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STERILIZATION:  
USE, MISUSE AND ABUSE

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State of Minnesota  
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## TABLE OF CONTENTS

	<u>Page</u>
Synopsis	i
Voluntary Sterilization	1
Legality	
Consent Procedure	
Reported Abuse	
Issues	
Sterilization of Minors	3
Validity of minors' consent	
"Total ban solution" pros and cons	
Minnesota	
Sterilization of Racial Minorities and the Poor	6
Reported abuse	
Procedural safeguards	
The right to procreate	
Minnesota	
Issue	
Sterilization of the Mentally Incompetent	8
Validity of consent	
Total ban solution	
The situation in Minnesota	
Eugenic sterilization laws: new developments and rationale	
Minnesota	
Issues	
Guidelines for procedural safeguards	
Genetic Counseling	16
Conclusion	16
Footnotes	18
Sources	19

## Synopsis

Over the past year, reports of abuse and coercion in the performance of sterilization operations have prompted renewed and heated discussions of the subject in legal, medical and administrative circles. Whereas sterilization was used as a punitive and eugenic tool in the early part of this century, increasing knowledge about the educability of the mentally retarded, greater concern for the rights of the mentally retarded and the mentally ill, and knowledge of disproportionate numbers of sterilization operations performed on racial minorities and the poor all point to the urgent need for careful thinking, research and statutory reform.

A survey of the present situation shows:

### I. Voluntary contraceptive sterilization

- A. being chosen by more and more adults as a form of family planning;
- B. dangerously open to abuse and coercion; and,
- C. being performed without uniform guidelines from statute or professional medical and hospital associations.

### II. Sterilization of minors

- A. prohibited in any federally funded program by Department of Health Education and Welfare regulations;
- B. no clear definition of minors' consent as provided for in M.S. 144.341-144.343; and,
- C. performed at the discretion of parents and physicians.

### III. Sterilization of the mentally retarded and mentally ill

- A. prohibited in any federally funded program by Department of Health Education and Welfare regulations;
- B. possible in Minnesota for mentally retarded wards of the state and mentally ill inmates of institutions under M.S. 256.07-256.10; and,

C. completely unregulated for mentally retarded minors under private guardianship and mentally retarded adult non-wards.

Many classes of persons, including minors, the mentally retarded and the mentally ill, persons receiving public benefits, and racial minorities, are extremely susceptible to coercion. It must be recognized that providing the accessibility of sterilization to these persons simultaneously opens the door to abuse. What must be weighed are, on the one hand, the protection of such persons' integrity and rights and on the other, society's overriding concern for all its members. Legislative intent must be clarified, state policy determined, and adequate procedural safeguards established. This report is intended to facilitate that process.

The disclosure last summer that two black girls in Alabama, ages 12 and 14, had been sterilized by an OEO funded family planning clinic allegedly without the informed consent of their parents, forced the courts, the press, the public and various agencies and associations to confront the issues involved in sterilization and create appropriate solutions. Consensus on these solutions will not be easily attained, for the issues involved are complex and cut across medical, legal, economic, ethical and moral grounds. Nevertheless, all agree that statutory reform is long overdue. The Minnesota Statutes on sterilization, dating back to 1925, apply only to mentally retarded wards of the commissioner and mentally ill inmates of the state hospitals. These statutes afford few procedural safeguards. Minnesotans seeking voluntary sterilization, and those who are mentally retarded minors under private guardianship or mentally retarded adult non-wards are left to the arbitrary discretion of individual doctors and hospitals. Sterilization is an irreversible procedure and affects one of our most basic rights, the right to procreate. Out of concern for all those involved, this report has been prepared in an attempt to 1) document the existing situation and alleged abuses; 2) clearly state the issues at hand; and, 3) suggest various possible bases of statutory reform. It is not intended to be the final word on the subject nor to advocate any particular reform. It should, however, raise the issues, spark debate, and provide a list of resources to be called upon in further study and consideration.

