Chapter 1

The referral

1.1 On 20 September 2012, the Senate referred the involuntary or coerced sterilisation of people with disabilities in Australia to the Senate Community Affairs Legislative Committee for inquiry and report by 24 April 2013. The Senate granted an extension of time for reporting to 17 July 2013.

1.2 On 7 February 2013, the Senate added an additional term of reference regarding intersex people:

> 2. Current practices and policies relating to the involuntary or coerced sterilisation of intersex people, including:
>
> a) sexual health and reproductive issues; and
>
> b) the impacts on intersex people.

1.3 This second term of reference will be the subject of a second, separate committee report.

Conduct of the inquiry

1.4 Information about the committee's inquiry was advertised in the national press and on the committee's website. The committee commissioned the preparation of an Easy English explanation of the inquiry, which was also released on the committee's website. The committee received 91 submissions from a diverse range of individuals and organisations, which included legal and medical professionals, disability support services, disability advocacy services, family planning services, and private individuals. Several submissions were received from persons with disabilities, and their families. In addition, the committee received correspondence from relevant state and territory courts and tribunals and from academics in the field of international law. This material is available on the committee's website.[1] A list of the individuals and organisations who made submissions is provided at Appendix 1.

1.5 Public hearings were held in Melbourne on 11 December 2012, Sydney on 27 and 28 March 2013, and in Canberra on 31 May 2013. Transcripts of the hearings are available on the committee's website.[2] A list of witnesses who gave evidence at the public hearings is provided at Appendix 2.

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1 Senate Standing Committees on Community Affairs, *Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia: Submissions received by the Committee* http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/involuntary_sterilisation/submissions.htm (accessed 12 July 2013).

2 Senate Standing Committees on Community Affairs, *Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia: Public hearings and transcripts* http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/involuntary_sterilisation/hearings/index.htm (accessed 12 July 2013).

Acknowledgements

1.6 The committee recognised that it was essential that it talk to and hear from people with disabilities. Their evidence is the most important, because this inquiry is about their bodies and their lives. To this end, it held a number of *in camera* (confidential) discussions with women with disabilities, in Brisbane, Sydney and Adelaide. These discussions were facilitated by trained support workers and interpreters. The committee is grateful not only for their willingness to share their accounts, but also for their willingness to allow the committee to refer to their evidence in the committee's report.

1.7 The committee thanks individuals and organisations who worked hard to facilitate the committee's inquiry. These include Carolyn Frohmader of Women With Disabilities Australia, Karin Swift (Brisbane), Matthew Bowden (Sydney) and Margie Charlesworth (Adelaide). This inquiry could not have been completed without them. The committee also thanks a number of health professionals who provided considerable assistance and answered the committee's many questions. It is grateful to the Australian Guardianship and Administration Council and its member organisations, which helped gather information, and answered questions. The committee is likewise grateful for the assistance of the Chief Justice of the Family Court, Diana Bryant AO.

Previous inquiries

1.8 This inquiry into the coerced or involuntary sterilisation of persons with disabilities is not the first conducted in Australia. The committee acknowledges the seminal work undertaken by both government and non-government organisations in exposing an otherwise hidden practice. In particular, the committee notes the following reports.

1994 report of the Family Law Council

1.9 In October 1992, the then Minister for Justice, Senator Tate, referred to the Family Law Council an inquiry into Commonwealth, state and territory laws regulating the sterilisation of children. Council was asked to consider what principles should govern sterilisation proceedings, whether uniform legislation should be introduced, and what penalties are appropriate in the event a child is sterilised without all necessary authorisations.[3]

1.10 Reporting in November 1994, Council concluded that a uniform and consistent approach is needed for all children regardless of where they live. Accordingly, Council recommended that application for child sterilisation procedures be heard only by the Family Court of Australia. Additionally, Council recommended that only specially trained judges hear sterilisation applications, that the costs of sterilisation cases be met by the government rather than the individual families, and that counselling services be provided. Council further recommended that sterilisation

