TA TAIT, J.A. Voluntary social sterilisation.

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Voluntary Social Sterilisation

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INTRODUCTION

This paper considers various aspects of voluntary social[1] sterilisation - sterilisation performed at the request, and with the consent, of the patient for whatever personal reasons he may have.

This may be contrasted with:

a) Therapeutic sterilisation - sterilisation intended to prevent conception for medical reasons

b) Eugenic sterilisation - sterilisation performed to prevent the transmission of certain undesirable hereditary traits

c) Punitive sterilisation - sterilisation performed as a punishment for the commission of sex crimes and other criminal offences[2].

Unless otherwise specified, in this paper the term "sterilisation" refers only to social sterilisation.

In order to ascertain general medical practice in matters relating to counselling and the assessment of the suitability of a patient for sterilisation, the writer surveyed gynaecologists and urologists in the Wellington area.

The following questions were prepared

1. Would you please indicate the criteria you use in assessing the suitability of a patient for sterilisation and note whether these are mandatory or may be waived on occasions.

2. Do you require, or merely prefer, spousal consent to the sterilisation operation?

3. Has your policy in respect of the above two questions changed in the past five years?

1 The Royal Commission on Contraception Sterilisation and Abortion in New Zealand used this term to distinguish sterilisation performed on these grounds from "therapeutic" sterilisation as both are voluntary. Report of the Royal Commission of Enquiry into Contraception Sterilisation and Abortion in New Zealand Wellington Government Printer 1977

2 There is no statute permitting the performance of either eugenic or punitive sterilisation in New Zealand. Statutes authorising both have elsewhere been enacted. There is in the United States some argument that such statutes are unconstitutional. Bloom notes several punitive sterilisation statutes have been declared unconstitutional on the grounds that that they called for 'cruel and unusual' punishment: Bloom S.L. "A Woman's Right to Voluntary Sterilization" 22 Buffalo Law Review 291 at 292

4. Who counsels the patient prior to the operation?

5. Do you impose a waiting period between counselling and the operation during which time a patient may reconsider his/her decision ? If so, how long is this period?

It was intended to assess the views of all gynaecologists and urologists in the Wellington area who were listed in the 1976 telephone directory. The writer wished to interview personally one urologist and one of two gynaecologists, and therefore sent the survey to the remainder (11) and to one general surgeon who performed vasectomies. Seven were returned completed, one was returned undelivered. Two replied requesting the writer to make an appointment to discuss the matter further and two did not reply (the general surgeon and one gynaecologist).

The writer interviewed the urologist intended and both practitioners referred to above. Following the interview with one gynaecologist there was little point in requesting an appointment with either gynaecologist intended.

As a result the writer canvassed the views of seven of the eleven gynaecologists and all three urologists listed in the Wellington directory.

The writer interviewed also Dr Sparrow of the Family Planning Association.

The results are referred to in Parts I and II of the paper.

Part I discusses various medical aspects of sterilisation, in particular outlining the procedure involved in the male and female sterilisation operation and the advantages and disadvantages of sterilisation compared with alternative contraceptive methods. Such matters are discussed by practitioner and patient prior to the operation. A short section on counselling is therefore included at this point.

Part II focuses on the availability of sterilisation. There is little statistical information available on the number of sterilisation operations performed in New Zealand but figures cited in the

first section at least give some indication of the increasing demand for sterilisation. Discussion of the social characteristics of those seeking sterilisation follows.

Two factors have traditionally limited the availability of sterilisation - uncertainty as to the legality of the operation and the imposition by the medical profession of criteria to be met by applicants for sterilisation. It is the writer's view that even prior to the enactment of section 2 Crimes Amendment Act 1977 sterilisation was lawful although there was no direct authority for this proposition. The relevant caselaw is reviewed in section C. In 1977 under section 2 Crimes Amendment Act 1977 sterilisation was declared lawful and at present the major factor restricting availability of sterilisation is the necessity to comply with criteria imposed by the medical profession. It is typically required that applicants obtain spousal consent and satisfy age/parity criteria. Two practitioners noted their fear of suit by the spouse of a patient if spousal consent to sterilisation was not obtained. One added that failure to obtain spousal consent enabled a spouse to sue the patient for divorce upon the basis of constructive desertion. Both legal issues are examined in section D. It seems likely there will be in the near future a substantial change in the grounds upon which divorce may be obtained Recommendations that divorce be granted on the basis of irretrievable breakdown will probably be accepted. The possibility of a spouse obtaining a divorce under this scheme where his partner has undergone a sterilisation operation without his consent is also raised in section D.

There follows a survey of criteria imposed upon applicants for sterilisation by the medical profession. This is justified on the basis that there is a high incidence of regret - and seeking of reversal - in those who are sterilised while young with few or no children. The available literature is reviewed with a view to determining whether this association is supported.

Part III discusses the legality and availability of sterilisation in other jurisdictions and in particular focuses on the debate current in the United States over the constitutionality of restrictive sterilisation provisions.

I MEDICAL ASPECTS OF STERILISATION

A MALE STERILISATION

The male sterilisation operation (vasectomy) is generally regarded as safe, quick (operating time about ten minutes) and simple. The operation may be performed in a doctor's surgery by a General Practitioner , a vasectomy clinic such as that operated by the Family Planning Association, or a hospital - usually on an outpatient basis[3].

A local anaesthetic is generally considered sufficient although a general anaesthetic may in certain circumstances be preferred. A short (1 cm) incision is made in the scrotal skin directly over each vas and carried down to the vas itself. The vas is seized with forceps and withdrawn as a loop through the incision. The vas may be cut, or a 1 - 4 cm section removed. Sperms may be washed from the semen and sterility obtained more quickly by at this stage irrigating the vas towards the urethra via a cannula with sterile water. Alternatively, irrigation with a spermicidal solution via a needle attached to a plastic syringe renders a patient immediately sterile. The cut ends may be sealed with diathermy, tied with silk, thread or catgut or occluded with clips. Some suggest the cut ends be doubled back or crossed over or that the two distal and proximal ends be tied together. Urquhart-Hay notes[4] in operating the surgeon should bear in mind the possibility of subsequent re-anastomosis (re-joining) - the practice of excising an excessive length of vas is to be

3. A survey conducted by the Department of Health showed 25% of sterilised males had the vasectomy performed in a private hospital, 60% in a doctor's surgery and 15% in a public hospital: Department of Health "Family Growth Study" Special Report No. 48 Wellington Government Printer 1976

4 Urquhart-Hay, D. "Vasectomy: When and How" 5 Patient Management 36 at 41

condemned[5]. Each wound is closed with a single suture and the area is sprayed with an aerosol dressing.

Unless spermicidal solution has been injected, the patient may be fertile for some months until the sperm store in the seminal vesicles is removed by further intercourse. The patient is advised to use alternative methods of contraception until there are two negative sperm counts.
The patient is advised to rest for a few hours after the operation.

Vasectomy has no physical effect on sex drive or capability to achieve an erection or ejaculation. The mortality rate is virtually nil.

Estimates of morbidity rates differ but all studies show a low complication rate - Davis[6] notes general reports on immediate morbidity range from 2 - 10%, the difference possibly being due to differing interpretations of "morbidity".

The Simon Population Trust[7] in a study of post-operative complications in vasectomy patients reported 2/3 of the 1012 men who completed the questionnaire had no side effects. Thirty-three had "medically serious side effects" - mainly local infection (13) and haemotomas (12).

In a survey of 1000 vasectomy patients the staff of the Margaret Pyke Centre[8] noted 122 patients reported early post-operative complications. Again, haemotomas (42), minor local infection (12) and minor symptoms such as bruising and tenderness (56) account

5 Altman M noted a fellow practitioner's removal of 7.5 cm of vas was contrary to a unanimous resolution of the Second International Conference on Sterilisation which stated the operation must always be done bearing in mind the possible necessity for future re-anastomosis: Correspondence 1974 1 British Medical Journal 198

6 Davis, J.E. "Vasectomy" 72 American Journal of Nursing 509

7 "Follow up after Vasectomy" 1970 Lancet 483

8 Margaret Pyke Centre "One Thousand Vasectomies" 1973 4 British Medical Journal 216 at 218

for a large portion of that figure.

B. FEMALE STERILISATION

Sterilisation of the female is effected by tubal ligation (cutting, cauterising or tying the fallopian tubes to prevent the passage of ovum and sperm)[9]. There are several techniques available:

a) Laparotomy - an abdominal incision is made and a small piece of each fallopian tube is cut out and the ends tied. There is a laboratory confirmation of the section removed. A general anaesthetic is administered and the patient hospitalised for 1 - 7 days.

b) Mini-laparotomy - the fallopian tubes are clamped with plastic clips through a small abdominal incision. The operation is performed in hospital under general anaesthetic.

c) Colpotomy - a small incision is made in the upper reaches of the vagina through which the fallopian tubes are located, cut, a section removed and the ends tied. This may be but is seldom performed as an outpatient procedure.

d) Laparoscopy - a laparoscope, a slender tube equipped with a lens, is passed through a small incision in the umbilicus to locate the fallopian tubes. The operating scope is inserted, the fallopian tubes lifted and cauterised in one, two or three places. If the operation is performed in public hospitals, the patient is admitted, but laparoscopy may be performed as an outpatient procedure in private hospitals.

The Royal Commission noted the advantages in techniques which may be performed on an outpatient basis as these services can be established by public hospitals without undue pressure being placed on staff and beds.[10] There is some indication that patients may also welcome this. Hartfield[11] performed 100 vaginal

9 Hysterectomy (removal of the uterus) is performed only where there is a medical indication which necessitates that procedure.

10 Report of the Royal Commission op. cit. at 130

11 Hartfield, V.J. "Daycase Pomeroy Sterilisation by the Vaginal Route" 85 New Zealand Medical Journal 223

sterilisations - 50 on a daycare, and 50 on an inpatient, basis. All patients offered early discharge preferred it for the following reasons

- like having family and own things around
- can continue to look after family
- dislike hospital
- good for family to look after mother for a change
- could be flexible at home
- quieter at home

Sterilisation does not affect the hormone secretions, ovaries uterus or vagina.

An estimate of the mortality ratio of tubal ligation appears from 1969 United States figures cited in correspondence to the New Zealand Medical Journal: [12]

Mortality ratio (Deaths per 100,000 procedures)

Legal abortion (1st trimester)	1.7
Ligation and Division of Fallopian Tubes	5.0
Lower Segment Caesarean section	111.0
Abdominal Hysterectomy	204.0

Hartfield[13] notes major post-operative complications of sterilisation - haemorrhage, salpingitis (inflamation of the tubes), severe lower abdominal pain and pain on defaecation - occurred in 11 of the 100 patients and minor complications - minor haemorrhage, vomiting, chest and shoulder pains, temperature rise, sore throat, and suchlike - occurred in 74 women.

Fitzgerald[14], referring to laparoscopic sterilisation, reports

> "Complications are commonly the result of faulty technique but reports of large series record a level of complications which is inherent in the method, even when carried out by or under

12 84 New Zealand Medical Journal 251

13 Hartfield, V.J. op. cit. at 224

14 Fitzgerald, J.P.B. "Sterilisation in the Female" 5 Patient Management 48 at 52

the control of skilled surgeons".

He lists:

- cardiac and respiratory difficulties
- burns of the skin and bowel
- emphysema
- bleeding
- organ perforation

However, he notes, "... complications are few and usually patients are discharged within 24 hours of the procedure." [15]

C. ADVANTAGES OF STERILISATION

For those who do not wish to conceive, or conceive again, there are several advantages in sterilisation - particularly in relation to effectiveness and freedom from the side effects associated with oral or injectible contraceptives.

Sterilisation operations are not 100% effective - regrowth of the vasa and fallopian tubes ("spontaneous recanalization") may occur. Although estimates of the incidence of spontaneous recanalization vary, in both sexes it appears to be less than 1%.

Urquhart-Hay notes[16] with a good surgical technique recanalisation after vasectomy should not exceed 1 in 2,000. In the Margaret Pyke Centre study of 1,000 vasectomy patients a recanalisation rate of 0.6 within 18 months was reported.[17] Potts and Swyer estimate the overall failure rate for vasectomy is probably the same as for tubal ligation[18].

The effectiveness of sterilisation may be compared with other methods of contraception.