#### VOLUNTARY STERILIZATION

Voluntary sterilization is legal in all 50 states. A few states require that specific conditions such as consultation, consent of spouse, parity or age be met before the operation can be performed. Others have statutes which clearly legalize voluntary sterilization by assuring immunity from criminal or civil suits (except for negligence) for physicians who perform such an operation. Nonetheless, voluntary sterilization is not illegal in those states without statutes specifically making it legal.<sup>1</sup> In the absence of statutory provisions, the courts have ruled that performance of voluntary sterilization for the preservation of health would not be considered violative of public policy (see Christensen v. Thornby, 255 N.W. 520 (1934)) and that a state cannot deny birth control information to a married couple because of the right of marital privacy guaranteed under the "penumbra" of the Bill of Rights (see Griswold v. Connecticut, 381 U.S. 479 (1965)). But in the absence of clear statutory

authority and a dearth of pertinent case law, regulation of voluntary sterilization is left to individual doctors and hospitals. Because of the relative complexity of the sterilization procedure for women as compared to the one for men, women voluntarily requesting sterilization are generally subjected to a more formal consent procedure than are men. Nonetheless, neither the AHA nor many individual hospitals have developed detailed written procedure to be followed prior to performance of sterilization operations. Information from the Journal of the AMA and the Hospital Law Manual Newsletter focuses more on the protection of physicians from civil or criminal liability than on the protection of patients' rights and the responsibility of physicians and hospitals to protect them.

Voluntary contraceptive sterilization is being chosen more and more often as a form of family planning. Statistics from Planned Parenthood report that among American couples over 30, sterilization is the most widely used form of family limitation. Moreover, 50% of requests for vasectomy and various forms of tubal ligation are presently coming from single and childless persons.<sup>2</sup>

But, according to the findings of the Nader Health Research Group in Washington, D. C., this dramatic increase in the number of sterilization operations being performed betrays a dangerous epidemic of abuse rather than a clear-cut choice of sterilization as a form of contraception. The group charges that patients are often not fully informed of all possible consequences, that many are not aware that the operation should be considered irreversible, that women are often scared into sterilization with unfounded threats of vaginal cancer or mortality from possible future caesarean sections, and that many women are encouraged to sign sterilization consent forms just prior to or after delivery, when still heavily sedated. Their report indicates that although abuse is greatest among low-income women and blacks in public hospitals, people under thirty with only one or two children are also affected. Sterilization is often presented to them as a danger-free panacean alternative to the publicized dangers associated with the IUD and the pill.<sup>3</sup>

The key to protection from abuse is the assurance that consent to the sterilization operation is both voluntary and informed. The guarantee of the protection of patients' rights and protection of physicians from civil and criminal liability is determined by the patient's ability to give voluntary informed consent. Legally adequate consent to sterilization (and any medical procedure) must be voluntary, competent and knowing. The person should be neither overtly nor covertly coerced into consent, whether through

fabricated medical reasons, threatened loss of medical treatment or public assistance. A consent must be from a person competent to give it - a person who has reached the age of majority and who is mentally competent to give consent.

Informed consent should include all the information a prospective sterilization patient reasonably needs in order to decide whether or not to undergo sterilization. Based on this researcher's reading of several court decisions on informed consent (see Canterbury v. Spence, 464 2d 772; Cobbs v. Grant, 8 Cal. 3d 229; 502P. 2d 1; and, Wilkinson v. Vesey 295A 2d 676), it would appear that a patient must be given a full explanation of the procedure covering both the inherent benefits and risks including an explanation that the sterilization is considered to be an irreversible procedure, and an explanation of alternative methods of contraception.

Ideally, there is no need for a special statute regarding sterilization, and in fact, some doctors have suggested that it be considered like other major surgery in terms of consent requirements. Given, however, the irreversible nature of the operation, its interference with the right to procreate, and reported abuse, special protection appears to this writer to be warranted.

### Issues

Issues in the regulation of voluntary sterilization brought to light are:

- a) The need for a statute legalizing the performance of voluntary sterilization operations, relieving physicians of threats of civil or criminal liability, except for negligence;
- b) Provision of equal accessibility to the operation regardless of race, sex, marital or economic status;
- c) Provision of adequate safeguards to prevent coercion into "voluntary" consent.

### STERILIZATION OF MINORS

It is generally assumed that minors cannot themselves give consent to sterilization operations. Traditionally, minors have been considered to be incapable of fully understanding the operation and its permanent implications.

Moreover, they are one of the classes of persons most susceptible to coercion and, therefore, in need of special protection.

