children.[147] The remaining Australian states have not enacted legislation dealing with the issue of sterilization of minors. As such, Women with Disabilities Australia (WWDA) has in its 2013 submission to the Australian government, recommended the enactment of national legislation that will prohibit the sterilization of minor women irrespective of their mental competence and of adult females with disabilities without first obtaining informed consent and in the absence of coercion to the sterilization procedure. It was further recommended that legislation should permit sterilization only if a failure to do so would pose a grave danger to the woman‟s life.[148]

[141] Note 128 above.
[142] Note 128 above.
[143] Note 128 above.
[144] [1992] HCA 15.
[145] Note 128 above.
[146] [1992] 175 CLR 218 (Austl.) at para 259.
[147] Note 124 above.
[148] Note 128 above, 14.

4.2 QUEENSLAND

The legal position in Queensland regulating the sterilization of mentally incompetent minors in light of the Guardianship and Administration Act[149] (hereinafter referred to as "the Act") is that the best interests of the child will determine whether a child should be sterilized.[150] The Queensland Civil and Administrative Tribunal is vested with the authority to consent to the sterilization of children and in terms of Section 80C (1) of the Act, the tribunal will only consent to such sterilization if it has been satisfied that the sterilization will serve the child‟s best interests.[151]

Section 80D of the Act enshrines the criteria to be taken into account in determining whether sterilization is in the best interests of the mentally incompetent child. According to Section 80D (1) (a) (i), the best interests of the child include sterilization for therapeutic purposes; as a method of contraception where no other method of contraception would be as successful as sterilization in terms of Section 80D (1) (a) (ii) and if menstruation related problems can only be remedied by the removal of the uterus in order to eliminate menstruation in terms of Section 80D (1) (a) (iii). Section 80D (1) (b) further provides that sterilization is in the best interests of a mentally incompetent child in instances in which the child is impaired to the extent that her capacity to communicate, socialize and learn is substantially reduced. In terms of Section Section 80D (1) (c) Sterilization is also in the child‟s best interests where the possibility exists that the child‟s impairment is permanent and accordingly, the child will not be competent to consent to sterilization upon attaining majority at age eighteen.

The Act has by virtue of Section 80D (2) (a) made it explicit that sterilization is not in the child‟s best interests if the procedure is to be performed on the basis of eugenics and in terms of Section Section 80D (2) (b) if the reason for sterilization is to prevent the risk of conception in consequence of sexual abuse.

[149] Guardianship and Administration Act 2000 (Qld) (Austl)
[150] Note 124 above, 83.
[151] Note 124 above, 83.

In Section 80D (3) (a), the Act further provides guidance to the tribunal determining whether sterilization is in the best interests of the child and provides that in making its decision, the tribunal must ensure that the child‟s dignity and privacy are not violated. Section 80D (3) (b) (i) further directs that the tribunal must take into account the age of the child and solicit the child‟s opinions on the matter. If possible, in terms of Section 80D (3) (b) (ii) the opinions of the child‟s parent or legal guardian or primary care giver and that of the child representative must be obtained and taken into consideration by the tribunal.

In addition, in terms of Section 80D (3) (c) (iv) the tribunal is directed to take into consideration the child‟s wellbeing; alternative options to sterilization that have been explored and not had the desired effect on the child as well as the long term and short term risks that sterilization may pose to the child and that of the proposed alternatives to sterilization.

The Act further provides in terms of Section 80D (4) that a child may express her views orally, in writing or in any other method which is inclusive of conduct.

In further protecting the interests of the child, Section 80L (1) of the Act requires the appointment of a child representative. The Act provides in terms of Section 80L (2) that only an attorney with experience in dealing with impaired children is an eligible candidate. The child representative has a duty to act in the best interests of the child; to take cognizance of the opinions and wishes expressed by the child on the matter and to endeavor to present the child‟s thoughts and wishes on the matter to the tribunal in terms of Section 80L (3).

In order to ensure that the child representative has sufficient information at his disposal to enable him to act in the best interests of the child, the Act provides that the tribunal may direct that the child‟s treating physician or a physician that has previously treated the child as well as the child‟s parents, furnish the child representative with information regarding the child.[152] The Act further provides that the person directed to furnish the child representative with information regarding the child is obliged to comply with the request unless he has a “reasonable excuse” for

[152] Section 80L (4)

not divulging any information.[153] The Act provides that it is a reasonable excuse for failing to furnish information to the child representative if divulging the information will have the effect of incriminating the person tendering the information.[154]

4.5 CONCLUSION

It is clear that the Guardianship and Administration Act 2000 seeks to ensure that sterilization is performed on mentally incompetent minors only if such procedure will serve the minor‟s best interests[155] and not on eugenic grounds or in order to prevent conception.[156] Additionally, in requiring that every effort is made to ensure that the minor‟s thoughts on the matter are obtained,[157] the act satisfies the ethical principle of respect for persons.

[153] Section 80L (5)
[154] Section 80L (6)
[155] Note 142 above.
[156] Note 149 above.
[157] Note 151 above.

CHAPTER 5
SOUTH AFRICAN LAW AND INTERNATIONAL INSTRUMENTS

5.1 INTRODUCTION

As has previously been stated, the South African constitution guarantees the right to, *inter alia,* bodily and psychological integrity[158] inclusive of the right to make decisions concerning reproduction[159] and to security in and control over the human body.[160] However, the rights and freedoms entrenched in the constitution are not absolute and can be limited in terms of Section 36 of the constitution.[161]

Section 36 of the constitution provides:

(1) The rights in the bill of rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including-
   (a) The nature of the right;
   (b) The importance of the purpose of the limitation;
   (c) The nature and extent of the limitation;
   (d) The relation between the limitation and its purpose; and
   (e) Less restrictive means to achieve the purpose.

In terms of section 36 (1) of the constitution, a right enshrined in the bill of rights can be limited provided that such limitation is in terms of a law of general application.[162] The law being used to limit a right must be clear and equal in its application and not applied arbitrarily.[163]

[158] Note 14 above.
[159] Note 15 above.
[160] Note 16 above.
[161] I. Currie & J De Waal *The Bill of Rights Handbook* 5 ed (2005) 136.
[162] Currie and De Waal (note 167 above) 168.
[163] Ibid.

According to the authors Currie and De Waal, the requirements that the law must be reasonable and justifiable means that the reason for restricting a right embodied in the bill of rights must be "acceptable to an open and democratic society based on human dignity, equality and freedom".[164] Reasonableness requires that the limitation must achieve a particular purpose and not infringe upon any other fundamental right.[165] Further, not only must the law be applied in order to achieve a goal that is constitutionally acceptable, in addition, the harm or infringement of the right enshrined in the bill of rights must be balanced against the purpose that the law aims to achieve.[166]

In the knowledge that the rights enshrined in the constitution are not guaranteed and are subject to section 36 of the constitution,[167] the constitutional provisions pertaining to reproductive health will be highlighted in this chapter as well as the pertinent sections of the Sterilisation Act and the Children"s Act respectively.

5.2 THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA

The Constitution of the Republic of South Africa enshrines the right to bodily and psychological integrity[168] which is inclusive of the right to make decisions concerning reproduction.[169] According to McQuoid-Mason, the latter includes the right to make decisions regarding contraception.[170]

The Constitution further prohibits unfair discrimination on any of the grounds provided in Section 9 (3).[171] Section 9 (3) of the constitution provides that "the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds including…disability". However, the constitution does allow for discrimination on a listed ground on condition that it is

[164] Currie and De Waal (note 167 above) 176.
[165] Ibid.
[166] Currie and De Waal (note 167 above) 176.
[167] Note 167 above.
[168] Note 14 above.
[169] Note 15 above.
[170] Ames Dhai & David McQuoid-Mason Ethics, Human Rights and Health Law (2011) 110.
[171] Harksen vs Lane NO 1998 (1) SA 300 (CC) para 49.

proved that such discrimination does not impact unfairly on those discriminated against.[172] In this regard section 9 (5) of the constitution provides that "discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair". Accordingly, sterilization of mentally incompetent patients on the grounds of disability will amount to unfair discrimination unless the discrimination is in accordance with a law of general application.

Regarding the rights of the child, the constitution provides that "the child's best interests are of paramount importance in every matter concerning the child".[173]

The aforementioned principles enshrined in the constitution have been given effect to in the Sterilisation Act[174] and the Children's Act[175] respectively and will be discussed below.

5.3 THE STERILIZATION ACT 44 OF 1998

The preamble to the Sterilization Act[176] (hereinafter referred to as "The Sterilisation Act") specifically states that the constitutional provisions relating to reproduction and the rights of men and women to exercise control over their bodies as well as the right to be informed of, and have access to, safe methods of contraception, are recognized.[177]

The Sterilisation Act not only creates a clear right to sterilization, but also allows for the sterilization of individuals who do not possess the requisite competence to consent to a sterilization procedure on account of mental disability.[178]

The Act further allows for the sterilization of a person who is incapable of providing informed consent to sterilization or is incompetent to provide informed consent on condition that certain

[172] Currie and De Waal (note 167 above) 246.
[173] Section 28 (2) of the Constitution.
[174] Note 22 above.
[175] Note 23 above.
[176] Note 22 above.
[177] The Sterilization Act 44 of 1998.
[178] Ibid.

requirements are satisfied.[179] In terms of Section 3 of the Sterilisation Act, a request for sterilization must be made to a person in charge of the hospital.[180] Consent to sterilization must be given by the patient‟s parent, spouse, guardian or curator.[181] If the patient concerned is mentally incompetent to the extent that the patient is deprived of the ability to make decisions regarding contraception or sterilization, develop mentally in order to gain the requisite mental competence to make decisions regarding contraception or sterilization and of assuming the responsibilities that follow giving birth to a child, the person in charge of the hospital is required to convene a panel consisting of a psychiatrist alternatively, a medical practitioner in the event that a psychiatrist is not available, a psychologist alternatively, a social worker, and a nurse.[182] In reaching a decision, the panel must have due regard to factors such as the age of the patient;[183] alternatives to sterilization that are both effective and safe in nature;[184] the patients wellbeing, mental and physical health;[185] the potential effects that sterilization may have on the patient‟s wellbeing, mental and physical health;[186] the nature of the procedure to be performed on the patient;[187] whether the possibility exists that the patient may become competent to consent to the sterilization procedure;[188] whether sterilization is in the patient‟s best interests[189] and finally, the benefits of sterilization for the patient.[190] After taking the aforementioned factors into consideration, the panel will then determine whether the patient is to be sterilized. It is worth noting that autonomy, beneficence, non-maleficence and justice are not enumerated in section 3 of the Sterilisation Act as factors to be considered in reaching a decision as to whether the mentally incompetent patient is to be sterilized.

