Golden Gate University Law Review

Volume 6 | Issue 1 Article 3

January 1975

Contraceptive Sterilization: The Need for State Regulation

Christine E. Motley

Follow this and additional works at: http://digitalcommons.law.ggu.edu/ggulrev

Part of the Family Law Commons, and the Health Law and Policy Commons

Recommended Citation

Christine E. Motley, *Contraceptive Sterilization: The Need for State Regulation*, 6 Golden Gate U. L. Rev. (1975).
http://digitalcommons.law.ggu.edu/ggulrev/vol6/iss1/3

This Article is brought to you for free and open access by the Academic Journals at GGU Law Digital Commons. It has been accepted for inclusion in Golden Gate University Law Review by an authorized administrator of GGU Law Digital Commons. For more information, please contact jfischer@ggu.edu.

Contraceptive Sterilization: The Need for State Regulation

Christine E. Motley*

INTRODUCTION

In recent years, contraceptive sterilization has become an important method of birth control.[1] Recent court decisions suggest that voluntary sterilization may be a fundamental right.[2] Controversy surrounding forced sterilization—that is, any sterilization which is *not* voluntary—has been associated in the past with eugenic sterilization.[3] Now, it has become clear that, apart from eugenic sterilizations, there are many forced sterilizations being performed under the guise of "voluntary" contraceptive sterilizations. While it is important to preserve sterilization as a right and as a readily-available family planning method, it is imperative that steps be taken to insure that all such sterilizations that are performed are voluntary ones. The importance of this proposition lies in the antithetical relationship between the right to sterilization and the right to procreation.

The right to procreation holds a special status: not only is procreation basic to the continuation of the human race and is

* Member, third year class.

1. All sterilizations, if effective, prevent conception. Sterilizations may be classified as therapeutic, *i.e.*, those performed for medical reasons, usually to preserve the health of the mother—and non-therapeutic, *i.e.*, those done for any other reason. Non-therapeutic sterilizations performed as a method of birth control are also referred to as contraceptive sterilizations. Both therapeutic and non-therapeutic sterilizations may be classified as voluntary or involuntary.

2. Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965); Hathaway v. Worcester City Hosp., 475 F.2d 701 (1st Cir. 1973). *See* text accompanying notes 46-54 *infra*.

3. Eugenic sterilizations are those sterilizations which are performed on certain classes of people, usually the mentally retarded and criminals, in an effort to control the passing of certain "inferior" genetic qualities. Forced sterilizations in this context involve complicated moral and legal issues which are beyond the scope of this article on contraceptive sterilization. For discussion of some of the issues not treated here see Buck v. Bell, 274 U.S. 200 (1927); Murdock, *Sterilization of the Retarded: A Problem or a Solution?*, 62 CALIF. L. REV. 917 (1974); Comment, *Sterilization of Mental Defectives: Compulsion and Consent*, 27 BAYLOR L. REV. 174 (1975).

Published by GGU Law Digital Commons, 1975

thus considered a basic human right, it is also afforded special legal protection, since the United States Supreme Court has declared that procreation is a fundamental *constitutional* right.[4] Sterilization eliminates any ability to reproduce and can, therefore, be a denial of the fundamental right to procreate.

But *voluntary* sterilization, to which every person[5] should have a right, is not an interference with the right of procreation. A person can waive his or her constitutional rights, and such a waiver is recognized so long as it is voluntary.[6] Thus, a person voluntarily seeking a contraceptive sterilization could be said to be exercising a valid waiver of the fundamental right to procreate. The essence of the right of sterilization, then, is in its being voluntary, since the voluntariness of the sterilization determines whether the sterilization is a denial of the fundamental right of procreation or an exercise of the right to sterilization.

A voluntary sterilization is one in which the person sterilized has voluntarily and knowingly chosen to be sterilized. Thus, the person must have chosen to be sterilized free of any coercion from another person. And this choice must be made on the basis of all relevant information.

Informed consent is a concept inherent in the right of every person to determine what is to be done with his or her body.[7] Although the standard of disclosure varies, this common-law rule requires that a doctor provide the patient with sufficient information to enable the patient to make an informed consent to the medical procedure to be performed. A doctor's violation of this right by not obtaining an informed consent results in liability for

4. Skinner v. Oklahoma *ex rel.* Williamson, 316 U.S. 535 (1942).

5. Practically speaking, the problem of when "voluntary" sterilization is in fact voluntary in the context of contraceptive sterilization has arisen mainly with women. This seems to be due partly to the greater presence of women in situations conducive to sterilization, since they are the childbearers. Women can thus more easily become the targets for abuse of the sterilization procedure. The author recognizes that proposed regulations are applicable to both men and women, but the focus of this article will be on involuntary sterilization as a woman's problem.

6. Miranda v. Arizona, 384 U.S. 436 (1966); Carnley v. Cochran, 369 U.S. 506 (1962); Von Moltke v. Gillies, 332 U.S. 708 (1948).

7. Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914); Canterbury v. Spence, 464 F.2d 772, 779-81 (D.C. Cir. 1972). For additional material on the subject of informed consent see Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U.L. Rev. 628 (1970); Note, *Informed Consent in Medical Malpractice*, 55 Calif. L. Rev. 1396 (1967); Note, *Informed Consent–A Proposed Standard for Medical Disclosure*, 48 N.Y.U.L. Rev. 548 (1973); Note, *Restructuring Informed Consent: Legal*

either negligence or battery.[8] The necessity of an informed consent is derived from the fact that a consent cannot actually represent a choice unless the patient knows of the risks, dangers and alternate forms of treatment. Without such an informed consent, the choice is ineffectual.[9] In general medical practice, this doctrine serves the dual purpose of assuring the patient of a source of information in order to make his or her decision, and insulating the doctor from liability for battery.[10] With sterilizations, this doctrine serves the additional purpose of insuring that the fundamental right of procreation is not denied any individual.

Recognizing the need for special protection in this area, California has recently enacted legislation[11] which, together with the state's power to regulate and license physicians and health facilities,[12] can provide effective protection to insure that sterilizations under the state's Medi-Cal program are performed only on those persons covered by the program who have given voluntary consents. Under this bill, the State Department of Health is required to promulgate regulations concerning informed consent for sterilization operations, and to adopt a "standard consent form in English and Spanish which is readily understandable to Medi-Cal beneficiaries . . . ."[13]

This article, while suggesting arguments that support sterilization as a fundamental right, examines the necessity and the constitutionality of enacting safeguards to regulate sterilization in order to protect the right to procreation. This article also suggests that all states adopt legislation similar to that which California has adopted, and proposes minimum standards for regulations that should be promulgated under such legislation.

Therapy for the Doctor-Patient Relationship, 79 YALE L.J. 1533 (1970).

8. Wall v. Brim, 138 F.2d 478, 481 (5th Cir. 1943); Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

9. Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520, 524-25 (1962).

10. Comment, *Informed Consent After Cobbs–Has the Patient Been Forgotten?*, 10 SAN DIEGO L. REV. 913, 914 (1973).

11. A.B. 214, (Cal. Reg. Sess., *as amended in Assembly* Feb. 11, 1975). Assembly Bill 214 was enacted into positive law in June, 1975, with an effective date of July 5, 1975. Ch. 220, [1975] Cal. Stat.—, *codifying* CAL. BUS. & PROF. CODE § 2361.8 (West Supp. 1976); CAL. HEALTH & SAFETY CODE § 1294.5 (West Supp. 1976); CAL. WELF. & INST'NS CODE §§ 14190-94 (West Supp. 1976).

12. See CAL. BUS. & PROF. CODE §§ 500 *et. seq.* (West 1974); CAL. HEALTH & SAFETY CODE §§ 1200 *et seq.* (West 1970).

13. CAL. WELF. & INST'NS CODE § 14191 (West Supp. 1976) (codified by ch. 220, [1975] Cal. Stat.—).

Published by GGU Law Digital Commons, 1975

I. THE NEED FOR SAFEGUARDS

Sterilization has become the fastest-growing method of birth control. In 1973, there were over 500,000 sterilizations performed on American women, an almost threefold increase in the incidence in female sterilization since 1970.[14] Others estimate the number of male and female sterilizations per year to be as high as one million each.[15]

Statistics from individual hospitals reflect this same dramatic increase. Between July of 1968 and July of 1970, Woman's Hospital of the Los Angeles County Medical Center reports that there was a 742 percent increase in elective hysterectomy, a 470 percent increase in elective tubal ligation, and a 151 percent increase in tubal ligation after delivery.[16] Sterilizations at Mt. Sinai Hospital in New York City are reported to have increased 200 percent between 1970 and 1974.[17]

This increase is partly due to increased liberalization in the availability of sterilization. In the past, contraceptive sterilizations were difficult to obtain, and many hospitals required special committee approval. Doctors were hesitant to perform sterilizations because they were uncertain of their legal liability. In recent years, however, a series of court decisions has established a more liberal climate concerning an individual's decision about contraception.[18] Thus, the basis for physicians' reluctance to perform sterilization (*i.e.*, the fear of criminal or civil prosecution) has been removed.

In 1969 the American College of Obstetricians and Gynecologists (ACOG) withdrew its age parity formula.[19] Under this formula a woman could be sterilized only when her age multiplied by the number of her living children equalled 120, as, for example, a woman aged thirty with four children. And in 1970 ACOG dropped its widely-used recommendation that the signatures of two doctors plus a psychiatric consultation be required

14. Association for Voluntary Sterilization, Inc., Estimate of Numbers of Voluntary Sterilizations Performed, Nov., 1974 (mimeographed paper).

15. B. Rosenfeld, S. Wolfe & R. McGarrah, Health Research Group Study on Surgical Sterilization 2, Oct. 29, 1973 (study distributed by Health Research Group, 2000 P St., N.W., Washington, D.C., 20036) [hereinafter cited as B. Rosenfeld].

16. *Id.*

17. *Id.* at 3.

18. *See* cases cited at note 2 *supra*.

