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"HER BIAS CLOUDS HER SENSE OF REALISM": JUDICIAL DISCOURSE SURROUNDING THE REPRODUCTIVE CHOICES OF INTELLECTUALLY DISABLED WOMEN

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While many women freely give birth all around Aotearoa New Zealand, the reproductive choices of some women are subject to state approval. Under the Protection of Personal and Property Rights Act 1988, intellectually disabled women can be ordered to undergo sterilisation or termination of pregnancy, or both, without their consent. Focussing on the case study of a woman referred to as "KR", this article argues that societal perceptions of intellectually disabled women unduly influence the legal reasoning process. Despite concern expressed by the United Nations in 2014 that New Zealand's process for sterilisation or termination of pregnancy of intellectually disabled women does not adhere to the Convention on the Rights of Persons with Disabilities — which New Zealand has ratified — there has been no legislative reform. New Zealand's legal approach to the reproductive choices of intellectually disabled women is woefully out of date and risks disregarding women's desires, rights and self-determination.

I INTRODUCTION

This article explores how the intellectually disabled woman is produced and shaped by discourse and the extent to which the courts uncritically accept and integrate that discourse into reasoning processes.[1] To illustrate this, this

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1 Because this issue deals with female reproduction and a set of cultural ideas about women, this text's analysis is best applied to those who were deemed to have a 'female' reproductive system at birth and are coded by society as women. This is most likely to be cisgender women. The forced sterilisation of

article focusses on the legal issue of court-ordered non-consensual sterilisation and termination of pregnancy of intellectually disabled women, particularly centring on the experience of KR as a case study.[2] Part II of this article will set out the relevant definitions, establish the historical background and legal framework for non-consensual sterilisation and termination, and outline KR's case history. Part III will discuss the legal test of "capacity", which determines whether a woman is unable to make her own reproductive decisions and thus whether the court has jurisdiction to make orders in respect of her fertility or pregnancy. This Part critically assesses the deployment of the masculine concepts of rationality, reason and logic to guide the courts' reasoning in assessing a woman's ability to understand and make reproductive decisions. Additionally, Part III outlines how narratives about the capability of intellectually disabled women contribute to a lack of educational resources and support, thereby reinforcing their perceived incapacity. Part IV assesses the "best interests" test which is the second step after a court determines a woman lacks capacity to determine appropriate orders. It examines how discourses about intellectually disabled women and their reproductive rights, sexuality and motherhood are employed in assessing her best interests.

II CONTEXT

A Definition of intellectual disability

It is extremely difficult to give a single definition of the term "intellectual disability".[3] Intellectual disability is not a condition or disorder itself, but "a description of society's current judgement on an individual's functioning".[4] However, it is often understood to be "an outcome of a diagnosable biological impairment or medical condition".[5] For example, the Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003 defines a person as having an intellectual disability if the person "has a permanent impairment that results in significantly sub-average general intelligence and results in significant deficits

transgender and gender diverse people is an important issue that, while related, falls outside the scope of this article.

2 *R v R* (2004) 23 FRNZ 493 (FC); *KR v MR* [2004] 2 NZLR 847 (HC); and *R v R (No 2)* [2004] NZFLR 817 (FC).

3 Anne Bray *Definitions of Intellectual Disability: Review of the Literature Prepared for the National Advisory Committee on Health and Disability to Inform its Project on Services for Adults with an Intellectual Disability* (National Advisory Committee on Health and Disability, June 2003) at 28.

4 At 28.

5 At 19.

in adaptive functioning … and became apparent during the developmental period of the person".[6] Courts have also used the language of "impairment", "limitations" and "compromised functioning".[7] Older terms used in New Zealand were "intellectual handicap" or "mental retardation", however these are now considered derogatory.[8]

In the context of assessing capacity under the Protection of Personal and Property Rights Act 1988 (PPPRA), intellectual disability has no automatic legal significance. However, this article argues that the court's perception of an individual as having an intellectual disability can bias its assessment of a person's capacity.

B Historical context

The horrific legacy of eugenics remains a critical reference point for discussions about sterilisation.[9] The theory of eugenics sought to shape the human population to retain only those who were "desirable" and "fit".[10] However, the criteria of who was and was not deemed desirable and fit was often based on race, class, disability, "degeneracy", or otherwise "problem populations".[11] Early eugenicists considered "poverty, criminality, illegitimacy, epilepsy, feeblemindedness, and alcoholism" to be genetically transmissible.[12] The now-infamous United States Supreme Court case of *Buck v Bell,* which upheld a compulsory sterilisation law for the "unfit", summarises the eugenic sentiment that we must still be vigilant for when entering this area of discussion:[13]

> It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind … Three generations of imbeciles are enough.

6 Intellectual Disability (Compulsory Care and Rehabilitation Act) 2003, s 7(1).

7 Hannah Johnston, Mark Henaghan and Brigit Mirfin-Veitch "The Experiences of Parents with an Intellectual Disability Within the New Zealand Family Court System" (2007) 5 NZFLJ 266.

8 Bray, above n 3, at 1.

9 Kristin Savell "Sex and the Sacred: Sterilization and Bodily Integrity in English and Canadian Law" (2004) 49 McGill LJ 1093 at 1120.