Mental disability as envisaged in the Act means “a range of functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a

[179] Ames Dhai & David McQuoid-Mason *Ethics, Human Rights and Health Law* (2011) 108
[180] Section 3 (1) (a) of the Sterilisation Act.
[181] Ibid.
[182] Section 3 (2) of the Sterilisation Act.
[183] Section 3 (1) (b) (i) of the Sterilisation Act.
[184] Section 3 (1) (b) (ii) of the Sterilisation Act.
[185] Section 3 (1) (b) (iii) of the Sterilisation Act.
[186] Section 3 (1) (b) (iv) of the Sterilisation Act.
[187] Section 3 (1) (b) (v) of the Sterilisation Act.
[188] Section 3 (1) (b) (vi) of the Sterilisation Act.
[189] Section 3 (1) (b) (vii) of the Sterilisation Act.
[190] Section 3 (1) (b) (viii) of the Sterilisation Act.

controlled environment through limited self-care and requiring constant aid and supervision, to restrained sensory and motor functioning and requiring nursing care".[191]

5.4 THE CHILDRENS ACT 38 OF 2005

The Children‟s Act[192] (hereinafter referred to as "The Children‟s Act"), gives effect to the rights enshrined in the Constitution that are applicable to children.[193] As has previously been stated, the Constitution provides that "a child‟s best interests are of paramount importance in every matter concerning the child".[194] The Children‟s Act provides guidance as to the factors to be taken into account in applying the „best interests‟ standard.[195] In this regard, the Act provides that, *inter alia,* the parents‟ ability to cater for the child‟s intellectual and emotional needs must be taken into account, as well as the need to provide protection for the child against psychological and physical harm.[196] Additionally, in terms of section 10 of the Act, if the child concerned is of an age and maturity that will enable him/her to participate in matters pertaining to him/her, the child must be given the opportunity to voice his/her opinions and such opinions must be taken into account. Boezaart has stated that The Children‟s Act does not provide guidance on the issue of whether sterilization is permissible where the patient concerned is a child – one who does not have the capacity to provide consent to the procedure.[197]

5.5 THE CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

On the 13 December 2006 the United Nations adopted the Convention on the Rights of Persons with Disabilities.[198] The aim of the convention was to transform the perception of people with disabilities from being objects in need of care and protection to being recognized as individuals

[191] Section 3 (7) Of the Sterilisation Act.
[192] Note 23 above.
[193] Note 124 above, 74.
[194] Section 28 (2) of the Constitution of the republic of South Africa
[195] Note 124 above, 74.
[196] Note 124 above, 74.
[197] Note 124 above 74.
[198] The Convention in Brief available at *www.un.org?disabilities/default.asp?navid=15&pid=150*, accessed on 25 November 2014.

capable of exercising their fundamental human rights; of tendering informed consent to treatment and medical procedures and as contributing members of society.[199]

The convention enshrines the inherent human rights to which people with disabilities are entitled to enjoy and provides that where there is a violation of their rights, the individuals affected are to be afforded protection.[200] Further principles enshrined in the convention are respect for dignity and autonomy - for people with disabilities to be free to make their own decisions; that people with disabilities are not to be discriminated against on the basis of their disability; people with disabilities are not to be ostracized from society; people with disabilities are to be respected and accepted as part of humanity; equal opportunities should exist for people with disabilities and between men and women alike and respect for children with disabilities.[201]

Article 12 of the Convention on the Rights of Persons with Disabilities "affirms the right of persons with disabilities to recognition everywhere as persons before the law and to enjoy legal capacity on an equal basis with others including access to the support they may require to exercise their legal capacity".[202]

Article 23 of the Convention on the Rights of Persons with Disabilities provides that for "the right of people with disabilities to found and maintain a family and to retain their fertility on an equal basis with others".[203]

Article 25 makes it explicit that prior to rendering health care services, informed consent to procedures must be obtained from the person with a disability in order to uphold the principle of respect for autonomy.[204]

The Convention on the Rights of Persons with Disabilities was ratified by South Africa on the

[199] Ibid
[200] Note 200 above.
[201] Note 200 above.
[202] Note 200 above.
[203] Note 200 above.
[204] Note 200 above.

30 November 2007.[205] However, to date, the provisions of the convention have not been incorporated into South African law.[206] The unfortunate consequence is that the convention can be relied upon to offer guidance however, it is not legally binding in the absence of a legal framework in South Africa.

5.6 THE CONVENTION ON THE RIGHTS OF THE CHILD

An additional international instrument of relevance to the issue of the involuntary sterilization of a mentally incompetent child is the Convention on the Rights of the Child (hereinafter referred to as the CRC).[207]

The CRC was ratified by South Africa on the 16 June 1995.[208] Article 2 of the CRC provides that children may not be discriminated against on any basis inclusive of disability.[209] In terms of article 3 of the CRC, the primary consideration to be taken into account in making decisions that may affect children is whether the decision is in the child‟s best interests.[210] Article 12 of the CRC provides that children have the right to express their opinions on a decision taken on their behalf. The convention encourages decision makers to take cognizance of the opinions expressed by the children and allow the child to participate in the decision making process.[211]

5.7 CONCLUSION

As has previously been stated, the convention on the rights of persons with disabilities enshrines the right for people with disabilities to found and maintain their own families[212] and the

[205]United nations Treaty Collection available at *https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=iv-15&chapter=4&lang=en*, accessed on 25 November 2014
[206] South Africa's compliance with UN Conventions on Rights of Persons with Disabilities and Rights of the Child: input by Civil Society available at *http://www.pmg.org.za/report/20110302-presentation-university-uwc-centre-disability-law-and-policy-complian*, accessed on 4 November 2014.
[207] United Nations Convention on the Rights of the child, 1989.
[208] Fact Sheet: A summary of the rights under the Convention on the Rights of the Child available at *www.unicef.org/crc/files/Rights_overview.pdf*, accessed on 24 November 2014
[209] Note 210 above.
[210] Note 210 above.
[211] Note 210 above.
[212] Note 200 above.

convention on the rights of the child embodies the requirement that the best interests of the child must be taken into account[213] and that such children are not to be discriminated against on the grounds of their disability.[214] Despite such aspirations, however, involuntary sterilization continues to occur. The reasons thereof will be discussed in the subsequent chapter.

[213] Note 210 above.
[214] Note 210 above.

CHAPTER 6
WHY INVOLUNTARY STERILIZATION IS PERFORMED ON MENTALLY INCOMPETENT ADOLESCENT FEMALES

6.1 INTRODUCTION

In this chapter, the basis for which sterilization of mentally incompetent females is requested by care givers will be highlighted, followed by a discussion of the alternatives to sterilization and the respective risks and benefits thereof.

6.2 MENSTRUATION AND ASSOCIATED ISSUES

Sterilization is commonly sought by care givers on the basis of menstrual management and generally becomes an issue under discussion at the time that the mentally incompetent patient has reached sexual maturity; however it may have to be considered in some cases when a child is at a young age.[215] The problem that is said to arise is whether sterilization is being resorted to for the prevention of reproduction or for the purpose of preventing the consequences that flow from sexual maturation, in other words, menstruation.[216]

Care givers seek to prevent the onset of menstruation on the basis that menstrual flow, pain and discomfort that accompany menstruation may be quite disturbing to a young girl who does not have the capacity to comprehend that menstruation is a natural part of life.[217] It is also challenging for females who are not only mentally incompetent but also physically impaired as they are unable to cope in terms of self-care on account of their immobility.[218] Additionally, certain drugs such as anticonvulsants may have adverse effects during menstruation.[219]

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[215] Note 72 above, 339
[216] Note 72 above, 339.
[217] A. Albanese, NW Hopper „Suppression of menstruation in adolescents with learning disabilities" (2007) 96 *Arch Dis Child* 629:629.
[218] Note 219 above.
[219] Note 219 above.

For care givers of mentally incompetent adolescent patients, menstrual hygiene is particularly problematic as the needs of the patient have to be balanced against the ability of the care giver to keep up with the demands of caring for such a patient.[220] In this regard it has been submitted that women who fall within the category of mildly or moderately retarded can be taught to use sanitary pads during menstruation, however, this is not always possible in profoundly retarded women.[221] On account of the problems pertaining to hygiene encountered by care givers of mentally incompetent young women, assistance is often sought from physicians for menstrual management.[222] It has been recommended that the problem be approached by first attempting behavioral education and thereafter hormonal control[223] and as a last resort, exploring the possibility of endometrial ablation or a hysterectomy if the patient‟s menstrual problems are severe.[224] It has been stated that that the amount and frequency of bleeding in mentally incompetent females as in other women, is also affected by factors such as thyroid disease and obesity.[225] In this regard, it has been submitted that when the problem encountered is irregular or heavy menstrual flow, the mentally incompetent patient should be treated in much the same way as the competent patient.[226]

The authors Albanese and Hopper, writing in the context of adolescents with learning disabilities submit that all possible methods of educating the individual as well as exhausting all symptomatic approaches should be attempted and only if the problem is such that it is causing the patient undue stress, should therapeutic intervention be considered.[227]

Educating the adolescent regarding issues such as hygiene and behavior that is acceptable depends on the individual‟s level of understanding.[228] However, the onset of menstruation must be allowed to occur naturally before the parents or care giver considers any form of therapeutic intervention.[229]

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[220] Note 3 above, 224.
[221] Note 3 above, 225.
[222] Note 3 above, 224.
[223] Note 3 above, 224.
[224] Note 3 above, 224.
[225] Note 3 above, 224.
[226] Note 72 above, 339
[227] Note 219 above, 629.
[228] Ibid.
[229] Note 219 above, 629.

