



News and Views



Obstetric Violence: Sterilisation without Consent. The Case of *Y.P. v. Russian Federation*

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Abstract

On 20 September 2022, the European Court of Human Rights (ECtHR) delivered its judgment in a remarkable case on sterilisation without the patient's consent, *Y.P. v Russian Federation* (ECtHR, application no. 43399/13, 20 September 2022). According to the Court, there is no inhuman and degrading treatment, but it was a justified medical procedure. However, the Court did conclude a violation of the right to private life, under Article 8 ECHR. This outcome is at odds with an earlier sterilisation case without consent, *V.C. v Slovakia* (*V.C. v. Slovakia*, ECtHR application no. 18968/07, 8 November 2011). The question is how both rulings can be understood, especially the legal consideration regarding the prohibition of torture. After all, both cases lacked the patient's consent.

Keywords

absence informed consent – ECtHR – sterilisation – obstetric violence

1 Introduction

Around the globe, various cases of involuntary sterilisation of disabled persons have been reported.¹ The practice of involuntary sterilisation occurs when the patient is not given an opportunity to provide consent, and without her knowledge has been performed, or the woman expressly refused the procedure. In the case of disabled persons, the practice has been justified as legitimised medical care or by consent of the patient's legal representative. For instance, in a medical emergency, the woman's health is threatened.

But what if a mentally competent adult explicitly refuses a sterilisation? Can the medical emergency argument overrule the woman's expressed wishes, or should the doctor act in the patient's 'best interest'? A difficult dilemma that was ultimately raised at the European Court of Human Rights.

2 Facts of the Case

Y.P. was admitted urgently in 2007 for a complicated pregnancy, resulting in the removal of the right fallopian tube, terminating the pregnancy.

One year later, during the second pregnancy, the woman was again admitted to municipal maternity hospital no. 2 in Krasnoyarsk (Russia). After examination, the doctors decided to perform a caesarean section as the foetus' condition had deteriorated, and there were signs of a lack of oxygen ('hypoxia').

The woman signed a consent form for the caesarean section without sterilisation, reading:

[I]n view of her diagnosis, pregnancy at 32–33 weeks, rhesus negative, suspected rhesus incompatibility, polyhydramnios, ..., hypoxia of the

1 E.g., National Women's Law Centre, *Forced sterilization of disabled people in the United States* (24 January 2022), available online at <https://nwlc.org/resource/forced-sterilization-of-disabled-people-in-the-united-states/>; Women With Disabilities Australia, Submission No 49 to Senate Standing Committee on Community Affairs, *The Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, March 2013; Open Society Foundation, *Against her will: Forced and coerced sterilization of women worldwide* (4 October 2011), available online at https://www.opensocietyfoundations.org/publications/against-her-will-forced-and-coerced-sterilization-women-worldwide#publications_download.

foetus, [the applicant] needs to undergo a Caesarean section without sterilisation. [The applicant] has been informed that examinations and the operation will be conducted by the standards set at maternity hospital no. 2, aiming to protect her from all possible complications. Nevertheless, complications such as bleeding during or after the operation, obstruction of the bowel, healing of the suture by secondary adhesion, or injury to the bladder, ureters, or bowel, as well as the expansion of the scope of the operation, cannot be completely ruled out. Based on the preceding, [the applicant] gives her consent to the Caesarean section and undertakes to follow all the doctor's recommendations.

The caesarean section was performed, and the doctors removed the baby suffering from serious complications. During surgery, the doctors identified a rupture of the uterus. Instead of repairing (suture) the uterus, they decided to seal the left fallopian tube, meaning that she would be sterilized. That decision was based on the patient's medical history and the fact that there was a real risk that the uterus would rupture in a future pregnancy, which could endanger the woman's life.

After surgery, the woman was informed that her only remaining fallopian tube had been sealed (i.e., sterilised), without further explanation. She did not clearly understand the consequences of the procedure. The doctor in charge advised her not to tell her husband since 'men have a negative view of such things'.

