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The Control of Life: Unexamined Law and the Life Worth Living

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THE CONTROL OF LIFE: UNEXAMINED LAW AND THE LIFE WORTH LIVING

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Two recent Reports urge upon us the need to make available to the mentally retarded the shared experiences of the entire community. The Williston Report[1] supports the general movement away from institutionalization, and contains suggestions for change in government arrangements for care and supervision. The Report of the National Institute on Mental Retardation[2] emphasizes the need for a comprehensive system of guardianship for those of the retarded who do not come within the protection afforded under existing statutes. It also suggests that such a system, with its special concerns, might even be extended to include those already protected by statute. While such a system would protect property, its particular concern would be the person. This concern with the person is shown in various places in the Report, usually in the context of rights relating to property, the franchise, standing before the courts and so on. These discussions indicate some considerations to be taken into account if we are to achieve the goal of normalization for the mentally retarded. But the greatest challenge to the policy is presented in Chapter III of the Report. Entitled "Sex and the Other Sex", it deals with marriage, being a parent, contraception, sterilization, abortion, annulment and divorce, and is said by the authors to have been the most difficult chapter to write owing to the controversial nature of the topics.[3] How much more difficult when to controversy is added handicap.

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[1] W. B. Williston, *Present Arrangements for the Care and Supervision of Mentally Retarded Persons in Ontario,* (Ontario Department of Health, 1971). The report is the result of an investigation undertaken on behalf of the Minister of Health of Ontario, after the alleged suicide of a mentally retarded person working out of the Rideau Regional Hospital at Smiths Falls, Ontario, and injury to another retarded person who had been discharged from the same hospital.

[2] B. B. Swadron and D. R. Sullivan, *Mental Retardation — The Law — Guardianship: The Report of the Project to Examine the Legal Aspects of Guardianship Protection as it Affects the Welfare of the Mentally Retarded,* (Toronto: National Institute on Mental Retardation). The introduction contains a suggestion that "caution should be taken generally" in relying upon the law contained in the Report. It should be heeded. At 32 under "making a will" we find: "The burden of proving incapacity is upon the party who alleges it, that is the party objecting to the validity of the will." No distinction is made between contestation of cases before or after probate is granted: see R. H. Hull, *The Onus of Proof in Contested Wills Cases After Probate is Granted* (1971), 19 Chitty's Law Journal 84. At any rate, only Ontario seems to have shifted the ultimate burden of proof where a will is contested after probate, and the Report purports to be a national one. At 120-21, under "Dependants' relief legislation", surely the extract from the judgment of Hogg, J.A. in *Re Beyor Estate,* [1949] O.W.N. 289; 2 D.L.R. 604 (C.A.) at 612 (D.L.R.) indicates that the conflict of interest created by the testator in the will amounted to inadequate provision at the testator's death. Incidentally, the widow was discharged from the hospital less than six months after the testator's death. These comments in no way detract from the general value of the Report.

[3] B. B. Swadron and D. R. Sullivan, *supra,* note 2 at 79.

The authors bemoan the evasive nature of the available literature, and the lack of practical advice.

It is true that the area abounds in short, unenlightening, oft-reprinted monographs. The reason is that with a dearth of literature, those in need of material have made use of whatever writing seemed relevant. Seminars are now providing the practical advice,[4] and hopefully evasion of the more difficult issues will become less common in the literature. What is important now is awareness that the topics which raise these issues are not limited to those mentioned in "Sex and the Other Sex", and that the issues must be resolved for the entire community. The topics we must examine in order to appreciate the full spectrum of relevant issues are those which involve the prevention, creation, alteration, maintenance, and termination of life through medical and other scientific means: in short, our attempts to control life. These topics include artificial insemination, organ transplantation, psychosurgery and the use of drugs to control behavior, the possibility of interfering with genetic determinants, experimentation on humans, and the use of machines and artificial organs to prolong life. Like abortion and sterilization, they are controversial. They define the attitudes of our society toward human life. It is therefore imperative that the legal responses to these issues reflect thorough analysis of underlying problems, e.g., the question of consent, and the role of the criminal law in regulating practices which involve the control of life.