19. Caress, *Sterilization: Women Fit To Be Tied*, HEALTH/PAC., Jan./Feb., 1975 (No. 62), at 3.

before performing a sterilization. California has enacted legislation to prevent such non-medical prerequisites from being required.[20] Sterilization is now generally available to all who seek it.[21]

But many sterilizations are being performed that are not voluntary; that is, sterilizations are taking place in which the decision to be sterilized was coerced, or was not made on the basis of all relevant information. This abuse takes two forms. Some women are persuaded to have sterilizations as a method of birth control when they would not have voluntarily chosen this as a method of birth control. Other women, who may or may not have decided on their own to be sterilized, are convinced to have hysterectomies once they have decided to be sterilized.[22] Although this procedure is 100 percent effective as a method of birth control, the serious complication rate is ten times higher than with tubal ligation.[23] In some cases, hysterectomies may be the method of choice, as when there is a medical condition that indicates the need for a hysterectomy. But the fact that there is no such medical indication for many of the women having hysterectomies illustrates that hysterectomy is being used for routine sterilization.[24]

A variety of pressure techniques are used. In many cases, doctors are "selling" sterilizations to patients by not informing the patient about the full scope of the procedure. For example, laparascopic tubal ligation, which involves an abdominal incision, has been described as "bandaid surgery."[25] In other cases, the patient is not told that a sterilization operation is irreversible. A National Institute of Health survey showed that 13 percent of men who had undergone vasectomy thought the operation was reversible, and 36 percent of those planning vasectomies were unaware that the operation is irreversible.[26] Some women have

20. CAL. HEALTH & SAFETY CODE §§ 1225, 1228 (West Supp. 1975).

21. Reproductive Freedom Project of the American Civil Liberties Union, Hospital Survey on Sterilization Policies, Feb., 1975 (mimeo available from ACLU, 22 East 40th Street, New York, N.Y. 10016) [hereinafter cited as Hospital Survey].

22. There are two methods of female sterilization: a tubal ligation consists of a cutting and tying of the fallopian tubes; a hysterectomy is accomplished by the removal of the uterus. Male sterilization is accomplished by a severing of the vas deferens.

23. B. Rosenfeld, *supra* note 15, at 11.

24. *Id.* at 13.

25. *Id.* at 2. A well-known clinic in San Francisco has used an information brochure on sterilization that has the tone of an advertisement. The cover says: "Worried about . . . Unwanted Pregnancies? Tubal Ligation 'Bandaid Surgery' is a Permanent Answer!"

26. *Id.* at 6.

Published by GGU Law Digital Commons, 1975

thought that their tubes could be "untied" after a tubal ligation.[27] Such misinformation about sterilization amounts to deceptive marketing practices, since it is well established that there can be side effects to tubal ligation,[28] and that tubal ligation fails one out of every hundred times.[29]

The coercion can be more direct. A glaring example of coercion is the physician in Aiken, South Carolina, who refused to deliver a third child for a welfare mother unless she "consented" to a sterilization.[30] Some women are asked to sign consent forms for sterilization while they are in labor,[31] while in other instances sterilizations are performed concurrently with abortions.[32] An order from a case concerning this problem establishes coercion of persons on welfare:

> [T]here is uncontroverted evidence in the record that minors and other incompetents have been sterilized with federal funds and that an indefinite number of poor people 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.[33]

A person placed in any of these situations would not be able to make the proper weighing of risks and benefits necessary for a true consent.

Such coercion is not the exception; it is widespread. An informal survey of more than twenty-five interns and residents showed that more than half of them admitted that hardsell pushing of elective sterilization took place in hospitals in which they had formerly trained. The hospitals and cities in which they had trained included Harper Hospital, Los Angeles; University of California at Irvine; Boston City Hospital; Charity Hospital, New Orleans and University of Tennessee Hospital in Nashville.[34]

27. *Id.* at 8.
28. 10 J. Rep. Med. 301 (1973).
29. B. Rosenfeld, *supra* note 15, at 12.
30. *Hearings on Title VI Enforcement in Medicare and Medicaid Programs Before the Subcomm. on Civil Rights and Constitutional Rights of the House Comm. on the Judiciary*, 93d Cong., 1st Sess., ser. 28, at 81 & *passim* (1973).
31. B. Rosenfeld, *supra* note 15, at 4.
32. Caress, *supra* note 19, at 5-6 (citing an interview with a physician).
33. Relf v. Weinberger, 372 F. Supp. 1196, 1199 (D.D.C. 1974) (footnote omitted).
34. B. Rosenfeld, *supra* note 15, at 8-9.

Two basic tenets of our health care system are responsible for a large amount of the coercion that occurs. First, in some instances, a higher value is placed upon teaching and research than upon patient care. As a result, residents in many city hospitals have done more "selling" of sterilization because the increasing amount of third-party payments is reducing the number of ward patients on which teaching programs rely to practice. When asked why a woman was having a hysterectomy instead of a tubal ligation, a resident of Boston City Hospital, a training hospital for several medical schools, replied:

> We like to do a hysterectomy, it's more of a challenge . . . you know a well-trained chimpanzee can do a tubal ligation . . . and it's good experience for the junior resident . . . good training."[35]

At a July, 1973 gynecology conference in Los Angeles, a staff doctor stated: "Let's face it, we've all talked women into hysterectomies who didn't need them, during residency training."[36] Making the decision to have a sterilization after the physician instead of the patient has initiated the idea is one circumstance in which sterilization is most often later regretted.[37]

The second primary feature of our health system which results in abuse of a woman's right of procreation is the fee-for-service system which allows the number and type of medical procedure to determine the doctor's salary. Hysterectomies cost up to $750 more than a tubal ligation.[38] One doctor has acknowledged this factor in a professional medical publication:

> It seems to me inevitable . . . that in any occupation where considerable income is available on the basis of events called operations, a small percentage of people can well identify this as a marvelous income-producing device . . . . [M]edicine is one of the few fields . . . where if a wife wants a new coat all you have

35. *Id.* at 3. A resident of Baltimore City Hospital, which now participates in an internship and residency program for Johns Hopkins Medical School, said of the program: "We didn't push sterilization very hard until Hopkins started sending their residents over here last year." *Id.* at 3-4.

