Legal Aspects of Surgical Castration[1]

Karen Harrison
Law School, University of Hull

[Sexual Offender Treatment, Volume 5 (2010), Issue 2]

Abstract

The use of surgical castration, whilst still legal in some European countries is now being practised only on a very small scale. This is largely due to the fact that many people have objections to the practice of surgically castrating offenders, especially if it is done against the offender's will. Even if consent is given there may be problems regarding whether this consent is truly free and informed (see below). Many regard the practice as barbaric and thus in contravention of a number of Articles contained within the European Convention of Human Rights (ECHR), including Article 3, Article 8 and Article 12. These issues will be addressed below.

Key words: surgical castration, sexual offenders, legal aspects

The European Convention on Human Rights

Article 3

Article 3 protects citizens against the use of torture, inhuman or degrading treatment and/or punishment and imposes on member states not just negative but also positive obligations. For example, a state is under a duty to not only not torture its citizens or subject them to inhuman or degrading treatment; but must also take measures to prevent such circumstances occurring. Furthermore it is under a duty to investigate allegations of torture, inhuman or degrading treatment (see *Assenov v Bulgaria* (1999) 28 E.H.R.R. 651) and must ensure that there is adequate protection and legislation in place to offer sufficient protection (see *Z and Others v United Kingdom* (2002) 34 E.H.R.R. 97). The right under Article 3 is a non-derogable right, meaning that the state cannot derogate from it, i.e. they must offer protection at all times regardless of competing interests such as national security and public protection. This, therefore, means that however unpopular or unworthy the individual is perceived to be, the right remains absolute (see *Chahal v United Kingdom* (1997) 23 E.H.R.R. 413).

When assessing Article 3 it is important to know what is meant by the terms used. For example in *Ireland v United Kingdom* ((1979-80) 2 E.H.R.R. 25) the European Court of Human Rights (ECtHR) defined inhuman treatment as that which is capable of causing if not bodily injury, at least intense physical and mental suffering and acute psychiatric disturbances. Furthermore, degrading treatment was said to be that which would arouse in the victim feelings of fear, anguish and inferiority which were capable of humiliating and debasing them. Interestingly, in the *Greek Case* ((1969) 12 Yearbook 186), degrading treatment or punishment was held to have occurred if the act grossly humiliated the applicant before others, or drove him to act against his will or conscience. For the ECtHR to accept that there has been degrading treatment a minimum severity has to be reached, although the Court will take into account individual characteristics of the individual and 'it is enough if the victim's treatment amounts to humiliation only in his eyes' (*Tyrer v United Kingdom* (1979-80) 2 E.H.R.R. 1 at para 23).

The question is therefore whether surgical castration amounts to torture, inhuman or degrading treatment or punishment. Whilst the Council of Europe's Committee for the Prevention of Torture have said that Surgical Castration does amount to degrading treatment, there have been no cases, to date, in the ECtHR. However, in *State v Brown* (326 S.E.2d 410 (1985)) the South Carolina Supreme Court held that surgical castration was a form of mutilation and thus illegal and void as cruel and unusual punishment in breach of amendment eight of the US Constitution, which is the equivalent of Article 3. Any operation such as surgical castration will leave a permanent scar and perhaps of more importance a permanent stigma which can be debasing and humiliating to the individual, especially if such scars have to be explained to future sexual partners. Even if the scar and loss of testicles is not witnessed by anyone else, they may still be humiliating for the offender, and as stated above 'it is enough if the victim's treatment amounts to humiliation only in his eyes' (*Tyrer v United Kingdom* (1979-80) 2 E.H.R.R. 1 at para 23). The operation is permanent and cannot be reversed if the offender changes his mind, leaving the individual with potentially the inability to orgasm or achieve an errection. Again this may be classed as degrading and humiliating.