If the necessary research and analysis is not done, we may be presented with legislation enacted on a piecemeal basis in response to emergencies. Such responses may be inadequate.[5] Certainly they are unlikely to provide guidance for the future. In addition, failure to integrate their situations into a community legislative framework for the control of life leaves the goal of normalization for the mentally retarded as far away as ever. Only through research in advance of lawmaking can we hope to deal in a comprehensive way with the problems of minors, the retarded, the mentally ill and others who are afforded special protection by the law.

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[4] For example, the six day intensive course on "Changing Trends in Mental Education" held at the National Institute on Mental Retardation in Toronto from August 21st to 26th, 1972. The subject areas included sex education. See also "Sex and the Mentally Retarded", the proceedings of an all-day institute sponsored as a Greater Cleveland Mental Retardation development project in Cleveland, Ohio, on May 22nd, 1967.

[5] For instance, are we to assume that the position taken by The Human Tissue Gift Act, 1971, S.O. 1971, c. 83 represents a considered policy decision, and that consequently in Ontario minors will not be considered as potential *inter vivos* transplant donors? See sections 2 and 3 (1) and (2). Minors cannot consent to *post mortem* gifts for transplants (see section 4 (1) and (2)), but section 5 (1) provides adequate opportunity for obtaining consent from a relative or "person lawfully in possession of the body" (section 5 (1) (f)). This phrase of last resort may give rise to dispute. Sections 5 (1) (f) and 5 (4) exclude certain persons from qualifying as possessors. See Ont. Leg. Debates, July 26, 1971 at 4775 - 78 for discussion of the Bill. Sections 3 (2) and 4 (2) validate consents given by minors under certain circumstances. Section 3 (2), which deals with *inter vivos* gifts, has been termed a dangerous provision: J.-G. Castel, "Medical-Legal Problems of Organ Transplantation", in J. S. Najarian and R. L. Simmons eds., *Transplantation*, (Philadelphia: Lea & Febiger, 1972) 325 at 334.

The form such legislation should take is not the least of the problems to be examined. It must be capable of accommodating rapid advances in medicine and biology, and also be able to profit from the knowledge of the social sciences. Another problem involves the reaction of doctors to the prospect of such legislation. Faced with technological advances, doctors have seen the need for legislation in such areas as transplantation.[6] Where legislation has been absent, or vague, some doctors would appear to support the enunciation of useful legislative or other guidelines. An example of vague legislation is section 251 of the Criminal Code,[7] which permits abortion by a qualified medical practitioner, other than a member of a therapeutic abortion committee for any hospital, where such a committee states that the continuation of the pregnancy would be likely to endanger a woman's life or health. A recent survey indicates that "a whole cluster of moral, ethical, political and socio-economic considerations attend each decision" which is supposedly based on likely danger to mental health.[8] There is no legislation in Canada governing the sterilization, for any purpose, of non-institutionalized persons done with consent.[9] In response to the demand for male and female sterilization, some hospitals formed sterilization committees.[10] Medical societies adopted guidelines to be followed in granting or refusing sterilization,[11] though they did not attempt to enforce them, and at one time the Canadian Medical Protective Association recommended that "sexual sterilization should be done, broadly speaking, only for the preservation of the health or life of the individual concerned."[12] Five years later, the Association changed its position: "the Association thinking has reached the point where it now feels the problems should be left for decision by the individual doctor faced with the patient requesting the operation, to be decided just as he would decide about any other request for non-essential treatment. One should start by realizing that under these particular circumstances, there is no medical indication for such an operation so that doctors should not use those words to themselves: they should think in terms of 'reasons' and then they should weigh their patient's reasons for wishing the operation to decide if they, the doctors, feel those reasons are valid."[13] Presumably age/parity formulae[14] are still being used, in conjunction with psychological and socio-economic criteria. Another response to the absence of legislation dealing with contraceptive sterilization is connected with abortion. At times, therapeutic abortion committee approval has been conditioned upon sterilization of the woman.[15] Even in cases where there were no specific indications for sterilization, some doctors have adopted "the increasingly popular device of penalizing the mother scheduled for a therapeutic abortion by packaging it as a unit with a procedure for sterilization."[16] Surely if our society is to legislate at all on matters involving the control of life, it must develop useful and comprehensive policies to assist medical practitioners in making decisions which do not involve medical expertise.