36. *Id.* at 8.

37. 89 AM. J. OBST. & GYN. 395, 401 (1964).

38. Caress, *supra* note 19, at 5 (citing an interview with a physician).

Published by GGU Law Digital Commons, 1975

> to do is a couple more hysterectomies and she can buy it.[39]

Another reason physicians "sell" sterilizations as a safe and simple method of birth control is that they allow their personal values concerning minorities and population control to enter into their practice of medicine. With relation to minorities, several studies reveal that sterilization is occurring more often among minority groups and less-educated populations.[40] It appears that some doctors feel that sterilization is more appropriate for minority groups. Certainly Dr. Clovis Pierce, the physician in South Carolina who bribes his patients into being sterilized by refusing to deliver their babies, is practicing his version of social control.[41] An investigation by the South Carolina Department of Social Services showed that he had performed twenty-eight sterilizations during a six-month period. The overwhelming number of these patients who were sterilized were black.[42]

It has been shown that some doctors are more likely to recommend sterilization to their poorer patients. Of doctors in Detroit, Grand Rapids, West Virginia and Memphis, who were questioned on their attitudes towards contraception for public and private patients, six percent said they would recommend sterilization to private patients, while 14 percent would recommend it to public patients.[43]

Many physicians value population control more than the individual's right to decide an appropriate birth control method. In an article in which he minimizes the side effects of sterilization, Dr. Curtis Wood, past president of the Association for Voluntary Sterilization, advocates population control:

> People pollute and too many people crowded too close together cause many of our social and economic problems. These, in turn, are aggravated by involuntary and irresponsible parenthood. As physicians we have obliga-

39. B. Rosenfeld, *supra* note 15, at 19, *citing* HOSPITAL PHYSICIAN, Feb., 1973, at 35-40.

40. Westoff, *The Modernization of U.S. Contraceptive Practices*, 4 FAMILY PLANNING PERSPECTIVES 9, 10-11 (1972). Statistics also show that there is a positive correlation between receipt of welfare assistance and the rate of sterilization. Vaughan & Sparer, *Ethnic Group and Welfare Status of Women Sterilized in Federally Funded Family Planning Programs, 1972*, 6 FAMILY PLANNING PERSPECTIVES 224, 229 (1974).

42. Caress, *supra* note 19, at 11.

43. *Id.* at 14.

> tions to our individual patients, but we also have obligations to the society of which we are a part. The welfare mess, as it has been called, cries out for solutions, one of which is fertility control.[44]

This same physician, when asked about the South Carolina physician's practice of requiring sterilization of pregnant women who already had three children, replied:

> I admire his courage. I'm sympathetic to his point of view. However, I question his method. After thirty years of delivering babies, I've found that if the doctor does a proper job of offering sterilization to these women [on welfare], a high percentage of them would accept it. I have found that after three or four minutes of talking with them, they will accept it—they want the sex, but not the babies.[45]

The very concept of informed consent that is applicable to all medical procedures acknowledges the influence on the patient's decision of the information the patient receives about the medical procedure she is considering. It is clear that the line between voluntary and involuntary sterilization is getting thin when such biased attitudes as those discussed above guide the tone and the content of information a patient receives about contraceptive methods. There is clearly a disregard by some doctors for the basic liberty to decide whether or not to bear children.

II. THE RIGHT TO BE STERILIZED

Although the preceding section discusses the abuses which have attended a dramatic increase in the number of sterilizations, and demonstrates that regulation is necessary to curb this abuse, this regulation should not interfere with a person's right to such an operation. But, in order to discuss the constitutionality of such regulations and the constitutional issues inherent in the tension between the right to procreate and the right to be sterilized, one must determine whether or not the right to be sterilized rises to the status of a fundamental right. This is necessary because the Supreme Court has used a strict standard of review to test the

44. *Id.* at 11.
45. *Id.*

Published by GGU Law Digital Commons, 1975

constitutionality of state action that infringes on a fundamental right.[46]

Although the Supreme Court has not ruled that sterilization is a fundamental right, certain lower court decisions strongly suggest that, if faced with a proper fact situation, the Court would reach such a decision. For instance, in *Hathaway v. Worcester City Hospital*,[47] the First Circuit held that a city hospital's prohibition of therapeutic sterilization operations violated a woman's right to equal protection when other surgical procedures were provided that involved no greater patient risk or demand on staff and facilities. Although the case was ultimately decided on equal protection grounds, it relied heavily on two due process cases, *Roe v. Wade*[48] and *Doe v. Bolton*,[49] in finding that sterilization performed to protect the health of the patient is a fundamental right. These cases ruled that state statutes which interfered with a woman's right of privacy in deciding to have an abortion before the end of the first trimester violated due process and were unconstitutional because they were more restrictive than was necessary to protect the state's interests. The scope of this right to privacy was outlined in *Roe v. Wade*:

> [O]nly personal rights that can be deemed "fundamental" or "implicit in the concept of ordered liberty" are included in this guarantee of personal privacy. . . . [I]t is clear that the right has some extension to activities relating to marriage, procreation and contraception.[50]

In relating this to sterilization, the court in *Hathaway* said:

> While *Roe* and *Doe* dealt with a woman's deci-

46. To ensure equal protection, the state must have a compelling interest, as opposed to a rational interest, to justify any regulation which restricts a fundamental right. Shapiro v. Thompson, 394 U.S. 618, 634 (1969); Sherbert v. Verner, 374 U.S. 398 (1963); Gunther, *In Search of Evolving Doctrine on A Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 7 (1972); *Developments in the Law: Equal Protection*, 82 HARV. L. REV. 1065, 1120-22 (1969). Under the due process clause, a state must show that any burden placed upon a fundamental right is no broader than is necessary and no heavier than is necessary to effectuate the purpose of the restriction. Griswold v. Connecticut, 381 U.S. 479, 485 (1965); Sheldon v. Tucker, 364 U.S. 479, 488 (1960); Cantwell v. Connecticut, 310 U.S. 296, 307-08 (1940).