3 Family Law Council, *Sterilisation and other medical procedures on children*, terms of reference, 1994, paragraph 1.06.

of a child only be authorised if necessary to save a life or to prevent serious damage to the child's physical or psychological health.[4]

1997 and 2001 reports by the Australian Human Rights Commission

1.11 In 1997, the Australian Human Rights Commission released the report *The sterilisation of girls and young women in Australia*. The report highlighted that the number of sterilisations being performed on children and young women with disabilities in Australia exceeded those authorised by a court or tribunal.[5] The Commission concluded that the law had failed to protect persons at risk of involuntary or coerced sterilisation:

> The law has failed to protect significant numbers of children from significant abuse of their fundamental human right to bodily integrity. Worse, the community has aided and abetted that abuse by funding it - all the 1045 sterilisations which are identified can be identified only because they were 'services which qualify for medicare benefit.[6]

1.12 In 2001, this was followed by a second report. The report noted that the 1997 inquiry triggered significant action among the government and non-government sectors. This included amendments to the Medicare scheme in 1998, to require that any claims for Medicare benefits in relation to the sterilisation of children be accompanied by either a court order or clinical details of the need for such a procedure. Additionally, the report noted that the 1997 inquiry prompted a Senate resolution requesting that the Australian Government review the laws relating to the sterilisation of children and adults with disabilities.[7] It was recommended that each state and territory enact legislation concerning the sterilisation of children, and that service providing agencies be provided with concise and accurate information about fertility and menstrual management and the law as it relates to the sterilisation of children.[8]

Government report to the Senate

1.13 In response to a Senate resolution calling for the government to review the legal, ethical and human rights mechanisms required to protect the reproductive health

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4 Family Law Council, *Sterilisation and other medical procedures on children*, terms of reference, 1994, Recommendations 1–4.

5 Australian Human Rights Commission, *The sterilisation of girls and young women in Australia: issues and progress*, http://www.humanrights.gov.au/publications/sterilisation-chapter-two (accessed 12 July 2013).

6 Australian Human Rights Commission, *The sterilisation of girls and young women in Australia: 1997 report*, http://www.humanrights.gov.au/sterilisation-girls-and-young-women-australia-1997-report (accessed 12 July 2013).

7 Australian Human Rights Commission, *The sterilisation of girls and young women in Australia: issues and progress*, http://www.humanrights.gov.au/publications/sterilisation-chapter-five (accessed 12 July 2013).

8 Australian Human Rights Commission, *The sterilisation of girls and young women in Australia: issues and progress*, http://www.humanrights.gov.au/publications/sterilisation-chapter-six (accessed 12 July 2013).

of women with intellectual and other disabilities, on 6 December 2000 the government tabled in the Senate the report *Sterilisation of women and young girls with an intellectual disability*. On the basis of data provided by the Australian Institute of Health and Welfare, the government estimated that there were a few sterilisations of girls with disabilities in the years 1993–1999.

1.14 Reporting to the United Nations' Committee in June 2003, the Australian Government commented that the report provided background information and recent statistics on sterilisation procedures. Following the release of the report, the then Attorney–General wrote to Australian medical colleges and associations to advise of the law and procedure applying to non-therapeutic sterilisation of children with an intellectual disability. In addition, the Attorney–General authorised changes to legal aid guidelines to improve access to legal assistance for Commonwealth child sterilisation cases.[9]

Key concepts and definitions

1.15 Before the committee turns to the substantive issues, there are a number of key concepts that need briefly to be explained, in part because they are quite complex and the subject of more detailed discussion in later chapters. The most significant of these is the final issue in this chapter: the meaning of 'therapeutic' sterilisation.

