Gradations of Coercion: The Plight of Women of Color and Their Informed Consent in the Sterilization Debate

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I. INTRODUCTION

"Se me acabó la canción," literally, "my song is finished" is a phrase used by some Mexican women after sterilization. [1] This phrase embodies the predicament women of color find themselves in when faced with the question of sterilization in the United States. The connotations of this single expression are very telling of the social, political, religious and economic forces that affect not only women's views about procreation but also the way in which reproductive decisions are intimately linked with their social identity.

In our age of hyper-technology and development, our aroused sense of social justice and political correctness tend to lead us to overlook the intricacies of human reproduction in the name of efficiency, control over economic markets and a "forge ahead, ask questions later" mentality. Mainstream society also reflects a positivist view that as a world power, the United States' domestic and international policies achieve more "good" than harm in the name of progress. This self-assurance is very prevalent on the home-front, especially relating to issues of population control and genetic research. Suspicion and cynicism about issues popularized by the eugenics movement of the early 20th century seem like an aberration. Today, mainstream society's antipathy for such "antiquated" ideas is prominent. Most people would agree that coerced sterilization is a dark page in our history, and that there is no room for such insidious policies in a democratic union. Nonetheless, the reality is that the debate over population control and reproductive rights continues to flourish in many arenas of social policy especially in the context of public welfare and reform. For example, as this paper later suggests long term forms of birth control have been marketed to low-income families as a way to keep procreation in check,

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[1] Carlos Velez, *Se Me Acabó La Canción: An Ethnography of Non-Consenting Sterilizations Among Mexican Women in Los Angeles*, *in* MEXICAN WOMEN IN THE UNITED STATES STRUGGLES PAST AND PRESENT 71, 71-91 (Magdalena Mora et al. eds., 1980).

which deprives women the flexibility and integrity to determine their own reproductive priorities.

This above example suggests that, although "coerced sterilization" in its grossly offensive conventional form may have seen its day, a much more insidious pattern of social engineering has come to replace it. I will refer to this model as de facto sterilization. The key in defining de facto sterilization is to investigate the gradations between coerced and voluntary sterilization and to reach an understanding of the ways in which this line is shifted within a continuum. This paper further argues that the reproductive fate of poor women of color has been tied all too closely with this movement, and has not only created, but bolstered racial stereotypes that legitimize de facto sterilization.

The main area of analysis will focus on how and why de facto forms of sterilization have developed and become ingrained in the fabric of society. This will be accomplished by exploring the various social, political and economic forces that have propelled family planning policies to favor sterilization and how these policies have targeted women of color.[2] In addition, this paper will seek to understand how women of color perceive their reproductive and healthcare rights and choices and how they have responded to notions of de facto sterilization.

This analysis will present a historiography of the eugenics movement in the United States as a backdrop for how theories of sterilization and population control evolved in the later decades of this millennium. This discussion will focus on the eugenics movement's intention to sterilize "fringe" groups including the mentally ill, physically disabled, the poor and those convicted of crimes. This history will set a framework for how people of color have been traditionally included in this latter group based on the "impurity of their race" and thus have suffered scientific racism.

This history will also survey the early legislation on sterilization and government population control priorities. This section will discuss recent legislative and governmental responses to sterilization as a way to enhance an understanding of the roots of eugenic thinking and aid in bridging the discussion to how sterilization policies and guidelines are addressed by state and federal law today.

Since this is an expansive area including such topics as contraception, family planning and population control, the analysis will specifically focus on the treatment of low-income women of color in the sterilization and family planning debate. This discussion will describe

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[2] Discussion of the religious forces has been specifically left out due to the breadth of its impact on this topic.

the various forms of de facto sterilization and the contexts in which they occur. Since the controversy around sterilization has traditionally focused on issues of medical consent, this paper will explore the notion of informed consent and the various legal cases that have developed specifically around the sterilization of women. A discussion of the attitudes and reasoning of the courts in deciding these cases will also be a telling documentation of the legal treatment of this subject matter.

I. THE IMPACT OF THE EARLY EUGENICS MOVEMENT

According to social historians, early eugenic thinking in the United States was imported directly from Europe to help explain, justify and solve the social problems that were becoming prevalent in the nation's cities. Literally, the term eugenics means "wellborn."[3] This flawed "pseudo-science" understood that social problems in America's society were due to "the misbehavior of degenerate persons, individuals whose biological origins predisposed or even predestined them to lives of crime, poverty, and prostitution."[4] Sir Francis Galton, an English scientist, popularized this idea through his notion of selective breeding of plants and animals which he later adapted to deal with the improvement of human "stock."[5] This mindset came about during an era where concepts of mental illness and disability were far from understood and justifications for racial inequality were being developed.[6] Another impetus was the effort to find ways to reduce the financial burden of public spending as the country experienced a general increase in the birth rate and an influx of immigrants.[7]

Early social scientists struggled to make a name for themselves by developing theories to explain such phenomena and influence social reform. Judging by the immense number of elaborate studies rendered on race and the connection between genetic heredity and intellect it is not surprising that by the 1920's a large influential body of research had developed indicating the variability of intellect in humans based on color and the heritability of deviance.[8] This racist research made it easier to

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[3] Michael Define, *A History of Governmentally Coerced Sterilization: The Plight of the Native American Woman 2* (1999) *at* http://res3.geocities.com/capitolhill/9118/mike2html.
[4] PHILIP REILLY, THE SURGICAL SOLUTION 1 (1991).
[5] DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION AND THE MEANING OF LIBERTY 59 (1997).
[6] REILLY, *supra* note 4, at 5.
[7] *Id.* at 12-18.
[8] *Id*.

label certain segments of society as inferior and to invoke sterilization programs to deal with them. The general presumption was that if certain cross sections of society were prohibited from procreating, crime, alcoholism, prostitution and feeble-mindedness would come to a halt, reducing a large part of the domestic economic burden. The mood of the times expressed a view that increasing propagation would not only endanger people's standard of living but also put a heavy burden on the welfare system. The early eugenic movement relied on grass roots approaches in educating the masses by getting their attention through engaging formats. One such method was to use city vagrants to walk around crowded areas in the city wearing placards that expressed the ideals of its authors. The cards read:

> I am a burden to myself and the state. Should I be allowed to propagate? I have no opportunity to educate or feed my children. They may become criminals. Would the prisons and asylums be filled if my kind had no children? I cannot read this sign. By what right have I children?[9]

Many used eugenicist arguments in introducing restrictive immigration legislation that would address concerns over American racial integrity by reducing the numbers of people of color allowed into the country.[10] For example, the Immigration Act of 1924, which restricted immigration to two percent of the national origin that occupied the nation in 1890, was passed with the help of research provided by the eugenics movement from army intelligence data concluding that the "superior Nordic blood" was decreasing rapidly.[11] There was a general fear that a mingling of the races or miscegenation would cause the rapid decline of society. Such ideas had been promoted from the top-down since the 1920's when eugenic courses became required in universities. According to Beverly Horsburgh, a typical text stated: "From the rate at which immigrants are increasing it is obvious that our very life-blood is at stake. For our own protection we must face the question of what types or races should be ruled out."[12] By the early 1940's these ideas were