47. 475 F.2d 701 (1st Cir. 1973), *application for stay of mandate denied*, 411 U.S. 929 (1973).

48. 410 U.S. 113 (1973).

49. 410 U.S. 179 (1973).

50. 410 U.S. 113, 152 (1973) (citations omitted).

> sion whether or not to terminate a particular pregnancy, a decision to terminate the possibility of any future pregnancy [that is, to be sterilized] would seem to embrace all of the factors deemed important by the Court in *Roe* in finding a fundamental interest, but in magnified form . . . .[51]

The full impact of *Hathaway* on the right to voluntary sterilization may be limited since the decision was made in the context of a therapeutic sterilization that was important to preserve the health of the woman. However, the reasoning in this case, together with the reasoning of *Griswold v. Connecticut*[52] and *Eisenstadt v. Baird*,[53] may be extended to include non-therapeutic contraceptive sterilizations as a fundamental right. In *Griswold* a person's decision to use contraceptives was held to be within the zone of the fundamental constitutional right of privacy. Since the right of privacy is a fundamental right, the Court used the strict test of constitutionality and declared unconstitutional the state laws banning distribution of contraceptives. In *Eisenstadt v. Baird*, a law which prohibited distribution of contraceptives to unmarried individuals was not tested under the strict scrutiny test. Deciding on equal protection grounds, the Court held that the law failed to satisfy even the more lenient "rationally related" equal protection standard. The Court, however, did acknowledge the fundamental right of privacy that was established in *Griswold*.[54]

The Court's articulation of the right to privacy in *Griswold* and *Eisenstadt* could be employed to support the inclusion of nontherapeutic contraceptive sterilizations into that fundamental right. *Griswold* established that the right of privacy included the decision whether to use contraceptives. This right of privacy could logically be extended to protect the decision of what contraceptive method to use. The distinction between the use of contraceptives and the particular method chosen is not great and the right of privacy which includes the right to use contraceptives would certainly include the right to choose what method is to be used.

51. 475 F.2d 701, 705 (1st Cir. 1973) (citation omitted).
52. 381 U.S. 479 (1965).
53. 405 U.S. 438 (1972).
54. *Id.* at 453.

Published by GGU Law Digital Commons, 1975

III. THE RIGHT OF PROCREATION: THE RIGHT NOT TO BE STERILIZED

Even if sterilization is a fundamental right, regulation of that right is not prohibited. As explained above, however, the regulations would have to meet the strict standards of review used by the Court to determine the constitutionality of any restrictions placed on a fundamental right.[55]

It is clear that safeguards could be upheld under the right to procreation. This fundamental right was established in *Skinner v. Oklahoma ex. rel. Williamson*,[56] where the Court held unconstitutional a state statute that singled out certain types of criminals to be sterilized. In so doing, the Court clearly identified the importance of the right involved:

> We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. The power to sterilize, if exercised, may have subtle, far-reaching and devastating effects . . . . [The sterilized individual] is forever deprived of a basic liberty.[57]

The right to procreate inherently includes the right not to be sterilized.[58] Safeguards that protect this right to procreation by insuring that only those individuals are sterilized who have waived their right to procreation with a voluntary consent to sterilization would serve a compelling state interest.

Safeguarding patients from coerced sterilizations also serves the compelling state interest of protecting the patient's right to privacy, which is the foundation of the right to sterilization.[59] While it may appear contradictory that a right can be maintained only if regulations are placed on the right, it is, in fact, realistic because of the nature of the right to privacy and the nature of the abuse that is taking place. The right to privacy consists of the right of the individual to make the decision whether or not to be sterilized. As *Eisenstadt* states:

55. *See* text accompanying notes 46-47 *supra*.
56. 316 U.S. 531 (1942).
57. *Id.* at 541.
58. *See* text accompanying notes 4-6 *supra*.
59. *See* text accompanying notes 47-55 *supra*.

> If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.[60]

The decision is truly the individual's only when it is made on the basis of full knowledge and rationality. The abuse that is taking place consists of a wrongful appropriation of the decision whether or not to be sterilized. Safeguards that insure that a consent to a sterilization operation is fully informed and not coerced, and thus truly the individual's decision, would meet the compelling state interest test because they would protect the right to privacy.

The classification created by selecting sterilization—and not other birth control methods or medical procedures—for special regulation is justified because of the unique nature of sterilization. Unlike other birth control methods, it is irreversible. And unlike other medical procedures, which are balanced by medical necessity in deciding whether they should be done, contraceptive sterilization is a surgical procedure done completely by choice, weighing its benefit and risk as compared with other birth control methods. Most importantly, sterilization is unlike other medical procedures because it permanently prevents procreation, which is a fundamental right.[61] In light of the discussion on abuse, the need for safeguards that protect that right is strong. Such safeguards, enacted to protect the patient's right of procreation and right of privacy, would be "based on differences that are reasonably related to the purposes of the Act in which it is found,"[62] and would thus not violate a patient's right to equal protection.