Policy usually manifests itself as principle. Traditionally legislators have looked to common law and custom for principles to use in the framework of reform. In the areas under discussion the principles are to be found in Torts, Property, Family Law and the Criminal Law. One of the most import-

[6] "The Human Tissue Gift Act, 1971, ... is, with minor changes, the draft pre-

pared in 1969-1970 by an *ad hoc* committee of the Medical-Legal Society of Toronto." Castel, *supra,* note 5 at 348.

[7] R.S.C. 1970, c.C-34.

[8] K. D. Smith and H. S. Wineberg, *A Survey of Therapeutic Abortion Committees* (1969), 12 Criminal Law Quarterly 279 at 303.

[9] Apart from the unlikely application of section 228 of the Criminal Code (maiming) to non-therapeutic sterilization. See G. Williams, *The Sanctity of Life and the Criminal Law,* (New York: Alfred A. Knopf, 1957) at 103-05; J. Miller and G. Dean, *Civil and Criminal Liability of Physicians for Sterilization Operations* (1930), 16 American Bar Association Journal 158, at 158-60; L. K. Champlin and M. E. Winslow, *Elective Sterilization* (1965), 113 University of Pennsylvania Law Review 415 at 428-29.

[10] See reference, *infra,* note 11, guideline 7. The same reaction to the absence of legislation occurred in the United States: Champlin and Winslow, *supra,* note 9 at 426.

[11] E.g., the guidelines for male and female sterilization which were approved at the annual meeting of the Manitoba Medical Association in April, 1970:

> 1. Where medical indication for sterilization exists, a documented consultation with an appropriate consultant or consultants is recommended.
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> 2. Where a woman is aged twenty-five and has five living children or is aged thirty and has four living children or is aged thirty-five and has three living children and the couple requests sterilization and the patient's doctor agrees sterilization of either the husband or the wife should be allowed without further consultation. The attending doctor should have adequate documentation to support his opinion.
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> 3. Where the patient does not meet the requirements outlined in No. 2 above and the couple requests sterilization, consultation should be required before either male or female sterilization is performed.
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> 4. The use of hospital beds for female sterilization should not be at the expense of longer waiting lists for patients requiring hospitalization for medical indications. In this connection immediate post-partum tubal ligation is desirable as it eliminates the necessity for a special hospital admission and should not involve a longer post-partum hospital stay.
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> 5. Hospitals in Manitoba which are financed through the Manitoba Hospital Commission should be asked to permit male and female sterilization.
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> 6. An operative consent form to be signed by both husband and wife should name the operation to be done, should state that the operation is not only consented to, but requested by the patient and his or her spouse, that the patient has been informed he or she may no longer be able to produce children, that the results of the operation may be permanent and irreversible and that having this knowledge he or she persisted in the request.
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> 7. If the above recommendations are adopted the need for sterilization committees no longer exists.

[12] T. L. Fisher, *Legal Implications of Sterilization* (1964), 91 C.M.A. Journal 1363 at 1365.

[13] *Sexual Sterilization for Non-Medical Reasons* (1970), 102 C.M.A. Journal 211.

[14] For some additional examples, see Champlin and Winslow, *supra,* note 9 at 420.

[15] *Id.,* at 423; H. J. Myers, "The Problem of Sterilization: Sociologic, Eugenic, and Individual Considerations", in H. Rosen ed., *Abortion in America,* (Boston: Beacon Press, 1967) 87 at 93.

[16] A. J. Mandy, "Reflections of a Gynecologist", in Rosen, *supra,* note 15, 284 at 290.

ant is the protean principle of consent,[17] which in the common law reflects the social policies of many periods. This and other principles have been developed without regard to their possible application in what must today be regarded as a new and distinct field, the Control of Life. It is necessary to understand the ways in which they have been used before they can be employed successfully in solving new problems. The writer proposes to describe briefly the results of sterilization movements active in the United States and Canada from the end of the nineteenth century to the present in order to illustrate the dangers of legislation proceeding from the enthusiasm of experts[18] and the fears of the general population.[19]