The protection proposed by DHEW in their new regulations on sterilizations by federally funded programs<sup>4</sup> (these regulations apply to programs financed and administered by the Public Health Service (the Health Services Administration, the Health Resources Administration, the National Institutes of Health, the Center for Disease Control and the Food and Drug Administration, as well as all their constituent agencies and programs) and by the Social and Rehabilitation Service (as they affect Titles IV-A, VI, and XIX) is a total ban on the sterilization of persons under 21 years of age. This ban was imposed to conform with Judge Gesell's ruling in Relf et al v. Weinberger et al., the suit brought as a class action by the Relf sisters against DHEW, that the family planning sections of the Public Health Service Act and of the Social Security Act "do not authorize the sterilization of any person who . . . is in fact legally incompetent under the applicable state laws to give informed and binding consent to the performance of such an operation because of age . . .".<sup>5</sup>

Judge Gesell stated that although minors may be competent to rely on temporary methods of birth control, they are not, under present statute, capable of voluntarily consenting to an irreversible operation such as sterilization. Proponents of this approach, such as Nader's Health Research Group, the Mental Health Law Project, and many other women's and civil rights groups, support the ACLU's statement that "while some minors may still get pregnant or impregnate, the net cost to society is much lower than the possible abuses which would continue to flow from provision by the government for the sterilization of unwitting minors."<sup>6</sup>

Critics of this total ban solution argue that such a prohibition on federal financial participation results in an unfair denial of such services to medically indigent minors who would have to rely on federally supported programs for this service. It is also argued that in some cases, the minor's consent should be sufficient.

Since questions about the validity of minors' consent have also been raised in reference to abortion, it may be relevant to this discussion of sterilization that a District of Columbia superior court judge ruled February 6, 1973, that a minor could not be denied an abortion solely because of her age. Referring to a Supreme Court decision, in re Gault, 387 U.S. 1 (1967), which held that "neither the Fourteenth Amendment nor the Bill of Rights is for adults

alone," the judge held that minors have the same right as adults to an abortion and parental consent is not necessary if the minor understands the nature and consequences of the operation.

### Minnesota

Validity of minors' consent in Minnesota is regulated by the "Consent of Minors for Medical Health Services" law (M.S. 144.341-144.343) which states:

144.341. LIVING APART FROM PARENTS AND MANAGING FINANCIAL AFFAIRS, CONSENT FOR SELF. Notwithstanding any other provision of law, any minor who is living separate and apart from his parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing his own financial affairs, regardless of the source or extent of his income, may give effective consent to medical, dental, mental and other health services for himself, and the consent of no other person is required.

144.342. MARRIAGE OR GIVING BIRTH, CONSENT FOR HEALTH SERVICE FOR SELF OR CHILD. Any minor who has been married or has borne a child may give effective consent to medical, mental, dental and other health services for his or her child, and for himself or herself, and the consent of no other person is required.

144.343. PREGNANCY, VENEREAL DISEASE AND ALCOHOL OR DRUG ABUSE. Any minor may give effective consent for medical, mental and other health services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

It is unclear whether or not these provisions apply to consent for sterilization operations. In response to inquiries by the writer, opinions range from "yes" to "yes with great reluctance" to "no". Apparently some hospitals will perform a sterilization operation on any parent who requests it regardless of age or marital status.

It should be obvious, then, that lacking a clear statutory indication of which minors can give consent to sterilization operations, there will be no uniform availability to such services across the state.

The crucial policy decision which must be made is: Is the desirability of minors' access to sterilization

in certain instances great enough to risk the possibility of coercive abuse inherent in the availability of the procedures? If the decision is made to make sterilization available to minors on a case-by-case basis, then provisions will be needed to insure that consent would be truly informed and voluntary.