Safeguards to protect the right to procreation that do not infringe on the right to sterilization are also supported by the Court's balancing approach in *Roe v. Wade*[63] and *Doe v. Bolton*,[64] where, like here, two fundamental rights were involved. Upon initial consideration, regulations of sterilization might appear to be violative of due process, under *Doe*, since the statute declared

60. 405 U.S. at 453 (1972).
61. 316 U.S. at 541 (1942).
62. Morey v. Doud, 354 U.S. 457, 465 (1956).
63. 410 U.S. 113 (1973).
64. 410 U.S. 179 (1973).

unconstitutional in that case provided for procedures to be followed before an abortion could be performed.[65] Examination of the decision in conjunction with *Roe* reveals that, in fact, it is perfectly consistent with and supportive of properly drawn regulations of sterilization. In *Doe* competing fundamental interests were involved: the state had an interest in the preservation of the woman's health and the potentiality of life in the fetus; the woman had an interest in protecting her privacy in deciding to have an abortion. Relying on *Roe*, the Court declared the woman's interest to be paramount in the first trimester.[66] During this period no restrictions can be placed on a woman in deciding whether to have an abortion. In deference to the interest in the woman's health, however, the Court did allow states to place certain restrictions on a woman's right to abortion during the second trimester of her pregnancy.[67] In striking down the statute, the Court applied the test: does the statute have any rational connection to the state's interest in the patient's needs?[68] This test was established as a balance between the two basic rights.

The regulation of sterilization presents an analogous situation in that competing basic rights are involved: the individual's right to privacy in the decision to be sterilized and the state's interest in protecting the right to procreation. If the state is to promulgate regulations in order to protect that latter right, the regulations must express a balance between those interests. The same test that is articulated in *Doe v. Bolton* would be applicable: do the restrictions have a rational connection to the patient's need? The need in this situation is, of course, the need to protect the individual's right of procreation.

This would be fulfilled by regulations that ensure that every patient knowingly and voluntarily consents to the sterilization procedure. A valid waiver of the right to procreate has not taken place unless the decision is uncoerced and is made on the basis of all relevant information. The burden of demonstrating that the waiver does meet these criteria should be on those who perform the sterilization.[69]

65. *Id.* at 193-200.
66. *Id.* at 189.
67. *Id.*
68. *Id.* at 195, 198-99.
69. This is not inconsistent with United States Supreme Court statements on waiver in other contexts. With reference to the waiver of the right to counsel, the Supreme

The safeguards, however, should go only so far as is necessary to insure that the individual's decision to be sterilized is her own. The regulations must be narrowly drawn so as to advance the state's interest in the protection of the right to procreation without unduly interfering with the right to sterilization by being too broad or too burdensome on that right.[70] Excessively restrictive or paternalistic provisions could be challenged as interfering with the right to privacy without furthering the compelling interest of the state in insuring that the sterilization is voluntary. Thus, a regulation requiring the approval of either a hospital committee or a second doctor would be unconstitutional. This is so because a requirement that a second person of the patient's own choosing be present when the patient signs the consent form could insure that an informed consent was given, while protecting more adequately the patient's right to privacy. This would also be the case with a regulation requiring spousal consent.[71]

IV. THE INADEQUACY OF PRESENT SAFEGUARDS

Although all states require an informed consent for sterilization, as with all medical procedures,[72] the common law requirements for informed consent in many states do not adequately protect the special needs of the sterilization patient. There is much disagreement and commentary as to the precise nature of the informed consent requirement and the obligation that it places upon the physician.[73] Very few jurisdictions have adopted

---

Court has said, in Caenley v. Cochran, 369 U.S. 506 (1962), that: "The record must show . . . that an accused was offered counsel but *intelligently* and *understandingly* rejected the offer. Anything less is not a waiver." *Id.* at 516 (emphasis added).

With reference to the right not to testify against oneself and the right to counsel, the Court said:

> If the interrogation continues without the presence of an attorney and a statement is taken, a *heavy burden* rests on the Government to demonstrate that the defendant *knowingly* and *intelligently* waived his [rights].

Miranda v. Arizona, 384 U.S. 436, 475 (1966) (emphasis added).

70. *Accord*, Griswold v. Connecticut, 381 U.S. 479, 485 (1965); Shelton v. Tucker, 364 U.S. 479, 488 (1960); Cantwell v. Connecticut, 310 U.S. 296, 307-08 (1940).

71. *Accord*, Doe v. Bolton, 410 U.S. 179 (1973).

72. *See* text accompanying notes 7-10 *supra*.

73. *See generally* Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533 (1970); Mills, *Whither Informed Consent?*, 229 J.A.M.A. 305 (1974).