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[9] KENNETH VAUX, BIRTH ETHICS: RELIGIOUS AND CULTURAL VALUES IN THE GENESIS OF LIFE 8-9 (1989).
[10] REILLY, *supra* note 4, at 22-29.
[11] Define, *supra* note 3, at 2.
[12] Beverly Horsburgh, *Schrodinger's Cat, Eugenics, and the Compulsory Sterilization of Welfare Mothers: Deconstructing an Old/New Rhetoric and Constructing the Reproductive Right to Natality for Low-Income Women of Color*, 17 CARDOZO L. REVIEW 531, 545 (1996).

further ingrained in American society with 30 states passing laws that made interracial sexual relationships illegal.[13]

Eugenic thinking also had a stifling affect on the development of welfare policies. With the well-promoted idea that the source of social ills was due to genetic degeneracy instead of environmental causes, supporters of eugenics were able to convince social reformers that "philanthropic funds were better spent on [eugenic endeavors]."[14] They argued that the disadvantaged had brought about their own plight and that subsidizing the poor would "undermine work incentives and a cheap workforce."[15] According to Dorothy Roberts, the main reason eugenicists opposed public assistance for the poor was that they believed an improvement in their living standard would harm society in allowing people of "inferior heredity to live longer and produce more children."[16] These ideas were probably partly responsible for black women's ineligibility for public assistance until the 1950's. One scholar suggests that once black women became eligible, "the morality of single motherhood became a public issue."[17]

Eugenics societies were to a large degree responsible for the propagation and study of eugenic ideals. The American Eugenics Society and the Human Betterment Foundation were two of the prominent organizations dedicated to eugenic thought and consciousness raising about the advantages of involuntary sterilization during the late 1920's.[18] These societies were headed by scientists, physicians and legal experts who motivated their followers in participating in a variety of activities from lobbying state legislatures to running "fitter family" contests at fairs (where families were awarded ribbons for their racial purity) or organizing lobbying efforts against charitable social causes.[19] These groups also funded most of the eugenic sterilization research conducted at that time and the categorization of sterilization candidates. Known to be a champion of sterilization, Harry Laughlin, who later became the superintendent of the Eugenics Record Office, was one of the most distinguished leaders of such societies and author of the most comprehensive legal survey on sterilization entitled *Eugenical Sterilization in the United States*.[20] Laughlin's main contributions to the

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[13] *Id.*
[14] *Id*. at 546.
[15] *Id.*
[16] ROBERTS, *supra* note 5, at 65.
[17] Horsburgh, *supra* note 12, at 546.
[18] REILLY, *supra* note 4, at 76-77.
[19] *Id.* at 77.
[20] *Id.* at 41.

eugenics movement was his collection of surveys conducted in various states which monitored state sterilization laws and the drafting of a model eugenical sterilization law promoting sterilization of the unfit.[21] His surveys show that by 1926, twenty-three states had enacted sterilization laws and 6,244 people had been sterilized.[22]

By the late 1930's, the influence of eugenics societies began to falter as mainstream society recognized that their focus on sterilization was too "negative."[23] Other reasons for the decline in the eugenics movement during this era were public awareness of the horrors of Nazi Germany and the rise of the civil rights movement.[24] These new awareness and social justice movements were directly antithetical to the eugenicists' call for wide spread involuntary sterilization and racial categorization. Proponents of eugenic sterilization had to look to new ways to expand and popularize their cause, forcing their discredited ideals of involuntary sterilization to take a new form.

II. POSTWAR EUGENICS AND THE RISE OF "VOLUNTARY" STERILIZATION

The policy and thinking of the new wave of post-war eugenicists went from overt to covert. They unleashed their campaign under the auspices of population control and family planning creating close ties with early birth control activists such as Margaret Sanger.[25] This alliance transformed the birth control movement from a feminist movement whose ideology was to espouse voluntary motherhood and reproductive freedom to a token device to be used by eugenicists in spreading their gospel of "voluntary" sterilization. Critics such as Horsburgh have seen this association as a downfall of the early liberal feminist movement: "What could have been a means of social mobility and an emerging sense of women's self-agency became new forms of social control."[26] For black women, sterilization was a double-edged sword. Although they saw it as a way to exercise control over their reproductive integrity, at the same time, they were skeptical about the way such policies would be applied.[27] The new wave of eugenicists were nothing more than wolves in sheep's clothing. Their main purpose

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[21] Horsburgh, *supra* note 12, at 553.
[22] REILLY, *supra.* note 4 at 67.
[23] *Id.* at 78.
[24] *Id.* at 128.
[25] Horsburgh, *supra* note 12, at 554.
[26] *Id.*
[27] *Id.*

was to increase the popularity of elective sterilization among indigent women using the borrowed rhetoric of the feminist movement. For example, they helped increase access to sterilization and lobbied for laws protecting physicians from liability in voluntary sterilizations.[28] Such eugenics groups as the Birth Control Federation targeted black communities where family planning services were absent. For example, the so-called "Negro Project" hired black ministers to campaign throughout the South to pressure black doctors to encourage women to submit to birth control.[29] The Project defended its crusade by reasoning that since blacks were from a portion of society which was less intelligent, they bred irresponsibly and thus were least able to properly raise children.[30] Eugenicists made justifications for sterilizing women of color under any popular cause they could champion including child abuse, temperance, birth control and social welfare.

In the 1960's and 70's, these revamped eugenicist organizations resembled progressive reproductive rights groups and made alliances with organizations such as Planned Parenthood in championing the cause of reproductive choice and family planning under the rubric of elective sterilization.[31] Today, the contemporary eugenics movement is propelled by private funding sources and has become a largely corporate scheme. According to Beverly Horsburgh, a scholar on the sterilization of women of color, there are thousands of private organizations, such as the Pioneer Fund, who annually sponsor millions of dollars worth of eugenic research. [32] Such research is a mouthpiece for the on-going perpetuation of racist beliefs developed by the eugenics movement in the sterilization and family planning debate. For example, although the Pioneer Fund's animosity is directed at blacks and Latinos, Horsburgh mentions that "the more zealous members believe people of color are being used to genetically destroy the white population so that Jews can take over the world."[33]

These modern endeavors continue to exploit the belief that social problems are caused by the "over-breeding" of non-whites and thus must be curbed by population control. Social policy on sterilization has been immensely influenced by this thinking with little public outcry or skepticism about the ways in which scientific misinformation is

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[28] REILLY, *supra* note 4, at 144-145.
[29] Horsburgh, *supra* note 12, at 554-555.
[30] *Id.* at 555.
[31] REILLY, *supra* note 4, at 146.
[32] Horsburgh, *supra* note 12, at 560-561.
[33] *Id.*

deployed. The impact of the emergence of this later movement will be discussed below.