Another factor to take into account is the negative side effects which can be caused through surgical castration. These can include hot flushes, softening of the skin; lethargy and decrease in muscle mass. Whilst these may not appear to be that severe, depending on how the individual reacts to the operation would depend on whether it could be said that the side effects are humiliating and or degrading. Furthermore, the ECtHR has limited the application of the ECHR in cases where the treatment in question is regarded as being necessary in a therapeutic sense (see *Herczegfalvy v Austria* (1992) 15 E.H.R.R. 437) and so another question to consider is whether surgical castration is therapeutically necessary. One way to look at this is to ask whether the treatment would be approved of by a reasonable body of medical opinion and on the basis that surgical castration is usually carried out because of public protection rather than medical needs it is unlikely that such a body of opinion would approve of its use. It is also necessary to consider what else could be used to achieve the same results, so if for example it could be shown that pharmacotherapy or cognitive-behavioural therapy was equally or more effective than surgical castration, then the least invasive form of treatment would be preferred by the courts so that the individual's dignity was maintained.

Article 8

Under Article 8, a member state must protect an individual's private and family life, which covers any factors which affect family relationships, sexual relations and moral and physical integrity. In relation to surgical castration, the obvious point to make is that the operation will affect the individual's ability to have sexual relations which can additionally affect his capacity to develop his personality. Furthermore, depending on the nature of the side effects following the operation, these could be considered to interfere with his bodily integrity. The ECtHR has interestingly stated that 'even a minor interference with the physical integrity of an individual must be regarded as an interference with the right to respect for private life under Article 8 if it is carried out against the individual's will' (*Storck v Germany* (2005) 40 E.H.R.R. 406 at para 143) and no doubt surgical castration would be included in this. Even though it is acknowledged that this may not apply where treatment is on a voluntary basis there are still issues regarding the validity of consent as discussed below.

Article 8 however, is not an absolute right, meaning that derogation from it can be justified if the interference is in accordance with the law, if it meets a legitimate aim and if it is necessary in a democratic society. To test the legality of surgical castration under Article 8, it therefore needs to be measured against these three factors. To ensure that a treatment method is in accordance with the law there must be sufficient legislative provision to allow the procedure to take place. This must be

accessible, predictable and its application foreseeable and ideally there should be a number of legal safeguards in place that are both regulated and accessible for the offender. Whether such things exist is a question of fact for the ECtHR. Another factor to be taken into account is whether or not the procedure has a legitimate aim, including whether it serves the purposes of public safety, crime prevention and/or the protection of others. This is unlikely to be a problem for a state to prove in relation to the surgical castration of sex offenders, as long as the reason for the operation is due to public protection and crime prevention rather than based solely on grounds of punishment and retribution.

The final factor which states need to prove is that the interference is necessary in a democratic society, i.e. whether it strikes a fair balance between the rights of the individual and the needs of society as a whole. To establish whether surgical castration is a proportionate measure, the ECtHR will consider factors such as whether there is a link between the measure and the legitimate aim it is meant to serve, whether it is the least intrusive measure available and whether it defeats the essence of the right in question (see *Hatton v United Kingdom* (2003) 36 E.H.R.R. 338). As stated above, it will thus be highly relevant that surgical castration is an irreversible operation and that its effects can arguably be achieved either through the use of anti-androgenic drugs or through cognitive-behavioural therapy. If this could be proven, then surgical castration is not the least intrusive measure available and the legitimate aim can be achieved by less intrusive means thereby arguably making its use in contravention of Article 8.

Article 12

Finally, Article 12 provides the right to marry and found a family. Similar to Article 3 this does not contain the qualifications found in Article 8(2), although it is limited by reference to the national laws which govern the particular member state in question. Fundamentally, Article 12 protects the right to procreate, a right which surgical castration categorically interferes with. The ECtHR have recently considered this right in relation to long-term prisoners held in custodial institutions in England and Wales (see *Dickson v United Kingdom* (2007) 44 E.H.R.R. 21). Although the circumstances are slightly different, the Grand Chamber held that the refusal to facilitate the removal of sperm from a prison establishment to a fertility facility was disproportionate and in breach of the ECHR. Interestingly, rather than just focusing on the right in relation to the prisoner, the ECtHR also considered the partner's rights arguing that these would be infringed if she was not able to partake in fertility treatment. This latter part may be very important for the partners of those who have been surgically castrated as not only will the offender's rights be infringed but all future partners will be prevented from founding a family as well.