The present significance of the terminology employed must first be considered. Voluntary sterilization is commonly divided into three categories: therapeutic, contraceptive, and eugenic. These terms indicate only the primary purpose for which the procedure is employed: obviously more than one term may be applicable in a particular case. Danger to the life of the wife is an indication for therapeutic sterilization of wife or husband, though there is no threat to the husband.[20] The threat of serious physical or mental defect in the offspring is an indication for eugenic sterilization. No doubt many

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[17] In the Criminal Code consent by a minor is usually a defence where a person is charged with an offence which requires the absence of consent. (Some exceptions are section 140, which refers to sections 149 and 156, and section 158, which refers to sections 155 and 157). An example of this general principle is the requirement of consent to an abortion recognized by section 251(7) of the Criminal Code, a section which does not require consent by the parents or guardian. The minor's consent is sufficient. However, in the civil law, the physician probably would be liable if the operation was performed without the consent of the minor's parents or guardian, although consent was given by the minor. These differing attitudes of the civil and criminal law to the question of consent are also found in the law of New York. See L. Holtzman, *Medical-Legal Considerations of Abortion in New York State under the New Abortion Law* (1971), 14 Clinical Obstetrics and Gynecology 36 at 38-40. The author is a Justice of the Supreme Court of the State of New York.

[18] M. H. Haller, *Eugenics: Hereditarian Attitudes in American Thought,* (New Brunswick, N.J.: Rutgers University Press, 1963) at 124.

In 1905 Pennsylvania became the first state to pass a sterilization bill. Governor Pennypacker refused to sign the bill, which was entitled "An Act for the prevention of idiocy", and in his message to the senate he criticized the wide powers entrusted to the scientific experts under the vague provisions of the bill. The Governor also objected that the bill would permit experimentation upon living human beings. His message to the senate is quoted at length in Ferster, *infra,* note 28 at 593. At the end of his term, Governor Pennypacker was called on to speak at a newspaper dinner held at the end of the Legislative session. He had hardly begun when the newsmen began to give him a hard time. "He was not the least taken aback but after some minutes of pandemonium he raised his arms for silence and then squeaked out in his funny voice: 'Gentlemen, gentlemen! You forget you owe me a vote of thanks. Didn't I veto the bill for the castration of idiots?' This brought down the house and assured him a respectful hearing." E. L. Van Roden, *Sterilization of Abnormal Persons as Punishment For and Prevention of Crimes* (1949), 23 Temple Law Quarterly 99 at 106.

[19] J. Paul, *The Psychiatrist As Public Administrator. Case in Point: State Sterilization Laws* (1968), 38 American Journal of Orthopsychiatry 76 at 77.

[20] See N. St. John-Stevas, *The Agonizing Choice,* (London: Eyre and Spottiswoode, 1971) at 25, n.4: "In 1970 vasectomy, the male sterilization operation, became available under the [U.K.] National Health Service on grounds of potential ill health to a husband *or wife.* (Author's italics).

therapeutic abortion committees would approve an abortion in such an instance on the ground of danger to mental health.[21] Risk of serious defect in the child would play a part in the decision, even though it is not a ground for abortion under section 251 of the Criminal Code.[22] Today, voluntary sterilization is not confined to medical indications. The husband would have little difficulty in obtaining a vasectomy. What of the woman who already has children, cannot make effective use of contraceptive devices, and whose socio-economic circumstances dictate that she should have no more children? Her husband may refuse to undergo vasectomy, or the physician may consider it inadvisable on psychological grounds. If she chooses her doctor carefully, she will "have her tubes tied" upon request after delivery. The operation is subject to the usual hospital regulations, but there is no legislation in Canada governing either male or female sterilization of non-institutionalized persons done with consent.[23] The only practical distinction between therapeutic and contraceptive sterilization, apart from the possible reluctance of some doctors to perform the operation for purely contraceptive purposes, is that in a situation involving immediate urgency, a doctor may be justified in performing therapeutic sterilization without waiting to obtain the patient's consent.[24] One of the reasons advanced for sterilization of the mentally retarded was that children were a burden which might lead to the breakdown of marriages which otherwise had a chance of succeeding.[25] This argument is one for therapeutic sterilization, but here, since the person involved is mentally retarded, the problem of consent is a difficult one. It is complicated by the fact that a great number of American state eugenic sterilization statutes as well as Alberta's Sexual Sterilization Act[26] provide for compulsory as well as voluntary sterilization of institutionalized persons,[27] and they contain a

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[21] See Smith and Wineberg, *supra,* note 8 at 298.

