Reproducing INEQUALITY

Kathy Munro

Women, medicine and the law.

The final report of the Australian Law Reform Commission, *Equality Before the Law,* covered many important issues. It was therefore disappointing, that the document omitted any discussion of the relationship between women's reproductive rights, medicine and the law, even though such questions were central to the inquiry's terms of reference.

As Mary O Brien[1] illustrated in *The Politics of Reproduction,* men and women have very different stakes in the sphere of reproduction. O'Brien makes the important point that men's historical involvement in reproduction has been obscured by the illusion of their distance from the process and that, despite this illusion, men have exercised an active involvement in the politics of reproduction.

Evidence of this involvement manifests itself in the form of unequal and often discriminatory responses to questions surrounding reproduction and pregnancy. This article discusses examples of the legal issues some women now face during the process of pregnancy.

'Foetal rights' and prenatal testing

As genetic and prenatal screening technologies become widely available and accepted, women are confronted with new and difficult ethical and personal decisions which are accompanied by concomitant legal responsibilities. Accompanying the growing imperative for women to undergo prenatal testing is the expectation that women will abort a foetus diagnosed with a problem. This may not be possible until well into the second trimester of pregnancy and is therefore not the straightforward procedure that the clinical literature suggests, particularly in light of the inconsistencies in women's legal access to abortion across Australian States.

In the USA, there has been an increase in 'wrongful' life suits from children born with disabilities, where women did not undergo prenatal testing or where test results were inconclusive or incorrect. Doctors are becoming increasingly anxious to be seen to have discharged their professional responsibilities by informing women of the 'benefits' of prenatal testing in order to avoid litigation for professional negligence. Public discussion and awareness on this issue, is essential to avoid the development of an excessively litigious climate fuelling provider-driven demand for prenatal testing. It is therefore disappointing that such issues were relegated to the periphery of the Government's inquiry on Women's Equality Before the Law.

There is a disturbing trend emerging of attributing legal personality to the foetus. Clearly this has the capacity to create an adversarial relationship between women and their foetus. Such a trend has disturbing implications for the legal autonomy and human rights of women. In Australia the first legal incident of this nature occurred in 1986 in Adelaide. In that case the Registry of the Family Court issued an injunction to prevent a pregnant woman from going overseas, when her estranged husband claimed she might not return, so depriving him of any rights in relation to the contemplative child.[2]

Kathy Munro is a Senior Policy Officer, Queensland Women's Policy Unit and is currently seconded to the Health Rights Commission.

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This trend has continued to slowly gain momentum in Australia. In 1991, the Supreme Court of New South Wales put an end to the notion that under Australian law the foetus has no personhood, and is not a legal entity with legal rights.[3] In the important case of *Lynch v Lynch and Anor* (1991) Aust Torts Reports 81-117, a young woman successfully sued her mother for injuries she received in a car accident whilst in the womb when her mother was pregnant.

In Australia, there has not been a strong trend of attributing legal personality to a foetus. The NSW Supreme Court decision raises many issues beyond those related to negligence actions, but the fact that the principle of negligence and liability has been established, has many implications for women who drink or take drugs. They are now particularly vulnerable to litigation suggesting that such behaviour is the cause of harm or injury to a foetus during pregnancy.

In the USA and Canada, foetal alcohol syndrome is a widely discussed and visible public issue. Women in these countries now face significant pressures with respect to medical monitoring and legal surveillance of their activities during pregnancy. Legislative intervention requiring liquor outlets and products to display warnings aimed at pregnant women is now commonplace. In the USA alone since 1987, there have been 166 criminal cases in 26 States against pregnant women, involving charges of child abuse, assault and manslaughter. Just over half of the women were sentenced to gaol, and 11% received a court order to undergo treatment. Eighty one per cent of these cases involved minority women treated by a white male physician. In 1988, a US Gallup poll found that 48% of respondents believed that a woman who smokes or drinks during pregnancy should be liable for damage to her infant.[4]