Published by GGU Law Digital Commons, 1975

a requirement of full disclosure.[74] New Mexico[75] and one federal jurisdiction[76] are examples of the few jurisdictions that have adopted a requirement of reasonable disclosure. *Cobbs v. Grant*[77] is a landmark California case in which the supreme court of that state ruled that the physician's duty to inform is measured by the patient's need, and that the test of this need is the information's materiality to the patient's decision. In most states, the duty to disclose is measured against the information that would be disclosed by a doctor in good standing within the medical community.[78] This could result in no disclosure at all. One commentator remarked that the law on informed consent is no better than the prevailing medical practice.[79]

While it is clear, therefore, that reliance on court rulings will not serve the needs of persons faced with involuntary sterilization, legislative action in the areas of informed consent or sterilization serves no better to provide adequate safeguards. Only one state, Georgia, has made legislative change in informed consent rules,[80] and provisions of this chapter specifically exempt its applicability to abortion or sterilization.[81] Georgia has passed a separate Voluntary Sterilization Act which prescribes procedures that must be followed before a voluntary sterilization can be performed.[82] A licensed physician must perform the sterilization in consultation with another physician; spousal permission, if appropriate, is required. A request must be made by the person, who must be twenty-one if unmarried. The only requirement of an informed consent is worded:

> prior to or at the time of such request [for sterilization] a full and reasonable medical explanation [must be] given by such physician

74. For a survey of court decisions on informed consent see *The Law of Informed Consent*, AM. COLLEGE OF SURGEONS BULL., May, 1974, at 21 [hereinafter cited as *Informed Consent*].

75. Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520 (1962).

76. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

77. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

78. Haggerty v. McCarthy, 344 Mass. 136, 181 N.E.2d 562 (1962); Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627 (1963); *Informed Consent*, *supra* note 74.

79. Hagrian, *The Medical Patients' Right to Know: Report on a Medical-Legal-Ethical Empirical Study*, 17 U.C.L.A.L. REV. 758, 764 (1970).

80. GA. CODE ANN. §§ 88-2901 to -2907 (1971).

81. *Id.* § 2902.

82. GA. CODE ANN. §§ 84-931 to -935.2 (Spec. Supp. 1974), *formerly* ch. 84, §§ 931-35 [1966] Ga. Acts 683.

to such person as to the meaning and consequence of such operation.[83]

Two other states, North Carolina and Virginia, have statutes specifying procedures to be followed before a sterilization.[84] These statutes provide for procedures similar to those in the Georgia statute, except that Virginia requires a thirty-day waiting period between the request and the operation for anyone who has not borne children before.[85] No specific provisions for enforcement or for sanctions against a physician who violates these statutes appear in any of these laws.

Federal regulation of sterilization has also proved ineffective in insuring that all sterilizations are voluntary. In September, 1973, the Department of Health, Education and Welfare (HEW) proposed regulations governing federally-funded sterilizations.[86] These regulations were wholly inadequate. They dealt only with sterilizations of persons under twenty-one and those persons legally incapable of consenting. The only insurance of informed consent in the requirements of the Social and Rehabilitation Service was the mere voluntary written consent of the patient "or some legally authorized individual acting on the [Medicaid] receipient's behalf."[87] No definition of informed consent or of voluntary sterilization was included in the regulations. Thus, none of the defects in the various common law or statutory provisions were cured.

On February 6, 1974, in response to some 300 comments that were received, and national publicity surrounding several cases of involuntary sterilization, HEW suggested certain revisions to its regulations.[88] The regulations now included a definition of informed consent for competent adults.[89] Further safeguards were proposed, such as a 72 hour waiting period between consent and the sterilization.[90]

As a result of a court challenge to the regulations, the effective date of these regulations was postponed.[91] The National Wel-

83. *Id.* § 932.
84. N.C. GEN. STAT. §§ 90-271 to -275 (1975); VA. CODE ANN. §§ 32-423 to -427 (1962).
85. VA. CODE ANN. § 32-423 (Supp. 1975), *amending* VA. CODE ANN. § 32-423 (1973).
86. 38 Fed. Reg. 26459 (1973).
87. *Id.* at 26460.
88. 39 Fed. Reg. 4730, 4733 (1974).
89. *Id.* at 4732, 4733.
90. *Id.* at 4732.
91. *Id.* at 5315, 9178.

Published by GGU Law Digital Commons, 1975

Golden Gate University Law Review, Vol. 6, Iss. 1 [1975], Art. 3

fare Rights Organization and two retarded sisters who were faced with involuntary sterilization sued HEW for failure to protect the rights of people who might be subject to involuntary sterilization. In March, the court in this case responded to the HEW regulations in its order which required that no sterilization be performed with federal funds unless someone legally competent consented to the operation. In addition, the court ordered that new regulations be drafted that would more adequately insure an informed consent.[92]

In response to the court order in this case, HEW released more complete regulations in April, 1974.[93] These regulations again specify the components of an informed consent,[94] and require all consent forms to display the notice that a patient's decision not to be sterilized will not result in the withdrawal of any federal benefits.[95] Documentation of the consent is provided for,[96] and a three-day waiting period between request and the operation is required.[97] A moratorium on all federally-funded sterilizations of minors or mental incompetents continues.[98]

Although these regulations are formally in effect, there are serious defects in their implementation. First, as the intransigence of HEW in developing even minimal regulations suggests might happen, there has been a significant lack of enforcement. The department can seek a court order requiring compliance. A more effective means of enforcement is the department's power to withhold federal financial assistance from any doctor or health facility that fails to comply with the regulation. A study conducted by the Reproductive Freedom Project of the American Civil Liberties Union shows that no enforcement action had been taken as of February, 1975.[99]

This lack of enforcement action is not the result of full compliance with the regulations. This same ACLU study shows that the regulations are having little impact: of nineteen hospitals which enclosed consent forms with their responses, only two complied with the federal regulations.[100] Many hospitals do not