10 Phillipa Levine and Alison Bashford "Introduction: Eugenics and the Modern World" in Alison Bashford and Phillipa Levine (eds) *The Oxford Handbook of the History of Eugenics* (Oxford University Press, Oxford, 2010) at 5.

11 At 6–7.

12 Rebecca Kluchin *Fit to be Tied: Sterilization and Reproductive Rights in America 1950-1980* (2nd ed, Rutgers University Press, New Brunswick, New Jersey, 2009) at 1.

13 *Buck v Bell* (1927) 274 US 200 at 274.

The Nazi regime also sought to reduce the burden on the state of "hereditarily tainted persons", leading to the widespread sterilisation of physically and mentally disabled people.[14] This included lower-class women whose promiscuity was seen as a sign of mental deficiency.[15] Other forms of eugenic theories and practices were found across the world.[16]

As put by Levine and Bashford, "[s]ince eugenics was always concerned with reproductive sex, it was also always about gender".[17] Eugenicists were preoccupied with women because of their childbearing capacities.[18] While eugenic theories were seemingly cast into disrepute following the Nazi regime, controlling the reproduction of certain types of women via sterilisation has continued.[19] Sterilisation was seen to be a cost-effective procedure that would prevent women who were "unfit for parenthood" from becoming pregnant without the need for permanent institutionalisation.[20] Ostensibly, the procedure is in the interests of the woman. But the cultural hangover of evaluating her "reproductive fitness" — the quality of an individual and the value of her reproduction — remains.[21] So too do concerns about her burden on the state, or more recently, on private caregivers.

Despite active participation in international dialogues about eugenics, New Zealand never had direct legislative and policy programmes of sterilisation.[22] Rather, eugenics operated informally, such as in healthcare, prisons, and mental institutions, "where innovation without legislative sanction was always possible".[23] New Zealand mostly pursued a segregation approach to reproductive control by institutionalising "incurables", thereby removing any

14 Susanne Klausen and Alison Bashford "Fertility Control: Eugenics, Neo-Malthusianism, and Feminism" in Alison Bashford and Phillipa Levine (eds) *The Oxford Handbook of the History of Eugenics* (Oxford University Press, Oxford, 2010) at 105.

15 At 105.

16 Levine and Bashford, above n 10, at 15–16.

17 At 8.

18 Kluchin, above n 12, at 3.

19 Elizabeth Tilley and others "'The Silence is Roaring': Sterilization, Reproductive Rights and Women with Intellectual Disabilities" (2012) 27 Disability & Society 413 at 415.

20 At 415.

21 Kluchin, above n 12, at 2.

22 Stephen Garton "Eugenics in Australia and New Zealand: Laboratories of Racial Science" in Alison Bashford and Phillipa Levine (eds) *The Oxford Handbook of the History of Eugenics* (Oxford University Press, Oxford, 2010) at 243–244.

23 At 244.

opportunity for reproduction. Sterilisation was still an available care option in these settings.[24]

Today, sterilisation justifications are brought under a medical framework.[25] It is usually claimed that the woman will not cope with the distress of menstruation or pregnancy. However, there is often a clear element of caregivers desiring to manage her sexuality and reproductive capacity, which raises concerns that the medical reasons given may mask underlying non-therapeutic, social reasons for sterilisation.[26] The intersection between medical justification and the social conception is discussed further below.

C Legal framework

Under the Health and Disability Commissioner Code of Rights, no person can be given medical treatment without their informed consent.[27] However, treatment may be provided to those who cannot consent via the PPPRA, which allows the court to order that a person be provided with medical treatment.[28]

The court may only make an order for medical treatment under the Act if it has determined that the person lacks the capacity to make the decision relating to the medical treatment.[29] This is the "capacity" threshold test. The test is enshrined in s 6 of the PPPRA, which provides the court has jurisdiction over a person who:

> i) lacks, wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; or
>
> ii) has the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare, but wholly lacks the capacity to communicate decisions in respect of such matters.

24 Carol Hamilton "Sterilisation and Intellectually Disabled People in New Zealand — Still on the Agenda?" (2012) 7 Kōtuitui 61 at 62.

25 At 61.

26 At 61.

27 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, right 7(1).

28 Protection of Personal and Property Rights Act 1988 [PPPRA], s 10(f).

29 Section 6. Sterilisation and termination of pregnancy have been found to be "medical treatment": *Re H* [1993] NZFLR 225 (FC).

There is a presumption in favour of capacity that must be disproved.[30] Additionally, the Act stipulates that jurisdiction cannot be grounded on the basis solely that the person's decision is one a prudent person would not make.[31]

Once jurisdiction is founded, the court has a discretion to make several orders in respect of that person under s 10 of the PPPRA, which is contained in Part 1 of the PPPRA.[32] Enshrined in s 8, there are two explicit primary objectives for making a personal order under s 10. The order should be the least restrictive intervention possible in the person's life, having regard to their degree of incapacity.[33] It should also enable or encourage the person to exercise and develop the capacity they have to the greatest extent possible.[34]

Conversely, under Part 2 of the PPPRA, relating to welfare guardians, the "first and paramount" consideration in the exercise of welfare guardian powers is the promotion and protection of the welfare and best interests of the person.[35] The High Court has suggested the best interests principle is best achieved by having regard to the two primary objectives of s 8 discussed above.[36] Similarly, the Court has held this "best interests" or welfare principle also applies to decisions made under s 10, despite personal orders being under Part 1 of the Act.[37]

In practice, the courts follow a two-stage test in making assessments of incapacity and determining the appropriate orders. First, does the person lack capacity to make the decision about the medical treatment in question? If so, what course of action is in their best interests, having regard to ensuring the least restrictive intervention into the person's life?