III. THE BEGINNINGS OF STERILIZATION LEGISLATION AND ITS SUBSTITUTES

Sterilization at the turn of the century was virtually unregulated due to the fact that the technology was still in its infancy. Therapeutic sterilization used to save a patient's life was clearly authorized and at the discretion of the physician because the beneficial affects outweighed the harm.[34] However, the line between therapeutic and eugenic sterilization was very vague. According to Robert Veatch, once the procedure was sufficiently perfected in 1907, there was an influx of intrusive eugenic legislation on "reproductive choice."[35] Most of the early legislation was geared towards criminals convicted of sexual crimes, the physically and mentally disabled, and the "feeble-minded."[36] Hence, there was a sense that not only was there a benefit to public policy in decreasing the number of offspring born of "defective" individuals, but also a benefit to the sterilized person who could be released from institutionalization and live independently.[37] Such imprecise categorizations made it easy to target immigrants who scored low on I.Q. tests either because they were illiterate or non-English speaking.[38]

Most of the early compulsory sterilization statutes did not withstand constitutional scrutiny until 1927 when the courts suddenly began validating them. In *Buck v. Bell,* the most infamous involuntary sterilization case, the United States Supreme Court upheld a Virginia law authorizing forcible sterilization under which an 18 year-old woman who was considered "feeble-minded" was sterilized.[39] Justice Oliver Holmes, Jr. added an enormous amount of credibility to the eugenic aspirations of compulsory sterilization in his decision:

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices . . . . It is

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[34] ROBERT VEATCH, MEDICAL ETHICS 105 (1989).
[35] *Id.*
[36] NORMAN ST. JOHN-STEVAS, STERILIZATION AND PUBLIC POLICY 8 (1965).
[37] *Id.*
[38] Horsburgh, *supra* note 12, at 554.
[39] Buck v. Bell, 274 U.S. 200 (1927).

> better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.[40]

Justice Holmes's suggestion that the personal liberties of those who "sap" the state must be subordinated to the general welfare of society opened the floodgates to an ever increasing variety of state statutes recognizing the growing use of forcible sterilization on the poor. By the late 1930's, twenty states had passed legislation mimicking Virginia's statute and public perceptions of welfare recipients were fraught with blame and discontent for unwed mothers seen as "promiscuous" and "breeders of illegitimate children."[41] In a summary of all the state statutes adopted up to 1950 dealing with sterilization guidelines, the various grounds and "persons covered" for sterilization are very vague in who they may apply to. For example, the North Dakota Revised Code of 1943 authorized mandatory sterilization of "potential producers of offspring…who because of the inheritance of inferior or anti-social traits, probably would become social menaces or wards of the State."[42] Such broad definitions gave a great deal of latitude to state agencies and institutions in interpreting who was suited for the procedure.

Poor women of color were the direct targets of such widespread stereotypes. These accepted classifications gave Southern legislators the incentive to introduce moral legislation in the late 1950's. Senators in Mississippi and North Carolina used statistics to show the large discrepancy between black children and white children born out of wedlock as proof of black women's feeblemindedness and introduced legislation which would put the legal responsibility on "the mother to show cause why sterilization should not be ordered."[43] Other legislative efforts targeting black populations included Senate Bill 91 in Maryland (the closest a forcible sterilization bill came to becoming law), seeking to

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[40] *Id.* at 207.
[41] See Adelaida Del Castillo, *Sterilization: An Overview*, *in* MEXICAN WOMEN IN THE UNITED STATES STRUGGLES PAST AND PRESENT, *supra* note 1at 66-67. See also *supra* note 1, at 65-70 for a discussion of *Buck v. Bell* on welfare policy.
[42] ST. JOHN-STEVAS, *supra* note 36, at 54-55.
[43] Del Castillo, *supra* note 41, at 67.

legalize the sterilization of women convicted of having more than two illegitimate children.[44] There was also the suggestion in Illinois of sterilizing those convicted of prostitution and broadening the definition of prostitution to include women who had conceived more than one illegitimate child (illegal abortions were defined as births).[45] Although births were not part of the offense, the implication of the legislation was to keep women from having illegitimate children.

IV. SUBSTITUTES FOR STERILIZATION LEGISLATION

Where mandatory sterilization legislation failed in legitimizing forced sterilization of women of color, medical ethics, judicial mandates and administrative regulations often succeeded.

A. The Role of Physicians, Medical Ethics, and Judicial Decisions

The influence of medical practitioners on sterilization policies has also been overlooked. Gynecologists and obstetricians were often known to be the most vocal proponents of compulsory sterilization despite a plethora of scientific research and critiques contradicting the common belief that high reproduction rates are related to genes and the fact that mental disabilities occur at similar rates across socio-economic classes.[46] For example, as early as 1936, there is evidence of a double standard perpetuated by medical practitioners in sterilizing the poor or mentally disabled more than the well to do.[47] Medical practitioners were noted for believing: "If she is weak-minded or diseased and is liable to become a public charge, the operation is justifiable . . . with pauper patients, it is our practice to effect sterilization at third (cesarean) section."[48] The main issue in this area is the way in which medical ethics standards have been perceived and distorted. Physician paternalism over their patients, in general, is very complex, but at its root it has been defined as either "a refusal to accept or to acquiesce in another person's wishes, choices, and actions for that person's own benefit."[49] There are three main underlying justifications for non-acquiescence with the

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[44] *Id.*
[45] *Id.*
[46] See REILLY, *supra* note 4, at 111-127 for a discussion on critics of eugenic sterilization.
[47] Del Castillo, *supra* note 41, at 68.
[48] *Id.*
[49] JAMES CHILDRESS, WHO SHOULD DECIDE? PATERNALISM IN HEALTH CARE 13 (1982).

patient's wishes, with "benevolence" as the basis for all three: 1) the protection her individuals or society as a whole, 2) fairness to those who are poor and cannot afford medical care and 3) the enforcement of morality.[50] All three justifications play an integral part in the ways in which physicians may see the utility of sterilization. Such impressions on the subject could be based on personal stereotypes, past experiences with the patient and economic incentives.