15 Fitzgerald, J.P.B. op cit at 52

16 Urquhart-Hay "Vasectomy: When and How" op. cit. at 37

17 Margaret Pyke Centre op. cit. at 219

18 Potts, D.M. and Swyer, G.I.M. "Effectiveness and Risks of Birth Control Methods" 26 British Medical Bulletin 26 at 28

Method [19]	Pregnancy per 100 women-years of exposure
Sterilisation	0.02
Oral Contraceptives	0.1
Intra-uterine devices	2.0
Condoms and diaghrams	15.0
Spermicides, calendar rhythm and coitus interruptus	25.0

It would therefore appear that sterilisation is the most effective method of contraception.

There are none of the side-effects - weight gain, nausea, severe leg cramps, blurred vision - frequently associated with oral contraceptives .

Although contraceptive injections are highly effective Evans[20] notes they disturb menstrual patterns, cause a delay and unpredictable return of fertility and are possibly associated with cervical dysplasia* and carcenoma†. They are therefore preferably restricted to patients who

- refuse to, or are unable to, accept the responsibility other methods need
- have had repeated failures with other methods
- are incapable of tolerating, or unwilling to tolerate the side effects of conventional methods
- are not perplexed about future fertility[21].

D. DISADVANTAGES OF STERILISATION

The chief disadvantage of sterilisation is that it may be

19 Source: Potts, D.M. et al op. cit. at 29

20 Evans, J.H. "Which Contraceptive Method" 5 Patient Management 27 at 31

21 The writer presumes this statement refers to those unable to appreciate the consequences of sexual intercourse - e.g. an intellectually handicapped person

* formation of abnormal tissue

† cancer

irreversible. Those who, through a change of mind or circumstance, wish further children, may later regret the decision to obtain a sterilisation operation. However, perfection of medical techniques involved in reversal operations, and the possibility of storing sperm for subsequent artificial insemination, may overcome this disadvantage.

1. Reversal of Vasectomy

The male sterilisation reversal operation (vasovasostomy) involves reconnecting each vas deferens under magnification. Urquhart-Hay reports the operation is performed under general anaesthetic and takes approximately 1 hour.[22] The patient is hospitalised for two days[23].

The success rate of reversal operations is difficult to gauge as the term "success" is used to indicate both the resumption of normal sperm count and subsequent pregnancy of a woman. In addition, some reports suggesting high success rates, reveal careful pre-operative selection. Two recent reports in New Zealand indicate it is possible to achieve a successful reversal rate (in terms of subsequent pregnancy) of 45% or higher.

Urquhart-Hay,[24] performing vasovasostomy on 20 patients, noted that in nine spouses a pregnancy followed. In 14, or 70% sperm reappeared in normal numbers. These figures are supported by those of an Auckland urologist.[25]

In the United States in 1977 Silber[26] using a microscopic technique on 42 unselected patients reported that 71% had impregnated their wives within 1½ years of the reversal operation.

22 Urquhart-Hay, D. "How effective is a reversal procedure following a vasectomy" 86 New Zealand Medical Journal 475 at 477

23 Urquhart-Hay noted, in an interview with the writer, that overseas reversal operations may be performed on an outpatient basis

24 Urquhart-Hay, D. op. cit

25 Hendy, L. "Sterilisation Reversal: the 'unthinkable' option" 12 June 1978 Women's Weekly 29

26 Silber, S.J. "Vasectomy and vasectomy reversal" 29 Fertility and Sterility 125

Davis[27] notes the factors which account for lack of success in reversal operations:

- reanastomosis technique
- quality of semen
- vasectomy technique
- interval between vasectomy and attempted reanastomosis.

Urquhart-Hay's results do not confirm the last factor. He concludes:[28]

> "Thus it seems that the time interval between the vasectomy and the reversal procedure is of little importance in determining the success or otherwise of the reversal procedure."

Patients in his sample sought reversal 14 months to 6 years after sterilisation.

2. Reversal of Tubal Ligation

The writer interviewed a Wellington gynaecologist who estimated the success rate for reversal operations is approximately 50%, but notes overseas specialists have achieved better results.
Specialists at the family planning consultation clinic at Auckland's National Women's Hospital estimate the tubal ligation reversal success rate (in terms of the subsequent production of a live baby) at 10-50%.[29]

Neither the male or female sterilisation operation is readily reversible. The Royal Commission recommended the operation should be considered as being irreversible and practitioners emphasize to patients that it is or at least may be so. However, both the gynaecologist and urologist interviewed

27 Davis, J.E. op. cit. at 512

28 Urquhart-Hay, D. "How effective is a reversal procedure following a vasectomy" op. cit. at 477

29 Lundy, L. op. cit.

by the writer noted that much higher success rates will come with the perfection of medical techniques involved.

3. Sperm Banks

The development of sperm banks and techniques of artificial insemination may permit a man to gain the advantages of sterilisation while retaining the ability to procreate should there be a change of mind or circumstance - as David suggests "... a form of insurance against sudden tragedy..."[30] This service is not available in New Zealand. However Davis in 1972 noted the large scale development in the United States of frozen semen banks which preserve the sperm of men who have had vasectomies.[31] He reports that to 1972 more than 400 children had been born as the result of artificial insemination with frozen semen. "Clients" of the bank deposit their semen, which is stored, to be withdrawn at a subsequent date and given either to the physician to artifically inseminate a wife, or to the client so that he may destroy it.

Even if this service were available in New Zealand it is not clear there would be a demand for it. Practitioners at an English clinic[32] asked of 26 consecutive vasectomy patients in 1970 "If it had been possible to keep some of your semen in cold storage in case a pregnancy should ever be wanted, would you have welcomed this?" The response was as follows:

Yes	3
Possibly	2
If I were younger	4
No	17

The question was asked during the operation, and, as the author notes, if it had been asked before the men had committed themselves there might have been a little more interest.

However, Ansbacher[33] writing in 1978 reports the initial

30 David, M. quoted in "Frozen Sperm Bank" 72 American Journal of Nursing 513

31 Davis, J.E. op. cit at 513

32 Reported in Correspondence 1970 Lancet 354

33 Ansbacher, R. "Artificial Insemination with Frozen Spermatazoa" 29 Fertility and Sterility 375 at 378

enthusiasm has waned due to the cost of maintaining the frozen semen samples and, with the freezing techniques currently employed, the inadequate fertility rates produced using frozen samples. He notes:[34]

> "Sperm banks are not reliable fertility insurance for men who elect to undergo vasectomy since there is no assurance that an individual's semen sample can tolerate the freezing procedure and subsequent thaw."

The possibility of failure of the freezing mechanism or similar accidents also operates against relying on such a service. For reasons of availability and adequacy of fertility rates following artificial insemination with frozen semen, the use of sperm banks is not likely to provide a means of overcoming the chief disadvantage of sterilisation. Ansbacher comments that the ideal method for freezing gametes has not yet been found. If such technical difficulties are overcome there may develop the commercialization of sperm banking predicted in the early 1970s.

* *

It appears that, although in the future sterilisation may be readily reversible or sperm banking a reliable method of fertility insurance, at present irreversibility remains a real disadvantage.

E COUNSELLING

Discussion of the matters outlined above - the nature and significance of the operation, advantages and disadvantages - takes place prior to the performance of the operation. The practitioner stresses that the operation is irreversible ensuring the patient has given thought to future possibilities of remarriage and the death of any children. [35]

34 Ansbacher, R. op. cit. at 378

35 Although such hypothetical situations are outlined by the practitioner and accepted by the patient these are the major reasons for seeking reversal. Urghuart-Hay notes the reasons given by 20 patients seeking vasovasostomy: divorce and remarriage - 60% death of spouse - 15%
desire for more children (usually on the part of the wife)- 25%
Urquhart-Hay, D. "How effective is a reversal procedure following a vasectomy" op. cit. at 476

In practice both a referring general practitioner and specialist perform this task.[36] The Family Planning Association vasectomy clinic in Wellington, however, rosters counsellors who are generally trained nurses, some of whom have marriage guidance experience.

The Royal Commission recommended counselling "... should be given sufficiently in advance of the date set down for the operation to give the couple proper time for reflection".[37] Six of the ten surgeons surveyed did not impose any waiting period between counselling and the operation. Four noted they did, three requiring a period of at least one month. However, as there has generally been some discussion of the matter between the patient and the referring general practitioner, regardless of the practice of the individual surgeon, it appears there is time for reflection between initial consultation with the general practitioner and the performance of the operation. However, the Family Planning Association clinic practice is that counselling takes place on the night of the operation.

There appears to be a variable drop out rate after counselling. Dr Sparrow of the Family Planning Association vasectomy clinic noted there was a small drop out rate, but a gynaecologist in Upper Hutt stated a significant number of couples enquiring about sterilisation defer taking that step after counselling, accepting an alternative means of birth control.

36 The Royal Commission noted counselling was carried out by medical practitioners and recommended that the use of trained counsellors be encouraged as doctors may be unable to devote sufficient time to each patient: Report of the Royal Commission op. cit. at 133

37 op. cit. at 132

II AVAILABILITY OF STERILISATION

A NUMBER OF STERILISATION OPERATIONS PERFORMED

The Royal Commission noted the inadequacy of statistical information as to the number of sterilisations performed in New Zealand.[38]

To remedy this defect the legislature enacted section 8 Contraception, Sterilisation and Abortion Act 1977 which requires every medical practitioner performing a sterilisation operation to forward tothe Director-General of Health a statement of:

- the reasons for the operation
- the age, sex, marital status, race and number of children of the patient
- whether the patient stayed in hospital for 1 or more nights
- whether the operation was performed post-partum.

None of these figures is available at the date of writing.[38a] The only figures available on the number of sterilisation operations performed in New Zealand are those given in the Report of the Royal Commission.

The table below shows the number of vasectomies performed in public hospitals in New Zealand in the five years ended 30 June 1975. No statistics are available on the number of vasectomies performed in doctors' surgeries (where, as noted earlier, most take place).

1970-1971	...	244
1971-1972	...	368
1972-1973	...	497
1973-1974	...	494
1974-1975	...	522

[39]

The number of female sterilisations performed in public hospitals in the postpartem period for the five years to 30 June 1975 appears below.

38 Report of the Royal Commission op. cit. at 134

38a In Sections A and B "sterilisation" includes therapeutic sterilisation

39 Report of the Royal Commission op. cit. at 117

1970-1971	...	672	
1971-1972	...	1,018	
1972-1973	...	1,384	
1973-1974	...	1,879	
1974-1975	...	2,607	39a

No updates on the above figures are available.
These figures are of use only in that they probably demonstrate a general increase in the number of sterilisations performed.

B CHARACTERISTICS OF THOSE SEEKING STERILISATION

Sherlock and Sherlock[40] note that in the United States males requesting vasectomy are predominantly white, middle-class in their 30s and 40s and in professional, white-collar or skilled occupations. Borland confirms that males seeking sterilisation have significantly more education, and a higher level of occupation and income[41]. Both authors indicate that female sterilisation is more widely used by those with lower educational levels in lower socio-economic groups.

The only available information on this point in New Zealand comes from a Department of Health survey of women in the Hutt Valley.[42] The authors note educational level and race appear to be factors influencing the awareness of sterilisation.

Knowledge of Sterilisation by Race[43]

Race	Never heard of female sterilisation	Never heard of male sterilisation
European	0.8	0.6
Maori	0	3.3
Islander	12.0	24.0
Total %	1.0	1.6

39a Idem
40 Sherlock R.K. and R.D. "Voluntary Contraceptive Sterilization the Case for Regulation" 1976 Utah Law Review 115 at 119
41 Borland, B.L. "Behavioural factors in non-coital methods of contraception: A review" 6 Social Science and Medicine 163 at 164
42 Department of Health "Family Growth Study" Special Report 48 Wellington, Government Printer, 1976
43 ibid at 44

44

Knowledge of Sterilisation by Woman's educational level

Level	Never heard of female sterilisation	Never heard of male sterilisation
No secondary	3.6	8.9
Secondary only	1.1	1.4
Exam or post-secondary	0.4	0.4
Total %	1.0	1.6

They found more highly trained women seemed less rather than more inclined to seek sterilisation than those with little or no training. [45]

The authors noted also that a higher proportion of sterilised couples were among the lower income group, which they suggested probably reflects the degree of financial embarrassment those people could face as a result of an unwanted birth. [46]

* * *

In New Zealand, as in other jurisdictions, there have been two factors operating to restrict availability of sterilisation - uncertainty as to the legality of the operation prior to 1977 and restrictive criteria imposed by members of the medical profession.

C LEGALITY OF STERILISATION

Until 1977 in New Zealand there was doubt as to the legality of a sterilisation operation. There was no clear provision to the effect such operations were either lawful or unlawful. It was arguable that several provisions in the Crimes Act 1961 while not specifically designed to render sterilisation operations unlawful had that effect.