Two years later, after several failed attempts to get pregnant, she was told by a gynaecologist that she had been sterilised and that the only option to conceive would be via in vitro fertilisation.

Afterwards, the woman initiated civil damages proceedings against the hospital for performing sterilisation without consent. The sterilisation allegedly violated applicable law (the Healthcare Act).²

National procedure: sterilisation according to professional standards

In the first instance, the claim was dismissed. The judges honoured the defence of the medical necessity of sterilisation because any future pregnancy would threaten her life. The alternative, a hysterectomy (removal of the uterus), would also end in infertility but cause further complications. The medical necessity was endorsed by a panel of court-appointed medical experts as 'a reasonable decision', in line with the professional standards, except for the lack of informed consent (para. 19). Contrary to the medical experts, the

² Federal Law no. 5487-1, including provisions on informed consent and medical sterilisation.

district court argued that sterilisation had been performed as an expansion of the scope of the caesarean section, to which the woman had consented (para. 22).

Since in vitro fertilisation would allow the woman to become pregnant, the experts concluded that the sterilisation had not caused any harm to the woman's health. That position was confirmed by the district court and upheld in appeal.

2.1 *The ECtHR's Decision: Doctor's Intentions Matter Despite the Missing Consent*

Having exhausted all national legal remedies, the applicant complained to the ECtHR against the Russian Federation under Articles 3 and 8 of the Convention. The applicant complained that she had been subjected to inhuman and degrading treatment due to being sterilised without her consent (Article 3) and that the sterilisation had severe psychological and emotional effects on her and her relationship with her husband (Article 8).

The Court found the Article 3 complaint inadmissible. Its reasoning is rather short and takes about 1 page. Whether a particular form of ill-treatment reaches the threshold of severity, is relative and depends on all circumstances of the case, such as the duration of the treatment, its physical and mental effects (para. 35).

On a previous occasion (*V.C. v. Slovakia*), the Court ruled that the sterilisation of a mentally competent adult without her full and informed consent violated Article 3 of the Convention. Decisive was the lack of imminent medical necessity, considering the circumstances, such as the applicants belonging to a vulnerable group (Roma), their young age, and the mental effects of the sterilisation. For treatment to be "inhuman" or "degrading", the suffering or humiliation involved must go beyond the inevitable element of suffering or humiliation connected with a given form of fair treatment (*V.C. v. Slovakia*, para. 104).

Unlike *V.C. v. Slovakia*, the doctors were faced with an unexpected complication. They had to decide on the extent of the surgery in a short time and sterilise the patient on medical grounds to avoid endangering the applicant's life. Moreover, the decision to sterilise was made by a panel of doctors, including the chief medical officer, after thorough consideration. For these reasons, the Court concluded that the doctors had not acted in bad faith, let alone with the intent of ill-treating, or degrading her (para. 37). As a result, the required threshold of severity was not reached in the present case, therefore no violation of Article 3 (inadmissible).

By contrast, the Court did conclude, unanimously, that there has been a violation of Article 8 ECHR. First, the Court reiterates that the notion of private life includes a person's physical and psychological integrity, in the context of

therapeutic abortion, referring to *Tysiac v Poland*.³ Moreover, the Court notes that patient's involvement and consent in medical treatment decision-making fall within the scope of Article 8.⁴

Since sterilisation affects the reproductive health status it has serious consequences to the applicant's private and family life. As a general principle, sterilisation might be legitimately performed at the request of the mentally competent adult patient. The only exception without consent is in emergency situations in which medical treatment cannot be delayed and appropriate consent cannot be obtained.⁵

Unlike the domestic courts, the European Court did not accept the argument that sterilisation is considered an expansion of the scope of the caesarean section, to which the woman had consented (para. 53). It emphasised that sterilisation is not a routine medical intervention. Moreover, sterilisation was explicitly excluded from the caesarean section consent form, and the conclusion of the expert report pointing the lack of consent. Although there was a surgery necessity for the sterilisation, there was no imminent risk to safe the patient's life during the caesarean section. Instead, sterilisation was defined as 'preventive surgery' (para. 54).