Definition of disability

1.16 The World Health Organization (WHO) defines 'disability' as:

> …an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.
>
> Disability is thus not just a health problem. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. Overcoming the difficulties faced by people with disabilities requires interventions to remove environmental and social barriers.[10]

1.17 Persons with a disability who are subject to sterilisation may be of different ages, different genders and have differing levels of capacity. However, it has been observed that sterilisation procedures are usually considered for, or performed on, persons with intellectual disability and/or cognitive impairment. However, the degree to which decision-making capacity is affected depends both on the nature of the

9 Australian Government, *Australia's combined fourth and fifth reports to the United Nations on the Convention on the Elimination of Discrimination against Women*, June 2003, p. 77.

10 World Health Organisation (2013) in Organisation Intersex International Australia Limited, *Submission 23*, p. 2.

disability, the extent of support with which a person is provided, and the subject matter about which the person is being asked to make a decision.[11]

1.18 Coerced or involuntary sterilisation is a gendered practice. According to a number of submissions[12] those subjected to the practice are 'predominantly…women and girls with disability'[13] and most matters that reach the courts and tribunals relate to girls with intellectual disabilities.[14] This is reflected in the evidence before the committee, which was overwhelmingly about the sterilisation of women and girls, and borne out in data received by the committee.

1.19 The committee was informed that the clinical reasons given in support of sterilisation for a person with a disability are usually linked to one of the following outcomes:[15]

- Avoidance of pregnancy;
- Management of menstruation where the cyclic nature of menstruation and the associated hormonal changes adversely impact on other existing health conditions such as epilepsy (increased seizures), asthma (increased breathing difficulties) and identified behavioural disorders (increasingly extreme and dangerous behaviour); or
- Management of menstruation where the cyclic nature of menstruation and the associated hormonal changes impact on the quality of life of the individual, for example meaning they are unable to attend school or to take part in everyday activities.

1.20 As will be discussed in later chapters, however, the arguments made for the use of sterilising procedures can be broader than just clinical in nature, and are controversial.

Definition of sterilisation

1.21 A purpose of this inquiry was to ascertain how sterilisation is understood and defined in the Australian community. The committee received varying definitions of

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11 See, for example, Sexual Health and Family Planning Australia, *Submission 52*, p. 3; Women With Disabilities Australia, *Submission 49*, p. 38.

12 Australian Human Rights Commission, *Submission 5*, pp. 3–4; Women With Disabilities Australia, *Submission 49*, p.19; Brady, J. Briton & S. Grover, *The Sterilisation of Girls and Young Women in Australia: issues and progress*, 2001, p. 28.

13 Women With Disabilities Australia, in Australian Human Rights Commission, *Submission 5*, p. 3.

14 Women With Disabilities Australia, *Submission 49*, p. 19; S. Brady, J. Briton & S. Grover, *The Sterilisation of Girls and Young Women in Australia: issues and progress*, 2001, p. 3.

15 Australian Human Rights Commission, *Submission 5*, p. 8; Women With Disabilities Australia, *Submission 49*, p.30; Professor Gwynnyth Llewellyn, University of Sydney, *Submission 21*, pp. 3–5; S.M. Brady & S. Glover, *The Sterilisation of Girls and Young Women in Australia; A Legal, Medical and Social Context* – report commissioned by the Federal Disability Discrimination Commissioner, 1997, pp. 28–29.

sterilisation. As explored further in chapter 3, it was notable that definitions of sterilisation are not consistent across Commonwealth, State and Territory legislation.[16] Submitters to this inquiry also varied in their understanding of what constitutes a sterilisation procedure.[17]

1.22 Broadly, it was recognised that sterilisation 'is a process or act that renders a person unable to produce children.'[18] However, within this framework various kinds of procedures were noted, including permanent (irreversible) sterilising procedures, medical procedures for which permanent sterilisation is the likely outcome and non-permanent contraceptive measures.