Regarding the mentally incompetent patient‟s level of understanding, according to the authors Zurawin and Paransky, mentally incompetent individuals are characterized as such by virtue of the individual having an intelligence Quotient (IQ) of approximately or below 70, in other words, below average intelligence and are incompetent in a minimum of two of the following areas: communicating on a meaningful level; caring for one‟s self; interacting at a social level;[230] "functional academic skills; work; leisure, health and safety".[231]

A mildly retarded individual is a person with an intelligence quotient of between 50 and 55 to 70.[232] Such an individual is competent to perform semi-skilled labour.[233] Contraception is advisable in instances where such a person expresses interest in sexual activity.[234]

A moderately retarded individual is one who has an intelligence quotient of between 35 and 40 to 50 and 55.[235] Such individuals historically lived in environments where caregivers watched over them with a high degree of vigilance however, these individuals now form part of society and are thus exposed to far greater risks than in the sheltered environment of an institution.[236]

A severely retarded person is an individual with an intelligence quotient of between 20 and 25 to 30 and 35[237] and a profoundly retarded individual is a person with an intelligence quotient that is below 20 or 25.[238] Personal hygiene is an issue as these individuals are quite often, unable to care for themselves and often express no interest in sexual activity.[239] That being said, sterilization purely on the basis of eliminating the burden of having to deal with menstrual hygiene is not a sufficient justification as less invasive options to surgery (as discussed in chapter 6 below) are available.[240]

[230] Note 3 above, 223.
[231] Note 3 above, 223.
[232] Note 3 above, 223.
[233] Note 3 above, 223.
[234] Note 3 above, 223.
[235] Note 3 above, 223.
[236] Note 3 above, 223.
[237] Note 3 above, 223.
[238] Note 3 above, 223.
[239] Note 3 above, 223.
[240] Note 72 above, 339.

6.3 PREMENSTRUAL SYNDROME

In addition to menstrual hygiene, the issue of premenstrual syndrome poses a challenge to parents and care givers on account of the behavioral changes that are experienced by the young woman in the week prior to and in the first few days of menstruation.[241] According to the authors Zurawin and Paransky, symptoms of premenstrual syndrome include "increase in behavioral seizures, aggression, tantrums, crying spells and self-abusive behavior".[242] Severely retarded patients are not capable of communicating the discomfort being experienced and the physician faces the challenge of having to link the symptoms that the patient is presenting with to premenstrual syndrome.[243] Once the physician is satisfied that the patient is suffering from premenstrual syndrome, he may then proceed to take steps to reduce the menstrual cycle by administering hormonal agents as opposed to sterilization.[244]

6.4 RISK OF CONCEPTION

An additional concern to care givers of mentally incompetent patients is the possibility of sexual exploitation of the mentally incompetent patient.[245] It has been submitted that the most frequent requests for sterilization come from care givers who are concerned about the welfare of the mentally incompetent individual after the care giver has died as there is no guarantee that remaining family members will exercise the same degree of care and vigilance as that of the primary care giver who had been responsible for the individual during his/her lifetime.[246]

Sexual autonomy, in the context of the mentally incompetent patient is governed by the choices made by the care giver.[247] According to the authors Nash and Novias, writing in the context of the 1971 Declaration on the Rights of Mentally Retarded Persons, state that one of the ethical implications that arises is that it is not just the rights of the mentally incompetent individual that

[241] Note 3 above, 224.
[242] Note 3 above, 224.
[243] Note 3 above, 224.
[244] Note 3 above, 224.
[245] Note 3 above, 224.
[246] Supra note 41 at page 439.
[247] HH. Pham, BH. Lerner „In the Patient‟s Best interests? Revisiting Sexual Autonomy and Sterilization of the Developmentally Disabled‟ (2001) 175 *West J Med* 2001; 280:282.

have to be considered but also the impact such "freedom" will have upon the person charged with her care.[248] What has to be borne in mind is that "not only are the parents burdened by the demands of offspring with a mental handicap for some form of sexual expression, but difficulties on the part some handicapped persons in meeting the demands of social life necessitate a reasonable amount of vigilance on the part of the parents".[249]

The care giver will either choose to allow the patient a degree of sexual freedom or the family may choose to withhold sex education from the patient in order to avoid sexual activity.[250] The primary concern is to avoid the risk of conception. However, it has been submitted that the care giver‟s reservations at the patient‟s desire for sexual expression also cannot found the basis for a request for sterilization.[251] It has been submitted that instead of sterilizing the patient, she can be taught socially acceptable methods of demonstrating affection.[252]

Care givers wish to guard against the mentally incompetent patient falling pregnant on the basis that coupled with the difficulties associated with pregnancy, the incompetent patient may experience much difficulty in giving birth to a baby. Not only will the patient have to endure the agony of labour but the same would be all the more challenging especially in instances where the patient has physical abnormalities or has difficulty following the instructions indicated by healthcare professionals in the delivery room.[253] In addition, the psychological effects on mentally incompetent individuals that flow from such experiences cannot be determined.[254]

6.5 ALTERNATIVES TO STERILIZATION

In instances where a patient requires medical intervention to regulate her menstrual flow, alternatively, to suppress excessive menstrual flow, oral contraceptives can be given to the patient.[255] Sterilization will have far reaching effects on the patient at a psychological level

[248] Note 39 above, 439.
[249] ibid
[250] Note 249 above, 282.
[251] Note 72 above, 339.
[252] Ibid.
[253] Note 249 above, 282.
[254] Ibid.
[255] Note 3 above, 225.

which cannot be remedied by administering medication to the patient, therefore, despite the unpleasant side effects mentioned below, alternative methods to sterilization such as counseling and training should be explored in order to achieve the goal of menstrual management and ensure that the patient does not suffer any harm. The non-surgical treatment options available to mentally incompetent adolescents are counseling, oral contraceptives, the contraceptive patch/injectable, Depot-Medroxyprogesterone Acetate and the Progestin Intrauterine Device.[256] The risks and benefits of each will be looked at in turn.

Albanese and Hopper cite DMPA (Depo-Provera) as a contraceptive as well as a means of suppressing menstruation that is frequently used by females who have learning disabilities by administering an injection every twelve weeks.[257] Whilst the drug DMPA achieves suppression of menstruation (although bleeding can still occur), one of the drawbacks of administering the drug, according to the authors is the "link between DMPA use and decreased bone mineral density in girls".[258] The implication being that the drug has the potential to increase the user's risk of obtaining osteoporosis at a later stage.[259] Another concern with the use of DMPA is weight gain which is a disadvantage particularly in patients that are immobile.[260]

Paransky and Zurawin have submitted that the risk associated with the prolonged use of DMPA is that like oral contraceptives, there is the risk of the development of cardiovascular disease and breast cancer.[261] In determining whether DMPA is the best method of contraception and menstrual suppression for the mentally incompetent adolescent, what needs to be determined is whether the risks outweigh the benefits of an injectable contraceptive that is administered to the patient four times per annum.[262]

Because of the risk associated with the use of DMPA, it has been submitted by the FDA (Food and Drug Association) and the United Kingdom's Committee on Safety of Medicines (CSM) that

[256] Note 3 above, 225 – 227.
[257] Note 219 above, 629.
[258] Ibid.
[259] Note 219 above, 629 – 630.
[260] Note 219 above, 630.
[261] Note 3 above, 225.
[262] Ibid.

DMPA should only be used in adolescents when all other alternatives prove to be inappropriate or inadequate.[263]

Counseling requires that the physician must interview the parents, caregivers, educators and other family members in order to narrow down the family‟s concern.[264] For each concern expressed by the family, behavioral training relating to socialization, menstrual hygiene, how to avoid sexual abuse as well as sexual education and family counseling should be provided.[265] As has previously been stated, mildly mentally incompetent adolescents can be taught to use sanitary pads however, the authors Zurawin and Paransky have submitted that provided that a severely mentally incompetent woman has been trained to use the toilet, with intensive training, she too can be trained to manage her menstrual flow.[266]

The contraceptive patch is applied on a weekly basis thereby eliminating the problem of the daily administration of oral contraceptives.[267] The alternative to the contraceptive patch is a contraceptive injection which is administered on a monthly basis.[268] However, problems may be encountered in administering the injection to the patient.[269]

The Progestin Intrauterine Device is a non-hormonal method of contraception. However, the difficulty that arises is that the IUD can cause an increase in menstrual bleeding and if the patient engages in sexual activity, there is a risk of infection.[270] In addition, a mentally incompetent patient may have to be sedated in order for the IUD to be inserted as she may offer resistance.[271]

Where all other methods of contraception have been exhausted and sterilization is being resorted to, the methods of sterilization available to the patient are endometrial ablation, tubal ligation and

[263] Note 219 above, 630.
[264] Note 3 above, 225.
[265] Note 3 above, 225.
[266] Note 3 above, 225.
[267] Note 3 above, 225.
[268] Note 3 above, 225.
[269] Note 3 above, 225.
[270] Note 3 above, 227.
[271] Note 3 above, 227.