44 ibid at 43
45 ibid at 48
46 idem

There was no decision in point.

The following provisions of the Crimes Act 1961 were possibly applicable:

- s196 "Common assault - Every one is liable to imprisonment for a term not exceeding one year who assaults any other person."

  "Assault" is defined in s2 as "the act of intentionally applying ... force to the person of another"

- s188 Wounding with intent to cause grievous bodily harm and wounding with intent to injure

  "To injure" under s2 means "to cause actual bodily harm"

- s189 Injuring any person with intent to cause grievous bodily harm

- s190 Injuring any person in such circumstances that if death had been caused the offender would have been guilty of manslaughter

- s193 Assaulting with intent to injure

It is clear s196 covers any surgical operation.
All other sections noted above require infliction of bodily harm. Whether a sterilisation operation may be said to cause bodily harm is open to dispute. It was the opinion of counsel engaged by the English and Scottish Medical Defence Union in 1960 that a surgical operation could never be said to cause bodily harm. In Burrell v Harmer [47] the defendant tattooed devices which became inflamed on the arms of boys aged 12 and 13. He was convicted of causing actual bodily harm to the boys. The High Court gave no indication as to whether tattooing per se would constitute the infliction of bodily harm. Even if it had, tattooing may be distinguished from non-therapeutic operations performed by a surgeon in sterile conditions.
The case is therefore of limited value in determining whether the performance of other non-therapeutic operations constitutes the infliction of bodily harm.

It seems clear that a sterilisation operation

47 1967 Criminal Law Review 169

performed without the consent of the victim would constitute the infliction of bodily harm. It is submitted therefore that prima facie the above sections applied also to sterilisation operations performed with consent, and that the difference in criminal liability between surgeons lay in the ability to invoke one of the defences in Part III Crimes Act 1961.

Two defences in that Part may have been available to one charged under one of the above sections with performance of a sterilisation operation.

1. Section 61 Crimes Act 1961

Section 61 provides:

> "Every one is protected from criminal responsibility for performing with reasonable care and skill any surgical operation upon any person for his benefit, if the performance of the operation was reasonable, having regard to the patient's state at the time and to all the circumstances of the case."

Adams notes that "unlawful operations will presumably be excluded by implication..."[48]. Thus he suggests a surgeon performing an illegal abortion cannot invoke s61 as a defence to that charge. It is submitted this view is correct - if the operation is illegal it is difficult to see that its performance would be "reasonable". This section therefore does not operate to legalise a sterilisation operation which is unlawful.

Whether a surgeon may have been convicted of any of the above offences, then, depended upon whether he could invoke consent of the patient as a defence.

2. Consent

The defence of consent is preserved by s20(1) Crimes Act 1961:

> "All rules and principles of the common law which render any circumstances a justification or excuse for any act or omission, or a defence to any charge, shall remain in force and apply in respect of a charge of any offence ..."

48 Adams F.B. Criminal Law and Practice in New Zealand (2 ed) Wellington, Sweet & Maxwell, 1971 at 170

As there has been in New Zealand or the United Kingdom no prosecution against a practitioner for performing a sterilisation operation, in the absence of negligence, there was no direct authority for the proposition that consent of the patient would operate as a defence. There was, however, dicta on this point. In Bravery v Bravery [49] Denning J. declared:

> "Likewise with a sterilisation operation. When it is done with the man's consent for a just cause, it is quite lawful, as, for instance, when it is done to prevent the transmission of an hereditary disease; but when it is done without just cause or excuse, it is unlawful, even though the man consents to it. Take a case where a sterilisation operation is done so as to enable a man to have the pleasure of sexual intercourse without shouldering the responsibilities attaching to it. The operation then is plainly injurious to the public interest. It is degrading to the man himself. It is injurious to his wife and to any woman whom he may marry, to say nothing of the way it opens to licentiousness; and, unlike contraceptives, it allows no room for a change of mind on either side. It is illegal, even though the man consents to it for it comes within the principle stated by Stephen J. ... in R v Coney" 50

Lord Evershed and Hodson L.J. commented: [51]

> "We ... feel bound to disassociate ourselves from the more general observations of Denning L.J. at the end of his judgment, in which he has expressed his view (as we understand it) that the performance on a man of an operation for sterilisation, in the absence of some "just cause or excuse" (as was not, in his view, shown to exist in the present case) is an unlawful assault, an act criminal per se, to which consent provides no answer or defence."
>
> "In our view, these observations are wholly inapplicable to operations for sterilisation as such, and we are not prepared to hold in the present case that such operations must be regarded as injurious to the public interest." 52

49 (1954) 3 All E.R. 59 at 67

50 Stephen J. in R v Coney had said where a person inflicts an injury of such a nature or inflicts it in circumstances where infliction is injurious to the public as well as the person, consent of the person is not a defence (8Q.B.D. 534 at 549) See post. at 22

51 op. cit. at 63

52 ibid at 64

That is the only reference in caselaw to the possibility of consent being raised as a defence in the context of sterilisation. However, there are several statutory provisions and decisions which provide guidelines as to circumstances in which consent will not be a defence to a criminal charge. From an analysis of those provisions and the caselaw one may predict whether consent of the patient may have been invoked by a surgeon charged under one of the above sections for performing a sterilisation.

(a) Where consent is not a defence under statute
It is provided in each of the following sections that the consent of the victim is not a defence to that charge.

Crimes Act 1961

s63	Infliction of death
s131	Intercourse with a girl who is living with the offender as a member of his family
s132	Sexual intercourse with a girl under 12
s133	Indecency with a girl under 12
s134	Sexual intercourse or indecency with a girl between 12 and 16
s139	Indecent act between woman of or over 21 and a girl under 16
s140	Indecency between a male over 21 and a boy under 16
s141	Indecency between males
s142	Sodomy
s209	Kidnapping of a child under 16
s210	Abduction of a child under 16

It seems from the above, as a matter of public policy consent is not generally a defence to sexual intercourse and indecency with a child and "indecency" between adults. Clearly there is no analogy between any of the above and sterilisation.

(b) Where consent is not a defence under caselaw

Rv Coney[53]

Two men held a knuckle fight before spectators who bet on the outcome. Both were charged with assault. The High Court held the contest was illegal as a prize-fight and the consent of the other combatant was no defence to either charge. Stephen J. stated: [54]

> "The principle as to consent seems to me to be this: When one person is indicted for inflicting personal injury upon another the consent of the person who sustains the injury is no defence to the person who inflicts the injury, if the injury is of such a nature or is inflicted under such circumstances that its infliction is injurious to the public as well as the person injured. But the injuries given and received in prize-fights are injurious to the public both because it is against the public interest that the lives and the health of the combatants should be endangered by blows, and because prize-fights are disorderly exhibitions, mischievous on many obvious grounds."

Sterilisation is not injurious to the public interest and is not a "disorderly exhibition". A surgeon performing such an operation would therefore not have been precluded by the principles established in this case from invoking consent as a defence.

R v Donovan [55]

The accused had privately caned a girl of 17 for the purpose of gratifying a form of sexual perversion. He was charged and convicted of common assault and indecent assault. The Court of Criminal Appeal considered the accused's defence that the girl had consented and held: [56]

> "As a general rule, although it is a rule to which there are well established exceptions, it is an unlawful act to beat another person with such a

53 8 Q.B.D. 534

54 ibid at 549

55 (1934) 2 K.B. 498

56 ibid at 507

> degree of violence that the infliction of bodily harm is a probable consequence, and when such an action is proved, consent is immaterial."

The court noted [57]

> "If an action is malum in se in the sense in which Sir Michael Foster used the words, that is to say, is, in itself, unlawful, we take it to be plain that consent cannot convert it into an innocent act."

Sir Michael Foster referred to a man who beats another "in anger or from preconceived malice" as doing an act malum in se. The court held Donovan beat the girl with the intention of doing her some bodily harm, what he did was malum in se and therefore her consent was no defence.

The court considered bodily harm [58]

> "... has its ordinary meaning and includes any hurt or injury calculated to interfere with the health or comfort of the prosecutor. Such hurt or injury need not be permanent, but must, no doubt, be more than merely transient and trifling."

The majority of the court in Bravery v Bravery noted[59]

> "In R v Donovan ... there was some discussion of cases of assault being per se unlawful, to which consent would be no defence, but none of the examples given appears to bear any close analogy to an operation for sterilisation, which was nowhere mentioned."

It is submitted this view is correct.

R v McLeod [60]

In a "Wild West Show" for the purposes of an exhibition of marksmanship McLeod asked a volunteer to sit at some distance from him while he blew the ash from a cigarette in the mouth of the volunteer with a shot from a rifle. The volunteer moved as the shot was discharged and suffered a serious injury. McLeod was charged with

- assault causing bodily harm
- common assault

57 ibid at 508

58 ibid at 509

59 op. cit. at 64

60 (1915) 34 N.Z.L.R. 430

- injuring a person in such circumstances that if death had been caused he would have been guilty of manslaughter

On a case stated, the Court of Appeal held that the prisoner was guilty of the third charge, for even though the sport was engaged in with the consent of the volunteer a lethal weapon was used in risky circumstances. The court in so deciding appeared to rely on other sporting parallels. Thus it noted:[61]

> "In England it has been said that engaging in a fight without gloves which ends in the death of one of the fighters would amount to manslaughter."

The court compared this situation with a lawful boxing match in which the opponents wear gloves.

The court stated,[62] however, that

> "...'even in lawful sports' it is said in Russell on Crimes 'if the weapons used are of an improper and deadly nature the party killing would be guilty of manslaughter..."

It is submitted a sterilisation operation would not have been covered by this decision.

Burrell v Harmer [63]

The defendant tattooed devices on the arms of two boys aged 12 and 13. The wounds became inflamed and the defendant was convicted of causing bodily harm. The appellate court dismissed the appeal of the defendant, noting that the consent of the boys was no defence. They held that if a child of the age of understanding was unable to appreciate the nature of an act, apparent consent to it was no consent at all.

In this case, therefore, there was no real consent as there was a lack of appreciation of the nature of the act of tattooing. Considerable emphasis is placed by the medical practitioner on ensuring patients prior to a sterilisation operation appreciate the nature and consequences of the operation. In ordinary events

61 ibid at 434

62 idem

63 1967 Criminal Law Review 169

therefore this case is inapplicable to sterilisation.

It is the writer's view that the performance of a sterilisation operation is not analogous to the fact situations in any of the above cases, or similar to any offence to which consent is by statute not a defence. It is therefore submitted that the consent of the patient may have been invoked by a surgeon charged under s196, 188-190 or 193 Crimes Act 1961 with performing a sterilisation operation.

It is the writer's view, then, that even prior to the enactment of s2 Crimes Amendment Act 1977 the performance of sterilisation was lawful in New Zealand.

In the United Kingdom, after 1960, the prevailing view was that sterilisation was lawful.[64] Legal opinion sought by the English Medical Defence Union declared no offence would be committed under s47 Offences against the Person Act 1861 (U.K.) (assault occasioning actual bodily harm) unless consent was absent. Counsel was of the view that s18 and s20 of that Act were not applicable. These provisions differed from the New Zealand provisions relating to infliction of bodily harm cited earlier.

Sections18 and 20 provide respectively[65]

> "Whosoever shall unlawfully and maliciously by any means whatsoever wound or cause any grievous bodily harm to any person with intent to do some grievous bodily harm to any person ... shall be guilty of an offence ... "

> "Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person either with or without any weapon or instrument shall be guilty of a misdemeanour ..."

64 See for example Smith J.C.& Hogan B. Criminal Law (3 ed) London, Butterworths, 1973 at 289

65 Ss 18 and 20 were amended slightly in 1967

Counsel advising the English Medical Defence Union considered sterilisation was not an offence under those provisions as:

- "unlawfully" meant forbidden by some definite law and there was no such definite prohibition

- "bodily harm" means serious interference with comfort or health and sterilisation does not inflict such harm

- "maliciously" means only with intent to inflict the particular kind of harm done 65a

The Secretary of the English Medical Defence Union stated[66]:

> "In view of this opinion, we now have no hesitation in advising members of the medical profession in Britain that sterilisation carried out merely on the grounds of personal convenience, in other words as a convenient method of birth control, is a legitimate legal undertaking."

However, the British Medical Association concluded:[67]

> "The state of the law on this subject is such that no-one can say with certainty what it is."
>
> "Whatever may be the law on sterilisation it is clearly most desirable that the courts or Parliament should now declare it."