1.23 The permanent sterilising procedures mentioned during this inquiry included:

- Hysterectomy – removal of the uterus and, depending on the need, the removal of the cervix, fallopian tubes, ovaries and part of the vagina.[19]
- Tubal ligation – blocking or closing of the fallopian tubes. It causes infertility but ovulation and menstruation can still occur.[20]
- Endometrial ablation – laser technology or similar is used to destroy the uterine lining, predominantly for the purpose of reducing or stopping menstrual loss. This process alone does not render a woman infertile but it is often performed in association with a tubal ligation.[21]
- Vasectomy – a procedure performed on males, cutting and sealing the vas deferens to prevent sperm passing from the testes to the penis.[22]

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16 See, for example, *Guardianship and Management of Property Act 1991* (ACT) and *Adult Guardianship Act 1988* (NT).

17 See, for example, Australian Human Rights Commission, *Submission 5*, p. 3; Women With Disabilities Australia, *Submission 49*, p. 18.

18 *Mosby's Dictionary of Medicine Nursing and Health Professionals* 2nd Australian and New Zealand Edition Peter Harris; Sue Nagy & Nicholas Vardaxis (Eds) 2009.

19 Department of Paediatric and Adolescent Gynaecology that Royal Children's Hospital, Melbourne, *Submission 69*, p. 3; S.M. Brady & S. Glover, *The Sterilisation of Girls and Young Women in Australia; A Legal, Medical and Social Context* – report commissioned by the Federal Disability Discrimination Commissioner, 1997, pp. 21–22.

20 S.M. Brady & S. Glover, *The Sterilisation of Girls and Young Women in Australia; A Legal, Medical and Social Context* – report commissioned by the Federal Disability Discrimination Commissioner, 1997, p. 23.

21 Department of Paediatric and Adolescent Gynaecology at Royal Children's Hospital, Melbourne, *Submission 69*, p. 3; S.M. Brady & S. Glover, *The Sterilisation of Girls and Young Women in Australia; A Legal, Medical and Social Context* – report commissioned by the Federal Disability Discrimination Commissioner, 1997, p.22.

22 Department of Paediatric and Adolescent Gynaecology at Royal Children's Hospital, Melbourne, *Submission 69*, p. 3; State of Victoria, Australia, Better Health Channel Fact Sheet Contraception Choices http://www.betterhealth.vic.gov.au/bhcv2/bhcpdf.nsf/ByPDF/Contraception_choices_explained/$File/Contraception_choices_explained.pdf (accessed 10 April 2013)

1.24 Permanent sterilisation procedures are in the majority of cases either completely non-reversible or difficult to reverse. The likelihood of a successful pregnancy after a sterilisation reversal is lower than that prior to sterilisation. However, pregnancy is not impossible if a sterilisation procedure fails. For example tubal ligation has a 3/1000 chance of failure rate.[23] Pregnancy can also be dangerous if a sterilisation procedure fails. For example pregnancy after an endometrial ablation can be life threatening to both the foetus and woman due to uncontrolled bleeding.[24]

1.25 Identified medical procedures for which sterilisation is a secondary, but likely, outcome included:

- Gonadectomies - involve the removal of testes and/or ovaries. These processes are considered sterilisation as they limit any future utilization of healthy reproductive tissue.[25] These procedures are often performed on intersex people.
- Bilateral oophorectomy – removal of both ovaries (because of cancer or other pathological conditions) is not a technique that is used to achieve sterilisation, however sterilisation can occur as the process will result in a cessation of hormone production and bring on menopause.[26]

1.26 The committee was also informed of a range of non–permanent contraceptive and menstrual suppression options. According to Sexual Health and Family Planning Australia 'there is a continuum of non-permanent options and strategies that can be used to help manage menstruation and/or prevent pregnancy.'[27] These range from short acting contraceptives such as the Oral Contraceptive Pill (including the emergency contraceptive pill), male and female condoms, vaginal ring, diaphragms/caps and intrauterine devices, to long acting reversible contraceptives (LARCs). LARCs were discussed regularly by witnesses to the inquiry, and include injections (such as Depo Provera), implants (such as Implanon) and intrauterine systems (such as Mirena).[28]

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23 Department of Paediatric and Adolescent Gynaecology at Royal Children's Hospital, Melbourne, *Submission 69*, p. 3.

