CHAPTER 11

WOMEN AND MEDICINE

The treatment of women by the medical profession raises important issues for feminism. In the United States of America, for example, the battle has long raged – and continues to rage – over a women's right to abortion. The seminal decision of the Supreme Court of America in *Roe v Wade*[1] which confirmed that a women's right to abortion is a right to be guaranteed under the right to privacy under the American Constitution, has continued to be subjected to attack from those who advocate the right to life for a foetus, or, in their terms, an unborn child. The United Kingdom's more pragmatic attitude towards 'constitutional rights' whereby – subject to the jurisdiction of the European Court of Human Rights under the European Convention on Human Rights and Fundamental Freedoms to which the United Kingdom government is a signatory – citizens enjoy freedoms rather than constitutionally guaranteed rights. Results in the consequence that matters such as abortion rights are regulated – rather than enshrined – under an Act of Parliament which has the constitutional status and importance conferred on it by the prevailing political climate.[2] Accordingly, the Abortion Act 1967 conferred a limited right to abortion, subject to approval on medical grounds (which were loosely framed). Nevertheless, echoes of the American debate were heard in the late 1980s (if indeed they have ever been silent), when the time limit for abortion was reduced to 24 weeks.[3] As a result of the differing constitutional arrangements in the United Kingdom, however, the academic debate has not achieved the level of intensity which it has in the United States of America. While 'pro-life' campaigners fight for the greater protection of the rights of the foetus, thereby seeking to pit foetal rights against women's rights, in the United Kingdom the law has for long denied that a foetus has – prior to the point at which it is capable of being born alive[4] – any 'rights' in law. Nor will English law confer rights on any other person in relation to decisions as to a woman's choice to undergo an abortion.[5]

From a feminist perspective, the right of the individual to determine questions relating to her own body are of fundamental importance. To deny the right to take decisions is to treat the individual as unequal and inferior and to deny the rationality of the woman's decision-making process and her right to autonomy. Scientific and technological advances in reproduction raise a further set of complex questions.[6] In the United Kingdom, for example, the recent

1 93 SCt 705 (1973).

2 See Hilaire Barnett, *Constitutional and Administrative Law* (London: Cavendish Publishing 1995), Chapters II and XIV.

3 Abortion Act 1967, s 1(1)(a), as amended by the Human Fertilisation and Embryology Act 1990.

4 See the Infant Life Preservation Act 1929.

5 See *Paton v British Pregnancy Advisory Services* [1979] QB 276; {1978] 2 All ER 987; *Re F (In Utero)* [1988] 2 All ER 987; *C v S* [1987] 1 All ER 1230.

6 See the *Report of the Committee on Human Fertilisation and Reproduction (the Warnock Report)* (Cmnd 9314) (London: HMSO, 1984).

decision of the Court of Appeal that it could give no remedy to a woman wishing to use her deceased husband's sperm in order to conceive his child, on the basis that the husband had not given written consent, has raised the issue of women's rights once more to the fore.[7]

Implicit in issues relating to conception and childbirth are many traditional assumptions: the role of women in the 'private sphere'; women's 'unique' mothering abilities, which in effect keep women out of the public sphere[8] and the power relationships between women, their partners and the medical profession. The mythology surrounding motherhood is enduring. Has society moved on at all from the view expressed by anthropologist Bradislaw Malinowski in 1927?

> Maternity is a moral, religious and even artistic ideal of civilisation, a pregnant woman is protected by law and custom, and should be regarded as a sacred object, while she herself ought to feel proud and happy in her condition. That this is an ideal which can be realised is vouched for by historical and ethnographical data.[9]

Issues such as forced sterilisation, the right to abortion, the right of pregnant mothers to choose their own lifestyle, the treatment of women found guilty of infanticide and the legal regime surrounding assisted contraception and surrogacy agreements raise complex questions for women. In this chapter, issues raised by the law and practice relating to abortion, infanticide, sterilisation, and matters relating to the scientific relief of infertility are considered.