There have been calls for this framework to be reformed to bring New Zealand in line with its obligations under art 17 of the United Nations Convention on the Rights of Persons with Disabilities, which affirms the integrity of the person.[38] In 2011, an Office for Disability Issues report

30 Section 5.
31 Section 6(3).
32 Section 10(1): "the court *may* … make any 1 or more of the following orders".
33 Section 8(a).
34 Section 8(b).
35 Section 18(3).
36 *KR v MR*, above n 2, at [62].
37 At [59].
38 United Nations Convention on the Rights of Persons with Disabilities 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008), art 17. This was ratified by New Zealand in 2008.

indicated sterilisation without consent is a key issue under the article.[39] In 2014 the United Nations recommended that "immediate steps" be taken in New Zealand to replace substituted decision-making (where the court makes a decision based on the person's best interests) with supported decision-making.[40] This recommendation is crucial, as supported decision-making seeks to maximise the person's potential to exercise their own decision-making to the greatest extent possible.[41]

Despite this, in 2014 the Family Court authorised non-consensual sterilisation of a woman with Down's Syndrome for solely contraceptive purposes.[42] The case did not discuss the developments of disability rights in international law, or how that might affect the application of the preceding case law. Notably, that same year, the United Nation's review of New Zealand's adherence to the Convention expressed concern "that courts may order that adults undergo sterilization without the individual's consent".[43] The review also called for legislation prohibiting the use of sterilisation "on adults with disabilities, in the absence of their prior, fully informed and free consent".[44]

D Case study: KR v MR

KR was a 29-year-old pregnant woman. She had a congenital disorder called Partial Trisomy 8. The evidence given about this disorder is that it involves "mild intellectual disability, developmental delays and certain physical characteristics".[45] Her father, MR, applied to the Family Court to have KR sterilised and her pregnancy terminated. KR gave evidence that her pregnancy was "a dream come true" and that she had deliberately ceased her birth control in order have children.[46] She loved children and had looked after babies at childcare centres she had worked at.[47] In 2004, the Family Court held KR

39 Office for Disability Issues *First New Zealand Report on Implementing the UN Convention on the Rights of Persons with Disabilities* (March 2011) at [116]–[122].
40 Committee on the Rights of Persons with Disabilities *Concluding Observations on the Initial Report of New Zealand* UN Doc CRPD/C/NZL/CO/1 (31 October 2014) at [22].
41 At 3.
42 *Darzi v Darzi* [2014] NZFC 359.
43 Committee on the Rights of Persons with Disabilities *Concluding Observations*, above n 40, at [38].
44 At [39].
45 *KR v MR*, above n 2, at [6].
46 *R v R*, above n 2, at [22].
47 At [22].

lacked capacity and both the termination and sterilisation orders would be in KR's best interests.[48]

KR appealed to the High Court. Her counsel argued that:

i) KR did not have sufficient time to see another psychiatrist. The psychiatrist at first instance, Dr Schuaib, was the same man KR had reacted adversely to in 2003 when he gave evidence on her father's application to become her welfare guardian;[49]

ii) the Family Court did not consider the possibility of KR raising the child in a supported fashion and incorrectly assumed that the choice was between termination or removal;[50] and

iii) the Judge failed to take into account less invasive contraceptive options.[51]

The High Court allowed the appeal but remitted the case back to the Family Court for reconsideration of new evidence.[52]

When considering the new evidence in the Family Court, Judge Fraser preferred the evidence of Dr Schuaib to the new psychiatrist, holding that KR still lacked capacity. However, he found that because of the progression of KR's pregnancy, he had to "reluctantly" decide that the least restrictive intervention was to allow KR to give birth.[53] Furthermore, at the rehearing, evidence of a "third medical possibility with respect to the issue of conception" was given. The Mirena IUD, which was not discussed at first instance, was found to be an appropriate form of contraception which was less restrictive than sterilisation.[54] The next sections of this article discuss in depth how the Family Court assessed KR's capacity under s 6 of the PPPRA and how the "best interests" standard was applied in making orders in respect of her pregnancy.

III CAPACITY

As set out above, the test for capacity in s 6 of the PPPRA requires a court to assess whether a person "lacks, wholly or partly, the capacity to understand

48 At [78].
49 *KR v MR,* above n 2, at [38].
50 At [39].
51 At [44].
52 At 864.
53 *R v R (No 2)*, above n 2, at [81]–[83].
54 At [91].

the nature, and to foresee the consequences, of decisions in respect of matters relating to [her] personal care", or whether the person has that capacity but lacks the ability to communicate decisions in respect of such matters.