#### STERILIZATION OF RACIAL MINORITIES AND THE POOR

Minnie and Mary Alice Relf are not only minors; they are black and supported by welfare money. From available information, both of these groups have been subject to disproportionate abuse in the performance of sterilization operations, not only in Alabama, but also in Texas, Florida, California and Pennsylvania.<sup>7</sup> In his Memorandum Opinion to the Relf decision, Judge Gesell states that an indefinite number of the 100,000 to 150,000 low-income persons sterilized over the past few years under federally funded programs "have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization".<sup>8</sup> Reported statistics from the North Carolina State Eugenics Board show that of the 1,620 persons sterilized between 1960 and 1968, 1,023 were black.<sup>9</sup> In Aiken, South Carolina, where three obstetricians were sued for refusing to deliver the babies of welfare women who had two or more children unless the women agreed to be sterilized at the time of delivery, records show that 18 of the 34 deliveries paid for in 1972 by Medicaid included sterilizations and that 16 of these 18 women were black.<sup>10</sup> Moreover, the Joint Program for the Study of Abortion, following a study of 72,988 women who had legal abortions between July 1, 1970, and June 30, 1971, discovered a significantly greater number of nonwhite women and women on welfare being sterilized at the time of abortion than white private service women: under similar circumstances. Even when taking age and number of children into account, the study conceded that this discrepancy was due in part to the likelihood that physicians more readily recommended sterilization to the poor than to their private, largely nonpoor and white patients.<sup>11</sup>

Again to conform with Judge Gesell's ruling, the new DHEW regulations seek to provide additional procedural safeguards for voluntary consent to sterilization by legally competent adults. Specifically, they provide that no nonemergency sterilization may be performed unless voluntarily requested by the person on whom the operation is to be performed and that any person requesting such an operation must be advised prior to his solicitation of or his consent for sterilization that no benefits will be withheld or withdrawn because of a decision not to be

sterilized. In addition, the regulations require a 72 hour waiting period between the giving of informed consent and the performance of the sterilization operation.

At the same time that civil libertarians and various "pro-life" groups are adamantly opposing any state or federal aid for sterilizations, a growing minority are proposing laws requiring the sterilization of welfare recipients in order to relieve what they term "the growing welfare burden". At least 14 states have considered or are considering legislation which would require certain people receiving welfare to submit to sterilization. In 1973, bills introduced in the Illinois and New Hampshire legislatures would have offered cash incentives to welfare recipients who would submit to sterilization. Bills in Ohio and Tennessee would have denied welfare payments to a woman with more than two illegitimate children unless she has undergone sterilization. This sort of coercive legislation, proposed by those who fear that the new DHEW regulations will create too many obstacles to sterilization, is adamantly opposed by many groups such as the NWRO, ACLU, American Public Health Association, Planned Parenthood, the National Center for Bio-Ethics, and others who fear its coercive nature and ramifications. The court, in Relf v. Weinberger, based its findings on the fact that the intent of Congress as expressed in existing statute, is to provide for voluntary family planning. The court then noted that involuntary sterilization is not only diametrically opposed to such voluntary planning, but also invades rather than complements the right to procreate. The Supreme Court has repeatedly stated that the right to privacy entails the right of the individual "to be free from unwarranted government intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." (See Skinner v. Oklahoma, 316 U.S. 535.541 (1942); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972); Cleveland v. La Fleur, 42 USLW 4186 (U.S. January 21, 1974); Roe v. Wade, 410 U.S. 113 (1973); Griswold v. Connecticut, 381 U.S. 479 (1965).)

### Minnesota

The existence and/or extent of such abuse in Minnesota is difficult to ascertain. An extensive survey of hospitals and clinics in the state being prepared by the MCLU has revealed no reported abuse. However, the writer has received information from two sources indicating cases of coercion into sterilization at the time of childbirth or legal abortion of several welfare mothers. These sources spoke favorably of DPW programs and personnel on the state level. But many indicated that while abuse is least likely to

occur in the Twin Cities, they had less confidence in county programs and questioned the possible situation in rural Minnesota. Clearly, an in-depth study of the situation in this state is necessary.

### Issue

The issue is similar to the one raised in the discussion of sterilization of minors. As stated in a letter to Weinberger from the four women members of the Black Caucus (Barbara Jordan, D-Texas, Yvonne Burke, D-California, Shirley Chisholm, D-New York, and Cardiss Collins, D-Illinois), "the heart of the issue is how do we make family planning information and services available to all those who want and need them and at the same time insure that no element of coercion creeps into programs which Congress has specifically mandated must be voluntary in nature."<sup>12</sup>

### STERILIZATION OF THE MENTALLY INCOMPETENT

In the 1920's and early 1930's, it was thought that mental retardation and mental illness were hereditary and, therefore, on eugenic grounds, society would be improved if it prevented the reproduction of "inferior individuals" or those whom it considered likely to become wards of the state. Many states passed voluntary or involuntary eugenic sterilization laws. Despite challenges, the U.S. Supreme Court upheld the constitutionality of such laws when it ruled in Buck v. Bell, 274 U.S. 200 (1926) that a Virginia sterilization law afforded adequate due process and equal protection. Justice Holmes, affirming the right of the state to sterilize those whom it believed to be a drain on society's resources, uttered the now famous dictum "Three generations of imbeciles are enough."