[22] "Despite the uncertain legal status of eugenic as distinguished from therapeutic abortion, such operations are regularly performed by responsible physicians in hospitals throughout the country." Comments on section 207.11, Tentative Draft No. 9, 1959, Model Penal Code of the The American Law Institute, at 154. Section 230.3 of the Institute's 1962 Proposed Official Draft of the Model Penal Code includes substantial risk of grave physical or mental defect in the child as a justification for abortion. A number of states have enacted legislation adopting this indication: see J. A. Knecht, *A Survey of the Present Statutory and Case Law on Abortion: The Contradictions and the Problems* (1972), 1 University of Illinois Law Forum 177 at 180 and n. 28. The U.K. Abortion Act 1967 (1967, c. 7) contains a substantially similar indication. See also note 46a *infra.*

[23] See note 9, *supra.*

[24] See *Murray* v. *McMurchy,* [1949] 1 W.W.R. 989; 2 D.L.R. 442 (B.C.S.C.).

[25] M. Woodside, *Sterilization in North Carolina,* (Chapel Hill, N.C.: The University of North Carolina Press, 1950) at 152-54; Brock Committee — *Report of the Departmental Committee on Sterilization,* (1934); Cmd. 4485) at 32-33.

[26] R.S.A. 1970, c. 341.

[27] Postwar administrative policy in many American states has been to require the consent of the patient, his next-of-kin or guardian. Paul, *supra,* note 19 at 78-80.

The writer has been advised that although the Alberta Sexual Sterilization Act does not require it, the practice of the Eugenics Board of Alberta has been to obtain consent wherever possible to the proposed sterilization of mentally defective persons. "Wherever possible", so far as the Board is concerned, has meant the permission of the parents or, in the absence of parents, the approval of the person in charge of the institutional care of a mentally retarded person.

variety of indications for the operation.[28] Some of the American statutes indicate punitive as well as eugenic objectives.[29] Geneticists have criticized the unscientific nature of the sterilization statutes,[30] and the student of social history may see in the legislation attempts by legislators to allay the fears of constituents. These attempts were encouraged by a number of interested individuals and organizations[31] concerned that the population would be overwhelmed by criminals, paupers and the mentally defective.[32] The legislation

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[28] See "Eugenic Sterilization", in S. J. Brakel and R. S. Rock eds., *The Mentally Disabled and the Law,* (Chicago: University of Chicago Press, 1971) at 207; G. T. Felkenes, "Sterilization and the Law", in *New Dimensions in Criminal Justice,* (Metuchen, N.J.: The Scarecrow Press, 1968) 113 at 139; E. Z. Ferster, *Eliminating the Unfit — Is Sterilization the Answer?* (1966), 27 Ohio State Law Journal 591; K. G. McWhirter and J. Weijer, *The Alberta Sterilization Act: A Genetic Critique* (1969), 19 University of Toronto Law Journal 424; "Sex and the Other Sex", in the *Report of the National Institute on Mental Retardation, supra,* note 2 at 87; "The Eugenics Board", in W.R.N. Blair, *Mental Health in Alberta,* (Edmonton: Government of Alberta, 1969) at 267.

Earlier analyses may be found in: Brock Committee, *supra,* note 25. Appendix 8—"Memorandum Regarding Foreign Laws on the Subject of Sterilization", at 109; J.H. Landman, *Human Sterilization,* (New York: The Macmillan Company, 1932) at 54; Committee of the American Neurological Association for the Investigation of Eugenical Sterilization, *Eugenical Sterilization: A Reorientation of the Problem* (New York: The Macmillan Company, 1936) at 7.

[29] See Felkenes, *supra,* note 28, at 139. See also discussion in *State* v. *Feilen,* (1912), 70 Wash. 65, 126 P. 75, 40 L.R.A. (N.S.) 418, and n. in 40 L.R.A. (N.S.) at 419.