A Social construction of incapacity

The test for capacity is vague, invites subjective value judgements from both medical professionals and judges and its reasoning is not routinely reported.[55] One academic describes the determination as "one of the most conceptually and ethically challenging areas of clinical practice".[56] This is because the descriptive language used in the test for capacity, namely whether a person can "understand the nature" and "foresee the consequences" of the decision,[57] obscures the additional "intrinsic normativity of the judgement".[58] The diagnostic tools used by health professionals rely heavily on ostensibly objective theories of cognitive functioning without explicitly recognising that the clinician is making a "normative [judgement] about the quality and content of an individual's beliefs, values and emotions".[59]

Additionally, a determination of mental capacity relies on expert evidence, but it is ultimately a legal test. It therefore is "not 'purely technical'" but has an "ethical" dimension: the judge must make a value judgement as to where to draw the line between respecting a person's autonomy and subjecting them to best interests decision-making.[60] This evaluation can be difficult due to a clash in priorities and perspectives between the medical and legal professions. Doctors are frequently more risk-averse and focused on minimising physical harm to health, whereas legal perspectives tend to give weight to principles such as autonomy that may not necessarily provide the "best" medical outcome.[61] This may explain why reasoning about the patient's best interests may bleed into a judicial assessment of their capacity from the medical expert evidence,

55 Alison Douglass *Mental Capacity: Updating New Zealand's Law and Practice* (New Zealand Law Foundation, July 2016) at 181–195.

56 Natalie Banner "Unreasonable Reasons: Normative Judgements in the Assessment of Mental Capacity" (2012) Journal of Evaluation in Clinical Practice 1038 at 1038.

57 PPPRA, s 6(1)(a).

58 Banner, above n 56, at 1038.

59 At 1040–1041. While this comment is made in respect of the United Kingdom context, it is the author's view these comments apply equally in New Zealand, where the same or similar clinical assessment tools are employed.

60 Paula Case "Negotiating the Domain of Mental Capacity: Clinical Judgement or Judicial Diagnosis" (2016) 16 Med L Intl 174 at 177.

61 At 198–199.

despite the clear legislative proviso that making a "bad" decision is not evidence of a lack of capacity to make the decision.[62]

The Committee on the Rights of Persons with Disabilities has stressed that "[mental] capacity is contingent on social and political contexts", and so too are the "disciplines, professions and practices" that play a dominant role in its assessment.[63] This shows that unchallenged norms, beliefs and judgements about women, especially intellectually disabled women, creep into both medical assessments and legal analysis of capacity.

Intellectually disabled women are often not given the resources and support they need to make decisions because of the assumption they inherently lack capacity to make reproductive decisions. However, "intellectual disability" is not a fixed state, but a descriptor for behaviour which demonstrates difficulty in general learning.[64] Capacity in decision-making is significantly affected by previous opportunities to make decisions, accessible information and the type of support provided.[65] The primary objective, of enabling the exercise and development of capacity, counterintuitively does not apply in the preliminary stages of determining capacity.[66] When evaluating capacity, the woman is often subject to "diagnostic over-shadowing": her difficulties in understanding or foreseeing consequences are attributed to her impairment and not a lack of support.[67]

B The incapacity assessment in KR's case

The social construction of incapacity is clear in the Court's assessment of KR's capacity. For example, at the time of the first interview, KR "could not tell what baby needs were or how those needs would be met".[68] Instead of a lack of capacity, this seems to demonstrate that nobody had ever explained to her, in an accessible manner, information about sexual and reproductive health and rights. The myth that disabled people are forever childlike, or parents' anxieties about their (adult) child becoming sexually active, mean that they

62 PPPRA, s 6(3).

63 Committee on the Rights of Persons with Disabilities *General Comment No 1 (2014)* UN Doc CRPD/C/GC/1 (19 May 2014) at [14].

64 Anne Bray "The Protection of Personal and Property Rights Act 1988: Progress for people with intellectual disabilities" (1996) 2 BFLJ 51 at 4.

65 At 4.

66 PPPRA, s 9.

67 Hamilton, above n 24, at 69.

68 *R v R*, above n 2, at [31].

are never given this information.[69] By the time of appeal to the High Court, KR "thought that babies need clothes, feeding, showering, a home and love".[70]

There was much emphasis put on the fact that KR believed she would be able to keep and look after the baby and have more babies afterwards. The Court appeared to imply that this indicated an inability to foresee the consequences of the decision and thus a lack of capacity. But if KR had never had a child before, how could she be expected to fully understand and foresee all the possibilities of what it might entail?[71] Many women embarking on their first pregnancy have only a vague idea of what raising a child is really like. Her naivety and lack of experience were, however, constructed as a lack of capacity.[72]

This point was largely put before the Court by Dr Bartlett who explained that while KR could not grasp abstract concepts, "when matters were put to her in simple language", she could comprehend the components of complex problems and work through them with time.[73] Dr Bartlett also noted that "[a]s this is her first pregnancy she has no prior experience of the process involved but I see no barrier to providing her with this knowledge in the format she can comprehend".[74] However, as discussed below, the Family Court Judge did not accept Dr Bartlett's evidence, seeing it as subjective and unrealistic.