In the past years, however, there have been several developments which should call into question this regulation of sterilization of the mentally retarded.

- a) The hereditary nature of mental retardation is very unclear. Geneticists have found from empirical studies that hereditary factors in mental retardation are so intertwined with other factors such as birth defects, improper prenatal care and environmental factors as to make the determination of the precise cause of mental retardation virtually impossible.

- b) Sterilization of the mentally retarded has been justified on the grounds that such persons are incapable of understanding or coping with their sexuality and are likely to be incapable of being good parents. This assumption has been challenged on various levels. A representative of the Minnesota Association for Retarded Citizens (Minn. A.R.C.) stated that many more mentally retarded can be taught to deal with their sexuality than was once thought. Therefore, an irreversible sterilization operation performed early in such a person's life would prematurely deny the possibility of such development. Studies have shown that women with IQs as low as 20 can learn to cope with their menstrual periods when they receive proper training.<sup>13</sup>
- c) Moreover, many retarded persons have a greater understanding of their sexuality than was once assumed. A study done in 1962 of 110 mentally retarded patients released from a California state hospital for the mentally retarded between June, 1949, and June, 1958, 42 of whom had been sterilized there, produced some rather startling information. Many were perfectly capable of expressing their reactions to sterilization, often in very poignant terms. Moreover, two-thirds of these did not approve of the operation. Women, particularly the married, were most likely to object to sterilization, whereas men, particularly the married, were least likely. Rejection seemed to be based most often on the feeling that it prevented the person from being able to pass as normal once he or she had been released from the institution and desired to be rehabilitated and returned to the community. Another objection was that the operation prevented parents from fulfilling their strong desire for parenthood.

The mentally retarded, like minors, constitute a class of persons especially susceptible to coercion. Sterilization of the mentally retarded was often justified as being in the best interests of the retarded person who, it was assumed, either did not understand or was a willing subject. However, such sterilization often arose out of the parents' concern for the social management aspects of the issue - fears of abuse of their children, illegitimacy, or the competency of their children for parenthood.

It has been generally held by the courts that mentally incompetent persons are incapable of giving consent to sterilization operations. However, parents of mentally retarded minors or the appointed guardians of mentally retarded persons have generally been able to consent for such person. (See Holmes v. Powers, 439 SW 2d 579, Ky., 1969). Similar substitute consent has not been accepted for mentally retarded adults.

In Relf v. Weinberger, the court indicated that voluntary consent "assumes an exercise of free will", "clearly precludes the existence of coercion or force", and "entails a requirement that the individual have at his disposal the information necessary to make his decision and the mental competence to appreciate the significance of that information". Judge Gesell went on to say that "no person who is mentally incompetent can meet these standards, nor can the consent of a representative however sufficient under state law, impute voluntariness to the individual actually undergoing irreversible sterilization." To comply with this decision, therefore, the new DHEW regulations provide that no non-emergency sterilization may be performed on individuals who are themselves unable to give legally effective informed consent - minors, whom we have already discussed, and the mentally incompetent.

In the Relf decision, Judge Gesell did not rule on the constitutional issues. Questions as to the constitutionality of these laws continue to be raised, however. At present, a suit being brought in Michigan challenges that state's sterilization statute on the grounds that it conflicts with the Fourteenth Amendment to the U.S. Constitution, and with the First, Fourth, Fifth, Eighth and Ninth Amendments, as made applicable to the state by the Fourteenth Amendment. (Densmore v. Yudashkin et al.) Similar suits have been filed in North Carolina (Trent v. Wright, et al. and Cox v. Stanton, et al.) and South Carolina (Roe v. Pierce, et al.)