[30] E.g., McWhirter and Weijer, *supra,* note 28; J. R. Miller, H. G. Dunn and L. A. Kerwood, *Report to the Research, Clinical Services and Education Committee of the A.R.C. of B.C., of the Sub-Committee on Sexual Sterilization in British Columbia* (1963), referred to in (1964), 14:3 Mental Retardation: (C.A.R.C.) at 25 (the British Columbia statute is the Sexual Sterilization Act, R.S.B.C. 1960, c. 353 as amended); Committee of the American Neurological Association, *supra,* note 28, *passim.*

As for cases presented under the Alberta statute, the Blair Report noted that essential evidence was often not available to the Eugenics Board. In other cases, it was inadequate. Blair, *supra,* note 28 at 268.

[31] "[T]he legislative victories of eugenics arose more from expert testimony before legislative committees than from public demands. ... Eugenics remained primarily a movement of specialists rather than a popular crusade. Haller, *supra,* note 18, at 124. For an account of the eugenics movement in the context of American social history, see Haller, *supra.* Those who are familiar with The New Yorker Profile entitled "Professor Sea Gull" may recall that Joe Gould, 'the last of the bohemians', "spent the summer of 1915 as a student in eugenical field work at the Eugenics Record Office at Cold Spring Harbour, Long Island. This organization, endowed by the Carnegie Institution, was engaged at that time in making studies of families of hereditary defectives, paupers, and town nuisances in several highly inbred communities. Such people were too prosaic for Gould; he decided to specialize in Indians. That winter he went out to North Dakota and measured the heads of a thousand Chippewas ... and of five hundred Mandans. . . ." J. Mitchell, *Joe Gould's Secret* (New York: The Viking Press, 1965) at 26-27.

Not all eugenists favoured sterilization legislation. "[T]he enthusiasm of some eugenists for sterilization was matched by the fear of others that neither existing knowledge, common decency, nor public opinion justified such laws." Haller, *supra,* at 124.

[32] Committee of the American Neurological Association, *supra,* note 28 at 24-25. See also Ont. *Report of the Royal Commission on Public Welfare,* (Toronto: King's Printer, 1930) at 9, which recommended the enactment of sterilization legislation to deal with immoral defectives and criminals.

could be made use of to save administrators from the publicity which might result from poor supervision. Less thought was given to the needs of the retarded. People were sterilized who could never leave an institution,[33] some were required to consent to sterilization before they were allowed to leave,[34] others were sterilized and later were found not to be retarded.[35] All this indicates that the legislation and its application reflected a desire to protect the general population, not primarily to help the retarded to adjust, so far as possible, to the larger society.

Nuremberg told people all they wanted to know about eugenics,[36] but twenty-six[37] state sterilization laws remain in force, as well as statutes in Alberta and British Columbia.[38] The post-war decline in statutory sterilizations is attributed not to critical public opinion, but to "significant post-war changes in administrative personnel and philosophy".[39] The administrative institution of strict consent procedures,[40] together with professional concern with the retarded person's ability to adjust to the larger community, represent attempts to help the retarded in spite of the eugenic and, in some cases, punitive objectives of the sterilization statutes. Unfortunately, it would appear that these objectives enjoy some current support. The writer has been advised that in the response to the Osgoode Hall Medical-Legal Questionnaire approximately 67% of the doctors who replied agreed that "forcible sterilization of persons judged criminally insane, mentally retarded or feebleminded is . . . a desirable social policy." Experience seems to have been a poor teacher.[41]

Few today would claim that the sterilization statutes are genetically sound, or that sterilization will rid society of 'poor heredity', but where these statutes exist, there remains the possibility that some of those responsible

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[33] Brock Committee, *supra,* note 25 at 36. See also R. R. MacLean and E. J. Kibblewhite, *Sexual Sterilization in Alberta* (1937), Canadian Public Health Journal 587 at 587.

[34] R. C. Allen, *Legal Norms and Practices Affecting the Mentally Deficient* (1968), 38 American Journal of Orthopsychiatry 635 at 638.

[35] McWhirter and Weijer, *supra,* note 28 at 424. See also J. B. O'Hara and T. H. Sanks, *Eugenic Sterilization* (1956), 45 Georgetown Law Journal 20 at 31.