C Rationality and incapacity

In law and medicine, the concept of "understanding" (as part of the test of capacity) immediately evokes concepts of rationality. In KR's case at first instance, her lack of rationality is mentioned 11 times, predominantly in the expert evidence of Dr Schuaib.[75] It is echoed in both subsequent iterations of the case.

The discourse of rationality is an old and enduring set of ideas stemming from the Cartesian divide of mind and body.[76] In this dualism, men are

69 Brenda Burgen "Still Not Accepted: When Women with Intellectual Disabilities Choose to Become Mothers" (2007) 19 Women Against Violence 54 at 55.
70 *KR v MR*, above n 2, at [16].
71 Bray, above n 64, at 4.
72 At 4.
73 *R v R (No 2),* above n 2, at [51].
74 At [52].
75 *R v R,* above n 2, at [26], [27], [31], [32], [53] and [71].
76 Andrea Nicki "The Abused Mind: Feminist Theory, Psychiatric Disability, and Trauma" (2001) 16(4) Feminism & Disability 80 at 91.

the mind: "the rational, unified, thinking subject".[77] Conversely, women, representing nature, are presumed inherently elemental and emotional, volatile and irrational.[78] This is reinforced by "biological essentialist and determinist paradigms" which define a woman by her reproductive anatomy.[79] A form of irrationality termed "hysteria" was historically attributed to a disturbance in a woman's womb.[80] Historically, this diagnosis was used as a tool to control women who rebelled against social mores.[81] However, early feminists theorised that the cause of hysterical symptoms was more likely the stress and trauma of facing oppression.[82] Women were therefore seen as inherently irrational for responding emotionally to oppressive cultural circumstances that men did not see as a problem.[83] The concept of rationality therefore has problematic gendered associations. However, it continues to shape medical theories of intelligence and cognitive ability.[84] As feminists, we should be acutely alert and suspicious when concepts of rationality are deployed in order to undermine a woman's decisions by constructing her as an irrational subject.

Furthermore, the close association between rationality — a detached, unemotional way of thinking — and capacity implies there is only one reasonable, objective form of making decisions. This fails to take into account that a person's subjective experiences and values may affect how they interpret and understand information.[85] There is a danger of clinicians or judges determining that a person cannot "reason rationally" because the person has used and evaluated the information in a way consistent with their own values but inconsistent with the assessor's values.[86] There is also a risk of inconsistency between different assessors' judgements as to the appropriateness or proportionality of the emotional response a person has to the information given.[87] The idea that rational reasoning must be detached from emotionality

77 Angela King "The Prisoner of Gender: Foucault and the Disciplining of the Female Body" (2004) 5(2) Journal of International Women's Studies 29 at 31.
78 Pam Oliver "What Do Girls Know Anyway?: Rationality, Gender and Social Control" (1991) 1(3) Feminism & Psychology 339 at 339.
79 King, above n 77, at 31.
80 At 31.
81 At 30.
82 Heather Meek "Of Wandering Wombs and Wrongs of Women: Evolving Conceptions of Hysteria in the Age of Reason" 35(3) English Studies in Canada 105 at 124.
83 At 124.
84 Licia Carlson "Feminist Approaches to Cognitive Disability" (2016) 11(10) Philosophy Compass 541 at 545.
85 Banner, above n 56, at 1040.
86 At 1041.
87 At 1042.

risks misdiagnosing a person's anger and frustration at a situation as an inability to rationally reason, and thus as demonstrating a lack of capacity.[88]

Judges therefore need to be particularly cautious that they do not use the fact that a woman is emotional or has different priorities to male clinicians or counsel as the sole justification for a finding of incapacity. The English Law Commission rejected a test based on rationality for the Mental Capacity Act 2005 (UK), as it would deny the patient "the freedom to act irrationally (or at least against reason)" according to the subjective interpretation of the doctor and his or her personal values.[89] In New Zealand, the imperative to take care in assessing rationality is enshrined in s 6(3) of the PPPRA itself, discussed above, which provides:

> The fact that the person in respect of whom the application is made for the exercise of the court's jurisdiction has made or is intending to make any decision that a person exercising ordinary prudence would not have made or would not make given the same circumstances is not in itself sufficient ground for the exercise of that jurisdiction by the court.

D The deployment of "rationality" in KR's case

In KR's case, she is identified as emotional by Dr Schuaib: "very short tempered and at times irritable".[90] (Ir)rationality is prominently employed in the evidence: "most of her decisions may not be based on rational reasoning".[91] Dr Scuaib's evidence immediately continues with, "[s]he has been involved in sexual relationships and though she has been informed of the high chances of getting [Trisomy 8] children, she still is not willing to use any contraception".[92] Similarly, Judge Fraser cites with approval Judge Callinicos' statement that capacity is:[93]

88 Case, above n 60, at 187.

89 United Kingdom Law Commission *Mentally Incapacitated Adults and Decision-making: An Overview* (Consultation Paper 119, 1991) at 48.

90 *R v R,* above n 2, at [26].