In the first extract, Elizabeth Kingdom considers feminist issues in relation to the sterilisation of women. As the author demonstrates in *Consent, Coercion and Consortium: the Sexual Politics of Sterilisation*[10] the traditional approach to issues of consent have been dealt with under English law as legal matters for the *ad hoc* determination of the courts. This 'rights-based' approach, the author argues, masks the need for the development of policies to regulate the complex questions raised by sterilisation. The author analyses the case-law and reveals the uncertainty surrounding the issue of legal consent to sterilisation. She then proceeds to analyse the differing approaches which may be taken in the formulation of policy.

In *Who is the Mother to Make the Judgment: the Construction of Women in English Abortion Law*,[11] Sally Sheldon examines the passage of the Bill leading to the Abortion Act 1967 through Parliament. The author argues convincingly that Members of Parliament (who are predominantly male), adopted very different constructions of the women subjects of abortion law, and the doctors who would be responsible for carrying out the operations. The woman is portrayed

7 *R v Human Fertilisation and Embryology Authority, ex p Blood* (1997) *Times LR*, 7 February 1997. The Court of Appeal remitted the case to the authority for reconsideration. See *The Times*, 26 February 1997.

8 See Shulamith Firestone, *The Dialectic of Sex* (1970).

9 B Malinowski, 'Sex and Repression', in CK Ogden (ed), *Savage Society* (London: Routledge and Kegan Paul, 1927).

10 From Elizabeth Kingdom, *What's Wrong with Rights?* (Edinburgh University Press 1991; 2nd edn 1996).

11 [1993] *Feminist Legal Studies* 3.

variously as 'immature; irresponsible; emotionally weak; marginal; deviant; a victim'. The doctors, by contrast, are constructed as 'mature; professional; sensitive; responsible.'

Katherine O'Donovan in *The Medicalisation of Infanticide*[12] traces the history of this sex-specific crime and analyses the manner in which women have been characterised by law: initially as criminals in need of punishment, through to psychologically damaged or insane, through to more recent perceptions about women's social and economic conditions. From her analysis the author identifies the difficulties in characterising infanticide in legal terms.

Rebecca Albury has analysed the implications for Australian women as that country sought to find the appropriate legal framework for the regulation of technological advances in the relief of female infertility. In *Law Reform and Human Reproduction: Implications for Women*[13] the author argues that the traditional 'public/private' dichotomy,[14] with all its implications for women in relation to assisted conception techniques and criticises the mechanisms of social control which are applied by the medical profession.

CONSENT, COERCION AND CONSORTIUM: THE SEXUAL POLITICS OF STERILISATION[15]

Elizabeth Kingdom

Introduction

Unlike abortion, sterilisation has not been a main target of feminist politics. There are several reasons, however, why it could become a major area of feminist struggle. Again, unlike abortion, sterilisation is not the subject of a specific act in statute law. Cases have been brought under a variety of legal headings, and the most frequently cited cases are characterised by a good deal of uncertainty, not to mention bizarre opinions. In the circumstances, it is perhaps not surprising that social commentators and members of the legal and medical professions should fall back on appeals to rights when debating these controversial cases. But there are good reasons why feminists should not follow that practice. Appeals to rights are notoriously vague and polemical. These qualities may be irresistible in the heat of an adversarial moment. Yet they inevitably frustrate the development of substantive and detailed policies. And in the particular case of sterilisation, uncertainty about which social, legal, and medical policies to adopt seems to invite the invocation of some uncomfortably atavistic rights which should be specially worrying to feminists.

Issues

In this section, I bring together a number of disparate issues relating to sterilisation, issues which are pertinent to the development of a sexual politics of sterilisation. As a preliminary, it will be useful to mention some standard terms which have been used to indicate the purpose of a sterilisation operation. As we shall see, the meaning and implications of these terms can become contentious.