Because individual autonomy is one of the highest values in our society, it is not surprising that there are ardent debates over the definitions of informed consent and substitutes for permission in creating safeguards against paternalism in sterilization cases. Informed consent consists of two duties imposed on physicians: the duty to adequately inform patients about the treatment (and make necessary disclosures), and the duty to obtain their consent.[51]

Some of the most grizzly sterilization abuses by physicians in the 1970's and early 80's were on Native American reservations due primarily to the lack of clear sterilization guidelines and regulations. Thus, its not surprising that in such medically destitute areas as the Navajo Reservation there were even less safeguards against coerced sterilization. The Indian Health Services, directly funded by the federal government, was in charge of contracting doctors for thirty percent of the reservation clinics when they were low on staffing or needed practitioners with specialties.[52] However, research on the Navajo Reservation revealed that female sterilization increased by almost 300% in the 1970's.[53] This increase in sterilization was probably due to the fact that contracted doctors were not required to follow a standardized federal guideline and were reimbursed per sterilization. [54] This lack of uniformity coupled with the monetary incentive to perform sterilizations probably gave rise to physicians failing to employ informed consent with their patients.[55] The report of the General Accounting Office found that the consent procedures particularly excluded information about the advantages and disadvantages of the process and notification that federal benefits would not be deprived if patients chose not to go through with the procedure.[56]

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[50] *Id*. at 15.
[51] Alan Meisel, *Informed Consent, Who Decides for Whom, in* MEDICAL ETHICS AND THE LAW 198, 197-217 (Marc Hiller ed., 1981).
[52] Define, *supra* note 3, at 6.
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] *Id.*

Judicial decisions tended to justify the sterilization of women of color and hold physicians blameless for the most part. It is interesting to note that the holding in *Buck v. Bell* has never been overturned and remains good law, leaving in place the principle that the state interest in its citizenry outweighs individual rights in this area. Many incidents of judicial advocacy for the sterilization of welfare recipients have gone unchecked. For example, in the 1971 case, *Wade v. Bethesda*, a Probate judge in Ohio forced the sterilization of a woman on public assistance on the basis of an affidavit submitted by the State Child Welfare Board that she was "feeble-minded" according to the definition of a state revised code that had been repealed three years earlier.[57] Another example of judicial provisos, in the 1970's, includes women of color who were forced to accept sterilization as forms of reduced sentences for welfare fraud and as probation for misdemeanor convictions.[58]

Another documented case of sterilization abuse affecting women of color is *Madrigal v. Quilligan.*[59] *This* case is particularly disconcerting because it highlights the inferior way in which medical professionals treated their female patients of color. In an analysis of the case by Carlos Velez, he indicates that ten Mexican non-English-speaking plaintiffs alleged that they were not given the opportunity to assert informed consent to sterilization procedures performed on them in urban county hospitals in Los Angeles.[60] The evidence, according to Velez (who was present at the trial), suggests that nurses and doctors either pressured patients into signing consent forms during intense stages of labor by withholding medical attention, did not inform patients about the permanency of sterilization, tricked their husbands into signing the consent forms, coerced patients into signing while under sedation or gave them false information that the State of California required tubal libation after three cesarean sections.[61] The plaintiffs lost their case and received an additional insult when the judge's decision suggested that the mistakes were due to a mere communication breakdown between the non-Spanish-speaking doctors and their Spanish-speaking patients.[62] The judge went on to justify the doctors' negligence by indicating that since they were operating in a busy inner city obstetrics ward they were not expected to have the time to carefully interpret the consent of people

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[57] See facts in *Wade v. Bethesda Hospital*, 357 F. Supp. 671 (1971).
[58] Del Castillo, *supra* note 41 at 67-68.
[59] Madrigal v. Quiligan, No. 75 Civ. 2057 (C.D. Cal June 30, 1978).
[60] Velez, *supra* note 1 at 77.
[61] *Id*.
[62] *Id*. at 86.

from "subcultures" different from their own.[63] According to Velez, the judge further sympathized with the doctors by giving more weight to the doctors' testimony that their custom and practice was not to suggest sterilization unless a patient asked for it.[64] This decision comes out of a climate of mistrust of non-white immigrants and a blind confidence in health care professionals in doing their "job."

As it later became apparent in the *Madrigal* case, destitute patients in inner city medical institutions were also used as practice cases by medical students. One glaring illustration of such practices occurred at a county hospital where low-income people received health care. According to the testimony of one staff member, a doctor told a group of training physicians: "I want you to ask every one of the girls if she wants her tubes tied, regardless of how old she is. Remember, every one who says yes to getting her tubes tied means two tubes (practice) for some resident or intern and less work for some poor son-of-a-bitch next year."[65]

B. Administrative Regulations

In the context of sterilization, the United States Department of Health and Human Services (DHHS) formally known as the Department of Health, Education and Welfare (DHEW) has been very closely tied to the supervision of medical ethical standards in sterilization procedures. In the 1970's, DHHS began promulgating regulations on how government funds pertaining to sterilization were to be spent.[66] Although these guidelines not only attempted to protect the rights of those dependent on governmental funds for health care and to standardize sterilization procedures, they fell short of these goals when it came to protecting the rights of minors and other people unable to give competent consent. Some courts were sensitive to this problem. For example, in the 1974 scandalous landmark case of *Relf v. Weinberger*, the DHHS guidelines were finally struck down where a physician was accused of sterilizing five black, teenage girls who were recipients of public assistance, without their consent.[67] In this case, the parents of the teenage girls consented to the procedure under a mistaken belief that

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[63] *Id.*
[64] *Id.*
[65] *Id.* at 77.
[66] Betty Gonzales & Robert Sansoucie, *Sterilization, Issues in Conflict, in* MEDICAL ETHICS AND THE LAW *supra* 51 at 361-362, 361-371.
[67] *Relf v. Weinberger*, 372 F.Supp. 1196 (1974).

they were receiving vaccinations.[68] The United States District Court for the District of Columbia held that federal funds could only be used to pay for sterilization services where competent persons gave a "voluntary, knowing and uncoerced consent."[69] The court further indicated that by definition minors and mentally deficient people were unable to give such informed consent even through a representative.[70] The court distinguished minors' legal incompetence for consenting to sterilization services from consent in the dissemination of general family planning information and products such as contraception. The court concluded that voluntary sterilization required a heightened level of consent because it "is an irreversible operation involving the basic human right to procreate."[71]

DHHS's "final rules" on the regulation of sterilization occurring under federally funded programs such as Medicaid (described below) came about in the aftermath of *Relf* and *Madrigal*. Such abuses came to attention of Congress. Four black congresswomen, Yvonne Burke of California, Shirley Chisholm of New York, Cardiss Collins of Illinois and Barbara Jordan of Texas were especially instrumental in the way in which the guidelines were drafted when they wrote to the DHHS secretary with their proposals.[72] According to Robert Weisbord, their main suggestion about the guidelines was to ensure family planning information and services were available to those who needed it and that standardized sterilization guidelines were promulgated to keep consent abuses in check.[73] In addition, another issue that was brought to the attention of the Secretary by the congresswomen was the inconsistent treatment of poor women of color by the welfare system. They pointed out that in prior years, recipients had to beg for public assistance, yet, suddenly social workers were eager to push them to use their Medicaid benefits for sterilization.[74]

The revamped guidelines detailed two major levels of consent before a sterilization procedure could be performed, all of which bar minors or mental incompetents from access except under very limited circumstances. The first was the signing of a special consent form. This

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[68] Meredith Blake, *Welfare and Coerced Contraception: Morality Implications of State Sponsored Reproductive Control*, 34 U. LOUISVILLE J. FAM. L. 311, 314 (1996).
[69] *Relf,* 372 F.Supp. at 1201.
[70] *Id.* at 1202.
[71] *Id.*
[72] ROBERT WEISBORD, GENOCIDE? BIRTH CONTROL AND THE BLACK AMERICAN 170-171 (1975).
[73] *Id.*
[74] *Id.*

consent would be valid unless the physician answered all the patient's questions, the patient had been advised that they are free to withdraw consent at any time before the sterilization without losing access to Medicaid benefits, the patient had been informed of alternative methods of family planning, and the patient had been supplied with an explanation of the procedure, its advantages and risks and its irreversibility.[75] The second level of consent includes a thirty-day waiting period.[76] The rules also forbid obtaining consent in situations when the patient is in labor, seeking services to terminate her pregnancy, under the influence of a controlled substance or unable to understand English and an interpreter is not provided.[77]