hysterectomy.[272] It has been submitted that only after having exhausted available non-surgical treatment options should surgical treatment be considered.[273]

Hysterectomy is the removal of the uterus and in some instances, involves the removal of the uterus together with the fallopian tubes.[274] Hysterectomy is frequently the sterilization method selected for mentally incompetent young women.[275] The implication is that if the uterus together with the fallopian tubes and ovaries are removed from a girl who has not yet reached puberty, the girl will not proceed to develop the physiological characteristics inherent to being a woman.[276]

It has been submitted that the hysterectomy may give rise to complications that are of such a nature that it does not outweigh the benefits of the procedure and as such, hysterectomy should only be chosen if there is a gynecological reason such as cervical cancer or any symptoms thereof or where there is severe bleeding that cannot be remedied by hormonal therapy.[277] As has previously ben stated, the most frequent reason for the sterilization of girls who are yet to reach puberty is in order to prevent the onset of menstrual flow.[278] In this regard it has been submitted by the authors Jones and Marks that when sterilization is requested for the purpose of menstrual hygiene, the care giver is requesting sterilization as a matter of convenience and without due regard for the best interests of the girl.[279]

6.6 CONCLUSION

The difficulty faced by care givers when attending to mentally incompetent patients who are not mobile or toilet trained is ongoing and is an issue that they are faced with on a daily basis as opposed to menstruation which occurs once a month.[280] In this regard it has been submitted that

[272] Note 3 above, 227 – 228.
[273] Note 3 above, 227.
[274] Jones, M & LAB Marks (1997) *'Female and Disabled: A Human Rights Perspective on Law and Medicine'* In (Ed.) K, Petersen, Intersections: Women on Law Medicine and Technology Dartmouth: Ashgate extracts accessed at wwda.org.au/issues/legal/legal1995/steril2/ on the 4 August 2014.
[275] Note 276 above.
[276] Note 276 above.
[277] Note 276 above.
[278] Note 276 above.
[279] Note 276 above.
[280] Note 276 above.

with counseling and training for both the care giver and the individual concerned, the extreme and invasive procedure that is sterilization can be avoided.[281]

[281] Note 276 above.

CHAPTER 7
THE BIOMEDICAL PRINCIPLES OF ETHICS

7.1 INTRODUCTION

Autonomy, beneficence, non-maleficence and justice – the four principles of biomedical ethics submitted by the authors Childress and Beauchamp in their book *Principles of Biomedical Ethics*[282] are the foundation upon which most ethical decisions are made.[283] The decision making process to perform sterilization on a mentally incompetent adolescent patient requires the application of the biomedical principles in order to determine whether the decision reached is ethically sound.[284] The ethical implications of performing sterilization on a mentally incompetent adolescent patient will be discussed in this chapter in light of the biomedical principles.

The first of the four biomedical principles that will be discussed is respect for autonomy.

7.2 AUTONOMY

The principle of autonomy requires that a patient is free to make decisions on her own free will in the absence of any form of coercion. Simply put, the patient‟s right to self-determination must be upheld or in instances where a patient is deprived of the ability to make her own decisions, such a patient is to be afforded protection.[285] In an attempt to promote the best interests of the patient, decisions taken by the patient – and not the healthcare practitioner must be given effect to.[286] In other words, respecting a patient‟s autonomy demands that the patient‟s informed consent to medical procedures and treatment is obtained.[287]

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[282] TL Beauchamp, JF Childress *Principles of biomedical ethics* 5 ed (2000).
[283] JA. Singh „Ethical Decision-making‟ in MA Dada and DJ Mcquoid-Mason (eds.) *Introduction to Medico-Legal Practice* (2010) 35.
[284] ACOG Committee Opinion Number 371 July 2007 „Sterilization of women, including those with mental disabilities‟ 2007 (110) 1 *Obstet Gynecol* 217.
[285] Ibid.
[286] Moodley K (ed.) *Medical Ethics, Law and Human Rights. A South African Perspective* (2011) 42.
[287] Note 288 above, 43.

Autonomy is the biomedical ethical principle that calls for respect for a patient‟s right to self-determination.[288] However, in dealing with a patient who has diminished autonomy on account of mental incompetence, the physician should satisfy himself that, *inter alia*, the patient‟s mental incompetence is irreversible to such an extent that she has no prospects of recovery and therefore the right to procreation is not an issue of utmost importance in determining whether sterilization is in the patient‟s best interests.[289]

As has previously been stated, article 25 of the Convention on the Rights of Persons with Disabilities provides that informed consent must be obtained before health care services are rendered to people with disabilities. This is in accordance with the principle of autonomy.

It has been submitted by the authors Howard and Hendy that in determining an individual‟s capacity to provide informed consent, a patient‟s autonomy must be balanced against the physician‟s duty to protect a vulnerable patient against harm.[290] The authors submit that there are three components to determining the issue of consent.[291] Firstly, whether sufficient information has been placed before the patient in order to enable her to make an informed decision;[292] secondly, whether the patient has the requisite mental capacity to make decisions and also to understand the consequences of her choices[293] and finally, whether the patient is making the decision on a voluntary basis, in the absence of coercion.[294]

Regarding the requirement that a patient must be able to understand the information communicated to her, if a patient does not have the capacity to understand, the patient will not be able to appreciate the nature and consequences of the proposed procedure or treatment.[295] Kluge submits that in the absence of the capacity to understand and reason, the patient‟s decision will

[288] Note 288 above, 42.
[289] Note 3 above, 231.
[290] R. Howard, S. Hendy „The sterilization of women with learning disabilities – some points for consideration‟ (2004) 50 (2) *The British Journal of Developmental Disabilities* 133:134.
[291] Ibid.
[292] Note 292 above.
[293] Note 292 above.
[294] Note 292 above.
[295] EHW. Kluge 'Incompetent Patients, Substitute Decision Making, and Quality of Life: some Ethical Considerations' *Medscape J Med* 2008; 10 (10):237

be random – with no motivation for the elected procedure or treatment.[296] The author therefore states that cognitive competence is essential in order for a patient to provide informed consent.[297] In instances where the patient is rendered incompetent to make decisions on account of minority, drug dependence, mental incompetence and suicidal tendencies, the healthcare practitioner must make disclosure to the patient‟s surrogate decision maker and look to the surrogate for the ultimate decision.[298]

When sterilization is requested by a married woman or a woman in a life partnership, the patient should be advised to discuss the issue of sterilization with her spouse/partner.[299] Whilst this is not a requirement in terms of the Sterilization Act, it is submitted on the basis that due regard should be given the spouse and his perspective on the matter as he may want to have children of his own at a later stage.[300] In this regard the Health Professions Council Guidelines for Good Practice in the Health Care Professions provides that even though spousal consent is not mandatory, it is advisable for the spouse to be counseled together with the patient to be sterilized as both their lives are affected by the decision.[301]

The physician is obliged to counsel the patient regarding all benefits and risks associated with the sterilization procedure, in addition, the irreversible nature of the procedure must be made explicit to the patient and she must be advised of all available alternatives to sterilization.[302] The patient‟s informed consent to the procedure must be obtained by the physician.[303] When the patient to be sterilized is mentally incompetent, physicians may have to interview a patient on multiple occasions and where necessary, seek the assistance of professionals who have been trained to communicate with mentally incompetent individuals such as psychologists, nurses and educators.[304]

[296] Ibid.
[297] Note 297 above.
[298] Note 288 above.
[299] Note 286 above, 218.
[300] Note 286 above, 218.
[301] HPCSA General Ethical Guidelines for Reproductive Health. Booklet 13 Guideline 5.1.1
[302] Note 286 above, 218.
[303] Note 286 above, 218.
[304] Note 286 above, 219.

One of the barriers identified by physicians in determining a patient‟s capacity to provide consent is that mentally incompetent patient‟s, on account of their position in society as well as due to cognitive factors, tend to concede when issues are put to them.[305] Secondly, a communication barrier is problematic as it deprives the patient not only of the ability to provide informed consent but also makes it difficult for the physician to make the patient understand the reasons for and the requirements of valid consent.[306] It has been stated that decision makers, in making decisions on behalf of a mentally incompetent patient undermine the patient‟s ability to make decisions on her own.[307] It has been submitted that this serves to disempower the patient as she is not afforded the opportunity to practice decision making independently.[308] The authors Howard and Hendy have stated that in assessing a patient‟s capacity to provide informed consent, the questions put to the patient must be easily understood and specific, leading questions may not be put to the patient and where necessary, the physician may employ visual aids; the environment must be comfortable and the patient must feel comfortable with the physician questioning her.[309]

It has been submitted that in instances where patients have severely diminished autonomy, the physician can attempt to restore the patient‟s decision making capacity by adjusting the patient‟s medication and by avoiding factors that cause the patient stress.[310] If the physician has exhausted the aforementioned to no avail, it has been submitted that the physician must make every effort to obtain the patient‟s belief and values pertaining to procreation from the patient‟s family and/or care givers and make decisions that conform to the patient‟s values and beliefs.[311] Secondly, the physician must satisfy himself that the decision to perform sterilization does not stem from undue pressure on the patient by family or the care giver.[312] The interests of the patient are paramount and should be given effect to – not the interests of the family or care giver.[313] Thirdly, the patient and her family should be offered education or training pertaining to

[305] Note 292 above, 134.
[306] Note 292 above, 134.
[307] Note 292 above, 134.
[308] Note 292 above, 134.
[309] Note 292 above, 134 – 135.
[310] Note 286 above, 219.
[311] Note 286 above, 219.
[312] Note 286 above, 219.
[313] Note 286 above, 219.