24 Department of Paediatric and Adolescent Gynaecology at Royal Children's Hospital, Melbourne, *Submission 69*, p. 3.

25 Organisation Intersex International Australia Limited, *Submission 23*, p. 3; Androgen Insensitivity Syndrome Support Group Australia Inc., *Submission 54*, p. 3.

26 Department of Paediatric and Adolescent Gynaecology at Royal Children's Hospital, Melbourne, *Submission 69*, p. 3; S.M. Brady & S. Glover, *The Sterilisation of Girls and Young Women in Australia; A Legal, Medical and Social Context* – report commissioned by the Federal Disability Discrimination Commissioner, 1997, p. 22.

27 Sexual Health and Family Planning Australia, *Submission 52*, p. 3.

28 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Submission 30*. pp. 1–2.

1.27 Short acting contraceptives are the most common contraceptives used and are easily reversible, usually through simply stopping their use.[29] In comparison to short acting contraceptives, LARCs reduce or eliminate menstrual flow.[30] They are also perceived as being more effective and convenient for carers as they involve minimal maintenance.[31] According to the Department of Paediatric and Adolescent Gynaecology at the Royal Children's Hospital, Melbourne, the aim of menstrual management is to improve the patient's quality of life.[32]

Risks associated with permanent sterilisation procedures

1.28 Evidence before the committee highlighted that there are a number medical risks associated with permanent and non–permanent sterilisation and menstrual suppression procedures. Many permanent sterilisation procedures require surgery under a general anaesthetic and as such require admission to hospital.[33] As a surgical procedure, there are associated risks and potential side effects. These include postsurgical pain, scarring, organ damage or obstruction, surgical injury, and pulmonary issues.[34]

1.29 The committee was also advised of potential risks associated with non–permanent contraceptive and menstrual suppression procedures. These include nausea,

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29 D. Mazza, C. Harrison, A. Taft, B. Brijnath, H. Britt, M. Hobbs, K. Stewart & S. Hussainy, 'Current Contraceptive Management in Australian General Practice: an analysis of BEACH data', *Medical Journal of Australia*, Vol. 197, No. 2, 2012, p. 110. https://www.mja.com.au/journal/2012/197/2/current-contraceptive-management-australian-general-practice-analysis-beach-data?0=ip_login_no_cache%3D81480516041c71bb078031b48a511e93 (accessed 10 April 2013).

30 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Submission 30*. p. 1.

31 D. Mazza, C. Harrison, A. Taft, B. Brijnath, H. Britt, M. Hobbs, K. Stewart & S. Hussainy, 'Current Contraceptive Management in Australian General Practice: an analysis of BEACH data', *Medical Journal of Australia*, Vol. 197, No. 2, 2012, p. 110; https://www.mja.com.au/journal/2012/197/2/current-contraceptive-management-australian-general-practice-analysis-beach-data?0=ip_login_no_cache%3D81480516041c71bb078031b48a511e93; State of Victoria, Australia, Better Health Channel Fact Sheet Contraception Choices http://www.betterhealth.vic.gov.au/bhcv2/bhcpdf.nsf/ByPDF/Contraception_choices_explained/$File/Contraception_choices_explained.pdf (accessed 10 April 2013).

32 Department of Paediatric and Adolescent Gynaecology that Royal Children's Hospital, Melbourne, *Submission 69*, p. 3.

33 Department of Paediatric and Adolescent Gynaecology that Royal Children's Hospital, Melbourne, *Submission 69*, pp. 4–5.