12 [1984] *Criminal Law Review* 259.

13 *Australian Women and the Political System* (ed) Marian Simms (Melbourne Longman, 1984) Chapter 13.

14 On which see further Chapter 5.

15 *What's Wrong With Rights?* (Edinburgh University Press, 1991), p 63.

'Therapeutic' sterilisation is performed for medical reasons, for example where the removal of diseased tissue involves an operation which has the effect of making the patient sterile. 'Non-therapeutic' or 'eugenic' sterilisation is performed for social reasons. It may be because the patient is thought likely to produce children with certain undesired characteristics. It may be because the patient, typically a woman, is thought to be vulnerable to sexual attack and/or is thought to be incapable of managing any other form of contraception and/or is thought to be incapable of caring for any offspring. In the UK, the proposal to sterilise a person for eugenic reasons is made in the light of the person's individual characteristics and circumstances. In some other countries the proposal is made, initially at any rate, on the basis of the individual's membership of one or more specific categories of persons. These categories are defined in assorted medical, psychological, or social terms, such as epileptics, the feeble-minded, and the morally degenerate; the categories feature explicitly in legislation. Sterilisation for contraceptive purposes is sometimes called 'elective', sometimes sterilisation 'for convenience', and once, in *The Guardian*, 'recreational' sterilisation.

The Brock Report

In 1932, under the minute of the Chairman of the Board of Control and with the approval of the Minister of Health, a Committee was appointed under the Chairmanship of LG Brock:

> to examine and report on the information already available regarding the hereditary transmission and other causes of mental disorder and deficiency; to consider the value of sterilisation as a preventive measure having regard to its physical, psychological, and social effects and to the experience of legislation in other countries permitting it; and to suggest what further enquiries might usefully be undertaken in this connection.[16]

Appendix VIII summarises legislation on the subject of voluntary and compulsory legislation in 27 of the United States of America and nine other countries in which laws existed or in which bills were being drafted. In the UK, the Committee observed, 'the legal position in regard to sterilisation is not free from doubt'. The Committee drew a distinction between eugenic and therapeutic sterilisation, commenting that the legality of therapeutic sterilisation 'is not disputed in principle', but 'that there is general agreement that sterilisation of mental detectives on eugenic grounds is illegal'. It added that 'the legal position in regard to the eugenic sterilisation of persons of normal mentality is less certain, but most authorities take the view that it is illegal'.[17]

The Committee recommended the legalisation of voluntary sterilisation in the case of mental defectives or of people who had suffered from mental disorder, of people who suffered from or who were believed to be carriers of grave physical disabilities shown to be transmissible, and of people believed to be likely to transmit mental disorder or defect. Operations for sterilisation were to be performed only under the written authorisation of the Minister for Health, and in that respect a number of procedures were to be followed. These included the requirement of the patient's written consent or, if the patient were deemed incompetent to give a reasonable consent, the written consent of a parent, guardian or spouse.

16 *Report of the Departmental Committee on Sterilisation* (Cmd 4485), p 5.

17 *Ibid*, p 7.

Over 20 years later, Glanville Williams pointed out that the recommendations of the Brock Report were not implemented, although they were supported by a number of public bodies such as the Royal College of Physicians.[18] He might have added that, interestingly enough, they were also supported in a resolution passed by the Business Conference of Women's Sections at the 36th Annual Conference of the Labour Party.[19]

Re D (a minor) (wardship: sterilisation)[20]