the avoidance of sexual abuse and sexual autonomy.[314] Fourthly, the physician must have regard to the patient‟s environment.[315] The physician must look at whether the patient lives in an environment in which there is a possibility that she may be sexually abused, is the patient fertile?, is it likely that the patient may fall pregnant?[316] The medical and social consequences of the patient becoming pregnant must be envisaged.[317] It may not be possible for the physician to predict the same and he may accordingly recommend that a form of contraception that is reversible such as an intrauterine device is used as opposed to the patient undergoing a hysterectomy.[318] The physician must take care to ensure that the method of contraception chosen must be such that it does not hinder the patient‟s ability to procreate in the future.[319] Notably, The Health Professions Council Guidelines for Good Practice in the Health Care Professions provides that in recommending the use of contraceptives to a patient, the patient‟s right to self-determination must be respected.[320]

7.3 BENEFICENCE

It has been submitted that in situations in which a patient is deprived of the ability to provide informed consent to medical procedures and that such a patient has no prospect of recovery, decisions must be taken according to the principle of beneficence.[321]

The principle of Beneficence instructs the healthcare professional to solely "do good."[322] It is the positive act of doing what is in the best interests of the patient.[323] According to Beauchamp and Childress, the rules of beneficence dictate that the rights of others are to be protected and defended; harming the patient is to be prevented; the root of harm is to be eliminated; those with

[314] Note 286 above, 219.
[315] Note 286 above, 219.
[316] Note 286 above, 219.
[317] Note 286 above, 219.
[318] Note 286 above, 219.
[319] Note 286 above, 220.
[320] HPCSA General Ethical Guidelines for Reproductive Health. Booklet 13. Guideline 4.2
[321] Note 286 above, 219.
[322] Note 288 above, 57.
[323] Ibid.

disabilities are to be helped and the endangered are to be rescued.[324] The golden rule of beneficence is for the healthcare practitioner to contribute to the patient‟s wellbeing.[325]

Regarding the duty to protect and defend the rights of others, it is submitted that the physician would be acting beneficently if he were to decline a request to sterilize a mentally incompetent patient on the basis that he is preserving the patient‟s right to found a family as envisaged in the Convention on the Rights of Persons with Disabilities[326] which provides in article 23 that mentally incompetent individuals have "the right to found and maintain a family and to retain their fertility on an equal basis with others."[327] Article 23 echoes the sentiments of the United Nations 1971 Declaration on the Rights of Mentally Retarded Persons which provides that mentally incompetent individuals have the same rights as competent individuals, inclusive of the right to express their sexuality, enter into a marital relationship and to procreate.[328] The authors Zurawin and Paransky state that whilst there are women who would never be competent as parents, there are women who may in future, together with the assistance of family or care givers, have the ability to nurture a child of her own.[329] It would thus be a beneficent act for a medical practitioner to decline to perform a sterilization procedure on a mentally incompetent patient in order to protect the patients‟ ability to procreate and at a later stage, found a family of her own. A patient may have little to no understanding of procreation but she may wish to have a child of her own.[330] It has been argued by human rights activists that "the right to bear a child is inviolable…because the patient cannot consent, society should err on protecting the right to procreate unless it is medically necessary to sterilize".[331] Accordingly it is submitted that a medical practitioner would be acting beneficently in refusing to perform sterilization on a mentally incompetent patient on the basis that he would be fulfilling the duty to protect and defend the patient‟s right to procreation.

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[324] Supra note 293.
[325] DJ Lawrence. „The Four Priniciples of Biomedical-Ethics: A Foundation for Current Bioethical Debate‟ (2007) 14 *Journal of Chiropractic Humanities* 34:35.
[326] Note 28 above.
[327] The Convention on the Rights of Persons with Disabilities accessed at *http://www.un.org/disabilities/convention/conventionfull.shtml* on 4 August 2014.
[328] Supra note 39 at page 439.
[329] Note 3 above, 232.
[330] Note 3 above, 232.
[331] Note 3 above, 232.

Regarding to the right to parenthood, what would have to be determined is whether the individual displays competence to care for a baby or has been able to care for a younger family member.[332] However, the ethical issue that arises is that children born of such a parent have the inherent right to be reared in a family that will be responsible for his/her development at not only an intellectual level but also at an emotional and moral level.[333] It is accordingly submitted that whilst preserving the mentally incompetent patient‟s ability to procreate and to allow for the patient to conceive a child later in life is a beneficent act, the act of beneficence extends only to the patient and the interests of the unborn child, a child who will be completely dependent upon its mother from infancy through to adulthood is not being taken into account.

Whilst it would be noble for the medical practitioner to decline to perform sterilization on a mentally incompetent patient on the basis that he is protecting the patient‟s right to bear a child of her own, the act of beneficence is futile in the case of a moderately incompetent woman, who may have the ability to understand sexual activity and be interested in sexual activity but not for the purpose of procreation.[334] It is argued that such a woman would not be eligible for parenthood on account of her inability to care for the physical and emotional needs of a child. In other words, the woman would be incapable of expressing love and affection towards her child, of determining whether the child is ill and in need of medical attention, of nurturing and protecting a child and imparting life skills.[335] Accordingly, it has been submitted that an interest in parenting does not exist and never will on the basis that there are no prospects of the patient recovering from her state of mental incompetence.[336] On the other hand, there may be patients that are so severely incompetent that they lack the ability to comprehend or even have the capacity to consider procreation.[337] In such cases, it can be said that there is no interest in protecting the right to procreation as the patient is incapable of exercising the said right.[338] In this regard, reference made to patients that are so severely incompetent that they are incapable of appreciating the act of sexual intercourse, the pre-requisite to procreation.[339] Accordingly, as has

[332] Supra note 39 at pages 439 – 440.
[333] Note 39 above, 440.
[334] Note 3 above, 232.
[335] Note 3 above, 232.
[336] Note 3 above, 232.
[337] Note 3 above, 232.
[338] Note 3 above, 232.
[339] Note 3 above, 232.

previously been stated, there is no interest in preserving the right to procreation; however, there is an interest in guarding against pregnancy and potentially, termination of pregnancy.[340] It is submitted that in both instances the medical practitioner would be acting beneficently in performing sterilization on a mentally incompetent adolescent patient on the basis that by removing the uterus, the risk of conception and the risks associated with pregnancy would be eliminated.

The principle of beneficence requires that harming the patient is to be prevented. It has been submitted that it is inappropriate for a hysterectomy to be performed for the sole purpose of sterilizing the patient as there are safer alternate methods of contraception and menstrual management available and on the basis that the risks associated with performing a hysterectomy and the cost involved outweigh the benefits of the procedure.[341] Recognizing that there are risks associated with having to undergo major abdominal surgery and that in the course of such surgery, the patient may potentially suffer harm, the medical practitioner would be acting beneficently in declining to perform a hysterectomy on a mentally incompetent patient who is incapable of understanding the risks and benefits associated with the procedure and providing informed consent to the procedure. In such circumstances and in order to prevent potentially harming the patient, the medical practitioner could recommend a safer alternative for the suppression of menstruation such as Depo-Provera (DMPA). Such a recommendation would be a beneficent act on the part of the medical practitioner as he would be protecting the patient against the potential harm that could arise during surgery. In this regard the Health Professions Council Guidelines for Good Practice in the Health Care Professions provides that "the principle of beneficence requires that contraceptive methods must be safe, effective, and acceptable to women". [342]

As has previously been stated, severely mentally incompetent women have no interest in sexual activity. However, it is their ignorance that often leaves them vulnerable to sexual abuse when in an environment in which there is no vigilant supervision.[343] It has been submitted that whilst a

[340] Note 3 above, 233.
[341] Note 3 above, 228.
[342] Supra note 303 at Guideline 4.1
[343] Note 39 above, 439.

hysterectomy serves the purpose of preventing pregnancy – in particular, what is envisaged is pregnancy stemming from sexual abuse, if it is a known fact that the individual is no longer capable of procreating and if she is severely mentally incompetent to the extent that she is incapable of communicating meaningfully or at all, she may be open to abuse or sexual exploitation by unsavory members of society who prey on such innocence.[344] It has been stated that instead of controlling such an intimate aspect of their lives on account of their mental incompetence and performing an invasive procedure such as sterilization, greater effort should be exerted in bringing perpetrators of crimes against mentally incompetent women to book.[345] It has been submitted in this regard that although the benefit derived from sterilization is that it achieves the goal of preventing pregnancy that arose on account of sexual abuse, on the other hand, sterilization is not a substitute for a safe environment in which the incompetent patient is protected from such harm and exploitation and neither does it prevent the transmission of diseases.[346] A beneficent act would be to afford the incompetent patient adequate training in sexual abuse avoidance to guard against sexual abuse[347] and not simply sterilize the patient in order to prevent an unplanned pregnancy.

It is accordingly submitted that sterilizing a mentally incompetent patient in order to prevent pregnancy arising in consequence of sexual abuse is not a beneficent act on the basis that rendering the patient infertile leaves her potentially susceptible to harm.

7.4 NON-MALEFICIENCE

The principle of non-maleficence dictates that the healthcare practitioner must do no harm to the patient.[348] Medical practitioners are prohibited from killing a patient and inflicting pain or suffering upon a patient. A medical practitioner must not incapacitate a patient, offend a patient or deprive a patient of a good quality of life.[349]

[344] Note 128 above, 51.
[345] Note 292 above, 136.
[346] Note 72 above, 339.
[347] Note 72 above, 339.
[348] Note 288 above, 63.
[349] Note 288 above, 63.