The statement had equal application in New Zealand. For although the prevailing view was that sterilisation was lawful the issue had never been tested in the courts.

Uncertainty as to the legality of sterilisation limited the availability of that operation - the Royal Commission noted for instance that vasectomies sought for socio-economic reasons or to safeguard the health of the patient's wife were not carried out in public hospitals in the Auckland Hospital Board area because of doubts as to the legality of the operation.[68]

The Department of Health in its submissions to the Royal Commission argued that s13 Hospitals Amendment Act 1973 was intended to clarify the law, authorising the performance of

65a Reported in 1960 British Medical Journal at 1518

66 Cited in the Report of the Royal Commission op. cit. at 121

67 1960 British Medical Journal at 1518

68 Report of the Royal Commission op. cit. at 123

vasectomies in public hospitals. The Minister of Health in moving the second reading of the Bill stated [69]

> "The important point to be covered by this clause is the legality of the operation known as vasectomy."

Section 13 amended s77A Hospitals Act 1956 by adding the underlined words:

> "Any Board may agree to provide relief, care and treatment free of charge to any person ... who is otherwise prepared to undergo medical or surgical procedure or operation for the purpose of assisting
> (a) the relief and medical or surgical treatment of some other person, or ...
> (b) ... <u>or for any other lawful purpose</u> [70]

However, as the Royal Commission noted[71] the section did not declare sterilisation operations to be lawful.

The Royal Commission recommended [72]

1. That a clear statutory enactment be made declaring sterilisation of the male or female to be legal provided it is carried out with the consent of the patient.

2. That s61 of the Crimes Act 1961 be amended to protect from criminal responsibility a person performing a sterilisation operation for therapeutic reasons or not, with the consent of the patient.

Section 2 Crimes Amendment Act 1977 inserted after s61 Crimes Act 1961 section 61A:

> "(1) Everyone is protected from criminal responsibility for performing with reasonable care and skill any surgical operation upon any person if the operation is performed with the consent of that person, or of any person lawfully entitled to consent on his behalf to the operation, and for a lawful purpose.
>
> (2) Without limiting the term "lawful purpose" in sub-section (1) of this section, a surgical operation that is performed for the purpose of rendering the patient sterile is performed for a lawful purpose."

69 cited in the Report of the Royal Commission op. cit. at 124

70 This section was repealed and a substantially similar section enacted in 1976

71 Report of the Royal Commission op. cit. at 124

72 ibid at 128

Sections 7 and 9 Contraception, Sterilisation and Abortion Act 1977 were enacted at the same time.

Section 7 declares that no-one has the capacity to consent to a sterilisation operation upon a person who lacks the capacity to consent by reason only of his age.

Section 9 makes it unlawful for any person to require a borrower or employee or his spouse to undergo a sterilisation operation as a condition of granting a loan or engaging his services.

Following the enactment of s2 Crimes Amendment Act 1977 the major factor regulating the availability of sterilisation is the imposition by the medical profession of requirements which applicants for sterilisation must satisfy.

D CRITERIA IMPOSED BY THE MEDICAL PROFESSION

1. Spousal Consent

The Royal Commission recognised that it is undoubtedly desirable that a spouse consent to the sterilisation operation. They noted however, that there are situations in which the consent is refused - often by a partner who has not previously displayed any noticeable interest in preserving the stability of the marriage. They recommen ed that it not be mandatory for a practitioner to obtain the consent of the patient's spouse to a sterilisation operation.[73] The practice of Wellington gynaecologists and urologists in this regard varies.

Dr Sparrow, of the Family Planning Association, stated that the the vasectomy clinic in Wellington had never been approached by a man seeking sterilisation without the consentof his wife. She considered however that the clinic may perform a vasectomy in that event, but would emphasize to the patient that he may be placing his marriage in jeopardy.

Five of the ten practitioners surveyed stated they merely preferred spousal consent to be obtained. Five noted they required the consent of the spouse. Two expressed concern over the possibility

73 Report of the Royal Commission op. cit. at 132

of litigation if the consent of the spouse was not obtained. Urquhart-Hay[74] considered a consent form should be signed by husband and wife as:

> "... the wife's signature is to protect the husband from a divorce suit on the grounds of 'constructive desertion'. The view has been expressed (although the issue has never been tested in the courts) that both the husband and wife might have a right of action in damages against the surgeon who sterilised one spouse either without the consent of, or in the face of a positive prohibition by, the other."

It is proposed to consider several issues raised by the above statement -

(a) May a person prevent his spouse from obtaining a sterilisation operation?

(b) What right of action does a person who not consent to the sterilisation of his spouse have against the practitioner who performed that operation?

(c) May a person who has not consented to the sterilisation of his spouse seek a divorce upon that basis?

(a) Preventing a spouse from obtaining a sterilisation operation

Section 61A Crimes Act 1961 renders the performance of a sterilisation operation performed with the consent of the patient lawful. There is no reference in that section or elsewhere to the necessity to obtain spousal consent to the operation.[75] It would therefore seem that a person has no basis upon which to prevent his spouse from obtaining a sterilisation. This view is supported by the English High Court decision in

74 Urquhart-Hay, D. "Vasectomy: when and how" op. cit. at

75 In the United Kingdom also this appears to be so. In 1973 the Minister of State for Health and Social Security, in response to a question in the House said "I am advised that there is no legal requirement under English or Scottish law that the consent of the spouse must be obtained for sterilization of the partner." Cited in Polak, A.L. "A doctrinaire or a rationalistic approach." 3 Family Law 86 at 87

Paton v Paton [76]. In that case a husband applied for an injunction against his estranged wife and the trustees of the British Pregnancy Advisory Service to prevent his wife from having a legal abortion. The High Court Judge held the Abortion Act 1967 gave no right to the husband to be consulted in respect of a termination of pregnancy and stated: [76a]

> "The husband in my view has no right whatsoever, certainly no right enforceable in law or in equity to stop his wife having the abortion nor to stop doctors carrying out that abortion."

It is suggested, by analogy, that in the absence of any provision relating to spousal consent, a person may not prevent his spouse obtaining a sterilisation operation.

(b) Action by Spouse against Practitioner

As noted above, under s61[A] Crimes Act 1961 sterilisation is lawful and there is nowhere a requirement for spousal consent. In the absence of negligence, there is no civil wrong to the patient, and in the writer's view no legal basis upon which a person may complain of a wrong to him occasioned by the performance of a sterilisation operation on his spouse.

In the United States a husband who did not consent to the performance of a sterilisation operation on his wife brought an (unsuccessful) action against the phsyciain for damage to his right of consortium.[76b] Even if applicable this course is not available in New Zealand as section 5(2) Accident Compensation Act 1972 abolishes the cause of action for loss of consortium.

76 Reported in "The Times" 25 May 1978 at 1

76a ibid at 2

76b Murray v Vandevander post at 64

(c) Sterilisation without spousal consent - a basis for divorce?

There is no New Zealand authority which suggests the obtaining of a sterilisation operation without the consent, or in the fact of opposition, of a spouse, may be grounds for divorce. There is English dicta to the effect that such a course of action may give rise to an action for divorce on the basis of cruelty. In Bravery v Bravery[77] the parties married in 1934 and had a child in 1936. Two years later, for personal non-medical reasons the husband obtained a sterilisation operation. In 1951 his wife left and subsequently sued for divorce alleging the obtaining of a sterilisation operation by her husband, without her consent, constituted cruelty. The Court of Appeal held she failed to establish cruelty as there was no evidence that the operation was performed against her wishes or that she suffered in health by reason of the operation, but they noted generally:[78]

> "(a)s between a husband and wife for a man to submit himself to such a process without good medical reason ... would, no doubt, unless his wife were a consenting party, be a grave offence to her which could without difficulty be shown to be a curel act, if it were found to have injured her health or have caused reasonable apprehension of such injury. It is also not difficult to imagine that if a husband submitted to such an operation without the wife's consent, and if the latter desired to have children, the hurt would be progressive to the nerves and health of the wife; ..."

They noted the operation had "obviously grave potentialities" for the parties to the marriage.[79]

Denning J., dissenting, considered the wife had established cruelty:

> "I cannot think of anything more disruptive of a marriage than for a party to sterilise himself in this way." 80
>
> "If the husband had undergone it without telling his wife about it beforehand, no one could doubt that it would be cruelty." 81

77 op. cit.
78 ibid at 61
79 ibid at 64
80 ibid at 66
81 ibid at 67

(i) Constructive desertion

In New Zealand cruelty in itself is not a ground for divorce but in view of the above dicta, submitting to a sterilisation operation without the consent of a spouse may be a sufficiently grave course of action to enable that spouse to obtain a divorce on the grounds of constructive desertion. Under this doctrine, if one spouse behaves in such a manner that the other is virtually compelled to leave, the first may be held in constructive desertion.

Section 21(1) Matrimonial Proceedings Act 1963 provides:

> "A petition for divorce, whether the marriage is governed by New Zealand law or not, may be presented to the court on one or more of the following grounds, and on no other ground ...
>
> (c) That the respondent without just cause has wilfully deserted the petitioner, and without just cause has left the petitioner continuously so deserted for two years or more.

There is no reference in s21(1)(c) to constructive desertion but the doctrine is accepted in New Zealand.[82]

There must be, in order to invoke the doctrine, de facto separation for two years, conduct which is equivalent to driving the complainant away and an intention on the part of the remaining spouse to bring co-habitation to an end.

De facto separation

This usually involves the complainant physically leaving the dwelling but it is sufficient if there has been a total cessation of cohabitation. In Dempster v Dempster [83] Gresson J. in the Supreme Court noted:

> "It is rarely that it can be held there is desertion by one or other spouse when the parties are living under the same roof. But... there can be desertion when the only element of living together is that they were actually residing in

82 See, for example, Franklin v Franklin [1934] N.Z.L.R. 900
A.v A. [1930] N.Z.L.R. 510

83 [1948] N.Z.L.R. 857 at 858

> one house with no physical separation between the parts of the house in which they were living respectively."

Conduct

Various formulations of the test for determining whether the conduct of the remaining spouse was sufficiently grave to hold him in constructive desertion have been put forward. Sir Jocelyn Simon in Saunders v Saunders [84] reviewed several recent authorities and held:

> "The generally accepted test of what conduct amounts to constructive desertion is this: has the defendant been guilty of such grave and weighty misconduct that the only sensible inference is that he knew that the complainant would in all probability withdraw permanently from cohabitation with him if she acted like any reasonable person in her position."

It is clear certain extreme behaviour will be sufficiently grave to enable a complainant to invoke this doctrine.

Thus in Lang v Lang [85] where a husband physically abused his wife, "forced sexual intercourse on her in circumstances of calculated and revolting indignity" and told her that he was going to "use her for the same purpose whenever he wanted to and as often as he wanted to" [86], the Privy Council noted there was not the slightest question that the conduct was sufficient. [86a]

The "irritating idiosyncracies" of a spouse, however, "are part of the lottery which every spouse engages in on marrying" [87] and do not provide a basis for a constructive desertion action.

> "(They) may so get on the wife's nerves that she leaves as a direct consequence of them but she would not be justified in doing so." 88

Between such extremes whether in any case conduct is sufficiently grave and weighty is a question of fact.

84 [1965] 1 All E.R. 838 at 841

85 [1955] A.C. 402

86 ibid at 420 86a ibid at 428

87 ibid at 418

88 idem

The behaviour of one spouse in each of the cases below was sufficiently grave.

Winnan v Winnan [89] A wife kept 25-30 cats. They roamed over the house which smelt badly from their excretions. Her husband asked her to get rid of them but she replied that cats were her life and her pleasure and that she preferred cats to him. He left. His wife was held to be in constructive desertion.

A v A [90] A husband suffering from venereal disease insisted on cohabiting with his wife. The wife, acting on medical advice had refused to continue to live with him. The Supreme Court held the husband was in constructive desertion.

Bodell v Bodell [91] The husband went overseas in the service of the armed forces. During his absence his wife took in a male boarder. Following his return the husband suspected on reasonable grounds that his wife was committing adultery with the boarder and requested her to get rid of him. The wife persistently refused and the husband left. Adams J the Supreme Court held the wife was in constructive desertion.

Hall v Hall [92] The marriage of the parties was unhappy as a result of the drinking habits of the husband, who was frequently drunk, returning home late at nights and causing disruption. He was held to be in constructive desertion.