As in 1934, the legality of therapeutic sterilisation is not in doubt today, but there is still uncertainty and disagreement about the legality of eugenic or non-therapeutic sterilisation. Robert Lee and Derek Morgan[21] have reviewed and analysed the tendency of recent cases of non-therapeutic sterilisation, but for purposes of this chapter I shall examine one of the most frequently cited cases. D was a girl with Sotos Syndrome. When D was a young girl her parents had decided that they should apply to have her sterilised when she was about 18 years of age to prevent her from having children who might be abnormal.[22] After discussion with a consultant paediatrician, however, arrangements were made to have D sterilised when she was ten. Among others, an educational psychologist challenged the social and behavioural reasons for sterilising D and applied to have her made a ward of court when the paediatrician refused to defer the operation. The case was heard in the Family Division. Heilbron J held that:

> … the operation was one which involved the deprivation of a basic human right, ie the right of a woman to reproduce, and therefore, if performed on a woman for non-therapeutic reasons and without her consent, would be a violation of that right. Since D could not give an informed consent, but there was a strong likelihood would understand the implications of the operation when she reached the age of 18, the case was one in which the courts [sic] should exercise its protective powers. Her wardship would accordingly be continued … A decision to carry out a sterilisation operation on a minor for non-therapeutic purposes was not solely within a doctor's clinical judgement. In the circumstances the operation was neither medically indicated nor necessary and it would not be in D's best interests for it to be performed.[23]

The leading article of *New Society*, written before the case was heard, commented that 'the plan to sterilise an 11-year-old Sheffield girl has quite rightly given rise to a sense of outrage about human rights'.[24]

What is the significance of this case? Feminists might be tempted to read it as a victory over paternalism in the matter of female reproductive capacities. But it is by no means obvious that it was D's sex that was the key issue. In *Re D* the court was preoccupied with, and the sense of outrage undoubtedly provoked by, the fact that D was a minor, mentally subnormal and incapable of giving informed consent to sterilisation proposed on non-therapeutic grounds.

18 G Williams, *The Sanctity of Life and the Criminal Law* (Faber and Faber, 1958).

19 J Weeks, *Sex, Politics and Society (*Longman, 1981), n 53.

20 [1976] 2 WLR 79.

21 R Lee and D Morgan (eds), *Birthrights: Law and Ethics at the Beginning of Life* (Routledge, 1989).

22 *Re D, op cit*, p 326.

23 *Ibid*, p 327.

24 *New Society* 1975, p 634.

This is not to say that there is no feminist interest in this case. Heilbron J's decision turned not only on the question of informed consent but also on the distinction between therapeutic and non-therapeutic sterilisation. For Heilbron J there seemed to be no difficulty in distinguishing the two types of sterilisation. Accordingly, and this is important to note, Heilbron J's stirring appeal to D's right to reproduce was predicated on the opinion that there were no medical reasons for sterilising her.

Fifteen years later, however, in a not dissimilar case, Lord Hailsham offered this critique of the distinction between therapeutic and non-therapeutic sterilisation:

> … for purposes of the present appeal I find the distinction … between 'therapeutic and non-therapeutic' purposes of this operation in relation to the facts of the present case above as totally meaningless … To talk of the 'basic right' to reproduce of an individual who is not capable of knowing the causal connection between intercourse and childbirth, the nature of pregnancy, what is involved in delivery, unable to form maternal instincts or to care for a child appears to me wholly to part company with reality.[25]

Now feminists involved in the struggles leading up to the passing of the Abortion Act 1967 will recall that one of the toughest fights was over the inclusion of the so-called 'environment clause'. This made it permissible, if not mandatory, for registered medical practitioners to take account of the woman's actual or reasonably foreseeable environment in determining the risk to her health if she continued the pregnancy. Whilst this clause did not, as some feminists and some opponents of the new Act claimed, provide for independent social grounds for lawful termination, feminists and a good many doctors welcomed its provision in the Act. Doctors were relieved because it legitimated widespread medical practice. And, as we saw in the previous chapter, feminists took the clause to be critical in the struggle to weaken the ever-present tendency of legal and medical practitioners to treat women as legal subjects defined predominantly in terms of medical, specifically gynaecological, criteria rather than in terms of their economic and social status and situation.