The Hippocratic Oath[350] specifically states that a physician must "above all, do no harm."[351] In accordance with the aforementioned principle, physicians performed surgery for the purpose of removing tissue that has become diseased and thereby restoring the body to a reasonable state of wellbeing.[352] However, a request for sterilization requires that surgery is not being resorted to for the purpose of preserving life but for the purpose of enhancing life.[353] The dilemma that arises is whether the physician is to uphold the principle of "do no harm" or follow the instruction of a patient and perform life enhancing surgery.[354]

Benn and Lupton, writing in the context of a young mentally competent patient requesting sterilization primarily on the basis of preventing pregnancy as her lifestyle would not accommodate the same, the authors have highlighted the ethical issues that arise in the aforementioned situation some of which can be applied by comparison to the case of the mentally incompetent patient.

Firstly, Benn and Lupton have submitted that an ethical consideration to be taken into account is whether there is a possibility that if the patient were to be sterilized, later on in life would the patient regret that she had been sterilized?[355] In the context of the mentally competent patient‟s request for sterilization at a young age, the authors submit that what needs to be determined is how best to weigh the patient‟s present desire to be sterilized against the patient‟s best interests.[356] Similarly, it is submitted that the physician should balance the request for sterilization by a surrogate decision maker which could be driven by selfish motivations against the best interests of the patient. It has been submitted by the authors Benn and Lupton that a physician should take a paternalistic approach and decline to perform sterilization on the basis of protecting an interest that the patient may have in the future – to procreate at a time when she has

[350] Oath of Hippocrates in Harvard Classics. Volume 38. (1910).
[351] P. Benn & M. Lupton „Ethics in Practice. Sterilization of Young, Competent, and Childless Adults‟ (2005) 330 *BMJ* 1323:1323.
[352] Note 352 above.
[353] Note 352 above.
[354] Note 325 above.
[355] Note 352 above, 1324.
[356] Note 352 above, 1324.

regained mental competence.[357] In doing so, the physician will ensure that the patient is not harmed or deprived of the ability to procreate.

Secondly, the authors have submitted that upon being requested to perform sterilization on a patient, the physician must make his ethical reservations known to the patient applied to the context of the mentally incompetent patient, the same must be communicated to the surrogate decision maker and if necessary, the physician must refer the patient to a physician willing to perform the procedure.[358] In explaining the ethical reservations that the physician may have, he must also explain the basis upon which he believes that it is not in the patient‟s best interests for her to be sterilized.[359]

In instances where the patient is deprived of the ability to make decisions concerning healthcare on account of mental incapacity, the physician must take care to ensure that the request for sterilization is made because it is in the patient‟s best interests and not motivated by selfish reasons on the part of the surrogate decision maker.[360] Alternatives such as counseling and training the patient in matters such as menstrual hygiene, how to guard against sexual abuse and sex education must be canvassed with the parents or care givers for their consideration.[361] Whilst one of the benefits of medical treatment is that it does not result in irreversible sterilization, physicians should take cognizance of the long terms effects of hormonal treatment on the patient.[362] In making the determination as to whether to proceed with medical or surgical treatment, the best interests of the patient must be the determining factor.[363]

The physician must help the parent or care giver to understand the situation and the available alternatives as opposed to permitting the decision to sterilize as a means of eliminating the problem.[364] As has previously been stated," the principle of beneficence requires that

[357] Note 352 above, 1324 – 1325.
[358] Note 352 above, 1325.
[359] Note 352 above, 1325.
[360] Note 3 above, 231.
[361] Note 3 above, 231.
[362] Note 3 above, 231.
[363] Note 3 above, 231.
[364] Note 3 above, 231.

contraceptive methods must be safe, effective, and acceptable to women".[365] In this regard, what needs to be borne in mind is that the effects of long term use of contraceptives through to menopause can have adverse effects on the individual and can result in cardiovascular disease as well as the development of breast cancer.[366]

7.5 JUSTICE

Justice, in the context of healthcare is the "fair treatment of patients".[367] Distributive justice refers to the fair distribution of limited resources or, as defined by the authors Beauchamp and Childress, the "fair, equitable and appropriate distribution in society determined by justified norms that structure the terms of social-cooperation".[368]

Justice demands that the mentally incompetent patient be treated in the same manner as a mentally competent patient. Article 12 of the Convention on the Rights of Persons with Disabilities specifically directs that people with disabilities are entitled to "enjoy legal capacity on an equal basis".[369] In this regard, just as mentally competent women have the right to elect not to have children and have access to contraception which allows for sexual expression without the burden of becoming pregnant in consequence thereof, the same right should apply to the mentally incompetent patient.[370] In such instances, contraception serves as a mechanism for preventing the physical and emotional burdens that stem from unwanted pregnancy.[371] The authors argue that the same benefit afforded to competent women should apply to mentally incompetent women.[372]

Justice further demands that the mentally incompetent patient is not deprived of her ability to procreate on the basis of her mental incompetence as envisaged in article 23 of the Convention on the rights of Persons with Disabilities which provides that "the right of people with

[365] Note 344 above.
[366] Note 3 above, 225.
[367] Note 288 above, 73.
[368] Note 288 above, 74.
[369] Note 204 above.
[370] Note 3 above, 232 – 233.
[371] Note 3 above, 232 – 233.
[372] Note 3 above, 233.

disabilities to found and maintain a family and to retain their fertility on an equal basis with others".[373]

In addition, justice demands that the mentally incompetent patient‟s informed consent be obtained for all medical procedures and that the patient is involved in the decision making process to the greatest extent possible as envisaged in article 25 which makes it explicit that prior to rendering health care services to people with disabilities, informed consent must be obtained.[374]

7.6 CONCLUSION

In light of the aforementioned it is apparent that sterilizing a mentally incompetent adolescent young woman is ethically undesirable as it violates the ethical principles of autonomy, beneficence, non-maleficence and justice.

It has been stated that sterilization, in the absence of consent is "generally not ethically acceptable because of the violation of privacy, bodily integrity and reproductive rights that it may represent".[375] In such instances even though informed consent cannot be obtained from the patient, the physician should attempt to obtain assent from the patient.[376] In this regard, the Health Professions Council Guidelines for Good Practice in the Health Care Professions provides that the rights of the mentally incompetent patient must be upheld and a patient‟s mental incompetence should not preclude the patient from participating in the decision making process.[377]

Further, sterilization that does not serve the best interests of the patient and enhance the patient‟s wellbeing will be in violation of the principles of beneficence and non-maleficence.

[373] Note 205 above.
[374] Note 206 above.
[375] Note 286 above, 219.
[376] Note 286 above, 219.
[377] Note 303 above.

Regarding the principle of justice, it is submitted that sterilization in the absence of the mentally incompetent patient‟s informed consent and thereby depriving the patient of the ability to procreate is a violation of the principle of justice.

CHAPER 8
ETHICAL THEORIES

8.1 INTRODUCTION

Ethical theories are guiding principles employed by healthcare practitioners to assist them in making decisions that are morally sound[378] or as the author Thomas Beauchamp aptly puts it "it is legitimate and rewarding to diagnose cases through the lens of general ethical principles".[379] In this chapter various ethical theories will be applied to the issue at hand in order to view the same from different ethical paradigms.

8.2 VIRTUE ETHICS

Virtue ethics focuses on the healthcare practitioner‟s moral fiber, development and education.[380] The question that is asked is does the healthcare practitioner want to do the right thing? Virtue ethicists believe that the healthcare practitioner‟s practical experience assists him in the decision making process in order to ensure that his ultimate decision is the best for the patient. Based on the healthcare practitioner‟s skills, his personal attributes and tendencies developed in the course of his life, virtue ethicists believe that the healthcare practitioner would make ethically sound decisions.[381] According to Oakley, from a virtue ethics perspective, "an action is right if and only if it is what an agent with a virtuous character would do".[382] Accordingly, the decision-makers character must be referred to in order to justify whether the action is correct.[383] From a virtue ethics perspective, a correct action is deemed to be correct provided that it would have been the action of choice for a virtuous person in the same circumstances.[384]

Faced with the dilemma of whether to perform sterilization on a mentally incompetent patient, it is submitted that a virtuous doctor would reflect on all previous sterilizations performed on

[378] Note 285 above, 37.
[379] TL Beauchamp: „Methods and principles in biomedical ethics" (2003) 29 *J Med Ethics* 2003 269:269
[380] Note 285 above, 37 – 38.
[381] Note 285 above, 38.
[382] J. Oakley 'A Virtue Ethics Approach' in H Kuhse & P Singer (ed) *A Companion to Bioethics* (1998): 88.
[383] Note 383 above.
[384] Note 383 above.

mentally incompetent patients in order to determine whether it is ethical to proceed to sterilize the patient.

8.3 DEONTOLOGICAL ETHICS

Deontological ethics advocates that in order to determine whether an action is right or wrong, one must look at the nature of the act itself.[385] If the act is deemed to be acceptable for everyone to do the same, it follows that the act is morally acceptable.[386]

Accordingly, from a deontological perspective, in determining whether it is ethical to perform a sterilization procedure on a mentally incompetent patient, the medical practitioner would have to determine whether sterilization is in the patient's best interests taking into consideration the nature of the sterilization procedure.

8.4 CONSEQUENTIAL ETHICS

In terms of consequentialist theory, whether an action is right or wrong depends on the consequences resulting from the action.[387] If the action is such that the consequence will be good, the action itself will be deemed to be good. If the consequences are bad, it then follows that the action is bad.[388]

From this perspective, a medical practitioner must look at the outcome of performing sterilization on a mentally incompetent patient. The medical practitioner must be satisfied that performing the sterilization procedure on a mentally incompetent patient achieves the goals of eliminating menstruation and the hygiene issues associated with menstruation, the risk of conception will no longer be an issue for care givers and in addition, the patient will not have to be administered contraceptive drugs on an ongoing basis thereby eliminating the risk of the patient developing, *inter alia,* cardiovascular disease and breast cancer which may occur in consequence of prolonged use of contraceptive drugs.