The experiences of the *Relf* and *Madrigal* plaintiffs typify many poor women of color's experience in getting adequate reproductive health care during the 1970's, 80's and today. Although the DHHS regulations set out a detailed procedure for obtaining informed consent, these guidelines are difficult to enforce when physicians choose to ignore them. There is also a large disparity in the diagnoses and treatments used by physicians in treating white women and women of color. One study indicates that white and black women with the same reproductive problem were not only diagnosed differently but the white women were treated with new reproductive technology while the black women was "cured " through sterilization procedures.[78] As will be further noted, sterilization abuse is at an increasing risk of becoming entangled with state sponsored reproductive control programs. Recent legislative proposes to provide incentives to welfare recipients to undergo sterilization or experiment with untested forms of long-term contraception.

V. DE FACTS STERILIZATION AND NEW CONTEXTS IN SOCIAL ENGINEERING

Sterilization is the most prevalently used form of birth control in the world and is used by over ten million women in the United States today.[79] Most techniques require surgical abdominal procedures including tubal libation and hysterectomy.[80] There are also long-term

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[75] REILLY, *supra* note 4, at 152.
[76] Gonzales, *supra* note 66 at 362-364.
[77] REILLY, *supra* note 4, at 152.
[78] Horsburgh, *supra* note 12, at 557.
[79] Blake, *supra* note 68, at 325.
[80] *Id.* at 325-328.

forms of contraception such as Norplant, Intrauterine Devices and Depo-Provera that require minor surgery and can be referred to as "temporary sterilization."[81] Although sterilization technology has improved immensely in the last thirty years, the risks of these procedures increase with certain factors including the patient's weight and susceptibility to certain illnesses.[82] A dangerous result of this procedure is an increased risk of contracting sexually transmitted diseases due to decreased condom use.[83]

Considering the permanent nature of sterilization procedures, it is significant to note that coerced sterilization has always been less controversial than other forms of contraception including abortion. This development is hardly coincidental. One reason for this phenomenon is that the "finality" of sterilization greatly decreases the need for future reproductive health. According to Loretta Ross, "by the late 1970's, female sterilization became the most widely used, medically encouraged, and financially reimbursable method of contraception among women in the United States who were over twenty-five" with Medicaid contributing ninety percent of the cost of most sterilization (while abortion received nearly no financial support).[84] Statistics show that sterilization rates tripled between 1970 and 1980 and in 1987 twenty-four percent of all women of childbearing age were sterilized.[85] This had wide reaching economic implications especially in reducing the cost of federally funded health programs such as Medicaid. As early as 1967, state and federal public assistance programs such as Aid to Families and Dependent Children (AFDC) promulgated two basic policies: 1) a requirement that at least six percent of funds for maternal and child care to be relegated to family-planning services and 2) to influence states to make a concerted effort in offering such services not only to present AFDC recipients but also to past and potential recipients in order to lower welfare expenses.[86]

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[81] *See generally* George Brown, *Long-Acting Contraceptives: Rationale, Current Development and Ethical Implications*, *in* COERCED CONTRACEPTION MORAL AND POLICY CHALLENGES OF LONG-ACTING BIRTH CONTROL 34-49 (Ellen Moskowitz et al. eds., 1996).

[82] See Blake, *supra* note 68, at 325-328 for an in depth discussion of the risks of sterilization.

[83] *Id.*

[84] Loretta Ross, *Why Women of Color Can't Talk About Population*, WINTER 1994 AMICUS J.L. 4, ¶ 6 (MARCH, 29, 1999) <http://www.nrdc.org/eamicus/clip01/lrwomen.html>.

[85] Define, *supra* note 3, at 3.

[86] VAUX, *supra* note 9, at 9.

There is no doubt that, for the government, a concern about the reproductive health of poor women of color is mainly a fiscal one. Coming from this perspective it is not surprising that the federal government subsidizes "temporary" sterilization or long term forms of birth control such as Norplant through Medicaid coverage but will not pay for other forms of contraception such as the "pill."[87] The implicit message is that poor women cannot be "trusted" to control their reproduction. In its 1991 decision in *Rust v. Sullivan*, the Supreme Court upheld a DHHS regulation that restricted health professionals from advising women who receive Medicaid about their family planning options and imposed a ban on abortion counseling.[88] According to critics of this decision, not only are family planning clinics forced to choose between federal funds or providing unrestricted medical information, "poor women who use federally-funded family planning clinics for health services have no right to expect to be fully informed about all medical options which might apply."[89]

There is little doubt that women of color, as a group, face disproportionate incidences of improper and coerced sterilization in comparison to white women in this country both past and present. Statistics show that in 1982, fifteen percent of white women were sterilized compared to twenty-four percent of black women, thirty-five percent of Puerto Rican women and forty-two percent of Native American women.[90] By region, the numbers are even more astounding. On Native American reservations nearly 50 sterilizations occurred in one month in the 1970's with the rate of sterilization doubling by the close of the decade.[91] Sterilization rates as high as sixty-five percent have been reported among Latino women in the Northeast, while in the South black women have undergone the highest rate of hysterectomy and tubal libation in the nation.[92]

The racial disparity in the incidences of sterilization cuts across marital status, economic class and education level. For example, black women, regardless of marital status, used sterilization as a form of contraception at a higher rate than white women.[93] Another study found that 9.7 percent of black women with a college-education and 31.6

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[87] Charolotte Rutherford, *Reproductive Freedoms and African American Women,* 4 YALE J.L & FEMINISM 255, 261-262 (1992).
[88] Rust v. Sullivan, 111 S. Ct. 1759 (1991).
[89] Rutherford, *supra* note 87at 266.
[90] Vicki Alexander, *Black Women and Health*, 6 CHOICES 6, 16 (1986).
[91] Define, *supra* note 3 at 4.
[92] Rutherford, *supra* note 87 at 274.
[93] *Id.*

percent without a high school diploma were sterilized compared to 5.6 percent of their white counterparts with a college education and 14.5 percent without a high school diploma.[94] There is a great deal of evidence which indicates that as more and more women of color were sterilized in the 1970's, 80's and recent 90's, white middle-class women had a very difficult time finding a doctor who would perform the procedure. One white woman indicated that her physician would not concede to sterilizing her unless she agreed to several sessions of psychiatric therapy, implying that a white woman who opts for sterilization must be suffering from a psychosis.[95] Although there is no data to indicate what percentage of the above sterilizations performed on women of color were coerced as opposed to voluntary, the disparity between the number of white women versus women of color who were sterilized is interesting and should be the subject of further research.