In the context both of abortion and of sterilisation, then, the distinction between medical, or therapeutic, criteria and social, or non-therapeutic, criteria is contentious. Accordingly, to return to *Re D*, if that distinction is contentious, and if possession of the right to reproduce is dependent on a judgement about the presence or absence of medical or therapeutic grounds for sterilisation, then at the very least there is no clear basis for ascribing this right to an individual. This problem is intensified by a legal debate about the proper parties to reach a decision in these matters. In *Re D*, Heilbron J seemed to argue that the presence of medical grounds for sterilisation was one which came 'solely within a doctor's clinical judgement' and that it was the medical criterion and the medical professional that could override any claim to have a right to reproduce. In contrast, in *Re F*, Butler-Sloss LJ averred that the decision should not be left to the family and to the medical profession alone and that it should always be subject to the supervision of the courts.

These cases are instructive for feminists, because they signal that the right to reproduce is not something which in some sense exists, nor something which belongs to human beings by virtue of their membership of the species, *nem con*. Rather the ascription of the right to reproduce is just that – an ascription. As with all ascriptions, complex and competing criteria are deployed. It would, of course,

25 *Re F (Sterilisation: Mental Patient)* (1988) 138 NLJ 350.

be against the theme of this book to make these two cases carry a definitive argument about appeals to rights. In particular, it would be unwise to make generalisations on the basis of these two cases about the right to reproduce, since so much of what was at issue concerned the capacity to give an informed consent, but, as we shall see in the next section, the distinction between medical/therapeutic and social non-therapeutic criteria is also an issue where the capacity to give an informed consent is not in doubt.

Bravery v Bravery[26]

The problematic nature of consent, informed or not, and the slippery distinction between therapeutic and non-therapeutic sterilisation were also at issue in another controversial case. Mr and Mrs Bravery had married in 1934 and had their only child in 1936. Two years later, the husband had a vasectomy with the wife's knowledge. The couple continued to live together, sexual intercourse continued, but there were rows about, for example, the husband's dirty habits, his bad language, and his excessive interest in Indian philosophy. The wife left in 1951 and petitioned for divorce on grounds of cruelty, namely, his having had a vasectomy. It was held that:

> … the wife had not made out a case of cruelty. As between husband and wife, for a husband to submit himself to an operation of sterilisation, without good medical reason, would, unless his wife were a consenting party, be a grave offence which could, without difficulty, be shown to be a cruel act, if it were found to have injured her health or to have caused reasonable apprehension of such injury. If a husband submitted to such an operation without the wife's consent, and if the latter desired to have children, the hurt might be progressive to the nerves and health of the wife.[27]

The case raises important questions. First, was Mrs Bravery a victim of gender stereotyping, explicit or covert, whereby a woman's capacity to control her sexuality is deemed less important than a man's? It is not clear how assiduous the surgeon was in eliciting Mrs Bravery's views on her husband's proposed vasectomy. In that respect, it is possible that she was the object of a particular form of discrimination which I discuss below. But as far as the court's deliberations were concerned, there was a strong suggestion that, had Mrs Bravery made it sufficiently clear, before the operation was performed, that she did not want Mr Bravery to be sterilised, the court would have expressed very different opinions, perhaps finding that she had made out a case of cruelty.

Now, on Mrs Bravery's own evidence, she knew that her husband was going to have the operation. What was at issue in cross-examination was whether she consented to it. As it happened, her husband worked at the hospital where the operation was performed, and she knew the surgeon and the nurse in question. She certainly did not give written consent, and it seems that at no time did she approach the persons concerned to say that she objected. What appears to have swayed Hodson LJ to the view that she did consent was, in the end, his finding it difficult to believe 'that any surgeon, a member of an honourable profession, would perform an operation of this kind on a young married man unless he was first satisfied that the wife consented'.

But, while there was doubt about whether the wife had consented to the operation, the court was in no doubt that the husband had given his consent.