However, among the guidelines included in a recent Alabama decision annulling a state law which had provided for involuntary sterilization of mentally retarded residents of the state's major mental retardation facility, was a stipulation that no inmate could be sterilized without his informed written consent. The court held that if a "court of competent jurisdiction" determines that the inmate is legally incompetent to give consent, or if the director cannot certify "without reservation" that the inmate understands the nature and consequences of the operation, the sterilization may not be performed unless the director, a review committee and a court, all agree

that it is in the inmate's best interest. Moreover, the review committee may not approve the proposed sterilization unless it can affirmatively determine that the inmate "has formed, without coercion, a genuine desire to be sterilized."

The ACLU argues that the consent of residents of mental institutions is per se involuntary and, therefore, cannot be used to enable sterilization operations. Although the ACLU recognizes that this approach denies certain possibilities to institutionalized persons, the overriding considerations of abuse of persons in compulsory institutions lead to the conclusion that such persons must be deemed incapable of giving voluntary consent to sterilization operations.

Contradictory conclusions could be drawn from two decisions involving mentally retarded adults on welfare. A Texas court of Civil Appeals held that the court had no authority to order a sterilization operation on a 34 year old mentally incompetent woman who was unable to support herself or her children. (Frazier v. Levi, 440 SW 2d 393.) An Oregon court, however, found that a "Statute allowing for involuntary sterilization of individuals whose children will become neglected or dependent as a result of their parents' inability by reason of mental illness or mental retardation to provide adequate care was not concerned with the parents' financial status but with the proper environment for the child and did not deny equal protection to indigents." In this case, the court held that "the state's concern for the welfare of its citizenry extends to future generations and when there is overwhelming evidence that a potential patient will be unable to provide a proper environment for a child because of his own mental illness or mental retardation, the state has sufficient interest to order sterilization." (Cook v. State, Or. App., 595P 2d 768.)

Again, the decision of Judge Gesell, which gave rise to the current DHEW regulations, mandated a total ban on sterilization of mental incompetents. In the face of reported abuse, this was seen to be the best solution. Many groups and concerned individuals feel, however, that sterilization of the mentally retarded may in some cases be the best solution. They advocate, instead, the adoption of adequate procedural safeguards to allow for the evaluation of sterilization decisions on a case-by-case basis which will insure that consent remains voluntary in each case. Moreover, as long as proper training is not available to all who could benefit from it, some feel that major surgery may be preferable to prolonged institutionalization or undesirable social experiences (untenable

family situation, staying out of school, etc.).

Minnesota

Minnesota Statutes presently contain provisions for the sterilization of feebleminded who have been committed to the guardianship of the commissioner of public welfare and of insane persons committed to the custody of the superintendent of a state hospital. Although the law no longer contains definitions of either "feebleminded" or "insane persons", the terms are assumed to refer to the mentally retarded and the mentally ill, respectively. The Minnesota law is considered to be voluntary since it requires consent of spouse or nearest kin for the mentally retarded and consent of the person and spouse or nearest of kin for the mentally ill. The DPW Manual also requires the written consent of the mentally deficient ward which shall be obtained by the staff of the state institution in which the ward resides.

256.07. STERILIZATION OF FEEBLEMINDED PERSONS; CONSENT TO OPERATION. When any person has lawfully been committed as feebleminded to the guardianship of the commissioner of public welfare and the commissioner of public welfare, after consultation with the superintendent of the state school for feebleminded, a reputable physician, and a psychologist selected by the commissioner of public welfare, and after a careful investigation of all the circumstances of the case, may, with the written consent of the spouse or nearest kin of such feebleminded person, cause such person to be sterilized by the operation of vasectomy or tubectomy. If no spouse or near relative can be found, the commissioner of public welfare, as the legal guardian of such feebleminded person, may give his consent.

256.08. INSANE PERSONS IN STATE HOSPITALS; CONSENT TO OPERATION. When any person has been committed as insane to the custody of the superintendent of a state hospital for the insane and has been an inmate of such hospital for a least six consecutive months, the commissioner of public welfare, after consultation with the superintendent of the hospital wherein such person is an inmate, a reputable physician and psychologist selected by the commissioner of public welfare, and after a careful investigation of all the circumstances of the case, may, with the written consent of the patient and of the spouse or nearest kin, or the duly appointed guardian of such insane person, cause such insane person to be sterilized by a competent surgeon by the operation of

vasectomy or tubectomy.

256.09. NO CIVIL OR CRIMINAL LIABILITY. Sterilization, as outlined in sections 256.07 and 256.08, shall be lawful and shall not render the commissioner of public welfare, or his employees, or other persons participating in the examination or operation, liable either civilly or criminally.