De facto sterilization is the unfortunate wave of the future. With a history of class-based racist ideology developed for nearly a century and a lack of proper information about other birth control options, it is not out of the question that women of color are coerced into sterilization while on the surface they seem to give voluntary consent. This could mean that many women opting for sterilization either do not understand its ramifications of irreversibility, do not know they have other non permanent options, are threatened into accepting this alternative due to population control policies or suffer unintended sterilization for reasons related to unsafe forms of contraception. Studies show that in a sample of sterilized black women, forty–five percent of the women interviewed did not realize they could no longer bear children and forty percent regretted the decision.[96] These statistics illustrate the reality that if women of color are given informed choices about reproductive health they will either opt for other methods of birth control or at least realize that sterilization is a serious binding procedure. Misunderstandings usually occur because the sterilization procedure is described by the physician as "tying the tubes" without any further detail.[97] Studies suggest that many women had the mistaken belief that "what can be tied can later be untied."[98] Thus, although it seems these women consented to sterilization, they were actually only consenting to what they thought to be temporary sterilization. The remainder of this paper will deal with

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[94] ROBERTS, *supra* note 5 at 97.
[95] *Id.* at 95.
[96] Rutherford, *supra* note 87 at 274.
[97] *Id.*
[98] *Id.*

the various ways in which de facto sterilization has been used to intimidate women from exercising their reproductive freedom with emphasis forms that seem to be the future trend.

A. Welfare Incentives

Welfare programs have a greater impact on women of color than on white women since the former are five times more likely to use public assistance, three times likelier to be unemployed and usually depend on assistance mainly to support their children.[99] Although more white women receive public assistance than women of color, the negative associated with being "on welfare" affect the latter in a very different way. For example, the myth of the "welfare queen" operates to bolster racist stereotypes that welfare programs encourage child birth and cause dependency when in fact women of color bear less children while receiving temporary aid.[100] Such myths set women of color apart from mainstream movements and insure that they are left out of the discourse on privacy and reproductive rights.[101] Given the history of the welfare debate as it relates to procreation, it may not be surprising that although more white women receive public assistance then women of color today, there seem to be a greater number of women of color on welfare who undergo sterilization.

As discussed above in the legal and legislative history of sterilization, the welfare system has always been very suspicious of poor women of color and their reproductive habits, often disregarding their right to quality health care. Community family planning clinics and medical centers across the country rely on public assistance programs to pay for services used by welfare recipients and are under strict guidelines in order to keep their eligibility for such federal subsidies. Researcher Beverly Horsburgh epitomized the healthcare plight of poor women of color when she stated:

> Single Black mothers on welfare are powerless to stop encroachments on their personhood . . . . [They] lack a political identity—a place in the law, separate from their

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[99] ROBERTS, *supra* note 5 at 111.

[100] See id. at 203-245 for a discussion of the welfare debate on procreation and its affects on Black women.

[101] Current statistics noted in Blake, *supra* note 68 at 323-324 show that welfare families are no larger than other families and that welfare mothers have less children while on public assistance.

> status as women and as nonwhites, that enable them to create a positive humanizing discourse to refute the negative dehumanizing imagery now defining them…they are invisible when it comes to claiming rights, but only too visible when it comes to blaming the poor.[102]

Poor women of color live in an alternative universe from white women where they are "penalized" for both choosing to have children or opting not to.[103]

In the arena of welfare reform, recipients are facing a disturbing new trend in making informed choices about family planning. These new policies are based on "behavior modification" models to encourage certain state-sanctioned sexual behavior in an effort to transform recipients into "responsible" parents.[104] Such proposals provide increased AFDC benefits to women who agree not to have more children or who submit to sterilization procedures or long-term contraception.[105] This implies that women can be "punished" if they do not obey the unwritten rules of "responsible" reproduction. Unfortunately, besides being reminiscent of the eugenic proposals of the 1920's, the effects of such reforms are to place direct pressures on poor women to chose sterilization in return for financial incentives or to avoid disincentives. Behavior modification incentives have loomed over the welfare system since the late 1970's, sometimes becoming the focus of lawsuits. In *Walker v. Pierce,* for example, two black women on Medicaid brought a civil rights action against their obstetrician for sterilizing one and threatening to sterilize the other, solely based on their race and economic class.[106] Their main issue in the complaint was that the defendant physician had a policy of requiring low-income patients to consent to voluntary tubal libation if they were delivering a third child.[107] The physician's service was directly contingent on this agreement. The physician himself admitted that he used this policy only "with people who were unable to financially support themselves . . . . If they did not wish [sterilization] as a condition for my care, then I requested that they seek another physician."[108] In addition, there was evidence that the

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[102] Horsburgh, *supra* note 12 at 575.
[103] *Id.* at 579.
[104] Blake, *supra* note 68 at 317.
[105] *Id.*
[106] *Walker v. Pierce*, 560 F.2d 609 (1977).
[107] *Id.* at 610.
[108] *Id.* at 611.

defendant had also threatened to get one of the plaintiff's public assistance terminated if she did not cooperate.[109] As a result of this threat one plaintiff tried unsuccessfully to find a new doctor but was told by her Social Services caseworker that no other physicians would be able to see her before she gave birth.[110] Realizing that further protest may endanger her pregnancy she signed three consent forms, fully aware that the surgery was permanent.[111] The court held for the physician, reasoning that "there was no judicial precedent or statute prohibiting [the physician's] personal economic philosophy…when all persons coming to him as patients are reasonably aware of his professional attitude [and] . . . At no time is he shown to have forced his view upon any mother."[112]

Walker is a glaring example of de facto sterilization. The plaintiffs were informed not only about the permanency of the procedure but were also given a full disclosure of the physician's policies. Yet, the evidence also showed that, if given the choice, these women would have chosen to be treated by another doctor and would not have elected sterilization, indicating that voluntary informed consent was impossible to give in such a threatening circumstance. The dissent pointed out that the physician's policy of requiring sterilization was voiced only if it appeared that the expenses would be paid from public funds.[113] In the case of one of the plaintiffs, the physician brought up his policy only after he learned from the patient's hospital records that she received Medicaid.[114]

Proposals for welfare incentives have the power to induce even greater myths about welfare mothers, causing an increase in sterilization abuses by doctors who already hold such views. As recently as 1993, Washington State and Oklahoma proposed bills that would set up a voluntary sterilization fund (proceeds to come from a five cent tax on soft drinks) from which welfare recipients would be paid a range of financial grants from $2,000 to $10,000 to undergo the procedure.[115] No such proposals have been adopted to date probably due to the controversial implications such legislation could have on the fundamental right to procreate and the danger of governmental infringement on this right. However, the growing concern over the costs

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[109] *Id.*
[110] *Id.*
[111] *Id.*
[112] *Id.* at 613.
[113] *Id*. at 614.
[114] *Id.*
[115] Blake, *supra* note 68 at 318.

of poverty has prompted government officials to continue pondering ways to deal with these issues.