The above give some indication of the degree of seriousness required before the conduct of a spouse will be considered sufficiently grave. However as there is no similarity between any circumstances which have given rise to an action in constructive desertion and the situation where one spouse has obtained a sterilisation operation without the consent of his partner, a review of the caselaw is of little assistance in determining whether that conduct is sufficiently grave. It is the writer's view that in certain circumstances a court would hold it is

89 [1949] P. 174
90 [1930] N.Z.L.R. 510
91 [1951] N.Z.L.R. 318
92 [1962] 3 All E.R. 518

sufficient. In Bravery v Bravery the court was of the view that obtaining a sterilisation operation without the consent of a spouse may be grounds for divorce on the basis of cruelty. In order to succeed on this ground in the United Kingdom a complainant must show his spouse has been guilty of grave and weighty misconduct and as a result the complainant has suffered injury to health or that there is reasonable apprehension thereof. The Court of Appeal in Bravery v Bravery must have therefore considered the obtaining of a sterilisation by one spouse with the consent of the other as grave and weighty misconduct. It would therefore probably be grave and weighty misconduct for the purpose of constructive desertion.
It is submitted that where one party is sterilised without the consent of the other this may be sufficiently grave. Whether it is will depend upon the facts of the case. Contrast two situations:

a) When the parties marry, the wife desires and expects at some time to bear children. Husband and wife have never discussed this matter. Several weeks later the husband undergoes sterilisation without the consent of the wife.

b) The husband and wife have been married 10 years and have 8 children. The husband considers he cannot support further children and undergoes sterilisation without consulting his wife.

In determining whether conduct is grave, there is a strongly objective element. Thus in the test formulated in Saunders v Saunders the court refers to the complainant acting "like any reasonable person in her position".[92a] Lord Reid in Gollins v Gollins[93] refers to conduct "which no ordinary woman would tolerate". Diplock L.J. in Hall v Hall[94] notes "... the conduct must be such that a reasonable spouse in the circumstances and environment of these spouses could not be expected to continue to endure."

92a ante at 33

93 [1964] A.C. 644 at 666

94 op. cit. at 526

It is a reasonable expectation, based on general practice, that, in the absence of an indication to the contrary, parties to a marriage will procreate. A reasonable woman may well withdraw from cohabitation in the first situation above, and it is submitted a court would be likely to find the conduct of the husband sufficiently grave. In the second situation, a court is less likely to come to that conclusion.

Intention to bring co-habitation to an end

It is most improbable that a person undergoing a sterilisation operation without the consent, or contrary to the wishes, of his spouse intends to bring co-habitation to an end. Generally his intention will be solely to become medically incapable of procreation for one of many reasons. He may not direct his mind to the effects of this upon his marriage, or if he does he may not desire to terminate the marriage. Nevertheless, it is possible in this situation that for the purposes of constructive desertion, a spouse "intends" to bring co-habitation to an end.

The requirements of "intention" were discussed in Lang v Lang in which case, as noted earlier, the husband seriously abused and humiliated his wife and threatened to continue to do so. There was no doubt that his conduct was sufficiently grave. However, the husband maintained he did not intend or wish her to leave and in fact, once she had left, wrote letters begging her to return.

The Privy Council held that prima facie a man who treats his wife with gross brutality may be presumed to intend the consequences of his acts. Such an inference may be rebutted, but if the only evidence is of continuous cruelty and no evidence in rebuttal is given, the natural and almost inevitable inference is that the husband intended to drive out his wife.
The Privy Council considered [95]

95 op. cit. at 429

> "If the husband knows the probable result of his acts and persists in them, in spite of warning that the wife will be compelled to leave the home and, indeed, as in the present case has expressed an intention of continuing his conduct ... that is enough however passionately he may desire or request that she should remain. His intention is to act as he did, whatever the consequences though he may hope and desire that they will not produce their probable effect."
>
> "... a high degree of probability (that separation will result) is required but no more ."

Thus it seems that if a person knows that there is a high degree of probability that as a result of his undergoing a sterilisation his spouse will leave him, he intends this. This remains the test to date[96]. However, Lord Reid in Gollins v Gollins, interpreting the decision in Lang v Lang adds that such conduct should be pursued without just cause or excuse.[97]

Again, whether this test is satisfied depends on the facts of the case. If a person consults his spouse to ascertain her view on the proposed sterilisation, and she objects, threatening to leave if he pursues the idea, this will probably be a sufficient basis upon which to find he knew that if he obtained the sterilisation she would probably leave him. Ormerod L.J. in Hall v Hall notes[98]

> "Evidence of warnings may well be of value to help the court to decidewhat is the real reaction of the other spouse to the conduct complained of..."

but he quotes Lord Greene in Buchler v Buchler[99] to the effect that "If conduct is not a justification for one spouse to leave another, it cannot be made such by threats of this kind."

Where a person does not consult his spouse, it will be more difficult to prove that person knew his spouse would probably leave and factors such as his knowledge of her desire, or expectation, to have children or further children would be relevant.

96 See e.g. Lord Diplock in Hall v Hall op. cit
Lord Simon in Saunders v Saunders op. cit.

97 op. cit. at 666
98 op. cit. at 522
99 [1947] P 25 at 45

In Summary, in order to succeed in an action for divorce based on constructive desertion a complainant must satisfy requirements relating to de facto separation, and misconduct and an intention to bring co-habitation to an end on the part of the remaining spouse. It is the writer's view that it may be grave and weighty misconduct to undergo sterilisation without the consent of a spouse. Whether it is so depends upon the facts of the case. In certain circumstances the intentional element may be satisfied but again this is dependant upon particular facts.

(ii) "No fault" Divorce

There has been some suggestion that the grounds for divorce in New Zealand may be changed to a no-fault basis. The National Party in its 1975 Manifesto stated [100]

> "National will legislate for the granting of a divorce where the court is satisfied, after a two year compulsory waiting period, that the marriage has irreconcilably broken down. The legislation will require consultation and a genuine attempt at reconciliation but will not require proof of fault."

The Secretary for Justice subsequently commissioned Patricia Webb to prepare a report and recommendations on legislation to replace the Matrimonial Proceedings Act 1963 and Domestic Proceedings Act 1968. She considered[101] that the ground for dissolution be along the lines of the Australian provisions - i.e. in terms of an irretrievable breakdown.

If this becomes the sole ground for divorce it may, as Buddin suggests[102], be argued that

> "...the failure of spouses to agree as to whether one of them should be sterilized would amount to irretrievable breakdown of marriage so as to entitle the disappointed spouse to institute proceedings for dissolution of marriage.."

100 National Party Manifesto (1975) at 41

101 Webb, P. Review of Matrimonial La w Wellington Department of Justice 1977 at 15

102 Buddin, T. "Voluntary Sterilisation" in Finlay H.A. Family Planning and the Law (2 ed) Sydney, Butterworths 1978 164 at 185

The writer concurs in the view of Citron who notes:[103]

> "Although in practice courts rarely look behind the sheer allegation of marital disharmony, if the need arose the spouse could support his or her charge by asserting that, as the disagreement concerned procreativity of the relationship, it struck the core of the marriage. Deep disharmony on so central an issue would approach irrebutable proof of marital breakdown."

(d) Decree of Dissolution on the basis of Non-consummation

It was once considered that where a husband or wife continuously used contraceptives, there could not be consummation of the marriage and a degree of nullity could be obtained. In J. v J.[104] this principle was extended to allow a decree of nullity to be granted on the basis of non-consummation where one party obtained a sterilisation operation prior to marriage. In that case, some months before the marriage of the parties, the husband sought a sterilisation operation. The doctor requested the future wife's consent. She initially refused to sign the consent form as she desired children but eventually agreed, exacting from her husband a promise that he would wait until after the marriage by which time she hoped to be able to persuade him against this course. He nevertheless obtained a sterilisation operation of which his wife became aware six weeks before the wedding. She did not realise she had grounds for seeking a decree of nullity until 1945, at which stage she left. The English Court applied Cowen v Cowen [105] in which case it was decided that a husband who had insisted on using a contraceptive when intercourse took place, had wilfully refused to consummate the marriage.[106] The court in J. v J. noted that the husband

> "... in the present case effected by the operation the same result which could have been effected by the use of a contraceptive on each successive occasion."

104 [1947] 2 All E.R. 43

105 [1946] P. 36

106 op. cit. at 44

103 Citron, R. "A Spouse's Right to Marital Dissolution Predicated on the Parties Contraceptive Surgery" 23 New York Law School Law Review 99 at 109

The House of Lords in Baxter v Baxter [107] overruled both Cowen v Cowen and J. v J., Viscount Jowett noting that he did not think the decision in J. v J. could be supported. The House held that where there had been complete conjunction of bodies, the marriage was consummated even though, in that case, the wife had refused to permit intercourse without the use of a condom.

In the light of Baxter v Baxter it is no longer possible where one party has been sterilised prior to marriage, to obtain a decree of dissolution on the basis of non-consummation.

2. Other criteria imposed by the medical profession

No guidelines or criteria for sterilisation are imposed by the New Zealand Medical Association.

Responses to the first question in the survey of gynaecologists and urologists in Wellington[108] indicates there is considerable variation in the criteria imposed by practitioners in assessing the suitability of a patient for sterilisation.

One urologist required only that a patient and his spouse (who must consent) be over 21[109] and understand the nature and consequences of the operation. All practitioners but the above preferred satisfaction of age/parity criteria expressing views which ranged from "the patient is entitled to sterilisation unless they are very young with few or no children" to a preference for a patiant to be aged 30 with 2 or 3 children. Three practitioners preferred the children to be of school age.

There appears to be varying flexibility in applying these criteria. One gynaecologist stated his criteria were "very flexible" - he would, for instance, sterilise a woman of 25 who had 4 children or a woman with no contraceptive discipline.

107 [1948] A.C. 274

108 ante at 1

109 This age appears on the consent form of that practitioner to be signed as follows:
"I of being over the age of 21 years hereby consent to undergo the operation of bilateral vasectomy ..."
The wife similarly affirms she is over 21. This seems an anomaly as the age of majority is now 20.

Another noted his criteria "may be waived for specific reasons" - which indicates presumably less willingness to waive criteria. Generally the factors listed were said to be guidelines only.

Six of the ten practitioners surveyed emphasized the necessity for a stable union between the patient and his spouse before sterilisation would be considered. One stated this is desirable "as a change of spouse may require further children".

Over the past five years, the demand for sterilisation has increased as it has become a more widely accepted method of contraception. There has been some criticism of the rigidity of the medical profession in applying criteria to assess the suitability of a patient for sterilisation[110]. The writer considered the combination of these two factors may have resultedin practitioners imposing less stringent criteria now than possibly five years ago. However, only two indicated their criteria had changed in this period.

Dr Sparrow noted the Family Planning Association vasectomy clinic in Wellington had no strict criteria but looked carefully at a person in one of the following categories:

a) under 25
b) not married
c) who had never had children
d) whose wife was pregnant[111]
e) with marital difficulties[112]
f) with strong religious views[113].

E INCIDENCE OF PATIENT REGRET FOLLOWING STERILISATION

Dr Sparrow probably voices the general reason for imposing the above criteria - she comments that the Family Planning Association likes to operate the vasectomy clinic with as little patient regret as possible. She adds that evidence

110 e.g. Report of the Royal Commission op. cit. at 130

111 This is on the basis of the possibility of the wife losing the child following sterilisation of the husband.

112 These patients may be referred to have any psycho-sexual problems looked at in another setting.

113 The official church doctrine of several sects is that sterilisation is immoral. The leader of the Roman ...

suggests psychological problems or regret are more likely to occur where the above guidelines are not followed. Two practitioners specifically echoed this sentiment - one commenting that he preferred women to be over 30 with three children on the basis that a study in Sweden showed 20% of women sterilised before that age came back for reconstruction. Another expressed the same preference on the basis of a further study which showed 90% of women seeking reversals were sterilised under 30. The following section looks at evidence of post-operative regret related to personal characteristics of the patient.

1. Female sterilisation

There are many difficulties in attempting to show or disprove that women who have undergone sterilisation at an early age or with few or no children regret that decision.
Several factors may bias results of studies in this area:

a) The studies reported below survey samples which consist of patients sterilised for medical, psychiatric and social reasons. The writer found no study in which the sample consisted solely of patients sterilised for social reasons [114]. The practice of surveying such mixed samples may bias results in the following way. Evidence suggests those sterilised for reasons of medical necessity are more likely to express dissatisfaction[115]. This group frequently contains those who are young and who have few or no children. If those seeking therapeutic sterilisation are in the younger age range the results will show an association between youth and low parity, and dissatisfaction. This is misleading if one is attempting to associate age and dissatisfaction in the context of social sterilisation.

b) Some samples include women sterilised immediately after

114 The study by Kopit and Barnes - post at 44 - may have but this is not clear from the report

115 See e.g. Studies of Sim, Emens & Jordan, and Thompson post at 43 and 44 respectively

an abortion[116] . Any psychological after-effects may be due to the abortion rather than sterilisation.

c) Follow up periods vary in the studies below from two months to several years. This factor may bias results as psychological difficulties may only last several months, or may not appear for some time.