In the absence of a life-threatening situation (medical emergency) that required urgent action, there was no medical justification for ignoring the basic rule of informed consent. Consequently, the Court concluded the patient's private life had been violated because the doctor failed to seek, and obtain her express, free and informed consent for sterilisation. Decisive was the absence of an imminent threat to the applicant's life or health. Indeed, the likely risk of a rupture would seriously threaten her health but was only likely to materialise in the event of a *future* pregnancy. That risk could have been prevented by means of alternative, less intrusive methods (para. 55).

Neither did the Court accept the argument that no damage had been inflicted on the patient's health. That was based on the rather bold argument that it was still possible for the applicant to become pregnant through in vitro fertilisation (IVF). That argument ignores the absence of medical necessity to sterilise the patient. Moreover, IVF is not always successful, and the fact that a young woman was permanently deprived of her natural reproductive capacity caused serious damage to her health (para. 56).

3 *Tysiac v Poland*, application no. 5410/03, para. 107, and in which the Court ruled that the authorities failed to comply with their positive State obligations to secure the applicant's right to respect for her private life.

4 E.g., *A.K. v Latvia*, application no. 33011/08, para. 63.

5 *V.C. v Slovakia*, para. 108.

According to the Court, compensation of €7500 for non-pecuniary damage is appropriate.

3 Comment: Consequences of *Y.P.*

Although the conclusion of a violation of Article 8 of the Convention can be applauded, the reasoning regarding Article 3 raises certain doubts. Especially the medical necessity and the good intentions of the treating physicians are questionable.

It is well known that the threshold of Article 3 is high. An imminent health threat is decisive here. But the present case concerned ‘preventive surgery’, i.e., sterilisation with a view to a *future* medical severe risk. Surely the Court cannot interpret the ‘imminent threat’ that widely? At least not in *V.C. v. Slovakia*. There, the ethnic background (Roma woman) played a specific role. Or, should we interpret ‘imminent threat’ differently — i.e., more widely — under Article 8?

Otherwise, how should one explain the difference in outcome of imminent threat in *Y.P. v. Russia*? Perhaps a more thorough comparison of both *V.C.* and *Y.P.* may clarify this further.

What *V.C.* and *Y.P.* have in common is that it involves two competent young women in the reproductive period of their lives who were not given accurate information about the treatment being undergone. *V.C.*, however, was a Roma woman who gave consent to sterilisation while in labour without knowing the consequences.

Y.P., on the other hand, had explicitly stated that she did not want to undergo sterilisation. This was ignored. By accepted medical professional standards, a patient must give informed consent to the proposed treatment. This is different in emergency cases when consent may be presumed, and the doctor acts in the patient’s health interest when her life is at risk. As the subsequent procedure is not immediately life-threatening but has significant consequences on the woman’s reproductive capacity and mental well-being, postponing the sterilisation was the most obvious option (see also partly dissenting opinion judge Serghides, para. 24). Another possibility runs counter to the recognised professional standards.

That the Court accepted a violation of the right to private life based on the above reasoning is in line with its case law on informed and free consent (e.g., *Ionita v. Romania*, no. 81270/12, 10 January 2017, para. 84; *V.C. v. Slovakia*; *N.B. v. Slovakia*, no. 29518/10, 12 June 2012, para. 95; *I.G. v. Slovakia*, no. 15966/04, 13 November 2013, para. 144). Medical treatment without the permission of a mentally competent adult affects his physical integrity (*V.C. v. Slovakia*,

para. 105; *Pretty v. the UK*, no. 2346/02, paras 63 and 65; and *Jehovah's Witnesses of Moscow v. Russia*, no. 302/02, para. 135).