[36] Haller, *supra,* note 18 at 180; Paul, *supra,* note 19 at 78.

[37] Brakel and Rock, *supra,* note 28 at 210.

[38] Sexual Sterilization Act, R.S.B.C. 1960, c. 353 as amended.

[39] Paul, *supra,* note 19 at 78.

[40] See *supra,* note 27.

[41] "[C]ompulsory sterilization of the 'hereditary' retarded ... like the discovery that the younger generation is going to the dogs, ... is a problem that every generation has to work out for itself."

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"I hope that this subject will be allowed to die a natural death, and that we will hear no more of it until the next generation rediscovers this marvellous and original solution to the problem of retardation." Letter from J. L. Evans to The Medical Journal of Australia, reprinted in (1969), 3 Australian Children Limited 254 at 254, 256.

There have been suggestions recently in Canada and the United States that those on welfare be sterilized. See J. Paul, *The Return of Punitive Sterilization Proposals: Current Attacks on Illegitimacy and the AFDC Program* (1968), 3 Law and Society Review 77; Ferster, *supra,* note 28 at 607-13, 623-24.

for the day-to-day care of the retarded will use the statutes to eliminate the possibility of propagation by their charges.[42] It is suggested that their motivation is at least three-fold:

1. They see the results of these unions, children who may themselves be retarded, and who in many cases cannot be raised by their parents.

2. They may resent the attitude of those retarded parents who see nothing unnatural in parenthood without responsibility.

3. In the face of government indifference to improving facilities and supervision both in institutions and in the community, some may find an application under the statute a convenient way to avoid possible embarrassment.

No doubt some would favour increased emphasis on a comprehensive system which would emphasize care and supervision outside of institutions. Such a system should include provision for an exhaustive review of each case designed to ascertain whether sterilization is really necessary for the well-being of the retarded person. This should be the primary consideration. The understanding of the retarded person concerning the operation and its advantages to him would be tested. Reluctance on his part to undergo the operation should be respected, even though it may involve additional supervision and expense. Consent in such circumstances should be defined in terms of the retarded person's understanding[43] rather than the wishes of those responsible for his care.[44]

There are a number of lessons to be learned from the sterilization experiment. In the first place, it should be obvious that sterilization, like abortion, is no panacea for social and economic problems. Secondly, it is important that programs be developed to acquaint the general public with the policy decisions with which doctors are now confronted as a result of advances in

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[42] In a study of six states which did not have sterilization legislation, institution officials in four jurisdictions were opposed to involuntary sterilization laws. Ferster, *supra,* note 28 at 606.

The Superintendent of a Home for the retarded in Manitoba advised the writer that he was opposed to compulsory sterilization legislation. Although Manitoba has no sterilization legislation, provision for the 'voluntary' (permission to be given by the defective or his parent or guardian) sterilization of defectives was included in Bill No. 7 of 1933. After considerable discussion, the Manitoba Legislature deleted the two sterilization sections from the Bill, which became The Mental Deficiency Act, S.M. 1933, c. 24. The proposed sterilization provisions met strong opposition from the Roman Catholic community. A pamphlet setting out reasons for this opposition, which was distributed in Winnipeg at the time, is reprinted in the February 27th edition of the Winnipeg Free Press. Accounts of the controversy appeared in the Free Press and the Tribune from February to May, 1933. One of the leaders of the opposition to the sterilization provisions was Reverend Father Antoine D'Eschambault, who later wrote a book entitled *Eugenical Sterilization* (Winnipeg: Canadian Publishers Limited, 1936).

[43] The experience with the original Sexual Sterilization Act of Alberta (S.A. 1928, c. 37), prior to the 1937 amendments (S.A. 1937 (1st Session), c. 47) is illuminating: "In former times, when the consent of mental defectives was necessary, it seemed most difficult to obtain that consent from the higher-grade defectives." MacLean and Kibblewhite, *supra,* note 33, at 588.