The study frequently cited as a starting point in looking at evidence of psychological after-effects of sterilisation is by Hans Binder in 1937.[117] His sample consisted of 128 women sterilised for medical, 22 sterilised for eugenic and 143 sterilised for social, reasons. The study revealed four patient groups:

- advantages completely predominant, no disadvantages or only slight 60%
- advantages outweigh disadvantages but disadvantages are considerable 30%
- disadvantages outweight advantages 7%
- disadvantages completely predominant 3%

Contraindications included:

- Youthful age (under 35)
- small number of children
- deep neurosis before sterilisation
- bad marriage before sterilisation
- where wife does not really wish operation but is urged by husband, or does not want any more children from an unloved husband
- strong mother drive of the woman
- tendency to hypochondriac attitude
- indication of religious view which sees sterilisation as sinful
- differentiated, exceptionally feminine-motherly women.

Thompson[118] conducted a follow-up of 186 sterilised women, 49 of whom had contemporaneous termination of pregnancy.

116 e.g. in the study by Kopit & Barnes - post at 44 - 46% of the sample had therapeutic abortion prior to sterilisation.

117 reported in Wolf R.C."Legal and Psychiatric Aspects of Voluntary Sterilisation" 3 Journal of Family Law 103

118 Thompson, B. "Follow Up of 186 Sterilised Women" 1968 Lancet 1023

She divided the sample into those who:

- regretted termination
- regretted sterilisation
- regretted the circumstances that made sterilisation necessary
- were satisfied.

Eight women regretted being sterilised:

1 had been widowed and now wished children by a second husband

1 had only one child by her second husband before sterilisation and wished for more now as this would ease family relationships

1 woman's baby died a few months after a post-partem sterilisation

1 woman had a still born child, but the couple insisted on sterilisation - a decision later regretted

2 felt lost after the youngest child started school. 1 was a Roman Catholic and felt guilty about being sterilised. Both had medical and social problems

1 was seriously disabled and maladjusted

1 expressed vague feelings of guilt

Fifteen women regretted the circumstances that made sterilisation necessary - 11 had been sterilised on medical grounds, 3 on grounds of extreme debility.
Thompson noted the results were least satisfactory when the grounds for sterilisation were specifically medical, psychiatric or obstetric alone.

Fifteen women regretted not being sterilised earlier.

Thompson reports a "striking association" between satisfaction and increasing family size[119], but notes "age at sterilisation seems to be relatively unimportant in determining reactions."[120]

Kopit and Barnes[121] interviewed 139 out of a sample of 187

119 Her results show:

93%	of patients	with	4 or 5	children	were satisfied
75%	"	"	3	"	"
66%	"	"	2	"	"

120 ibid at 1026

121 Kopit, S. and Barnes, A.B. "Patients' Response to Tubal Division" 236 Journal of the American Medical Association 2761

women who had obtained a sterilisation operation. The most common reason given by the patient for seeking sterilisation was that she had enough children. There is no indication given of the grounds on which the remainder sought sterilisation. The ages of the women ranged from 22 to 46, and 46% had contemperaneous therapeutic abortion. One hundred and nineteen (85.6%) said they were satisfied with their decision, 17 (12.2%) had ambivalent feelings (although 12 said they would have made the same decision again) and 3 (2.2%) regretted the operation. More than half said they would have liked the operation earlier. The authors found no substantial differences in answers to questions regarding age, gravidity, parity, religion and feelings aboutfemininity between those who were satisfied and those who expressed regret.

Sim, Emens & Jordan [122] conducted a follow up of 151 women who had been sterilised 1-3 years earlier for social and gynaecological reasons. One hundred and forty-six (96.7%) expressed themselves as completely satisfied and 5 (3.3%) as dissatisfied.
The authors analyzed the personal characteristics of those who expressed dissatisfaction:

1. Patient aged 35, of limited intelligence, with a strong cultural resistance to the operation
2. Patient aged 32 with 1 child, strong cultural resistance to the operation
3. Patient aged 38 with two children, depressed after an abortion
4. Patient aged 28 with two children. Financial state improved after sterilisation.
5. Patient aged 29 with two children. Patient claimed frigidity because of fear of childbirth - sterilisation did not remove the frigidity.

They note "From our limited experience the most stubborn cases of dissatisfaction and regret were women sterilised because of a medical condition, but who would have wished to have more children." [123]

122 Sim, M., Emens, J.M. and Jordan, J.A. "Psychiatric Aspects of Female Sterilisation" 1973 3 British Medical Journal 220

123 ibid at 222

The authors concluded they had achieved good results and "on the basis of this study we believe adverse psychiatric sequelae can be kept to a minimum with careful selection of patients".[124] They suggested:

1. the patient should be over 30 and if younger should have had two or more children
2. the operation should not be performed at childbirth
3. the patient should not be suffering from post-abortive depression
4. the patient should be culturally adjusted to the operation
5. the operation should not be undertaken for frigidity.

Enoch and Jones[125] surveyed 98 sterilised women - 34 had requested the operation on the basis of high parity or for other reasons (including minor obstetrical problems) and 64 were advised to undergo sterilisation, mainly for medical, obstetrical or psychiatric reasons. Seventy-six percent said they were satisfied, 21% regretted the operation sometimes and 3% regretted the operation constantly. Those women who asked for the operation fared best - none of the "constant regret" group had requested the operation.
None of the women experienced any religious difficulties arising from belief. The authors note:[126]

> "Those with a previous history of psychiatric illness were found to be particularly susceptible to psychiatric illness post-operatively."

Enoch and Jones concluded:[127]

> "... age was not found to be an important factor in any of the results. There was, however, considerable increase in the incidence of regret when the woman had less than two children."

124 ibid at 220

125 Enoch, D. and Jones, K. "Sterilization: A review of 98 sterilised women" British Journal of Psychology 583

126 ibid at 586

127 ibid at 586

Conclusions

The above findings appear contradictory in relation to the effect of age[128] and religious beliefs[129]. However there appears to be general agreement that the highest incidence of regret is amongst those who are sterilised for medical reasons, have psychological problems before sterilisation or have a small number of children.

In view of the possible bias occurring through the analysis of mixed samples, it is difficult to draw any definite conclusions. In addition it is clear the writer has been unable to locate all the relevant research - two gynaecologists noted they had seen studies which showed 90% of patiants seeking reversal were sterilised before the age of 30 and 20% of those sterilised under 30 subsequently sought reversals. The writer could not find either study. This suggests age of the patient may be a more important factor than the above research indicates.

As the availability of sterilisation is regulated by the medical profession upon the basis that there is a high incidence of regret among those who fail to fulfill age/parity criteria, it is necessary to point to evidence of that correlation. For this purpose, valid conclusions may only be drawn from an analysis of more carefully selected samples - those including only patients seeking sterilisation for social reasons, who have not undergone contemporaneous termination of pregnancy.

2. Male Sterilisation

Some authors view women as being more able than men to cope psychologically with sterilisation operations. Forbes considers:[130]

> "... men are often emotionally unstrung by the surgery. Confusing fertility, virility and masculinity, otherwise indolent husbands feel compelled to lift weights, wear crew cuts, jog and flex their muscles to demonstrate

128 Compare the studies of Enoch & Jones,(ante at 46), Kopit & Barnes (ante at 44) and Thompson(ante at 43) with those of Sim, Emens & Jordon (ante at 45) and Binder (ante at 43)

129 Compare the studies of Kopit & Barnes and Enoch & Jones withthose of Binder and Thompson

130 Forbes, P.R. "Voluntary Sterilisation of Women As A Right" 18 De Paul Law Review 560 at 561

> their equality with men who can still impregnate their wives. Women ... are much more sensible from a psychological point of view. They do not usually confuse the feminine role with reproductive capacity after they have given birth to a number of children."

Research into the psychological after-effects of vasectomy does not bear this out. The surveys of vasectomy patients do not suffer from the drawbacks noted in relation to studies of female patients - although there is no indication given in any of the studies below of the reasons for seeking vasectomy it is assumed that these are almost exclusively social since vasectomy is not frequently performed for medical reasons. There appear to be fewer studies in relation to incidence of regret following vasectomy, although the size of sample in each study is much greater. However, there is little analysis of the personal characteristics of those who express dissatisfaction and what analysis there is of results is fairly crude and the conclusions often vague.

The Simon Population Trust - established in 1965 in the United Kingdom to promote sterilisation as a method of birth control - sent a questionnaire to 1092 men who had undergone a vasectomy.[131] One thousand and twelve patients responded. The Trust asked "Would you recommend the operation to others?" Ninety-nine percent said yes. Seventy-three point one percent of the men noted an improvement in sex life, 1.5% reported a deterioration.

Drury[132] conducted a follow up of 200 vasectomy patients two years after the operation. The only criteria imposed for performance of the sterilisation were that the patient was in a stable marriage and the procedure was being sought as a permanent contraceptive measure and not as a remedy for

131 Simon Population Trust "Follow up after vasectomy" 1970 Lancet 483

132 Drury V. "Vasectomy - a two year follow up" 24 Journal of the Royal College of General Practitioners 812

a physical or emotional problem. The patients' ages ranged from 26 to 47 and the number of children in each case from 1 to 5. One hundred and seventy two completed questionnaire forms were returned. The patient and his wife were asked to rate the effect of the operation on (inter alia) their emotional relationship. Fifty-seven percent of patients (66% of wives) reported it as better, 43% of patients (34% of wives) reported it was the same. None of the patients or their wives considered their emotional relationship had deteriorated.

Fifty-eight percent reported an increase in sexual activity.

Patients were asked to rate the effect of vasectomy upon their feelings of masculinity. One hundred and forty two reported no change, 30 felt their masculinity had been improved. All respondents reported they had no regrets about the decision to obtain a vasectomy.

The Margaret Pyke Centre undertook to follow up 1,000 vasectomy patients.[133] They had not laid down rigid or minimal requirements of age, marital status or family size but were reluctant to offer vasectomy to young men (34/1000 were under 25 and 191/1000 under 30). At the time of reporting they had sent out 460 questionnaires, of which 271 had been returned.

Two hundred and fifty-seven patients stated they were pleased the vasectomy had been performed. Five reported they were sorry, 8 were uncertain and 1 did not answer. Most of those who regretted the operation or were uncertain had suffered post-operative complications. A table of patient replies to questions relating to family harmony and sexual life follows:

	Better	Same	Worse	Doubt
Effect on family harmony	77	190	4	2
Effect on sexual life	167	92	12	

133 Margaret Pyke Centre "One thousand vasectomies" 1973 4 British Medical Journal 216

Two hundred and seventeen said they would recommend the vasectomy operation to friends.

However, Wolfers[135] commenting on this type of study notes:

> "The collection of data by questionnaire surveys is too simple a procedure to assess reliably the psychosocial and sexual effects of contraceptive vasectomy."

She conducted a study of 95 men who had undergone vasectomies and had been sent questionnaires. She requested patients who believed they had encountered sexual or marital adjustment problems as a result of the operation to request an appointment with a visiting psychologist. Seven couples (of 82 who returned the questionnaires) sought an interview. Only three were unaware of any physical or psychological problem in their sexual lives before the operation. Those three suffered serious physical sexual deterioration - complete impotence, vaginismus[136] and persistent premature ejaculation. Three had pre-existing sexual problems - premature ejaculation, declining potency or frigidity. One was neurotic and unstable. Wolfers considered[137]

> "... Some screening of applicants for contraceptive vasectomy is required, and it is tentatively suggested that men with marital, psychological or sexual problems should be dissuaded from this form of contraception."

Conclusions

The incidence of regret or dissatisfaction after the performance of a vasectomy varies but this figure is generally small. It is difficult to assess whether regret is associated with any personal characteristics of the patient - in none of the above studies is such an analysis carried out.

In three of the above studies [138] patients report either an increase

135 Wolfers, H. "Psychological Aspects of Vasectomy" 1970 4 British Medical Journal 297 at 300

136 Painful muscular spasm of the vaginal walls resulting in painful coitus

137 Wolfers, H. OP. CIT. at 300

138 Studies of the Simon Population Trust (ante at 48) Drury (ante at 48) and the Margaret Pyke Centre (ante at 49)

in sexual activity , a "general improvement in sex" or that there is no change in this area - few report deterioration.