Different from Article 3, in the Article 8 assessment in *Y.P.*, the doctors' good intentions were irrelevant and surgical necessity cannot justify the absence of consent in the case of such a major intervention, having serious consequences for reproduction.

But why, then, a violation of Article 8 in the case of sterilisation without consent and not of Article 3 ECHR? Perhaps because the Court reserves Article 3 exclusively to forced and eugenic (racist) sterilisation, as argued by judge Elósegui in a concurring opinion (paras 12–13)? This reasoning is not entirely convincing precisely because the element of harmful intent is not always necessary (see also *V.C. v Slovakia*, para. 101).

Moreover, harmful intent was also absent in *V.C.* In that case, the Court concluded that there was 'no indication that the medical staff had acted with the intention of ill-treating the applicant' (harmful intent or bad faith). But they had nevertheless acted with gross disregard for the right to autonomy and choice as a patient. Therefore, such treatment breached Article 3 (para. 119). So, no harmful intent but still a breach of Article 3. Considering that sterilisation had been carried out immediately after the caesarean section, based on consent given in the stressful event of giving labour. Furthermore, sterilisation was not a life-saving intervention, and was not in accordance with generally recognised standards.

Different as expected, one cannot conclude that doctors' good intentions are decisive for a breach of Article 3. The only significant factor remains the Roma ethnicity, and thus belonging to a vulnerable group. But that vulnerability should be determined on a case-by-case basis (Judge Senghides, para. 29). In that case, the woman's medical history confirms that there is indeed a 'situational vulnerability'. But one may argue that *Y.P.* did not understand the consequences of sterilisation and was only informed about the implications after visiting a gynaecologist, which makes her vulnerable too. What is then needed for vulnerability?

What remains is that the inadmissibility conclusion of Article 3 in *Y.P.* is disappointing. The assessment of the minimum severity level is relative; it depends on all the circumstances of the case, such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health, and ethnicity. But in applying these criteria, consistency is absent.

3.1 *Sterilisation without Consent and the Pattern of Obstetric Violence: The Role of Law*

Unfortunately, *Y.P.* and *V.C.* are not isolated cases of obstetric violence, i.e., disrespectful and abusive treatment against women during childbirth in health

facilities. Since *V.C.*, the Court ruled on other instances of sterilisation without consent involving Roma, such as *N.B. v Slovakia* and *I.G. and others v Slovakia*, with similar outcomes.⁶ In a similar case, the Committee on the Elimination of Discrimination against Women (CEDAW) concluded that unnecessary examinations and episiotomy (incision in the perineum) without consent violated the woman's rights under the Convention.⁷ These cases make painfully clear the State's failure to protect applicants' physical integrity from unnecessary medical interventions, non-consensual sterilisation and unwanted birth control. Mistreatment or abusive care during childbirth on a global scale is also reported in the literature.⁸

The pattern of violence against women during labour was confirmed by the UN Special rapporteur reporting on mistreatment and violence against women in reproductive health services, focusing on childbirth and obstetric violence.⁹ The Special Rapporteur affirms that 'this form of violence is widespread and systemic in nature'.¹⁰

The list of reported abuses overlaps the WHO definition prohibiting: outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilisation), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, denial of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their new-borns in facilities after childbirth

6 *NB v Slovakia*, application no.29518/10, 12 Sept 2012 (final) and *IG and others v Slovakia*, application no 15966/04, 29 April 2013 (final).

7 *SFM v Spain*, CEDAW Committee Communication No. 138/2018, 28 February 2020.