[44] Consent by the latter "does not make the operation a voluntary one". Ferster, *supra,* note 28 at 622.

technology. For example, genetic screening is now being done in Canadian and American communities where the population at risk is identifiable.[45] Tests can often identify apparently normal individuals who are carriers of serious, sometimes fatal diseases. Where husband and wife are both carriers, their children may be affected. If the couple elect to have children, amniocentesis will, in a number of cases, make possible prenatal diagnosis of disease in the foetus. If the foetus is affected there is the possibility of abortion. Indeed, one authority has stated that where diagnosis is made before birth, "most physicians require both that the couple be willing or, more precisely, desirous of terminating the pregnancy by aborting the abnormal foetus and that the obstetrician be willing and able to do so. Otherwise, the entire procedure becomes one which potentially may be psychologically very traumatic to the pregnant woman".[46] In a pamphlet entitled "Facts You Should Know About Tay-Sachs Disease", published by the Tay-Sachs Testing Programme of The Hospital for Sick Children in Toronto, it is stated that "a pregnancy in which the foetus with Tay-Sachs disease is identified [through amniocentesis] can be therapeutically terminated." The purpose of the procedure is to ensure that only unaffected children are born. The eugenic abortions performed in the course of furthering this purpose are not based on probabilities but on proven defect. Yet they are permitted by law in Canada and most American jurisdictions only under the fiction of danger to the mental health of the mother.[46a]

Should proven defect be a justification for abortion? The prohibited degrees of consanguinity have a eugenic basis,[47] and in Ontario a marriage within the prohibited degrees is void.[48] Punishment for incest[49] is similarly based in part on the possibility that a child of such a union might be defective. Our legislators have yet to deal with situations involving the certain knowledge of defect before birth. Their reluctance is understandable, since we have not yet adequately examined the policy bases of our present laws.

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[45] See Time Magazine, September 13, 1971 at 58; pamphlet on testing for Tay-Sachs disease, *infra.*

[46] C. J. Epstein, *Medical Genetics: Recent Advances with Legal Implications* (1969), 21 Hastings Law Journal 35 at 43.

[46a] This was written before the decisions of the United States Supreme Court in *Roe* v. *Wade* (1973), 93 S.Ct. 705 and *Doe* v. *Bolton* (1973). 93 S.Ct. 739. The result of *Roe* v. *Wade* is that American states may now proscribe abortion only for the stage subsequent to viability. Excepted from possible state proscription, however, are abortions which are necessary, in appropriate medical judgement, for the preservation of the life or health of the mother. It would therefore appear that the fiction referred to above has been extended by the Court, for the stage subsequent to viability, to states which have not yet enacted legislation making substantial risk of grave physical or mental defect in the child a justification for abortion. As to the earlier stages, the Court's insistence that "the abortion decision in all its aspects is inherently, and primarily, a medical decision", and that "basic responsibility for it must rest with the physician" is inconsistent with physicians' assertions that most abortions approved on psychiatric grounds are based on non-medical considerations. If the result of the Court's decisions is to increase the pressure on physicians to perform abortions based on non-medical considerations, presumably physicians must resort to the formula of fiction if they are to avoid "the usual remedies, judicial and intra-professional", which the Court indicates are available against the practitioner who "abuses the privilege of exercising proper medical judgement". *Roe* v. *Wade* (1973), 93 S.Ct. 705, per Blackmun, J. at 733.

A distinguished biologist has suggested that, having identified the carriers of defective genes, we try to discourage them from marrying each other. He would leave the decision to the engaged couples themselves.[50] Such questions bring us back to the need for considering the entire field of Control of Life. Consideration need not await the further achievements of technology, and should not await the enthusiasms awakened by other social and economic problems. Finally, we must make sure that whatever legislation results will deal with the retarded and others in need of special protection in a manner which recognizes their rightful place in the community.

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[47] Bromley, *Family Law* (4th ed. London: Butterworths, 1971) at 26.

[48] The application of the prohibited degrees in Ontario is dealt with in H. R. Hahlo, "Nullity of Marriage", in D. Mendes da Costa, ed., 2 *Studies in Canadian Family Law* (Toronto: Butterworths, 1972) 651 at 660.

[49] Criminal Code, R.S.C. 1970, c. C-34, s. 150.

[50] P. B. Medawar, "Genetic Options: An Examination of Current Fallacies", in D. H. Labby ed., *Life or Death: Ethics and Options,* (Seattle: University of Washington Press, 1968) 94 at 109-10.