92. Relf v. Weinberger, 372 F. Supp. 1196, 1204-05 (D.D.C. 1974).
93. 42 C.F.R. § 50.201-04 (1974).
94. *Id.* § 50.202(d).
95. *Id.* § 50.202(d)(6).
96. *Id.* § 50.202(d)(7).
97. *Id.* § 50.203(c).
98. 39 Fed. Reg. 13873 (1974).
99. Hospital Survey, *supra* note 21, at 4.
100. *Id.* at 8.

http://digitalcommons.law.ggu.edu/ggulrev/vol6/iss1/3

give the required notice to welfare recipients that their decision not to be sterilized has no impact on their benefits.[101] And only seven of the total of 51 responding hospitals had any waiting period at all between consent and the sterilization procedure.[102] Thus, it is clear that effective enforcement is fundamental to effective regulation.

Second, the federal regulations, because of the very fact that they are federal, can apply only to health facilities or physicians receiving federal money. This leaves unregulated other facilities or physicians that cannot be reached under the federal power to regulate.

V. PROPOSAL FOR SAFEGUARDS

Safeguards are crucial, and the preceding section has shown that the form that these regulations take is very important. Recent legislation in California has resulted in the most far-reaching legislative action to date in the field of sterilization.[103] This bill requires the State Department of Health to promulgate regulations concerning informed consent for sterilization operations under the state's Medi-Cal program, and to adopt a standard consent form in both English and Spanish which is readily understandable. Furthermore, the bill provides for enforcement: non-compliance will result in non-payment of Medi-Cal reimbursements, and willful failure to comply with the requirements is deemed unprofessional conduct. The Department of Health is also empowered to suspend or revoke any license of a physician or health facility that willfully fails to comply with the regulations. Recognizing the importance of this statute and citing the failure of the federal regulations to provide adequate protection, the Senate and Assembly provided for immediate application of this statute by voting for an urgency clause.

This legislation rectifies deficiencies in other methods of regulation. It carries with it effective enforcement measures that are lacking in the other state statutes on voluntary sterilization described above. And because this legislation will be implemented on a state level, it can be expected that it will be more effective than the federal regulations. State departments of health have

101. *Id.* at 14.
102. *Id.* at 15.
103. For citations to the relevant legislative provisions see note 11 *supra*.

Golden Gate University Law Review, Vol. 6, Iss. 1 [1975], Art. 3

closer contact with local health facilities, which will enable closer supervision than has occurred with the federal regulations. The most serious deficiency of the bill is in its failure to cover patients other than Medi-Cal recipients. This deficiency can be cured, however, by issuing the regulations under the state's power to regulate and license doctors and health facilities, as well as under the legislation.[104]

The best possible remedy for the abuse in sterilization would be the adoption of legislation which reflects the goals of California's recent enactment, but which goes even farther and protects all patients. It is crucial that the regulations adopted under such legislation be effective ones. The safeguards that follow are a suggestion of strong yet constitutional regulations that fill the gaps left by the common law and statutory law on informed consent and the federal regulations promulgated by HEW.[105] It should be recognized, however, that such state regulations are effective only if there is a strong commitment on the part of the state to enforce and promote compliance with the regulations. Strong safeguards together with such a commitment could solve a serious problem.

1. There must be an absolute duty imposed to inform the patient of all the relevant facts before she signs the Consent Form that is required by the legislation itself. This should include a description of all risks, complications, side effects, alternatives, as well as a thorough description of the procedure. The patient should also be notified of the physician's name and level of experience. Special emphasis should be placed upon the irreversibility of the operation. If the primary purpose of the proposed sterilization is birth control, the patient must be totally informed of all alternative methods of birth control, as well as all methods of sterilization. If the sterilization procedure is part of the treatment for a medical condition, the patient must be fully informed of alternative methods of treatment.

2. Restrictions must be placed upon a physician's ability to offer sterilization to the patient.

104. *See* authorities cited at note 12 *supra*.

105. In April, 1975, the California Coalition for the Medical Rights of Women, 433 Turk St., San Francisco, petitioned the California Department of Health for an adoption of regulations which encompass the safeguards suggested herein. In response to this administrative petition, such regulations have been proposed, and will be the subject of public hearings in early 1976.

http://digitalcommons.law.ggu.edu/ggulrev/vol6/iss1/3

3. Patients must be advised that public assistance program benefits cannot be withdrawn by their refusal to be sterilized.

4. The information must be conveyed to the patient in written form, and then discussed orally. The information should be given in the patient's own language.

5. The State should provide Patient Information Booklets for interested persons to be distributed through licensed agencies performing sterilization. Ideally, a video-tape presentation would be made available.

6. The Consent Form must be signed by an auditor-witness of the patient's own choosing.

7. Sterilization cannot be performed sooner than fourteen days after signing an approved Consent Form. The patient should be entitled to a longer wait if the patient so desires. The patient should be able to sign a waiver of this fourteen-day waiting period, but in no circumstance should a non-therapeutic sterilization be performed less than three days after the consent form has been signed.

8. The State should require that licensed agencies keep demographic statistics on sterilization operations. Provisions should be made for patient follow-up on a volunteer basis.

9. The regulations must provide for enforcement of the regulations by the State Department of Health.

10. The regulations should be reviewed one year after promulgation, to insure that they are effective in preventing forced sterilizations, while not unnecessarily restricting access to sterilization.