Wolfers suggests the screening out of those with marital, psychological and sexual problems - this appears to be general practice in Wellington at least.

III COMPARATIVE VIEW OF STERILISATION

The increasing demand for sterilisation in New Zealand is paralleled elsewhere. There is a greater acceptance of sterilisation as a method of birth control. This was recognised by the Second International Conference on Voluntary Sterilisation in 1973 which affirmed that all persons should be considered as having "freedom of choice in the matter of voluntary infertility." [139]

The extent to which this principle is recognised by states varies, determined in part at least by such factors as religious belief. In several jurisdictions statutory provisions prohibit or authorise the performance of sterilisation. Stepan and Kellogg[140] report, however, that in most states the legality of sterilisation is uncertain.

In the United States in particular there is pressure for sterilisation to be readily available and argument that restrictive statutes and regulations are unconstitutional.

It is proposed below to consider the legality of sterilisation in foreign jurisdictions, examine the provisions contained in the recent comprehensive sterilisation statutes enacted by Sweden and Singapore and assess the constitutionality of restrictive sterilisation provisions in the United States.

A OVERVIEW

States may

1. authorise by statute the performance of sterilisation;
2. prohibit by statute the performance of sterilisation; or
3. have no provision applying specifically to sterilisation.

Examples are given below of states in each category.[141]

139 Reported in Buddin, T. op cit at 171

140 Stepan, J. and Kellogg, E.H. The World's Laws on Voluntary Sterilization for Family Planning Purposes Law and Population Monograph Series No. 8

141 The information in this section is obtained from Stepan, J. and Kellogg, E.H. op. cit and the International Advisory Committee on Population and Law Annual Review of Population Law 1974 and Annual Review of Population Law 1975 The law is at 1975.

1. States authorising the performance of sterilisation

Denmark, Sweden, Singapore, Japan, Panama and five of the United States - Georgia, Oregan, New Mexico, North Carolina and Virginia - have statutes authorising the performance of sterilisation. Typically there are criteria and procedural restrictions imposed by such statute.[142]

a) Age limit

Denmark, Sweden -	25
Georgia -	21
North Carolina -	18
Singapore -	no lower level stipulated and statute specifically allows sterilisation of those under 21:

"s3.2(b) in the case of a person under 21 years of age who is married, if the person gives consent to such treatment

(c) in the case of a person under 21 years of age and is not married if the person together with his parent or guardian ... gives consent to such treatment". [143]

b) No of children

Panama -	5
Japan -	"several"
Czechoslovakia	4

c) Consent of Spouse

Japan	Eugenic Protection Law 1948 This covers also a person who while not legally married possesses marital status with the applicant
Georgia	
Virginia	

142 The following are only examples of states which insist upon the applicant fulfilling statutory criteria. It is not intended to canvas each state on each aspect.

143 Voluntary Sterilisation Act 1974 (Singapore)

d) Waiting period

North Carolina	-	At least 30 days
Virginia		" (only when the applicant has never given birth to a child)

e) Procedural requirements

Sweden	"Only a licensed physician is authorised to perform a sterilisation. Sterilisations of women can be performed only in a general hospital or other medical institution which has been approved by the National Board of Health and Welfare" 144
Singapore	Similar provision to above

2. States Prohibiting the Performance of Sterilisation

Turkey s471 Turkish Criminal Code 1926

"Whoever by his acts causes a man or woman to become sterile and any person giving consent to the performance of such acts on himself shall be punished by imprisonment for six months to two years and by a heavy fine ..." 145

Italy s552 Italian Penal Code

"Whoever performs acts on persons of either sex, with their consent, intended to render them incapable of procreating will be punished by imprisonment ...
Whoever gives consent to those acts being performed on himself shall suffer the same punishment."

Nicaragua s360 Penal Code

3. States with no provision relating specifically to sterilisation

There is in the majority of jurisdictions no provision which either specifically prohibits or authorises sterilisation.

144 Section 6 Law on Sterilization of 12 June 1975 (Svensk Forfattningssamling 1975:580)

145 Regulations were introduced in 1967 permitting sterilisation on therapeutic or eugenic grounds.

Where this is so, the legality of the operation is generally uncertain.[146] The difficulty is that experienced in New Zealand prior to 1977 - sterilisation may be caught under general criminal provisions relating to assault or infliction of bodily harm. There is, in addition, often doubt as to the relevance of consent of the patient, if sterilisation is caught under one of those general provisions.

Consent to such crimes is in some jurisdictions irrelevant - it is provided by statute that consent is not a defence.

Elsewhere, for example in Costa Rica, there is a statutory provision which renders an offender acting with the consent of the victim liable to a lesser penalty.[147]

In other jurisdictions by statute consent of the victim may exculpate the person inflicting the injury. Stepan and Kellogg note[148], for instance, that several South East Asian countries have provisions similar to that of s88 of the Indian Code which provides:

> "Nothing which is not intended to cause death, is an offence by reason of any harm it may cause or be intended by the doer to cause, or be known by the doer to be likely to cause, to any person for whose benefit it is done in good faith, and who has given consent whether express or implied to suffer that harm, or to take the risk of that harm."

It may be that under this provision consent of the patient would be a defence to a charge of performing a sterilisation operation. Yet this is not clear, and Stepan and Kellogg[149] note the Opinion of the Vice Chancellor of the University of Malaya, that under a similar Malaysian provision consent is probably not a defence.

In the majority of jurisdictions, however, there is no specific provision relating to consent and this is a matter of doctrinal interpretation and caselaw.

146 Stepan and Kellogg note that typically correspondents, replying to the authors' request for information on the legal status of sterilisation, began "The state of the law governing voluntary sterilization in this country is obscure" op. cit. at 27

147 s207 Penal and Police Code 1941

148 op. cit. at 16

149 ibid at 17

B COMPREHENSIVE STERILISATION STATUTES

There may now be a trend towards the enactment of comprehensive sterilisation statutes. Sweden and Singapore, following the lead of several of the United States, have recently enacted such statutes.[149a] These follow a similar pattern, containing provisions which:

- declare the performance of sterilisation lawful
- specify requirements to be satisfied by the applicant - e.g. age limits and obtaining of spousal consent
- permit sterilisation of those with a eugenic or medical indication
- require a doctor to give an explanation to the patient of the nature of the operation
- require the patient to certify that he understands the implications of the operation
- authorise the performance of sterilisation only by registered medical practitioners in Government or approved institutions
- prohibit a person with access to medical records or a person who participated in the operation disclosing information relating thereto
- permit medical practitioners to refuse to perform a sterilisation operation on the basis of conscientious objection.

C UNITED STATES

Regulation of the availability of the means of birth control is in the United States the prerogative of individual states, which frequently restricted access to contraception until 1965 and to abortion until 1973.

Since 1965 the United States Supreme Court has acknowledged the right of a married couple and a single person to obtain and use contraceptives and the right of a woman to obtain an abortion, without the consent of her husband, during the first and to some extent during the second trimester of pregnancy. All statutes in conflict with the above are

149a Singapore - Voluntary Sterilisation Act 1974
Sweden - Law on Sterilization of 12 June 1975 (Svensk Forfattningssamling 1975:580)

unconstitutional.

The validity of restrictive sterilisation statutes and regulations is now debated.

In the following section it is proposed to briefly cover the landmark decisions of the Supreme Court relating to access to contraceptives and abortion as any constitutional attack on restrictive sterilisation laws will rely heavily on the principles established in those cases. The validity of a state statute or hospital regulation imposing an absolute prohibition on the performance of sterilisation or requiring satisfaction by applicants of restrictive criteria is then considered.

1. Validity of Restrictive Contraception and Abortion Statutes

Griswold v Connecticut [150]

A Connecticut statute made the use of contraceptives a criminal offence. Griswold, Executive Director of the Planned Parenthood League, gave information, instruction and medical advice to married persons as to the means of preventing conception. He was charged with violating the statute as an accessory and convicted of that offence at first instance. The Supreme Court reversed that decision. The Court considered the statute was unconstitutional as it invaded the right to privacy of a married couple. There was no right to privacy specifically mentioned in the Bill of Rights, but the Court held specific guarantees in the Bill of Rights have penumbras formed by emanations from them. The right to privacy was a fundamental personal right emanating from the totality of the constitutional scheme and the marriage relationship lay within that zone of privacy.

Eisenstadt v Baird [151]

Baird, following a lecture on contraception, invited members of the audience to help themselves to contraceptive articles on the stage. He gave a package of contraceptive foam to a

150 381 U.S. 479 (1965)
151 405 U.S. 438 (1972)

woman and was convicted at first instance of violating a Massachucetts statute which made it an offence to sell or give away contraceptives except as provided in section 21A of that statute under which a physician could administer contraceptives to married persons. The Supreme Court declared the statute unconstitutional as it violated the equal protection clause of the Fourteenth Amendment.[152] The Court stated that whatever the rights of individuals to access to contraceptives may be, the rights must be the same for the unmarried and married alike:

> "If under Griswold the distribution of contraceptives to married persons cannot be prohibited a ban on distribution to unmarried persons would be equally impermissible. It is true that in Griswold the right of privacy in question inhered in the marital relationship. Yet the marital couple is not an independent entity with a mind and heart of its own but an association of two individuals each with a separate intellectual and emotional make. If the right of privacy means anything it is the right of the individual married or single to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." 153

The Fourteenth Amendment did not deny to states the power to treat different classes of person in different ways. But any classification of people for this purpose must be reasonable and rest upon some ground of difference having a fair and substantial relation to the object of the legislation. The Court held there was no ground of difference that rationally explained the different treatment accorded married and unmarried persons.

Roe v Wade [154]

Roe sought a declaration that the Texas abortion law was unconstitutional. That statute provided the performance of

152 The relevant section of the Fourteenth Amendment reads:

Section 1. "... No state shall ... deny to any person within its jurisdiction equal protection of the laws."

153 op. cit at 453

154 410 U.S. 113 (1973)

abortion was prohibited unless this was "for the purpose of saving the life of the mother".

Blackmun J.,delivering the majority judgment, declared the law unconstitutional as it invaded the right to privacy of a woman. He said:[155]

> "This right to privacy, whether it be founded in the Fourteenth Amendment's (156) concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's (157) reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy".

However, the Court held the right to privacy, within which fell the decision to terminate a pregnancy, was not absolute - it could be qualified if there was a compelling state interest which required it. The Court decided the State had an interest in the health and life of the mother which became compelling at the end of the first trimester. The risk to the mother involved in a termination at this stage justified state regulation of the abortion procedure in ways reasonably related to maternal health. The Court considered the State's interest in protecting potential human life became compelling at the end of the second trimester - at the stage of viability of the fetus. After this point, a woman's right to privacy and therefore her right to terminate a pregnancy was qualified by that interest and a state may during the third trimester regulate or prohibit abortion except where this is necessary for the protection of the life or health of the mother.

2. Validity of Restrictive Sterilisation Provisions

(a) Prohibition on the Performance of Sterilisation

No state of the United States prohibits absolutely the

155 op. cit. at 153

156 The relevant section of the Fourteenth Amendment reads: Section 1. "... No state shall make or enforce any law which shall abridge the privilege or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty or property, without due process of law ..."

157 The Ninth Amendment reads:
"The enumeration in the Constitution of certain rights, shall not be construed to deny or disparage others retained by the people."

performance of sterilisation. That situation may reflect the view of many that an absolute state prohibition on sterilisation would undoubtedly be unconstitutional after Griswold and Roe.[158]

Myers argues: [159]

> "The right to privacy which was extended to a married couple's choice to use contraceptive devices in Griswold logically should be extended to protect their choice of contraceptive operations."

If this is correct, and in the writer's view it is, the state may not, after Roe, invade the right to sterilisation in the absence of a compelling state interest which requires it. In Roe itself there was held to be no compelling state interest in a fetus until the third trimester. There seems therefore little likelihood there will be a compelling state interest in life not yet conceived.
There may well be a compelling state interest in the health of the patient which requires state regulation in matters related to patient health but this will not extend to permitting a state to prohibit absolutely the performance of sterilisation operations.