26 [1954] 1 WLR 1169.

27 *Ibid*, p 1169.

Denning LJ did not dispute that; he dissented from the court's decision on altogether different grounds. He argued that an operation of sterilisation was, in the absence of some just cause or excuse, a criminal act in itself, an unlawful assault, to which consent gave no answer or defence. Denning LJ 's argument was based on the view that a person cannot effectively consent to mayhem (the act of maiming) against himself. Denning LJ was also concerned with a rather different form of assault when he concluded that 'if a husband undergoes an operation for sterilisation without just cause or excuse, he strikes at the very root of the marriage relationship'.[28]

Denning LJ's remark is clearly predicated on a view of the relation between marriage and the purpose of sexual intercourse which is at once familiar and horrifying to feminists. Since that view is discernible in all manner of legal proceedings and public debate, however, I shall not pursue the general feminist critique of it. But the possibility that non-therapeutic sterilisation might be a criminal act has given rise to conflicting legal opinions on the specific question of the legality of non-therapeutic sterilisation. In examining this legal controversy, I arrive at the consideration of a legal doctrine of serious concern to feminists, the doctrine of consortium.

The legality of non-therapeutic sterilisation

The reference to mayhem may seem bizarre in the context of sterilisation of a man, not least since mayhem has been defined as an injury to a man so that he is rendered less capable of defending himself.[29] But, whether they merited this attention or not[30] the grounds of Denning LJ's dissent continued to feature in discussions 'of the legality of sterilisation' for some years. AE Clark-Kennedy, for example, pointed out that all surgery is an assault on the body, irrespective of the patient's consent, and that it is justified only when a greater evil has been averted. Writing in 1969, he took the view that the sterilisation of a woman merely as a method of birth control and without any medical justification would probably be found to be illegal if the case were brought to court, and he thought the same might be true for sterilisation of a man.[31] It is interesting to note here that while the National Health Service (Family Planning) Act 1972 allowed local authorities to provide for sterilisation by vasectomy there was no mention of the various methods of female sterilisation. I shall return to this.

Similarly, Bernard Knight has pointed out that no Act of Parliament or judicial dictum has reversed the concept of law whereby sterilisation is a maiming operation. In contrast to Clark-Kennedy, however, he subscribes to the view held by the medical defence organisations that there has been a change in the climate of public opinion regarding sterilisation for purposes of birth control and that the courts would take a more liberal line than Denning LJ's about its legality.[32] J Leahy Taylor confirms this view when he says that a surgeon who performs a sterilisation operation on one of a married couple with the consent of both would not be putting himself at risk.[33]

28 *Ibid*, p 1171.

29 G Williams, *The Sanctity of Life and the Criminal Law*, *op cit*, pp 102–03.

30 *cf* B Dickens, 'Reproduction Law and Medical Consent' (1985) 35 *University of Toronto Law Journal* at 255–86.

31 AE Clark-Kennedy, *Man, Medicine and Morality* (US Distribution: Shoe String Press Inc), p 34.

32 B Knight, *Legal Aspects of Medical Practice* (Churchill Livingstone, 1987), pp 237–38.

33 J Leahy Taylor, *The Doctor and the Law* (Pitman Medical, 1970), p 81; *cf* JK Mason and A McCall Smith, *Law and Medical Ethics* (Butterworths, 1987) Chapter 4.

If, as seems likely, Knight and Taylor are right about the likely attitude of the courts to the legality of sterilisation for birth control purposes, then the question of consent will not be, as Denning LJ thought, an irrelevancy. On the contrary, it becomes one of the central issues.

Consent

In developing his argument about changing attitudes to non-therapeutic sterilisation, Knight cites the opinion of the representative body of the British Medical Association (BMA) in 1967 that 'if the doctor is satisfied that an operation for sterilisation is in the interests of the health of the patient and that the patient has given valid consent and understands the consequences of this operations there is no ethical reason why the operation should not be performed'.