The strength of this trend is clearly exemplified by the uncommon but important cases of foetal apprehension and forced caesarean sections using statute law to promote the interests of the foetus over those of pregnant women. In a well publicised case in Vancouver, British Colombia in 1987, welfare authorities used child protection legislation to apprehend a foetus when a woman was in labour in order to force her to undergo a caesarean section against her will, in order to protect the 'health and well being of the child'.[5] Similarly problematic is the emerging practice of foetal surgery, which also raises questions about the creation of adversarial relations between women and their foetus, particularly in cases where treatment may harm the woman.

Issues surrounding the creation of adversarial relationships between women and their foetus, were the focus of the 1993 inquiry by the Australian Medical Association into *Foetal Welfare and the Law*. Therefore, any move toward the creation of a Bill of Rights, or similar instrument, should as a priority and a matter of principle ensure that the personal and reproductive autonomy of women is codified nationally. The emergence of a foetal legal entity would then be balanced by the recognition and legal accommodation of pregnancy as a normal bodily process for many women. These principles need to be explicitly stated as a means of counteracting the trend toward the criminalisation of women's behaviour during pregnancy.

Forced sterilisation

Irreversible procedures

Irreversible forced sterilisation is sometimes used for the purpose of facilitating menstrual management or preventing reproduction in women with intellectual disabilities. In May 1992 in the case known as *Re Marion (Secretary, Department of Health and Community Services v JWB and SMB* (1992) FLC 92-293), the High Court issued a judgment clarifying that parents do not have the legal authority to consent to a sterilisation operation on their child, otherwise than as an incidental result of surgery performed to cure a disease or to correct a physical malfunction, and further that the Family Court has the authority to grant the necessary authorisation.[6] As Family Court judges are now called on to make judgments in such cases, serious attention needs to be given to introducing judicial education on this sensitive and important issue.

There are a variety of guardianship acts operating across Australian States, using models encompassing a spectrum from legalistic to welfare in orientation with wide discretionary powers vested in boards and/or social workers.[7] There is a need to consider what mechanisms are available to establish national minimum standards or guidelines for major medical procedures to protect the human rights and dignity of these very vulnerable women.

Reversible procedures

Long acting contraceptive drugs such as Depo Provera and Norplant raise a number of human rights issues. In 1988, Ms Chris George, Director of Anyinginyi Health Congress in Tennant Creek stated that many Aboriginal women were given Depo Provera without their informed consent, and that following treatment, some women still of child-bearing age had never had another child.[8] Since the release of the subcutaneous hormonal contraceptive, Norplant, on the North American market, a number of American States have legislation pending to link the contraceptive to welfare payments. US courts have also ordered the use of Norplant in cases where women receiving welfare are convicted of child abuse or neglect. Black women are over represented among those at risk of coercive practices to reduce their fertility.

The situation in Australia is less grave in respect of these issues, but there have been cases where women seeking finance have been asked to provide proof of tubal ligation or some other form of semi-permanent contraception.[9] Proposed amendments to the *Sex Discrimination Act 1984* Cth*(SDA)* should address this by including some reference to the potential for pregnancy as well as the presence of pregnancy in cases of discrimination against women consuming goods and services.

Gamete donation

Dispositional authority and informed consent

There is an emerging trend of vesting dispositional authority for consent to medical procedures undertaken on women during pregnancy with the 'pregnant couple'. South Australian legislation requires couples to consent to the 'disposal' of embryos formed from their semen and ova. As Jocelynne Scutt observed:

> This raises questions about women's autonomy, (for in law) if a man has no right to dictate a woman's control of her own body as to abortion, why should he have this right where donations to reproductive technology programs are in question.[10]

This question of jointly vesting dispositional authority for informed consent has now extended to the context of women donating their eggs in in vitro fertilisation (IVF) programs, for example, the consent forms used in the IVF program at the Royal Women's Hospital in Melbourne, Australia. Both the 'husband and wife' (sic) are required to consent to all aspects of the procedure. Ironically, even though almost all of the procedures are undertaken on women, the husband is always listed as the first party on consent forms, thus subsuming her autonomy in the new entity of the collective patient.