Although no state statute declares sterilisation to be unlawful, many state institutions prohibit the performance of sterilisation on their premises. It appears this may also be unconstitutional. In Hathaway v Worcester City Hospital[160] a woman required a therapeutic sterilisation. Worcester City Hospital was a municipal hospital established pursuant to state law as an "acute short term general hospital". The hospital barred physicians from using operating room facilities for sterilisation (therapeutic or social) on the basis of a Solicitor's opinion that the legality of sterilisation was "highly doubtful". [161] The First Circuit Court of Appeals noted:[162]

158 See, for example, Myers, W.D. "A constitutional Evaluation of Statutory and Administrative Impediments to Voluntary Sterilization" 14 Journal of Family Law 67

159 ibid at 74

160 475 F 2d 701 (1973)

161 This seems most unusual - the writer has not encountered an argument elsewhere that therapeutic sterilisation may be unlawful

162 op. cit. at 703

> "Whatever merit his conclusion as to the illegality of such operations may have had at the time, subsequent authority makes it clear that the Commonwealth no longer has or could have, such an all-encompassing anti-birth control policy as he took the cited statutes to describe."

The Court stated that after Roe v Wade and Doe v Bolton[163] a fundamental interest was involved, requiring a compelling rationale to justify banning a sterilisation operation which involved no greater risk or demand on staff and facilities than other operations performed at the hospital. The Court balanced this fundamental interest against possible state interests in prohibiting the performance of sterilisation, stating:[164]

> "The state interests, recognized by Roe as legitimate, are far less compelling in this context. Whatever interest the state might assert in preserving the possibility of future fetuses cannot rival its interest in preserving an actual fetus, which was found sufficiently compelling to outweigh the woman's interest only at the point of viability. The state maintains ... a significant interest in protecting the health and life of the mother... Yet whatever health regulations might be appropriate to vindicate that interest ... it is clear under Roe and Doe that a complete ban on a surgical procedure relating to the fundamental interest in the pregnancy decision is far too broad when other comparable surgical procedures are performed."

The Supreme Court held the hospital's prohibition on the use of its facilities for sterilisation violated the Equal Protection Clause of the Fourteenth Amendment, and stated:[165]

> "... once the state has undertaken to provide general short term hospital care, as here, it may not constitutionally draw the line at medically indistinguishable surgical procedures that impinge on fundamental rights."

Although Hathaway sought sterilisation for medical reasons,

163 410 U.S. 179 (1973) The Supreme Court in Doe v Bolton, a companion case to Roe v Wade, declared Georgia's restrictive abortion law unconstitutional.

164 op. cit. at 706

165 idem

as the Court relied heavily on the principles established in Roe v Wade and Doe v Bolton, Hathaway v Worcester City Hospital may be applied in cases of public hospital refusal to permit its facilities to be used for performance of non-therapeutic sterilisation operations.

In the light of the above, a complete prohibition on the performance of sterilisation by the state itself, or a state institution is probably invalid.

(b) Imposition of Criteria

Similarly, the practice of the state or state institut .ions requiring applicants for sterilisation to fulfill restrictive criteria may be unconstitutional. A patient may be required to possess marital status, obtain spousal consent tothe operation, conform with an age/parity formula or comply with procedural regulations.

(i) Marital Status

It is the writer's view that any statutory or hospital requirement that applicants for sterilisation be married would be unconstitutional under the principles established in Eisenstadt v Baird[158].

(ii) Spousal Consent

It is the writer's view that spousal consent requirements would be struck down as unconstitutional after the decision in Planned Parenthood v Danforth[159] and the comment of the Supreme Court in Eisenstadt v Baird cited earlier.

The Supreme Court in Danforth invalidated a statute which required a woman to obtain spousal consent to an abortion. The arguments put forward by the state in that context have equal application to sterilisation provisions. The state argued: [160]

158 ante at 57
159 428 U.S. 52 (1976)
160 ibid at 68

> "(r)ecognizing that the consent of both parties is generally necessary ... to begin a family, the legislature has determined that a change in the family structure set in motion by mutual consent should be terminated only by mutual consent."

The Court nevertheless held the state could not

> " ... delegate to a spouse a veto power which the state itself is absolutely and totally prohibited from exercising during the first trimester of pregnancy." 161

This approach may be open to criticism[162]. However, having so reasoned in Danforth, the Court may regard a spousal consent requirement in a sterilisation statute in a similar light - that is, once it is established the state does not have the power to prohibit sterilisation, that power cannot be delegated to a spouse.

The Court in Danforth quoted also the comment in Eisenstadt referred to earlier: [163]

> "... the marital couple is not an independent entity with a mind and heart of its own, but an association of two individuals each with a separate intellectual and emotional make up. If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."

On this basis, the right to sterilisation if it exists will probably be seen as a right of the individual. There are several minor decisions to this effect. Myers notes[164] in Doe v North Ottawa Community Hospital Authority [165] a mother of five children desired sterilisation for which operation the hospital required spousal consent. The Ottawa Circuit

161 op. cit. at 69

162 See for example the judgment of White J. dissenting in Planned Parenthood v Danforth op. cit. at 92 and Schell M.S. "Third Party Consent to Abortions before and after Danforth: A Theoretical Analysis" 15 Journal of Family Law 508

163 op. cit. at 70

164 op. cit. at 79

165 Civil No. 2706 (Ottawa; Mich. Circuit Court May 15 1973)

Court held that the hospital may request spousal consent but not require it.

Ponter v Ponter 165a

The parties had been separated for six years at which point the wife wished to obtain a sterilisation operation. The hospital doctors would not perform the operation unless she obtained the consent of her husband. There was in New Jersey no statute requiring spousal consent. The Superior Court of New Jersey recognised[166]

> "... the sensible logical and well-reasoned desireability of consultation between husband and wife regarding decisions in such matters. However this is not to say that the spouse does or should have a power of veto.
>
> It is this court's opinion that Judith Ponter has a constitutional right to obtain a sterilization operation without the consent of her husband. Such protection is available whether it be in the form of the proscription of state action requiring the contrary or refusing to recognise the spouse's civil suit against the treating physician as meritorious."

Although technically the decision may be restricted to its facts and apply only where the parties are separated, this is most unlikely as the judgment is framed in terms of "women's continuing struggle for the establishment of their individual rights." [167]

Murray v Vandevander [168]

A husband who did not consent to the performance of a hysterectomy on his wife brought an action against the physician and hospital for damage to his right of consortium and the right to produce another child. The judgment did not specify whether the operation was performed for therapeutic or social reasons, although it referred to a married woman's "natural right to her health". The Court of Appeals of Oklahoma stated: [169]

165a 342 A 2d 574 (1975)
166 ibid at 577
167 ibid at 576
168 522 P 2d 302 (1974)
169 ibid at 304

> "We have found no authority and plaintiff has cited none which holds that the husband has a right to a child bearing wife as an incident to their marriage. We are neither prepared to create a right in a husband to have a fertile wife nor to allow recovery for damage to such a right. We find that the right of a person who is capable of competent consent to control his own body is paramount."

(iii) Age/Parity formula

Hospitals often work on an age/parity formula[170] in assessing the suitability of a person for sterilisation. Myers argues[171] this is an arbitrary classification:

> "the number of children a patient has relative to her (his) age bears no reasonable relationship to factors relevant to the question of whether she should be sterilised - e.g. the health of the patient, socio-economic ability of the patient to take care of additional children."

In McCabe v Nassau County Medical Centre[172] the Centre would perform a sterilisation operation only if the patient satisfied an age/parity formula. McCabe was aged 25 with 4 children - in order to fulfil the hospital criteria she required 5 children. She commenced an action for damages against the Centre at which stage the Centre reversed its decision. The Court of Appeals Second Circuit adjudicated upon whether McCabe's claim was moot. McCabe argued that the rule, based on an arbitrary age/parity formula was "as unconstitutionally odious as a rule prohibiting voluntary sterilisation of blacks",[172a] and violated her constitutional rights. The judge commented:[173]

> "We need not determine whether plaintiff's contentions are sound, particularly without a full development of the facts, but it is a massive understatement to say that they are not frivolous."

It is submitted regulations which impose an age/parity are invalid.

(iv) Procedural requirements

The statutes of Georgia and North Carolina require the applicant

170 i.e. applicant aged 25 must have 5 children
" " 30 " " 4 "
" " 35 " " 3 "

171 op. cit. at 80

172 453 F 2d 698 (1971) 172a ibid at 704

173 idem

for sterilisation to have the consultation and acquiesence of two physicians. It was argued earlier that the only compelling state interest which may justify state interference in the decision whether to undergo a sterilisation is patient health. It is difficult to see how this requirement is reasonably related to patient health. It is therefore submitted that this requirement is unconstitutional.

Myers[174] notes a public medical facility may not impose restrictions which are unconstitutional. But private medical facilities may decide for themselves under what circumstances to accept or exclude sterilisation patients. There is some difficulty in defining those terms. Bloom[174a] argues the distinction has been waning as private hospitals accepting federal monies have been deemed vulnerable to suit. McKenzie states that[175]

> "With the growth and importance of hospitals coupled with the presence of tremendous amounts of governmental involvement through funding and regulation, it appears likely that all hospitals will be required to abide by constitutional mandates".

It seems clear that, if a prohibition on the performance of sterilisation, or the imposition of criteria discussed above, is unconstitutional, no state or state hospital may prohibit absolutely the performance of sterilisation therein, or restrict access to sterilisation on the basis of a patient's marital status, inability or unwillingness to obtain spousal consent or failure to comply with an age/parity formula. It may be that at least a private hospital accepting state funds must also refrain from pursuing policies in conflict with the above.

174 op. cit. at 82

174a op. cit. at 304

175 McKenzie, J.F. "Contraceptive Sterilization: The Doctor the Patient, and the United States Constitution" 25 University of Florida Law Review 327 at 346

CONCLUSION

There is frequent reference in the literature to the right to sterilisation[176] - particularly in the United States context as this is seen as being conferred by the Bill of Rights. It should be recognized, however, that there is no absolute right[176a] to sterilisation. One may pressure the state to authorise the performance of sterilisation and to remove criteria imposed by statute or hospital regulation. If this constitutes gaining the right to sterilisation the term is misleading. For the "right" to sterilisation means nothing in the absence of a practitioner willing to perform a sterilisation, and practitioners have a right to refuse to perform a sterilisation operaction which in New Zealand is protected under section 46 Contraception Sterilisation and Abortion Act 1977:

> "46 (1) ... no registered medical practitioner, registered nurse, or other person shall be under any obligation
> (a) To perform or assist in the performance of any operation undertaken or to be undertaken for the purpose of rendering the patient sterile:
> if he objects to doing so on grounds of conscience"

Subsection (2) provides it is unlawful to discriminate against a person refusing to perform a sterilisation operation on grounds of conscience.

This provision is paralleled elsewhere. In the United States the federal Health Programs Extension Act prohibits discrimination against physicians or health care personnel who refuse to assist in the performance of a lawful sterilisation proceeding because of religious beliefs or moral convictions. The comprehensive sterilisation statute of Singapore contains a conscience clause similar to s46(1).[177]

176 e.g. Forbes, P.R. "Voluntary Sterilisation of Women As A Right" 18 De Paul Law Review 560

Bloom S.L. "A Woman's Right to Voluntary Sterilization" 22 Buffalo Law Review 291

177 Section 10 Voluntary Sterilisation Act 1974 (Singapore)

176a Buddin T ... defines a right as "the inalienable and inviolable freedom of a person to pursue ... a certain course of conduct"
Buddin T op cit at 170

There is only a small minority of practitioners who refuse absolutely to perform sterilisation operations on the grounds of conscience. The remainder may refuse to perform a sterilisation operation on one who fails to fulfill certain criteria. These no doubt vary considerably from one practitioner to another as they do in Wellington. One practitioner may require only that a patient is over the age of majority and appreciates the significance of the operation, another may impose strict age/parity criteria. Those who tend towards the latter practice do so on the basis that evidence shows there is a high incidence of regret and subsequent application for reversal amongst those who fail to fulfill certain age/parity criteria. The writer found the evidence inconclusive on this point, although it is conceded at least two relevant studies were not located. It is the writer's view, however that even if evidence of this association is available, this does not justify refusal to operate on a patient who appreciates the nature and significance of the operation and who is not psychologically or emotionally disturbed.

While this discretion to refuse to perform sterilisation absolutely or on certain patients exists, and in the writer's view that right must be recognised, there can be no right to sterilisation.

It is suggested there would be a greater readiness on the part of the medical profession to sterilise those who are young or have few or no children if sterilisation was readily reversible. Both a gynaecologist and urologist interviewed by the writer indicated this would come. It seems the debate over the merits of refusing sterilisation to certain patients upon the basis that evidence suggests some of them will later regret that decision may be overtaken by medical technology.