The wording of the BMA's statement is noteworthy. It suggests that it is the valid consent of the patient alone that is required. In fact, both Knight and Taylor make a point of stressing the desirability – from the point of view of the surgeon's protection – of obtaining the consent of both husband and wife where the patient is married. Taylor suggests: 'Where sterilisation is being considered purely as an operation of convenience then, in all probability, no surgeon would be prepared to operate without the consent of both parties.'[34] Again, both Knight and Taylor take the view that a surgeon might proceed with an operation to sterilise a wife without the husband's consent if medical circumstances appeared to necessitate the operation, and Knight seems to countenance a similar possibility where the operation is on the husband.

On the other hand, the views of both Knight and Taylor are called into question on the issue of the spouse's consent by Appendix III of the Birth Control Trust's document *Sterilisation and the National Health Service*.[35] Written on information supplied by the Medical Defence Union, the Appendix states: 'only the patient can give consent. There is no legal requirement for the spouse's consent. However it is advisable in the interests of marital harmony to obtain the agreement of the spouse when the operation is done simply as a means of contraception.'[36]

The distinction between consent and agreement is not developed, however, and in the absence of precise clarification one imagines that surgeons might well want to cover themselves by getting the consent of the patient and the agreement of the spouse. In fact, the Liverpool Area Health Authority issues a form, to be used in cases of primary (that is, non-therapeutic) sterilisation if the patient is married and living with the spouse. There is provision on this form for the consent of the patient and the agreement of the spouse, and it urges that both parties should sign the form at the same time.

Discrimination and consent

Whatever the legalities of consent to non-therapeutic sterilisation, it would seem that surgeons' practices have not been uniform throughout the country. In 1976 it was reported that the NCCL was collecting evidence of cases where women were being denied intra-uterine devices and sterilisation for contraceptive purposes because they could not, or would not, get the written consent of their husband.

34 J Leahy Taylor, *The Doctor and the Law*, *op cit*, p 81.

35 Birth Control Trust 1978.

36 *Ibid*, p 104.

And, says the NCCI, the same doctors who demand a husband's consent will perform a vasectomy on a man without asking if she consents'.[37]

There can be no justification for this discrimination against women. One attempt to outlaw it might be made by bringing a test case under or proposing an amendment to the Sex Discrimination Act 1975, or through drafting a Bill dealing with this issue and others relating to sterilisation. In assessing the measures most likely to eliminate this form of discrimination, however, feminists will also need to investigate the various practices that have supported it. To help with that investigation, I put forward the following points.

Until recently at any rate, vasectomy has been a quicker and safer operation than the various methods of female sterilisation. It is possible, though not defensible, that the male patients and medical personnel have accordingly been inclined to see the decision to operate as unproblematic. On the other hand, as feminists involved in struggles to improve access to abortion facilities will testify, considerations of speed and safety do not appear to have been topmost in the mind of the majority of medical practitioners. It is the non-medical attitudes of those in a position to control access to wanted medical operations that have frequently been decisive.[38]

In the case of doctors' discriminatory practices over consent to non-therapeutic sterilisation, the inference must be that such doctors, consciously or not, attribute a legitimate interest in a spouse's potential fertility to husbands but not to wives. As it happens, that attitude could find support in law, at least until 1982, through the doctrine of consortium. Briefly, this is the ancient notion that a husband has a legitimate proprietary interest in his wife's services (servitium) or society (consortium). Very much in the spirit of this doctrine, it was possible, until 1982, for a husband to bring an action for loss of the services or society of his wife, but not vice-versa. The Administration of Justice Act 1982, however, rectified this anomaly in providing that no person shall be liable in tort to a husband for any such deprivation.