34 Patient.co.uk, *Common Postoperative Complications*, http://www.patient.co.uk/doctor/common-postoperative-complications (accessed 12 April 2013); Australian and New Zealand College of Anaesthetists, *Risks and complications*, http://www.anzca.edu.au/patients/frequently-asked-questions/risks-and-complications.html/?searchterm=risks and complication (accessed 12 April 2013).

breast tenderness, headaches, increased appetite and potential complications such as deep vein thrombosis (blood clots), heart attacks and strokes.[35]

1.30 According to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, LARCs have the potential to interact with medications commonly used for the control of epilepsy and behavioural disturbance. They state that 'such interactions may decrease their contraceptive efficacy.'[36] Depo-Provera has been reported as causing weight gain and in some cases an increased incidence of depression. Its extended use is also limited by the risk of osteoporosis.[37] Side effects of Implanon can include menstrual irregularity, and variable menstrual flow.[38] The use of Mirena is reported as causing continuous light menstrual bleeding in some women and may be contraindicated by pelvic infection. According to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Mirena is not appropriate for disabled women at risk of sexually transmitted diseases.[39]

1.31 On a more practical level there may be difficulties with the use of some of these non-permanent contraceptives, particularly if a person is:

> 'unable to swallow or take anything by mouth, is terrified of needles [or] becomes upset at the sight of even a spot of blood.'[40]

Definition of involuntary or coerced sterilisation

1.32 According to the Australian Human Rights Commission (AHRC), 'involuntary or coerced sterilisation' refers 'to the sterilisation of children (regardless of whether they have a disability), and the sterilisation of adults with disability in the absence of their fully informed and free consent.'[41] The AHRC submitted that there are distinct differences between involuntary sterilisation and coerced sterilisation:

> A sterilisation is 'involuntary' when it is performed against the person's will, or without the person being aware that it has happened (that is, without any form of consent from that person). In this situation, the right to make the decision about the sterilisation is removed from the person…'Coerced' sterilisation refers to situations in which pressure, trickery or inducements are employed to convince the person with disability to 'consent' to the

35 State of Victoria, Australia, Better Health Channel Fact Sheet Contraception – The pill http://www.betterhealth.vic.gov.au/bhcv2/bhcpdf.nsf/ByPDF/Contraception_oral_methods/$File/Contraception_oral_methods.pdf (accessed 10 April 2013).

36 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Submission 30*, p. 2.

37 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Submission 30*, p. 2.

38 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Submission 30*, p. 1.

39 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Submission 30*, p. 1.

40 Australian Association of Developmental Disability Medicine Inc, *Submission 59*, p. 3.

41 Australian Human Rights Commission, *Submission 5*, p. 3.

> procedure or menstrual suppression medication, usually in the absence of information being given to that person about the true nature and implications of the procedure or medication.[42]

1.33 Women With Disabilities Australia also distinguished involuntary sterilisation from coerced sterilisation:

> 'Forced/involuntary sterilisation' refers to the performance of a procedure which results in sterilisation in the absence of the free and informed consent of the individual who undergoes the procedure - including instances in which sterilisation has been authorised by a third party, without that individual's consent. 'Coerced sterilisation' occurs when financial or other incentives, misinformation, misrepresentation, undue influences, pressure, and/or intimidation tactics are used to compel an individual to undergo the procedure. Coercion includes conditions of duress such as fatigue or stress. Undue influences include situations in which the person concerned perceives there may be an unpleasant consequence associated with refusal of consent.[43]

1.34 Some submitters believed that sterilisation could be involuntary or coerced even if authorised by a court or tribunal.[44] This matter is further considered in chapter 4.

Definitions of therapeutic and non-therapeutic sterilisation

1.35 The difference between therapeutic and non-therapeutic sterilisation was a major theme throughout the submissions to this inquiry. Where used, the term 'therapeutic sterilisation' generally referred to procedures undertaken in a medical emergency to prevent serious harm.[45] In contrast, non-therapeutic sterilisations were equated with forced or involuntary sterilisations.[46]

1.36 However, not all submitters agreed with this definition. Ms Lesley Naik argued that the definition of therapeutic needs to be scrutinised to ensure that it genuinely means procedures intended to save lives and prevent serious damage to health. Ms Naik warned that:

> There is a real risk of an illegitimate broadening of the category of sterilisation procedures that may proceed without court or tribunal consent

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42 Australian Human Rights Commission, *Submission 5*, p. 5.