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[385] Note 285 above, 38.
[386] Note 285 above, 38.
[387] R. Hare 'A Utilitarian Approach' in H Kuhse & P Singer (ed) *A Companion to Bioethics* (1998): 80.
[388] Note 285 above, 39.

Accordingly, despite the risk involved in performing an invasive sterilization procedure on a mentally incompetent patient, the consequences that flow from the procedure will be good resulting in the act of sterilization being deemed to be good.

8.4.1 UTILITARIAN ETHICS

Utilitarianism is a form of consequential ethics. According to a utilitarian approach, the act must be of maximum benefit to the majority of people. The long and short term consequences of the action will be considered in order to determine the extent to which the action will benefit or harm the majority.[389] According to the author Hare, utilitarianism consist of two components – the primary component being consequentialism and the second being welfarism.[390] Utilitarians have regard to the welfare of those affected by the action.[391] Such consequences impact either negatively or positively on the welfare of those affected by the action.[392] In an attempt to ensure neutrality, utilitarianism requires that the interests of others should be treated as though they are the decision-makers own interests.[393]

From a utilitarian perspective, a medical practitioner must be of the opinion that performing sterilization on a mentally incompetent patient will be ethical on the basis that there will be maximum benefit to the majority.

It is submitted that the medical practitioner must be satisfied that rendering a mentally incompetent patient sterile would be beneficial to the families and care givers of the patient on the basis that the families and care givers will no longer have to concern themselves over issues such as the risk of conception[394] if the patient were to be sexually abused or chooses to express sexual autonomy, Premenstrual syndrome, menstruation and the hygiene issues associated with

[389] Note 285 above, 39.
[390] Note 388 above, 80 – 81.
[391] Note 388 above, 80.
[392] Ibid
[393] Note 388 above, 83.
[394] Note 72 above, 339.

menstruation will be eliminated.[395] Care givers will no longer be burdened with having to care for the patient during menstruation – especially in instances where the mentally incompetent patient is not capable of being toilet trained.[396] Sterilizing an individual who will never be competent to raise a child would be a sigh of relief for the care givers who will no longer have to worry about potential unplanned pregnancies – specifically pregnancy arising in consequence of sexual abuse.[397]

Accordingly, the majority will stand to benefit from the mentally incompetent patient undergoing sterilization and on this basis, the act of sterilizing the patient will be deemed to be ethical.

8.5 CASUISTIC ETHICS

Casuistic ethicists employ reasoning by analogy in the decision making process. Issues that are similar in nature and have previously been dealt with are compared in order to determine the best possible solution, similar to the doctrine of precedent used by the courts in decision making.[398]

The medical practitioner must be able to compare the case at hand to mentally incompetent patients who had previously been sterilized in order to justify the decision to perform sterilization. It has been submitted by Boezaart[399] that the courts should be vested with the power to grant consent to the sterilization of mentally incompetent patients.[400] By placing the decision to sterilize a mentally incompetent patient in the hands of the courts, in the event of a conflict of interest arising between the interests of the patient and that of the care giver, the court will ensure that the best interests of the patient are upheld. The court will look at the matter before it in its entirety, taking into account all the evidence placed before it as well as ethical issues and therefore will reach a decision that is truly in the patient‟s best interests as opposed to the panel created in terms of section 3 of the Sterilization Act which is restricted to considering

[395] Note 3 above, 224.
[396] Note 276 above.
[397] Note 276 above.
[398] Note 285 above, 39 – 40.
[399] Note 124 above, 85.
[400] Ibid.

the factors enumerated in the Sterilization Act before reaching a decision as to whether the patient is to be sterilized.

8.6 NARRATIVE ETHICS

Storytelling is characteristic of narrative ethics. When the patient consults with a healthcare practitioner, the patient‟s account of his illness is viewed as a story. The healthcare practitioner is required to listen to the patient, show interest in his story, empathize and express compassion and understanding in order to obtain maximum information from the patient regarding his state of health.[401]

By employing this approach, healthcare practitioners are able to obtain all relevant information from the patient in order to assist the patient in making a decision that is appropriate in the circumstances.[402]

In the context of the mentally incompetent patient, the medical practitioner may not be able to secure much information from the patient and will have to rely on the information volunteered by the patient‟s care giver in order to determine whether it is ethical to perform sterilization on the mentally incompetent patient.

8.7 A CARE APPROACH

Manning has submitted that a care approach "is a way of understanding one‟s moral role, of looking at moral issues and coming to an accommodation in moral situations".[403] There are five essential concepts that constitute a care approach, the first being moral attention.[404] Moral attention requires that the medical practitioner must consider the state of affairs in its entirety.[405] In taking cognizance of every detail, the medical practitioner must be able to respond to the

[401] Note 285 above, 40.
[402] Ibid.
[403] RC. Manning „A Care Approach‟ in H Kuhse & P Singer (ed) *A Companion to Bioethics* (1998) 98.
[404] Note 404 above.
[405] Note 404 above.

patient‟s needs with understanding and sympathetically.[406] The second concept is sympathetic understanding.[407] In applying sympathetic understanding to the matter at hand, the medical practitioner must be able to satisfy the patient‟s needs by giving effect to the patient‟s request and best interests.[408] The third concept is accommodation.[409] This requires that whilst it is not always possible to give effect to the requests of all patients, the medical practitioner may do whatever he/she deems best in the circumstances whilst simultaneously allowing all patients to feel that they are given due consideration. The final concept is that the response from the medical practitioner must indicate the element of care.[410]

Faced with the ethical dilemma of whether to perform sterilization on a mentally incompetent adolescent female, a care approach would require the medical practitioner to look at the situation in totality. The medical practitioner must consider that the patient is unable to provide informed consent to the medical procedure on account of her mental incompetence, that sterilization is requested on the patient‟s behalf by a surrogate decision maker and the reasons advanced in support of the request for sterilization. The medical practitioner must listen to the patient‟s needs and interests as articulated by the surrogate decision maker and advise of the ethical implications of sterilizing an adolescent patient as well as discuss the available alternatives to sterilization in a caring and compassionate manner. The medical practitioner must tactfully advise the surrogate decision maker that sterilization will be performed on the patient only if it is in the patient‟s best interests.

[406] Note 404 above.
[407] Note 404 above.
[408] Note 404 above.
[409] Note 404 above, 99.
[410] Ibid

CHAPER 9
THE BEST INTERESTS OF THE PATIENT TO BE STERILIZED

9.1 INTRODUCTION

It seems apparent that the key to ensuring that it is morally acceptable to perform sterilization on a mentally incompetent patient is to ensure that the procedure is performed on the basis that it is in the patient‟s best interests. This sentiment is enshrined in the Convention on the Rights of Persons with Disabilities and echoes in the Australian Guardianship and Administration Act 2000.

Closer to home, section 3 (b) (vii) of the Sterilization Act 44 of 1998 directs that the best interests of the patient to be sterilized must be taken into account. Save for directing that regard must be given to the patient‟s best interests, the Act provides no guidance as to what constitutes the best interests of the mentally incompetent patient in determining whether the patient is to be subjected to a procedure that will irreversibly render her infertile. Whilst the Children‟s Act does not provide guidance regarding the best interests of mentally incompetent minors, the Act does set out factors to be taken into account in applying the „best interests‟ standard in regard to children. The same is noted on the basis that children, together with mentally incompetent children have diminished autonomy and accordingly the provisions of the Act pertaining to the „best interests‟ standard can be applied to the issue at hand.

The factors to be considered in applying the „best interests‟ standard are enshrined in section 7 of the Act. Section 7 of the Act provides that, *inter alia*, characteristics such as the child‟s gender, age, background and stage of development must be taken into account[411] as well as the child‟s „physical and emotional security,‟[412] disability[413] or chronic illness that the child may have,[414] and the child‟s need to be raised in a stable family environment.[415] An additional factor to be

[411] Section 7 (1) (g)
[412] Section 7 (1) (h)
[413] Section 7 (1) (i)
[414] Section 7 (1) (j)
[415] Section 7 (1) (k)

taken into account is the necessity to protect the child against physical or psychological harm[416] and family violence.[417]

Whilst it is recognized that the judgment of the Australian family court in Marion‟s case[418] is not binding on South African law, the primary consideration is succinctly stated by Judge Brennan in his dissenting judgment in which he stated, "the best interest approach is useful only to the extent of ensuring that the first and paramount consideration is the interests of the child, not the interests of others".[419] This will be the point of departure of the discussion on how best to determine whether sterilization is in the best interests of the mentally incompetent patient from an ethical perspective.