91 At [27].

92 At [27].

93 At [29] (emphasis added). Judge Callinicos determined KR's capacity regarding whether she should have a welfare guardian appointed in 2003.

> … the ability to make decisions going to the heart of the ability to function in everyday life to decide whether one should *wisely have children or not*, … In all respects sadly [KR] lacks those capacities …

The Court's value judgement is clear: "[h]ad [KR] the capacity to understand about the *need not to become pregnant* then the issue of sterilisation would not be such a critical matter".[94]

These statements are extremely problematic, as they suggest disabled women who make reproductive decisions that could lead to pregnancy are inherently irrational. Assessing the evidence that KR may genetically pass her disability to her child, the judges involved are careful to explicitly frame this as relevant to whether KR has the capacity to raise the child.[95] However, the spectre of eugenics is present. There appears to be an underlying belief that bringing a disabled child into the world is wrong, hence the need to prevent pregnancy.[96] As Johnson argues, the "presence or absence of a disability doesn't predict quality of life" and people with disabilities build rich and satisfying lives.[97] KR is seen as irrational for wanting to bring a child (potentially) with a disability into the world because of the prejudiced assumption that a disabled life entails so much suffering that it is more bad than good. This societal prejudice is treated as fact and colours the assessment of KR's rationality.

KR's defiance against the decision the doctors and judges think she should make is assessed and measured through the masculine discourse of rationality and determined to be irrational, demonstrating a lack of capacity. This is despite the proviso in s 6(3) above that a person does not lack capacity simply because they are thought to be making imprudent decisions.

In the author's view, the (woman) psychologist in *R v R (No 2)* more closely adhered to the caution contained in s 6. In Dr Bartlett's opinion, KR *understood* what was involved in an abortion and sterilisation.[98] She highlighted that KR could *foresee consequences* related to this decision: KR discontinued her contraception to become pregnant and changed her behaviour when she

94 At [69] (emphasis added).
95 See *KR v MR,* above n 2, at [45].
96 *R v R,* above n 2, at [69].
97 Harriet McBryde Johnson "Unspeakable Conversations or How I Spent One Day as a Token Cripple at Princeton University" *New York Times* (New York, 16 February 2003) at 53.
98 *R v R (No 2),* above n 2, at [49].

learnt that drinking and smoking could harm a fetus.[99] However, Judge Fraser nevertheless preferred Dr Schuaib's evidence:[100]

> While I accept that Dr Bartlett has had more experience dealing with people with intellectual disabilities than Dr Schuaib, it is clear from her evidence that she has a *liberal bias with respect to the abilities of people with intellectual disability*. It may be that *that bias clouds her sense of realism*, forcing a defence of K[R]'s position and creating a block to acknowledging the alternative perspective provided by Dr Schuaib.

Other writers have found this particular piece of reasoning curious, especially given the acknowledgement that Dr Bartlett specialised in disability.[101] It is interesting that Judge Fraser considers Dr Bartlett's perspective of KR's capabilities to be a product of bias but does not consider whether the same might be true of Dr Schuiab's perspective. Dr Schuiab's approach is to assess whether KR's decision-making is "objectively" rational.

KR's naivety about how difficult it may be for her to raise a child by herself is transformed into an unchangeable "lack of understanding" about the decision to have children. In contrast, non-disabled women may be unaware of what raising a child may entail and could even be unfit to parent, without being assumed legally incapable of deciding to give birth. Intellectually disabled women, if challenged by any person entitled to apply for an order under the PPPRA, must proactively prove they are fit to mother a prospective child in a way that no other woman is required to. The rationality of the decision to bear children is uniquely interrogated, disincentivising and preventing intellectually disabled women from becoming mothers. This leads to further stigmatisation and exclusion of women with intellectual disabilities in the intimate and sexual realm, which isolates them from the benefits of these relationships.[102]

This assessment of KR's capacity is rooted in a value-laden question: is it rational to think KR could take care of a child? KR, based on her experiences working with children, believes she could take care of a child. This could be naive, but it is arguably still a reasonable conclusion from her perspective. Dr Bartlett thinks it is reasonable for KR to look after a child if she is given

99 At [52].
100 At [59] (emphasis added).
101 Johnston and others, above n 7.
102 Elizabeth Emens "Intimate Discrimination: The State's Role in The Accidents of Sex and Love" (2009) 122 Harv L Rev 1307 at 1310.

information and support to raise one, recognising the social barriers to disabled women raising children. However, Dr Schuiab (and ultimately Judge Fraser) maintain that KR cannot raise a child, and furthermore that it is irrational or unrealistic to believe she could do so. This is despite the evidence about KR's ability to raise a child being disputed in the case. The Court's analysis demonstrates how the value judgement of what decision is in the "best interests" of the person can influence the assessment of their capacity. If a woman with a disability does not make the "correct" decision based on others' perceptions of her best interests — that pregnancy and child rearing are not in her best interests — she is more likely to be perceived as irrational and thus lacking capacity.