256.10. RECORDS KEPT. A complete record of the case shall be made and kept as a permanent file in the office of the commissioner of public welfare.

Sterilization of Mentally Defective Wards in Minnesota<sup>14</sup>  
1964 - 1973

Authorized in Conformance with M.S. 256.07

1964	0
1965	0
1966	0
1967	0
1968	0
1969	1 (institutionalized ward)
1970	0
1971	3 (wards in the community)
1972	5 (wards in the community)
1973	10 (wards in the community)

In Minnesota, rapid developments in programming for mentally retarded persons, including special residential living and sheltered workshops have meant that more mildly retarded persons are living and working out in the community. Only the more severely retarded are still in state institutions where they are segregated by sex and always under close supervision. The Social Service Manual of the Department of Public Welfare refers to a few types of mental retardation which appear to be hereditary. Where a hereditary condition is suspected, a request for sterilization should be accompanied by a genetic report from the Human Genetics Unit of the Minnesota Department of Health.

The manual specifically rejects sterilization on social management grounds. Private doctors and hospitals, however, with no statutory guidelines on this subject, can and do perform sterilization operations on these grounds. One hospital in the Twin Cities area has performed only one or two sterilizations of mentally

retarded persons in the past few years. In lieu of any clearly defined written consent procedure, it appears that letters from psychiatrists or other persons with specific knowledge of the patient and a court order or parent's consent would be sufficient consent for such procedures. However, it has also been reported that vaginal hysterectomies have been performed on two or three mentally retarded girls in early adolescence to relieve them and their parents of ever having to deal with the girls' sexuality.

### Issues

The issues raised in such an approach are complex. Some of the questions which would have to be answered are:

- 1) Assuming that there has not been a prior court adjudication of incompetency, what should be the standard by which competency is measured?
- 2) How can informed and voluntary consent be assured?
- 3) What standards should be established to determine the "best interests" of the incompetent individual?

The guidelines issued in Wyatt v. Aderholt could perhaps serve as an example of procedural safeguards which could provide an alternative to the total ban solution proposed by the DHEW Regulations. Although these guidelines apply specifically to inmates of the Parlon State School and Hospital, the safeguards they specify could cover other situations in which sterilization is to be performed.

The guidelines are as follows:

- 1) No inmate may be sterilized unless it has been determined that no temporary measure for birth control or contraception will adequately meet the needs of the inmate.
- 2) No inmate under 21 may be sterilized unless it is a medical necessity.
- 3) No sterilization may be performed on any inmate without the prior approval of a review committee "competent to deal with the medical, legal, social and ethical issues involved".
- 4) No inmate may be sterilized without his informed written consent. Such consent must be informed, that is "a) based on an understanding of the

nature and consequences of sterilization, b) given by a person competent to make such a decision, and c) wholly voluntary and free from any coercion, express or implied".

- 5) If the inmate is legally incompetent or if the director cannot certify without reservation that the inmate understands the nature and consequences of the operation, sterilization shall not be performed unless a) the director shows that such sterilization is in the best interests of the inmate; b) the Review Committee approves such sterilization; and c) it is determined by a court of competent jurisdiction that such sterilization is in the best interest of the inmate. (The preamble statement to the DHEW Regulations notes that "without an express grant of authority some state courts may hold that they have no jurisdiction to approve the sterilization of persons legally incapable of consenting for themselves". Planned Parenthood proposes the provision of an alternative legal process to obtain the necessary judicial review in these instances.)
- 6) In all procedures before the review committee, the inmate must be represented by legal counsel who shall "insure that all considerations militating against the proposed sterilization have been adequately explored and resolved".
- 7) The review committee must report monthly on the number of sterilizations approved and disapproved and the reasons why.
- 8) Consent to sterilization may not be made a condition for receiving any form of public assistance or health or social services or for admission or release from the state school.

In addition, the procedural safeguards which the Supreme Court held constitutional in Buck v. Bell, 274 U.S. 200, 207 (1927) could be considered. They require notice, attendance at the hearing if the patient desires, presentation of the evidence in writing to the patient and the possibility of appeal to the Circuit Court and then to the Supreme Court of Appeals.

It has also been suggested that some sort of penalty be stated for those who would violate a sterilization statute.