The precise nature of consortium has always been in doubt. In 1977, however, legal advice obtained by the NCCL contained a warning. A consortium probably would not be thought to include the right to a wife's potential fertility, there was still a risk that 'a husband could succeed in an action for damages against a doctor even though the wife had asked for and consented to the operation … on the ground that the doctor has assisted in procuring damage to the husband's consortium'.[39]

The belated removal of the anachronistic doctrine of consortium in this context will rightly be a source of relief to feminists, but there is no reason to suppose that the atavistic rationale of the doctrine will be moribund forthwith. In this respect, it will be interesting to watch the progress of a recent claim for loss of consortium and distress brought by the wife of a haemophiliac who contracted HIV from infected blood. Her lawyer comments that 'interference with a sexual relationship is a recognised claim'.[40] So, the vestiges of the doctrine of consortium may have to be reckoned with for some time to come, if not through explicit reference to consortium then through ideologically related notions such as conjugal rights or the right to reproduce.

37 (1978) *New Society*, p 431; cf B Dickens *op cit*, p 277.

38 *cf* J Aitken-Swan, *Fertility Control and the Medical Profession* (Croom Helm, 1977).

39 *Re: Sterilisation* (National Council for Civil Liberties, 1977).

40 *The Independent,* 1990.

I would urge that feminists engaged in the development of a sexual politics of sterilisation should be extremely wary of formulating policies in terms of such rights – for fear of being drawn on to territory long dominated by ideologies and practices inimical to feminist objectives. There is a serious risk that the appeal to a woman's right to reproduce will be appropriated by those who would invoke a general right to reproduce or a human right to reproduce. Appealing to this more general right may in turn be a less than innocent practice, if the alleged general right is identified, covertly or not, with a man's, or worse, a husband's, right to reproduce. There are, furthermore, additional and independent reasons for not framing policies in terms of rights, and it is to this issue that the next section is addressed.

Policies

Two recurrent features of the literature on sterilisation provide the impetus for a review of the various policies which feminists might adopt. First, a good deal of research in the last decade or so has shown that there is increasing demand for sterilisation for contraceptive purposes. In 1972 it was found that hospitals which deliberately adopted a favourable attitude to sterilisation experienced a dramatic increase in spontaneous requests for sterilisation.[41] Two years later, a survey of 1,079 women in Coventry during their confinement produced the estimate that the potential demand for sterilisation was between 60 and 80 per 1000 confinements.[42] Two surveys by M Bone from the Social Survey Division of the Office of Population Censuses and Surveys on behalf of the Department of Health and Social Security showed a marked increase in favourable attitudes towards sterilisation for contraceptive purposes in the 1970s. Briefly, in 1973, of the total sample of women interviewed:

> only 20% said they would think about it if they had about the number of children they planned to have and most thought it only appropriate in more extreme circumstances, for example if further pregnancies would endanger their health or if they had had several more children than they wanted.[43]

The survey was admitted to give only a sketch of women's attitudes but it was surmised that the irrevocability of sterilisation made it 'very much a method of last resort for most women' (see *ibid*). In 1978, however, the picture had changed. The results of this survey suggested that:

> sterilisation was becoming less of a last resort for the desperate and more of a chosen method for couples who had just achieved the number of children they thought sufficient … Sterilisation was therefore not only spreading but increasingly impinging on young couples who had had few pregnancies and, it seems, quite soon after they had decided that their second or third baby was to be the last.[44]

Additional evidence for the demand for sterilisation for contraceptive purposes has been collected, and explanations for its increased popularity are available.[45]

The second recurrent feature of the literature on sterilisation has not been so thoroughly researched. It concerns a practice which is generally frowned on (or

41 AER Buckle and KC Young in (1972) *New Society*, 24 February, p 402.

42 LJ Opit and ME Brennan, in (1974) *New Society*, 18 July, p 157.

43 M Bone, *Family Planning Services in England and Wales* (Office of Population Censuses and Surveys, 1978).

44 *Ibid*, p 62.

45 *Birth Control Trust* (1978), Chapter 1.