IV BEST INTERESTS

Making an order which is in the "best interests" of the woman is not the statutory test for orders under s 10(f) of the PPPRA. However, case law has determined this test should apply, based on the overlap between Part 1 and other sections of the Act.[103]

The imposition of the best interests assessment on the exercise of such orders has the result that, if the court decides a sterilisation or termination order is in the woman's best interests, it is often artificially constructed as the least restrictive intervention. As demonstrated above, there is often a "bleeding in" effect of best interests into the capacity test, and it is sometimes unclear which facts are being applied to which test. Furthermore, the evaluation of medical evidence, legal principles and wider social factors is not immune from discursive power which may change how the woman's body is considered by a court.

A Bodily integrity, pregnancy and menstruation

The common law principle of bodily integrity, that the body is sacred and no one has a right to meddle with anyone else's, conceives of the body as inviolate.[104] This is based on an understanding of bodies as bounded and individual. This conception is thrown into question with pregnancy, as the fetus conceptually

103 In *R v R (No 2)*, above n 2, at [26], the Court decided to deal with the termination under s 18(6) because of the apparent statutory limitations under s 10 preventing the primary application of the best interests test or welfare principle.

104 Savell, above n 9, at 1105–1106.

violates both the boundedness and individuality of the body.[105] The conceptual difficulty of pregnancy and termination has been interpreted in opposite ways by the Supreme Court of Canada and the House of Lords (the latter followed by New Zealand courts).

The Canadian Supreme Court in *Re Eve* saw pregnancy as consistent with bodily integrity, as sterilisation would deprive Eve of "the great privilege of giving birth".[106] This is in line with an understanding of Eve's body as "properly" constructed as a sexed female subject, for whom giving birth is both natural and expected.

Conversely, English courts understand sterilisation of disabled women as protecting bodily integrity from the violation of pregnancy.[107] This approach reflects the difficulties women with disabilities have in gaining social recognition as women.[108] An intellectually disabled woman's right to have children is called into question because she is assumed to be unable to perform "proper" womanhood. Her (perceived) inability to perform gender roles means that her body becomes culturally unintelligible; her womanness and her humanness, and thus whether she should have rights, are called into question.[109]

Sterilisation is often supported by doctors and judges as a convenient form of menstrual management. Experiencing menstruation is uncritically accepted as traumatic and undesirable, often without any evidence that a particular woman does in fact find it traumatic.[110] Handsley questions why a lack of understanding necessarily implies trauma — when applied to other bodily functions or organs, it does not make sense.[111] It is often unclear whether the desire for a "clean" way to manage periods comes from a pressing medical or psychological need of the woman, or whether it is simply related to the stigma, shame and disgust associated with the female body.

The stigma and lack of understanding by (mostly male) judges about the female body may also be contributing to the common and bewildering

105 At 1107.

106 *E (Mrs) v Eve* [1986] 2 SCR 388 at [6] and [92].

107 Savell, above n 9, at 1141.

108 Rachel Mayes, Gwynnyth Llewellyn, and David McConnell "'That's Who I Choose to Be': The Mother Identity for Women with Intellectual Disabilities" (2011) 34 Women's Studies International Forum 112 at 114.

109 Judith Butler *Bodies That Matter: On the Discursive Limits of Sex* (Routledge, New York, 1993) at xvii.

110 Susan Brady "Sterilization of Girls and Women With Intellectual Disabilities: Past and Present Justifications" (2001) 7 Violence Against Women 432 at 443.

111 Elizabeth Handsley "Sterilisation of Young Intellectually Disabled Women" (1994) 20 Mon L Rev 271 at 289.

conclusion that sterilisation is the least restrictive intervention possible out of all contraceptive options. In KR's case, the Family Court determined that because KR was unwilling to continue Depo-Provera injections (due to side-effects and a desire to have children), sterilisation was the least restrictive option possible.[112] The Judge did not consider any other contraceptive options. However, it appears in further discussion of the original evidence (found in the High Court's decision on appeal) a doctor gave evidence that an IUD would be inappropriate because the wearer can dislodge it, and so the Depo-Provera injection that KR was reluctant to take due to side effects was the "only reliable option".[113] Except, as it turns out in *R v R (No 2)*, the strings of the IUD could simply be removed (to avoid tampering) and an IUD would become a viable option.[114]

Instead of seriously interrogating the "icky business" of women's reproductive options and asking for more evidence (perhaps from someone with specialist expertise in contraception), courts defer to the judgement of medical practitioners.[115] Hamilton argues that unless we move past the feelings of shame and disgust about the female body, rights claims may not be enough to protect disabled women from being subjected to treatment to "modify the person rather than the custom".[116]

B Fitness to be a mother

Most courts examine whether the woman is fit to be a mother as a primary consideration of whether sterilisation is in her best interests.[117] This involves subjective values about what a good mother is, and who it is appropriate for mothers to receive support from.[118]

The discourse of the "ideal mother" dictates that the mother must be solely responsible for raising the child and always immediately present to care for them.[119] This ideal is imported into a court's evaluation of whether a woman is fit to be a mother based exclusively on her own capabilities as of the

112 *R v R,* above n 2, at [66].
113 *KR v MR*, above n 2, at [30].
114 *R v R (No 2)*, above n 2, at [90]–[92]. Of course, this coercive approach is still less than ideal, and working with KR to find a contraceptive option she would be happy with would have been better.
115 Brady, above n 110, at 439–440.
116 Hamilton, above n 24, at 70.
117 Savell, above n 9, at 1137.
118 Burgen, above n 69, at 56.
119 Claudia Malacrida "Performing Motherhood in a Disablist World: Dilemmas of Motherhood, Femininity and Disability" (2009) 22 International Journal of Qualitative Studies in Education 99 at 101.

time of the hearing. However, mothering often realistically occurs in a social context, with fathers, wider family, or communities participating in child-rearing, which "suggests that something other than engaging in the physical and emotional care of children is relevant to assuming the mother identity".[120] Therefore, requiring social support should not preclude intellectually disabled women from performing a valid form of motherhood.