Another issue raised involves the "conscience clause", that is, the ability of hospitals and doctors to refuse

to perform sterilization operations if they object on religious or moral grounds. Idaho, Pennsylvania and Maryland passed laws in 1973 giving hospitals and medical personnel the right to refuse to perform sterilization operations. A 1973 Massachusetts law gives private hospitals the right to refuse. However, the outright ban on the performance of sterilization operations by a city hospital in Massachusetts was declared unconstitutional by a U. S. Court of Appeals. (Hathaway v. Worchester City Hospital, 475 F. 2nd 701 (1st Cir. 1973).) On the other hand, Congress enacted a federal "conscience clause" in 1972, which prohibits any judge from finding that receipt of Hill-Burton funds (federal tax money) puts any hospital in the position of having to perform sterilization contrary to the religious belief of its sponsors. In line with this legislation, a U. S. District Court in Montana dissolved a temporary injunction which had required a Catholic hospital there to allow limited sterilization operations.

#### GENETIC COUNSELING

A word should be added about the possible implications of increased genetic counseling. More and more programs of this sort are being formed to detect hereditary birth defects such as mental retardation and sickle cell anemia. Some have already expressed fears about the obvious implications for the use of sterilization operations. At a recent genetics course for medical professionals in Minneapolis, Philip Reilly, Professor of Law at the University of Houston, cautioned that the rights of individuals remain paramount, despite the public welfare derived from genetic screening.

#### CONCLUSION

In any case, it appears hazardous, in lieu of statutory guidelines, to rely on the sound judgment and good faith of various individuals in determining the performance of sterilization operations - whether it be the medical director of DPW, individual doctors, or individual hospitals. In light of current confusion and abuse, the state should clarify the principles and standards which are to control in given cases. Judge Gesell's conclusion in the Relf case can be pointedly applied to the state level:

Surely the Federal Government must move cautiously in this area, under well-defined policies determined by Congress after full consideration of constitutional and far-reaching social implications. The dividing line between family planning and eugenics is murky.  
. . . Whatever might be the merits of limiting

irresponsible reproduction . . . it is for Congress and not individual social workers and physicians to determine the manner in which federal funds should be used to support such a program. We should not drift into a policy which has unfathomed implications and which permanently deprives unwilling or immature citizens of their ability to procreate without adequate legal safeguards and a legislative determination of the appropriate standards in the light of the general welfare and individual rights.<sup>15</sup>

Almost all of Minnesota's citizens are potentially affected by the regulation of sterilization - adults seeking sterilization voluntarily as a form of contraception, institutionalized and non-institutionalized mentally retarded and mentally ill, minors, racial minorities, and persons receiving public assistance. The rights of all these persons to freely chose sterilization and to be free from abuse must be protected. What is urgently needed is clarification of legislative intent, a determination of state policy, and the implementation of adequate procedural safeguards.

FOOTNOTES

- <sup>1</sup>AMA Journal, May 27, 1968.
- <sup>2</sup>St. Paul Dispatch, October 10, 1973, p. 34.
- <sup>3</sup>Health Research Group Study of Surgical Sterilization.
- <sup>4</sup>Federal Register, Vol. 39, No. 76, April 18, 1974, pp. 13872-13873 and 13887-13888.
- <sup>5</sup>Relf v. Weinberger, p. 7.
- <sup>6</sup>ACLU Memorandum, p. 5.
- <sup>7</sup>Slater, p. 152.
- <sup>8</sup>Relf v. Weinberger, p. 3.
- <sup>9</sup>Slater, 152.
- <sup>10</sup>Slater, p. 152.
- <sup>11</sup>Lewit, p. 182.
- <sup>12</sup>Family Planning/Population Reporter, August 1973, p. 78.
- <sup>13</sup>Reported by Eunice Davis, M.D.
- <sup>14</sup>Provided by Frances Ames, Supervisor Family and Guardianship Services, Bureau of Residential Services, Department of Public Welfare
- <sup>15</sup>Relf v. Winberger, pp. 11-12.

SOURCES

In preparing this report, the researcher has contacted many individuals and organizations and has read a great number of cases and articles from various periodicals, journals, newspapers, and law reviews, many of which are on file in the House Research Department. The following list of individuals, organizations, and some of the most pertinent articles can be referred to for further information.

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