The future of this debate is wide reaching. One argument raised is that such coercive measures would normally be found to violate a married couples' constitutional right to reproduce. The question is whether single mothers could receive similar privacy safeguards for their reproductive rights against such infringing measures.[116] This discrepancy also raises equal protection issues for procreation within the contexts of single parenthood and traditional nuclear families. It also focuses on the analysis of states' interests in population control and the discouragement of "irresponsible reproduction weighed against the welfare recipients' right to choose voluntary sterilization."[117]

B. Norplant

The use of Norplant as a form of contraception has been very closely tied to the welfare incentive scheme mainly because it has been utilized similarly in a range of contexts to "combat" poverty and control procreation. When the drug was approved in 1990 by the FDA, it seemed to promise sexual freedom with ease. The device works automatically after it is implanted under the skin of the upper arm through minor surgery and provides birth control for up to five years with little monitoring.[118] The early criticism of the drug was its cost. Norplant was seen as a rich woman's contraception because it cost about $365 per insertion, included additional costs of $150-650 for counseling and checkups and $150-300 for removal.[119]

A continuing controversy around Norplant is the three major uses it has been proposed for: 1) as incentives for "responsible" procreation by low-income women, 2) as a way to prevent drug addicted women from bearing children and 3) as a court-ordered condition of probation for mothers convicted of child abuse.[120] This section will deal

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[116] John Robertson, *Norplant and Irresponsible Reproduction*, *in* COERCED CONTRACEPTION MORAL AND POLICY CHALLENGES OF LONG-ACTING BIRTH CONTROL, *supra* note 81 at 89-90, 79-107.

[117] See *id.* generally for a discussion of the constitutional issues arising out of incentives for contraceptive sterilization.

[118] Robertson, *supra* note 116 at 79-80.

[119] *Id.*

[120] *See* Melissa Burke, *The Constitutionality of the Use of the Norplant Device as a Condition of Probation,* 20 HASTINGS CONST. L.Q. 207 (1992) for an extensive discussion of all 3 major proposed uses for Norplant.

exclusively with proposals for the use of Norplant as welfare incentives and why informed consent can be near impossible.[121]

As soon as the drug first entered the market, there was an influx of various proposals as to its possible uses in poor populations. The first public commentary was published by the *Philadelphia Inquirer* in a 1991 editorial which became the newspaper's greatest embarrassment. The article proposed making Norplant a condition of welfare in order to reduce the size of the "'underclass,'" with specific mention of poor African-Americans.[122] These racist sentiments fueled many legislators to propose bills that advanced such policies, similar to welfare incentives for sterilization. In 1991 a Kansas bill proposed to give welfare mothers a $500 incentive to use Norplant was rejected.[123] A bill in Ohio was much more extensive calling for an increase in public assistance of up to 150%. It required that the mother pass a parenting test or risk having her child put into foster care. It also required identification of the father of the existing children, who had the options of paying child support, doing community service or being paid to be sterilized.[124] Other similar bills were defeated in Maryland proposing mandatory use of Norplant in certain cases.[125] Critics of the measure argued that the money should be provided to welfare recipients in more practical forms such as scholarships or child care instead of an incentive to manipulate women into using birth control.[126] Some measures were later accepted after the cash incentive was removed and 48 other states enacted legislation that would provide Norplant, free of charge, to female welfare recipients.[127] Although, the latter legislation may be praiseworthy because it subsidized expensive birth control to low-income women, it is important to understand the contexts in which Norplant has been tested and to realize that many see it as a way to decrease "irresponsible" reproduction and not necessarily as a form of sexual freedom and reproductive choice.

There are many controversies about the drug itself, especially in regards to its infancy as a contraceptive option and its ethical implications of informed consent. The circumstances in which Norplant has been used shed light on the potential for its future applications. For

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[121] See generally, Robertson, *supra* note 116 at 79-103 for a discussion of the use of Norplant in fetal drug and child abuse contexts. See also Burke, *supra* note 120 for an in depth exploration of Norplant as a condition of probation.
[122] *Id.* at 81. *See also*, Blake, *supra* note 68 at 317.
[123] Burke, *supra* note 120 at 211.
[124] H.R. 343, (Ohio, 1993).
[125] Robertson, *supra* note 116 at 81.
[126] Burke, *supra* note 120 at 212.
[127] *Id.*

instance, one of the first populations on which Norplant was tested was in Baltimore at an inner city school for pregnant teenagers and teenaged mothers, the majority of whom were Black.[128] Although the program does not "push" Norplant on the teenagers and observes required informed consent guidelines, groups such as the National Black Women's Health Project worry that such programs target poor women of color into using long-lasting contraception that may not be safe.[129] Some critics go as far as considering such "trials" genocide.[130] The controversy regarding the reliability of Norplant is two-fold. First, there are concerns about both its known and unknown side-effects. Warnings, given at insertion indicate that there may be serious side-effects and complications including blood clots, heart attacks and strokes and others that have not been disclosed.[131] There is also research suggesting that certain groups of women may be at a higher risk of serious side effects either due to their habits, such as smoking, or due to being possible carriers of certain genetic diseases of which they are not aware of at the time of insertion including diabetes, anemia and breast cancer.[132] Specifically, black women seem to be at an increased danger of experiencing complications with Norplant due to the fact that certain illnesses caused by the drug (e.g. kidney disease, Keloid scarring, high blood pressure and obesity) are seen at a greater rate in black populations.[133] The second safety issue involves indirect risks, which are most prevalent in teenage populations. Studies have found that the use of Norplant by teenagers has lead to an increase in the contraction of HIV infection due to a reduction in the use of condoms.[134]

The stereotype of the "welfare queen" has been especially resounding in motivating physicians to steer women of color towards Norplant. A health care worker in an urban clinic who was interviewed by Dorothy Roberts in *Killing the Black Body*, confirms this suspicion when she indicates that doctors tell black women that they have "the answer" to their birth control problems and merely give them the choice between Norplant and Depo-Provera.[135] Such suggestions can be

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[128] Bonnie Steinbock, *The Concept of Coercion and Long-Term Contraceptives, in* COERCED CONTRACEPTION MORAL AND POLICY CHALLENGES OF LONG-ACTING BIRTH CONTROL, *supra* note 81 at 73, 53-78.
[129] *Id.* at 74.
[130] *Id.* at 73.
[131] Blake, *supra* note 68 at 331-332.
[132] *Id.* at 332.
[133] *Id.* at 333.
[134] Steinbock, *supra* note 128 at 75.
[135] Roberts, *supra* note 5 at 130.

coercive if women are not given sufficient information about their other options. For example, many women are introduced to Norplant at the hospital immediately after child birth. Since post-birth can often be a hectic, emotional and impressionable time in a woman's life, critics argue that it is not a coincidence that women are easily persuaded into accepting Norplant at that time.[136] Often, the counseling women of color receive from nurse practitioners or physicians about Norplant emphasizes the benefits of the drug and down plays the negative side-effects described above.[137] Women who are not given other contraceptive choices may see Norplant as their only alternative.