9.2 DETERMINING WHETHER STERILIZATION IS IN THE PATIENT'S BEST INTERESTS FROM AN ETHICAL PERSPECTIVE

The principle of justice dictates that all people are entitled to equal treatment and not to be discriminated against.[420] Kluge submits that in accordance with the principle of justice, society provides a mechanism to guard against the mentally incompetent patient losing his/her right to equal treatment owing to diminished mental capacity.[421] Further, if society did not provide a mechanism to cater for patients with diminished autonomy, treating such patients as autonomous agents, on an equal footing to mentally competent patients, according to Kluge, amounts to discrimination.[422] Not all patients are the same. Ethics therefore requires that their differences be recognized and that such patients are treated equitably.[423] To give effect to a decision taken by a mentally incompetent patient is tantamount to punishing the patient for his/her mental incompetence.[424] The author illustrates this point by comparing it to giving effect to decisions made by children and people with dementia. Substitute decision making is accordingly resorted

[416] Section 7 (1) (l)
[417] Section 7 (1) (m)
[418] Sec,y, Dep‟t of Health & Cmty Servs v JWB (Marion‟s case) (1992 175 CLR 218 (Austl)
[419] Note 419 above, 175 CLR at 273 – 274
[420] Note 298 above.
[421] Note 298 above.
[422] Note 298 above.
[423] Note 298 above.
[424] Note 298 above.

to when a patient lacks the ability to provide informed consent.[425] Kluge argues that substitute decision making is a duty assigned to an individual by society in order to prevent discrimination against mentally incompetent patients and is to be discharged in accordance with the principles of justice and equality.[426]

An issue that comes the fore is what values should form the basis upon which the substitute decision maker makes decisions.[427] Values form the basis upon which decisions are made.[428] Consistent values are vital as they provide the motivation for the chosen treatment or procedure. Accordingly, respect for patient autonomy will entail applying the values specific to an individual

When faced with a patient who at no point was mentally competent, there is no moral code specific to the patient to which the substitute decision maker can refer to in the decision making process.[429] Kluge submits that there are five models available to the substitute decision maker to be invoked when confronted with the aforementioned situation.[430]

The five models submitted by Kluge are as follows:

1. Medical appropriateness;
2. The shared values held by the patient"s family;
3. The course of action that is in the patient"s best interests in accordance with the principle of beneficence;
4. The values that the mentally incompetent patient would have used as a moral compass has he/she held values;
5. The values of exploring all possible options.

[425] Note 298 above.
[426] Note 298 above.
[427] Note 298 above.
[428] Note 298 above.
[429] Note 298 above.
[430] Note 298 above.

Kluge points out that the pitfall of using the model of medical appropriateness is that medical facts are used in order to achieve a positive outcome.[431] In the healthcare setting, medical appropriateness although an important factor to be considered, the author‟s position is that in the absence of values, medical facts are insignificant in the decision-making process on the basis that what may seem reasonable from a medical perspective may appear differently from a moral or even religious perspective.[432] Moreover, the model invokes the values held by the medical profession and not that of the patient concerned.[433] The implication is that in applying the values held by the medical profession, the mentally incompetent patient is being treated differently in comparison to mentally competent patients, which is a violation of the principle of justice.[434] Therefore Kluge‟s submission that the medical appropriateness standard will result in inequality is an acceptable submission.

Regarding the second model – to invoke the common values held by the patient‟s family, Kluge points out that whilst it is assumed that all family members share common values, there is evidence suggesting the contrary.[435] Accordingly, the common values held by the family would not necessarily be held by the mentally incompetent patient.[436] The implication is that if the family‟s common values were applied in the decision making process, there is the possibility that values not held by the patient would be forced upon him/her. In this regard Kluge‟s argument that applying the family‟s common values to the mentally incompetent patient violates the principle of respect for autonomy is acceptable.[437]

The third model requires that decisions must be made with a view of achieving that which is in the patient‟s best interests and in accordance with the principle of beneficence.[438] Beneficence is a helpful point of departure in the decision making process however, the implication that arises in applying the third model to the decision making process is that what constitutes an act of beneficence varies from person to person and depends on the individual‟s interpretation of what

[431] Note 298 above.
[432] Note 298 above.
[433] Note 298 above.
[434] Note 298 above.
[435] Note 298 above.
[436] Note 298 above.
[437] Note 298 above.
[438] Note 298 above.

it means to do good.[439] Kluge makes it explicit that the values used in substitute decision making must be consistent in their application.[440] It follows then that using a beneficent model for substitute decision making is no different to using the medical appropriateness model or the values held by the family on the basis that instead of applying the values held by the medical profession in the former model or that of the family in the latter model, a decision is reached based on the substitute decision maker"s interpretation of what is the beneficent course of action and in the patient"s best interests.[441]

The challenge that arises in adopting the fourth model – that of the values which the mentally incompetent patient would have had regard to had he/she held values is that the model requires the substitute decision maker to step into the shoes of the mentally incompetent patient.[442] Kluge"s criticism of this model is that stepping into the shoes of the mentally incompetent patient would result in the substitute decision maker looking at the situation from the perspective of one who is mentally incompetent and incapable of making an informed decision.[443] In addition, the mentally incompetent patient did not previously hold any values. The substitute decision maker would have to speculate regarding the values that the mentally incompetent patient would have held had he/she held any values.[444] Although this model is in accordance with the principle of respect for persons in that it endeavours to give effect to the values that the patient would have had regard to had he/she held values, Kluge is of the opinion that the model is subjective and cannot be applied consistently to all matters.

The final model - to do everything possible for the patient avoids the challenge of having to determine the values to be considered in the decision-making process. The model simply requires that the substitute decision maker must do everything possible for the patient and in doing so, fulfills the duty to make a decision that is in the patient"s best interests. Whilst this model aims to leave no stone unturned and satisfies the decision maker that he or she explored all possible alternatives before reaching a decision, bearing in mind that there may be constraints

[439] Note 298 above.
[440] Note 298 above.
[441] Note 298 above.
[442] Note 298 above.
[443] Note 298 above.
[444] Note 298 above.

in terms of resources, there is no possible way of knowing whether the decision reached by the surrogate decision maker would be sanctioned by the patient had she/he been mentally competent.

9.3 CONCLUSION

In summation, the author expresses that whilst the aforementioned five models do have their challenges and are not without merit, an ideal framework for substitute decision making would be an approach that gives expression to the principles of equality and respect for persons as envisaged in the Universal Declaration of Human Rights. Closer to home, the decision reached will be in accordance with section 9 of the constitution – upholding the patient‟s right to equality and not to be subjected to unfair discrimination on the basis of disability. In addition, the final decision made by the substitute decision maker must not stifle the patient‟s growth in respect of opportunities that are otherwise available to mentally competent members of society. In applying the guideline suggested by kluge in the decision-making process, the decision reached will be in accordance with the principle of justice.[445]

[445] Note 298 above.

CHAPTER 10
RECOMMENDATIONS AND CONCLUSION

10.1 RECOMMENDATIONS

As has previously been stated, in terms of the Sterilisation Act, a request for the sterilization of a mentally incompetent patient vests in the hands of, *inter alia,* the patient‟s parents.[446] A panel is thereafter convened in terms of section 3 of the Sterilization Act to determine whether the patient is to be sterilized. The actual consent to the sterilization procedure comes from the panel. Boezaart has stated that the decision to sterilize a mentally incompetent adolescent female should not vest in the hands of the parent‟s or care giver‟s on the basis that the request may be driven by selfish motivations and the child‟s best interests may not necessarily be at heart.[447] Additionally, Boezaart submits that the decision to sterilize should not be the prerogative of medical professionals on the basis that the consequences flowing from sterilization extend beyond medical consequences and affect the individual concerned at a social as well as psychological level.[448] Accordingly, Boezaart recommends that the decision to sterilize a mentally incompetent minor should vest in the hands of the courts.[449]

It is accordingly submitted that Boezaart‟s recommendations should be implemented on the basis that the court will look at the matter before it and take into account the medical, psychological and social consequences that sterilization will have on the patient as well as the legal and ethical issues associated with the matter and after hearing both sides of the matter, will make an equitable determination. The panel as envisaged in the Sterilisation Act consists of a psychiatrist, a psychologist and a nurse – there are no lawyers. Accordingly, as the matter is not purely a medical matter and involves human rights issues, the determination to sterilize a mentally incompetent patient should be taken by a court and evidence can be led by the psychiatrist, psychologist and the nurse who constituted the panel. Costs should be borne by the applicant. The High Court of South Africa is the upper guardian of all children and if the court

[446] Section 3 of the Sterilisation Act.
[447] Note 124 above, 85.
[448] Note 124 above, 85.
[449] Note 124 above, 85.

were to be tasked with the duty of determining whether a minor is to be sterilized, the best interests of the child will no doubt be served.

10.2 CONCLUSION

In light of the aforementioned it is submitted that in order to ensure that the decision to sterilize a mentally incompetent adolescent patient is taken purely on the basis that it is in the patient‟s best interests, the determination should be made by the courts.

CHAPTER 11
CONCLUSION

From the aforementioned review of the literature available on the issue of the sterilization of mentally incompetent patients, what is apparent is that it is lawful to sterilize a mentally incompetent patient provided that it will serve the patient‟s best interests.[450] However, on an ethical level, the act of sterilizing a patient in the absence of informed consent is a grave violation of the principle of respect for persons as well as the patient‟s right to bodily integrity.[451] It has been submitted that medical practitioners should attempt to obtain assent to the procedure from the patient[452] as well as the patient‟s thoughts on the matter.[453]

Further, the request for sterilization often comes from a parent or care giver seeking relief from having to deal with the inconvenience of caring for a mentally incompetent adolescent during menstruation as well as eliminating the risk of conception.[454] In this regard it has been submitted that measures such as counseling and training for both the adolescent and the care giver can be implemented in order to lessen the burden on the care giver and thus eliminate the need for sterilization.[455] The medical practitioner must be satisfied that sterilization truly is in the patient‟s best interests and not requested by the care giver for selfish reasons,[456] failing which, the act of performing sterilization on a mentally incompetent adolescent patient will not only violate the principles of beneficence and non-maleficence but will also be a grave injustice to the patient who will effectively be stripped of her ability to procreate and have a family of her own.[457]

In order to ensure that sterilization of mentally incompetent adolescent patients is performed both lawfully and ethically, it is submitted that Boezaart‟s recommendation that the courts be vested with the power to determine whether sterilization is appropriate for mentally incompetent

[450] Section 3 (1) (b) (vii) of the Sterilisation Act.
[451] Note 286 above, 219.
[452] Note 286 above, 219.
[453] Note 157 above.
[454] Note 2 above.
[455] Note 276 above.
[456] Note 3 above, 231.
[457] Note 2 above, 2.

adolescent females be implemented in order to ensure that the best interests of the mentally incompetent adolescent patient are served.[458]

[458] Note 124 above, 85.

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