43 Women With Disabilities Australia, *Submission 40*, p. 7.

44 See, for example, Women With Disabilities Australia, *Submission 40*, p. 17.

45 Australian Human Rights Commission, *Submission 5*, p. 3; Women With Disabilities Australia, *Submission 49*, p. 18; Dr Wendy Bonython, *Submission 22*, p. 18; Catholic Women's League Australia Inc., *Submission 32*, p. 2; People With Disability Australia, *Submission 50*, p. 5; Family Planning, Victoria, *Submission 58*, p. 4; Associate Professor Lee Ann Basser, *Submission 61*, pp. 3–5; Queensland Advocacy Incorporated, *Submission 65*, p. 4.

46 See, for example, Australian Human Rights Commission, *Submission 5*, p. 6; Women With Disabilities Australia, *Submission 40*, p. 18.

> if 'therapeutic sterilisation' is not adequately distinguished from procedures that are necessary to 'save life' or prevent 'serious damage' to health.[47]

1.37 This view was shared by Ms Linda Steele, who warned that broad interpretations of 'serious damage to health' reinforce 'gendered and disabled stereotypes'.[48]

Legal definitions

1.38 In Australia, the legally recognised concept of therapeutic and non-therapeutic sterilisation is derived from the High Court of Australia's 1992 decision in *Re Marion.* While noting that there is uncertainty about the dividing line between therapeutic and non–therapeutic sterilisation, the High Court drew a distinction between sterilisation procedures and sterilisation that is a by–product, that is, a secondary outcome, of a medical procedure carried out for some other, necessary, purpose. The High Court held that the latter does not require court authorisation.[49] Specifically, their Honours stated:

> It is necessary to make clear that, in speaking of sterilisation in this context, we are not referring to sterilisation which is a by-product of surgery appropriately carried out to treat some malfunction or disease. We hesitate to use the expressions "therapeutic" and "non-therapeutic", because of their uncertainty. But it is necessary to make the distinction, however unclear the dividing line may be.[50]

1.39 While their Honours did not provide further guidance on the distinction between therapeutic and non-therapeutic sterilisation, the case has been taken as authority for the proposition that there is a distinction between therapeutic and non-therapeutic sterilisation, and, further, that there must be authorisation of 'non-therapeutic sterilisation' that would not be required for 'therapeutic' procedures.[51]

1.40 The Law Institute Victoria advised that the difference between therapeutic and non-therapeutic sterilisation continues to be a subject of debate within the legal community, and has recently been considered by the Family Court of Australia in *Re: Sean and Russell (Special Medical Procedures)* (2010) FamCA 948. In this case, the Family Court held that court approval was not needed for a sterilisation procedure that

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47 Ms Lesley Naik, *Submission 7*, p. 6.

48 Ms Linda Steele, *Submission 44*, p. 30.

49 Mason C.J., Dawson, Toohey and Gaudron JJ, *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) ALJR 300 (*Re Marion*), at 48.

50 Mason C.J., Dawson, Toohey and Gaudron JJ, *Secretary, Department of Health and Community Services (NT) v JWB and SMB* (1992) ALJR 300 (*Re Marion*), at 48.