There are indications that there may be abuses with not only the carrying out of informed consent when some of the risks are unknown, but also in the removal of Norplant. There is evidence of clinics that have delayed poor women of colors' requests for removal of the device, claiming a lack of Medicaid funds.[138] Considering the fact that Norplant is funded by Medicaid in most states, as mentioned above, it only makes sense that its removal should also be covered. For example, a study tracking thirty-eight poor black Norplant-users, in the rural South, showed that they all had difficulties getting the device removed because their doctors either told them Medicaid did not cover the cost of removal and they would have to pay for it out-of-pocket or that they should "wait out" the side effects they were experiencing.[139] A Native American woman was told removal of the device was contingent on agreeing to a sterilization procedure.[140] This misinformation and refusal to abide by a woman's wishes is a coercive method that keeps poor women of color on long-lasting contraception against their will.

Ethical issues of voluntariness and consent appear to be just as vague in the context of providing incentives for Norplant as they are in sterilization. Although the two forms of contraception seem to be worlds apart in the forms they take, they both place immense barriers in the ability to chose motherhood either directly or indirectly. The idea that Norplant is less intrusive on individual rights then sterilization seems misguided. The above examples of the dangerous ways in which Norplant dissemination can be abused testify to de facto ways in which women of color have been persuaded or kept from exercising their right to bear children. Theoretically, there is very little difference in

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[136] *Id.* at 129.
[137] *Id.*.
[138] Blake, *supra* note 68 at 330-331.
[139] Roberts, *supra* note 5 at 132.
[140] *Id.*

contraception which is indefinite because it relies on an unwilling medical professional to remove and contraception which is permanent and entered into under duress or misinformation.

The constitutional debate is particularly pronounced around the issue of welfare incentives for Norplant use. Legal scholars have fervently debated the "doctrine of unconstitutional conditions" which indicates that the government cannot condition a benefit it confers on the relinquishment of a constitutional right.[141] Proponents of cash incentives argue that such schemes merely give "bonuses" to women on welfare and thus do not take any benefits away for noncompliance.[142] Critics of cash incentives suggest that the concept of "benefit" should be defined in the context of comparing women who chose to take Norplant for the incentive and women who opt out, thus indicating that those who choose not to comply are lose out financially.[143] Others have suggested that conditional grants benefiting the poor create impermissible hierarchies and thus should be subject to strict scrutiny that will measure whether the state's interest is compelling enough to justify the denial of a constitutional right.[144] The difficult question comes down to whether the state's interest in reducing the economic burden placed on society by poverty is justification enough to deprive the least socially and politically powerful facet of society from exercising their right to procreate. Perhaps the debate should focus on a more honest discourse about why poverty exists in the first place before proactive solutions can be evaluated.

VI. EPILOGUE

The gradations of coercion in the area of population control of low-income women of color seem to be shifting as new contraceptive technologies are invented. Old definitions of "coercion" and "involuntariness" such as physical force or constraint have developed new meaning in the intricate discourse about informed consent and free choice. One scholar has characterized the concept of coercion as, "how much, and what kind of, influence or pressure deprives actions and decision of their autonomous character."[145] The concept of coercion has

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[141] Steinbock, *supra* note 128 at 68.
[142] *Id*. at 70.
[143] *See generally,* David Coale, *Norplant Bonuses and the Unconstitutional Conditions Doctrine,* 71 TEX. L. REV 208 (1992).
[144] Steinbock, *supra* note 128 at 70.
[145] *Id.* at 55.

been applied in most of the examples of sterilization cited in the body of this paper; each seems to create an intuitive idea of where the line should be drawn. However, the legal complexity of the issue, especially its de facto contexts makes this insight murky.

Certainly, there are many valid uses for sterilization. Many women freely chose these procedures and are glad to have the option to do so even if they have regrets later. There are also justifications for public health interventions that recommend certain forms of long-acting contraception or sterilization. The problem with sterilization is the way in which the technology seems to be systematically applied to certain poor target populations. Here the responsibility may fall on specific medical practitioners to exhaust the informed consent guidelines before going forward with the procedure, but isn't the state ultimately responsible for supervising its medical care especially when it is funded by federal monies? This responsibility is not well shouldered.

Today, critics of sterilization and long-acting contraception are cynical about the government's motives of state sponsored sterilization policies given its notorious history. For example, this pessimism can be seen in a scholar's statement: "[the] state makes it easier for a mother on welfare to obtain sterilization than to keep warm in winter, find child care, or provide nourishing meals for her children."[146] If there is any truth to this statement the future of poor women of color's reproductive integrity could be in grave danger. Another interesting addition to the debate is to note the various interest groups that are either advocates of fertility control or are critical of it. For example in a list demarcating the organizations that have aligned themselves with either "side," it seems inconsistent that groups such as Planned Parenthood and the National Organization for Women are on opposite sides of the debate.[147] Both organizations uphold the liberal ideology that women should have a right to reproductive integrity and choice. Yet, it is important to realize that such agendas can be very complex and multifaceted, espousing very different goals about sterilization. Another problem is that such agendas are often created and promoted by white upper class women who may not be aware of the intricacies of poor woman of color's experience with reproductive healthcare.

Women of color sustain immense long-term trauma to their identity and self-being as a consequence of coerced sterilization. This paper unfolded with an embodiment of the multicultural aspect of how

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[146] Blake, *supra* note 68 at 339.

[147] *See,* ROBERT BLANK, FERTILITY CONTROL NEW TECHNIQUES, NEW POLICY ISSUES 102 (1991).

coerced sterilization affects the way in which women of color may identify themselves as women, mothers and citizens. Many women have suffered severe depression after realizing that without their procreative abilities they not only carry the stigma of being poor and branded "immoral" but in addition are no longer accepted by their community because they have lost the ability to procreate.[148] Scholars argue that acknowledging the importance of such cultural factors is key in understanding why the state cannot make judgments about who is fit to have children. Using the framework of cultural relativism, one critique is that "middle-class professionals simply have no business judging and trying to influence the reproductive choices of poor women of color.[149] Sensitivity towards issues of multiculturalism and class, specifically, the way people of different races are disparately impacted politically, economically, socially and culturally should be at the core of the solutions to stop institutionalized forms of de facto sterilization. More importantly, when all women are given control over their reproductive choices through neutral information and are able to decide the number and timing of their children, de facto sterilization may fade into the history for which it came. Until then, complacency over present projects that can be deemed eugenic in the name of "a better society" only contribute and further encourage a climate where de facto sterilization flourishes.

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[148] *See* Weisbord, *supra* note 72 at 159-160 for an account of a young, poor black minor whose mother consented to the sterilization without understanding the implications of the consent which left her daughter barren at a young age. The minor was coerced into believing that her family would lose their welfare benefits if she refused the procedure.

[149] John Arras & Jeffrey Blustein, *Reproductive Responsibility and Long-Term Contraceptives*, *in* COERCED CONTRACEPTION MORAL AND POLICY CHALLENGES OF LONG-ACTING BIRTH CONTROL, *supra* note 81 at 121, 108-133.