C KR's "best interests"

At first instance, the Family Court did not hear evidence about support available to KR should she give birth.[121] Further information was given in the appeal before the High Court about support services available to KR. Two individuals provided a detailed service proposal for KR: Ms Gordon and Ms Cameron. Ms Gordon was a service manager who supported 18 families where women with intellectual disabilities had children in their care. Ms Cameron was a community services manager with the IHC which provides services to people with intellectual disabilities and knew KR personally for 15 years.

Dr Schuaib observed in his affidavit that the proposal for support "confirms she lacks the cognitive skills to keep herself safe".[122] This is an example of dependency negating a woman's perceived ability to be a mother, which precludes most disabled women from ever being able to fit into the "mother" role.[123] This is compounded by a lack of resources, information and support, which is cyclically perpetuated by the belief that intellectually disabled women make "bad" mothers.[124]

In the rehearing, the further evidence did not change Judge Fraser's decision that KR was not fit to be a mother. The Judge concluded:[125]

> Whilst support may be available to [KR], enabling her to care for her child after birth, if history is any reliable predictor of the future, then [KR] will soon become hostile and non-cooperative with the service providers. This will mean that her child would be removed from her for care and protection reasons.

120 Mayes, Llewellyn and McConnell, above n 108, at 113.
121 *KR v MR,* above n 2, at [39].
122 At [41].
123 Mayes, Llewellyn and McConnell, above n 108, at 114.
124 Burgen, above n 69, at 54.
125 *R v R (No 2)*, above n 2, at [82].

It is concerning that the Judge made this assumption about KR, especially when her hostile behaviour in the past was with people who sought to take away her personal freedoms and questioned her ability to raise a child, rather than those who were trying to enable her to achieve what she desired.[126] The Judge appears to engage in the stereotype that intellectually disabled women are more likely to abuse or neglect their children, predicting that it is inevitable that KR's child will be removed from her.

Intellectual disability has little bearing on parenting ability or outcomes, it is not inevitable that intellectually disabled parents will abuse or neglect their children, and parenting skills can be learnt if education is tailored.[127] Additionally, wider social concerns, such as poverty and isolation, often create the most difficulties for disabled parents, rather than an innate impairment.[128] However, non-disabled people are routinely able to have children in difficult or impoverished conditions, so long as the children are not abused or neglected. Research has consistently reported that the prevalence of abuse and neglect is not higher among intellectually disabled parents.[129]

Moreover, it is often assumed that removal of the child (i.e. through adoption) will be more traumatic than the abortion and sterilisation of the pregnant person with an intellectual disability. This does not seem to take into account the fact that these procedures are extremely invasive and permanent. They can also be extremely traumatising, especially if the woman is opposed to the surgery and may physically resist. People with disabilities often view sterilisation as a signifier of reduced or degraded status, and this can have a significant negative psychological impact.[130] Dr Bartlett points out that undermining KR's clear desire and wish to have a child would lead to disempowerment, a loss of self-determination and a grief reaction.[131] These factors should be more clearly and deeply examined in respect of the particular person on a case-by-case basis, rather than uncritically accepting the claim that it would be more traumatic to undergo removal than termination.

126 *KR v MR,* above n 2, at [25]–[26].
127 Burgen, above n 69, at 56.
128 Johnston and others, above n 7.
129 Johnston and others, above n 7.
130 *E (Mrs) v Eve,* above n 106, at [80].
131 *R v R (No 2),* above n 2, at [75].

V CONCLUSION

In making orders as to sterilisation and termination of pregnancy of intellectually disabled women under the PPPRA, New Zealand courts must critically evaluate medical evidence, and avoid adopting prejudices against women with disabilities when undertaking the capacity and best interests assessments.

This is still a live and pressing issue. In 2014, ten years after KR's case, Swati, a woman with Down's Syndrome, was sterilised, largely relying on *KR v MR* as a leading case.[132] *KR v MR* remains a leading authority in the application of the provisions of the PPPRA to the sterilisation and termination of pregnancy of women with intellectual disabilities. The lack of progress in this area, despite repeated urges from the United Nations, is similarly worrying. Our decisions in this area continue to adopt discourses that perpetuate demeaning and incorrect ideas about intellectually disabled women. While sterilisation and termination may be appropriate in *some* instances, the use of gendered discourses to paternalistically undermine women's desires, reproductive rights and self-determination is a cause for concern.

132 *Darzi v Darzi*, above n 42.