51 See, for example, ABC Commercial, *Interview with Chief Justice Alistair Nicholson*, 12 May 2003, http://www.abc.net.au/4corners/content/2003/20030616_sterilisation/int_nicholson.htm (accessed 12 April 2013).

was proposed to prevent cancer.[52] Ms Lesley Naik, private capacity, submitted that the courts' interpretation of therapeutic sterilisation is 'restrictive'.[53]

Concerns with the use of the terms 'therapeutic' and 'non-therapeutic' sterilisation

1.41 It has been argued the High Court did not clearly endorse the use of the terms 'therapeutic' and 'non-therapeutic' sterilisation. As the Family Law Council has noted, an endorsement of both terms is clearer in international case law. In the 1986 case *Re Eve*, the Supreme Court of Canada clearly distinguished therapeutic from non-therapeutic sterilisation. As the Family Law Council has explained:

> In its decision in *Re Eve*, the Supreme Court of Canada drew a distinction between therapeutic and non-therapeutic procedures when it decided that sterilisation could not be authorised except for some therapeutic purpose. The court defined a 'therapeutic procedure' as a 'surgical operation that is necessary for the health of the person' and indicated that, by health, the court meant 'mental as well as physical health'.[54]

1.42 The Family Law Council concluded that 'there is no merit in drawing a distinction…between therapeutic and non-therapeutic sterilisation'. Rather, the Council recommended that legislation provide precise criteria for decision-makers to take into account before making a decision in a particular case.[55]

1.43 Submitters to this inquiry also debated the merits of using the terms 'therapeutic' and 'non-therapeutic' sterilisation. According to Dr Wendy Bonython, Assistant Professor, School of Law, Faculty of Business and government and Law, University of Canberra, the meaning of the terms is unclear:

> The term ‘therapeutic’ itself is difficult to define. Pertaining to ‘therapy’, it is not clear whether legally it is limited to clinical treatment of a physical disorder, or whether it can encompass broader aspects of health and welfare, such as minimising emotional or behavioural disturbances.[56]

1.44 Some submitters were concerned that the terms therapeutic and non-therapeutic sterilisation were also inappropriate for members of the medical community. Ms Lesley Naik submitted that the term is unhelpful for medical professionals, providing little guidance about legal requirements. Ms Naik advised that 'the legal meaning of the term therapeutic sterilisation differs from the meaning of the term as understood by medical practitioners.' For example, Ms Naik submitted that the legal notion of therapeutic sterilisation 'often results in a sterilisation procedure that may be described as therapeutic according to principles of medical ethics being

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52 Law Institute Victoria, *Submission 79*, p. 15.

53 Ms Lesley Naik, *Submission 7*, p. 4.

54 Family Law Council, *Sterilisation and other medical procedures of children*, November 1994, paragraph 4.15, citing *Re Eve* (1986) 31 DLR (4th) 1.

55 Family Law Council, *Sterilisation and other medical procedures of children*, November 1994, paragraph 4.18.

56 Dr Wendy Bonython, *Submission 22*, p. 17.

described as non-therapeutic'.[57] The Office of the Public Advocate also noted that the legal terminology may be unhelpful for the medical community, advising that since *Re Marion* 'the distinction between "non-therapeutic" and "therapeutic" sterilisations has become blurred'.[58]

1.45 It was submitted that legislation should avoid these terms, and instead simply and clearly articulate the circumstances in which court approval is required. The Law Institute of Victoria preferred an approach whereby legislation clearly specifies the nature of the sterilisation procedures that require approval.[59] Such an approach, it was submitted, would provide greater clarity for members of the medical and legal community, and reduce the potential for court approval being sought merely to reduce a medical practitioner's potential liability.[60] Similarly, Dr Wendy Bonython recommended that rather than using terms such as 'therapeutic' or 'non-therapeutic', legislation should clearly articulate the circumstances under which court authorisation should be sought.[61]

1.46 Later in this report, and in its forthcoming report on intersex issues, the committee will discuss the issue of circumstances that should require authorisation, and how these should be defined.

57 Ms Lesley Naik, *Submission 7*, p. 3.

58 Office of the Public Advocate, *Submission 14*, p. 6.

59 Law Institute of Victoria, *Submission 79*, p. 22.

60 Law Institute of Victoria, *Submission 79*, p. 22.

61 Dr Wendy Bonython, *Submission 22*, p. 4.