8 E.g., A. Annborn and H.R. Finnbogadóttir, 'Obstetric violence a qualitative interview study (Sweden)', *Midwifery* 105 (2022) 103212; D. Mena-Tudela, S. Iglesias-Casás, V.M. González-Chordá, M.J. Valero-Chillerón, L. Andreu-Pejó and Á. Cervera-Gasch, 'Obstetric violence in Spain (Part III): Healthcare professionals, times, and areas', *International Journal of Environmental Research and Public Health* 18 (2021) 3359; R. Chadwick, 'Commentary. The dangers of minimizing obstetric violence, violence against women', *Violence Against Women* (2021). DOI: 10.1177/10778012211037379 (2021); L. Katz, M.M. Amorim, J.C. Giordano, M.H. Bastos and A.V.M. Brillhante, 'Who is afraid of obstetric violence?', *Revista Brasileira de Saúde Materno Infantil* 20(2): 623–626; M. Meijer, T. Brandão, S. Cañadas and K. Falcon, 'Components of obstetric violence in health facilities in Quito, Ecuador: A descriptive study on information, accompaniment, and position during childbirth', *International Journal of Gynecology and Obstetrics* 148 (2020) 355–360; E. Kukura, 'Obstetric violence (USA)', *Georgetown Law Journal* 3 (2018) 706–798.

9 Report of the UN Special Rapporteur on Violence against Women, A/74/137, 11 June 2019.

10 *Idem*, para. 4.

due to an inability to pay.¹¹ Similar examples of obstetric violence during gynaecological consultations were confirmed in the Council of Europe report on obstetric violence, including disrespectful and humiliating remarks during medical consultations, denial of access to pain relief, and unnecessary episiotomies (so-called ‘husband stitch’) without consent.¹²

The health systems conditions and constraints are considered as the main cause of mistreatment and obstetric violence.¹³ Poor working conditions require States to prioritise investing in maternal health care facilities and services, as well as providing adequate training to health professionals on good practices, including medical ethics and patients’ rights.¹⁴

Apart from training health professionals, patients must receive adequate information in advance to give informed and free consent. To fight obstetric violence, informed consent must be codified in national health laws with access to effective legal remedies. Informed consent must be provided in all reproductive health services, particularly for invasive treatments during childbirth, such as caesarean section and sterilisation.

Discriminatory laws and practices, such as ‘Roma-only’ delivery rooms (*V.C. v Slovakia*), or the systemic dimension of forced abortion and contraceptives for the intellectually disabled (*M.G. v Moldova*),¹⁵ contribute to violence and mistreatment of women in reproductive health services and must be annulled and abandoned.¹⁶

In a Parliamentary Resolution, the Council of Europe supported the prevention of and fight against all forms of obstetric violence, starting with initiating a public debate and awareness-raising activities for the public are essential to put an end to such violence.¹⁷

In a way, these measures have already been confirmed by existing human rights documents. In a joint statement, the Special Rapporteur and human rights experts urged States to address acts of obstetric and institutional violence suffered by women in health care facilities” and “to take all practical and legislative measures to prevent, prohibit, and punish such acts and guarantee

11 *Idem*, paras 18–35.

12 Council of Europe, report *Obstetrical and Gynaecological Violence*, Parliamentary Assembly Doc. 14965 16 September 2019.

13 UN report, para. 39.

14 *Idem*.

15 *M.G. v Moldova*, Application no. 44394/15, 22 November 2022.

16 *Idem*, paras 42–44.

17 Parliamentary Assembly, Resolution 2306 (2019) on *Obstetrical and Gynaecological Violence*, text adopted on 3 October 2019.

redress".¹⁸ Taking women's reproductive rights seriously must therefore be part of the overall women's rights agenda.

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- 18 Joint Statement by UN human rights experts, the Rapporteur on the Rights of Women of the Inter-American Commission on Human Rights and the Special Rapporteurs on the Rights of Women and Human Rights Defenders of the African Commission on Human and Peoples' Rights (24 September 2015), available online at <https://www.ohchr.org/en/statements/2015/09/joint-statement-un-human-rights-experts-rapporteur-rights-women-inter-american>, quoted by UN report, para. 52.