This new notion of the collective patient appears on all the Royal Women's Hospital reproductive technology consent forms with the exception of consent to donate semen. In this instance men are required to individually fill in a form and women are given the opportunity to provide consent separate from the consent offered by the man agreeing to donate his sperm.

The assumptions of the hospital ethics committee and any other regulatory bodies who approved these forms are implicit in their structure and content. Clearly they believe that it is acceptable for women's identity to be subsumed in the collective construction of the 'consenting couple', yet there is no corresponding provision for a couple to provide 'collective consent' to sperm donation.

The willingness of legal, medical and public policy institutions to adopt this view is again testimony to the inability of existing women's advocacy structures within these systems to articulate and challenge such practice. This issue needs to be more fully explored by women's health and legal policy analysts to examine the precedents created and/or consolidated by this practice. If language defines meaning then this may be a classic case in which it will later become very difficult to question the very fabric of the assumptions embedded in the discussion and treatment surrounding the 'infertile couple'.

This is an issue of direct and indirect discriminatory treatment of men and women in the medico-legal context. As such, potentially it falls within the jurisdiction of the *SDA* in the discriminatory and differential provision of medical services to men and women. The proposed changes to the *SDA* which shift the onus of proof to the respondent in such complaints of discrimination may help to discourage such practices in the future. However, it is vital that the Human Rights and Equal Opportunity Commission is adequately resourced to respond to an increase in complaints relating to the human rights issues arising in instances of discrimination involving pregnancy and reproductive rights.

Egg maturation and donation

The successful maturation of immature eggs, as reported by the Melbourne-based Monash IVF team in September 1993 has disturbing implications for women's reproductive autonomy. It has been posited that using this technique[11] even a foetus could become a mother since after the 12th week of foetal development the ovary is formed with thousands of immature eggs.

Until now scientists access to eggs for experimental embryo creation has been predominantly limited to donations made by women on IVF programs and women about to undergo some form of reproductive surgery. When maturing these eggs becomes a technological simplicity, then the way will be opened for the unlimited production, storage and exchange of human embryos for experimental and commercial purposes.

It is, therefore, now imperative that there be some uniform national recognition of the fact that egg cells are not equivalent to sperm and that this is codified in ways that embrace three critical principles:

- Egg cells can only be retrieved from a woman's body by means of an invasive surgical procedure and therefore women as donors are in a very different position to men with respect to gamete donation issues.
- In order to protect women's reproductive integrity it is necessary that egg cells are accorded the same protected status as embryos under existing legal provisions.
- Human tissue acts should recognise the particular and special characteristics of reproductive tissue to prevent its extraction from cadavers.

Informed consent and women as experimental subjects

Over the past few decades there has been a disproportionate use of women in clinical medical trials, particularly in the sphere of reproductive health, signifying an unprecedented blurring of the boundaries between clinical treatment and research. This has generated many questions concerning informed consent and the subsequent capacity for civil litigation. For example:

- Drugs such as DES, Thalidomide and pituitary gonadrophins such as hPG have all caused significant problems for the health of women and are now the subject of court action. DES was a drug administered to women during pregnancy in the 1950s and 1960s to prevent miscarriage. DES was found to cause cancer in a significant proportion of women who took the drug, and infertility and vaginal cancer in a significant proportion of their children. Thalidomide, was administered as a morning sickness drug and was found to cause multiple birth defects in a significant proportion of the offspring of the women administered the drug. Pituitary gonadotropins (hPG) were taken from dead bodies and administered to some infertile women and given as a growth hormone (hGH) in some children with pituitary insufficiency. They have induced Creutzfeldt-Jakob disease which is fatal. The Commonwealth Government has yet to ensure that all women who were administered this extract are advised that they are at risk of serious ill health and/or death.
- Devices such as the Dalkon Shield and Copper 7 IUD's have caused deaths, infertility and ill health in a significant proportion of women. Similarly, silicone breast implants, broke and leaked in women's bodies with serious consequences for their health and well being. Women consented to the insertion of these devices on the recommendation of their doctor, and the corporations who manufactured these devices were reluctant to inform women of the risks. These devices continue to be the centre of considerable controversy and legal action.
- In January 1993 the US Food and Drug Administration requested the manufacturers of Clomid and Pergonal (two frequently used drugs in conventional infertility/IVF treatment) to add a warning to their package insert, advising women that these drugs may increase the risk of ovarian cancer. In Australia, the Royal College of Obstetrics and Gynaecology has supported this move.

These cases raise questions about the notion of informed consent, particularly about the legal system's response to questions of culpability in the administration of dangerous drugs and devices with known short and long term effects. Some of these questions were addressed in the November 1992 Australian High Court decision in the matter of *Rogers v Whitaker* (1992) 109 ALR 625 which held that:

> a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should be reasonably aware that a particular patient, if warned of the risk, would be likely to attach significance to it. [at 626]

A Queensland Barrister[12] has suggested that in such cases s.52 of the *Trade Practices Act 1952* (Cth) could be invoked. This section provides that a corporation shall not in trade or

commerce engage in conduct that is misleading or deceptive or is likely to mislead or deceive. According to this practitioner, it is arguable that a plaintiff who suffers damage because of a doctor's failure to advise or because information given was misleading may be able to obtain damages pursuant to the *Trade Practices Act*. Such an opinion may be worthy of further consideration at least in the context of company liability in cases such as those outlined above.

These cases have also raised questions about the necessity to enshrine the principles of rules against bias in the broader context of medical tribunal deliberations and the rulings under the Commonwealth Government's *Therapeutic Goods Act 1989*. In these hearings much of the 'independent' medical and expert scientific evidence presented originates from research undertaken by pharmaceutical companies with a considerable pecuniary interest in ensuring a particular outcome.

Jurisdictional uniformity

There is presently no uniformity in Australian law relating to surrogacy. This issue will become increasingly critical if the Victorian Government proceeds with its previously stated intent to amend the law to permit so called altruistic surrogacy. This may have the effect of encouraging border hopping in order to avoid prohibitions in other jurisdictions.

Similar issues are raised about the rights and responsibilities of parties to assisted conception procedures involving donated gametes and the offspring's access to information about their biological origins There is a lack of uniformity in policy and legislation in Australia regulating provision and access of information for gamete donors and recipients. On the ABC program *Lateline* on 20 September 1993, Dr John McBain of the Monash IVF program stated that he personally knew of at least 20 couples from Victoria who had sought donor gametes in NSW in order to avoid the compulsory register in Victoria. This trend of border hopping in order to avoid jurisdictional limitations clearly demonstrates the importance of uniformity across State statutes on such questions.

Conclusion

Although a number of these issues currently affect comparatively small populations of women, the gradual but persistent erosion of women's reproductive rights and autonomy ultimately has profound implications for all women.

These scenarios highlight the scope and gravity of anomalies arising from the legal system's response to women's reproduction. Legal precedents are evolving on an ad hoc basis with little opportunity for an integrated response from women. One legal writer commented on this point :

> It is surprising that in an era when statute law has achieved a position of dominance as a source of law in Australia, so many issues of medical law are left to be dealt with in the framework of common law principles which are ill-adapted to this purpose.[13]

When these issues are addressed in a legal, medical or public policy context, women's human rights are frequently relegated to the status of peripheral concerns. It is, therefore, critical that in any further work undertaken on women's equality before the law, questions of reproductive rights and autonomy must be integrated into the discussion and proposals for legal reform.

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