Consent

The main justification for continuing to use surgical castration is on the premise that the treatment is voluntary and therefore legal because the offender's consent is acquired. When treatment is on a voluntary basis the initial issue is whether the offender has the capacity to give his consent, i.e. whether the offender is classed as being legally competent. Obviously problems can arise when the offender either has mental health issues or is of insufficient age. Whilst age is unlikely to be an issue, mental capacity may be problematic, especially if offenders are detained within mental health settings rather than in criminal justice establishments. Those offenders who have been assessed as having mental disorders will therefore need to be properly assessed and their capacity to consent will need to be carefully monitored. If this is not done then the validity of that individuals consent must be doubted.

Assuming that there are no issues with regards to the offender's capacity to give consent, the next stage is to determine whether the offender has indeed consented. This is perhaps one of the most problematic areas in voluntary sex offender treatment, as just because an offender appears to have given consent to surgical castration does not necessarily mean that this consent is morally valid. Validity of consent therefore includes not just the practical matter of gaining consent (i.e. a signature on a form); but also whether the offender possesses a sufficient understanding of the nature and effects of the treatment, including all of the potential side effects and has been given the freedom to make a real choice without coercion or influence of any kind. With reference to surgical castration, offenders should be fully informed of all aspects of the treatment, including what is involved in the operation, the fact that it is irreversible and, as mentioned above, the potential side effects involved and, if appropriate, information regarding other potential treatment options. On the basis that it may be unclear how an individual will react to the surgery and how it will physically and emotionally impact on him it is arguable that an offender can never truly give informed consent because he will never be able to be told the full extent of the effects to which he is consenting. From a morality point of view, it can be contended that if consent is not fully informed then it can never be truly valid.

It is also important that any decision which is reached by the offender is not coerced or influenced, even where this influence is perceived to be for the offender's benefit. This could be the case either because the offender wants to please the practitioner who is seeking the consent or because surgical castration is perceived to be the only means by which release into the community is achievable. Indeed it can be argued that if the decision is between custody and surgical castration, it is highly likely that consent for treatment will be given, regardless of concerns surrounding health or other personal issues such as the ability to perform sexually or to have a family. It is questionable whether such consent, whilst legal, is also morally valid. Whilst it is acknowledged that a prison/closed mental health setting does not in itself negate consent, practitioners need to be aware that there is a real risk that consent obtained under these circumstances is not real.

At an international level, international bodies have underlined the need for free and informed consent to protect individual dignity and autonomy. For example, the Council of Europe has issued several documents concerning prisoners which underline the need for valid consent when treatment is provided. The Council of Europe has developed guidelines for sex offenders offered treatment whilst in prison. The offender should have the right to refuse treatment and be made aware of any consequences this may have on his release and he should be informed of the positive and negative implications of any such treatment (Council of Europe European Committee on Crime Problems The State of Work on the text of A Draft Recommendation on the Treatment of Sex Offenders in Penal Institutions and the Community CDPC-BU (2006) 02 E.)

The recent Convention on the Protection of Children Against Sexual Exploitation and Sexual Abuse (2007 Council of Europe CETS. No 201 [Not yet in force] Article 17) has emphasised that offenders who are recipients of intervention measures should consent to procedures with full knowledge of the facts. It does allow for intervention programmes being linked to conditional release, but notes that offenders should be told the consequences of refusing intervention programmes. The success of intervention programmes seems to depend in most, if not in all cases, on the adherence of the person concerned to the measures or programmes implemented.

Footnote

[1] Much of this discussion has been taken from Harrison, K. and Rainey, B. (2009) 'Suppressing human rights? A rights-based approach to the use of pharmacotherapy with sex offenders', *Legal Studies*, 29(1): 47-74; Harrison, K. and Rainey, B. 'Morality and Legality in the use of anti-androgenic pharmacotherapy with sex offenders' in D. Boer et al. (eds) *International*

Perspectives on the Assessment and Treatment of Sexual Offenders. Theory, Practice and Research. Wiley & Sons (forthcoming April 2011).

Author address

Dr. Karen Harrison
Law School
University of Hull
Hull, HU6 7RX
United Kingdom

karen.harrison@hull.ac.uk