

## From Coercion to Coercion: Voluntary Sterilization Policies in the United States

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### Introduction

The Patient Protection and Affordable Care Act (ACA) has required that sterilization be added to the list of “preventive care” services that insurance policies must cover for women’s healthcare.<sup>1</sup> The Department of Health Resources and Services Administration’s (HRSA) addition is a welcome one and a major success for women’s reproductive health. However, in practice the ACA will have limited impact on access to sterilization as a contraceptive method. Physicians, in the absence of state laws that mandate otherwise, still retain unfettered authority to prescribe or refuse sterilization procedures.<sup>2</sup> Moreover, some state laws make it difficult for some women to access sterilization at all, despite the fact that the HRSA interprets the ACA as mandating

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1. The ACA mandates health insurance to cover “preventive health services” in full. Patient Protection and Affordable Care Act § 2713, 42 U.S.C. § 300gg-13 (2010).

2. The ACA requires coverage for preventive care only insofar as the services are prescribed by a physician. *Id.* For state laws that give physicians and facilities the freedom to refuse to sterilize a person, see *infra* note 6. It should also be noted that plans provided by certain religious employers (who must meet the guidelines set out by the Health Resources and Services Administration) are not required to provide insurance coverage for contraceptive methods to which they object, which could include sterilization. See Coverage of Preventive Health Services, 45 C.F.R. § 147.130(a)(1)(iv)(B); see also Health Res. and Servs. Admin., *Women’s Preventive Services: Required Health Plan Coverage Guidelines*, U.S. DEPT OF HEALTH & HUMAN SERVS. [hereinafter HRSA], <http://www.hrsa.gov/womensguidelines/> (last visited Jan. 25, 2013) (pointing out that the federally mandated coverage guidelines for contraceptive methods and counseling do not apply to women who participate in or are beneficiaries of plans sponsored by religious employers, and accommodations are also available to certain eligible organizations and student health plans). In its next session, the Supreme Court will decide the issue of whether it is constitutional to require contraception coverage in health plans. See Brigitte Amiri, *Birth Control Goes to the Supreme Court*, ACLU BLOG OF RIGHTS (Nov. 26, 2013), <https://www.aclu.org/blog/reproductive-freedom-religion-belief/birth-control-goes-supreme-court>.

coverage for the procedure.<sup>3</sup> For example, some state laws disparately impact women who receive Medicaid benefits<sup>4</sup> and women who are unmarried<sup>5</sup> or childfree,<sup>6</sup> while other state laws make it difficult for Planned Parenthood and other clinics to offer sterilization procedures, notwithstanding the new out-patient, non-surgical hysteroscopic methods which allow a woman to be on her feet and back to her daily activities in only a matter of hours.<sup>7</sup> The amalgamation of state restrictions and unchecked

3. See HRSA, *supra* note 2.

4. In 2012, the American College of Obstetricians and Gynecologists (ACOG) explained that Medicaid regulations require women to sign a consent form thirty days before all sterilization procedures, and if any number of clerical errors occur or the insurance company deems it "illegible," her request for sterilization will be denied. ACOG lamented that current federal consent rules for sterilization procedures "place an undue burden on women and effectively creates a two-tier system of access." Press Release, The Am. Coll. of Obstetricians & Gynecologists, Women Face Unfair Burdens to Sterilization Requests (June 21, 2012), available at [http://www.acog.org/About\\_ACOG/News\\_Room/News\\_Releases/2012/Women\\_on\\_Medicaid\\_Face\\_Unfair\\_Barriers\\_to\\_Sterilization\\_Requests](http://www.acog.org/About_ACOG/News_Room/News_Releases/2012/Women_on_Medicaid_Face_Unfair_Barriers_to_Sterilization_Requests).

5. See, e.g., GA. CODE ANN. § 31-20-2 (West 2013) (making it unlawful for any physician to sterilize a legally married person under eighteen years of age or an unmarried person over eighteen years of age unless the physician (1) obtains a written request by the person for the procedure and (2) prior to or at the time of the request, provides the patient with a "full and reasonable medical explanation . . . as to the meaning and consequence of such operation").

6. Compare CAL. HEALTH & SAFETY CODE § 1258 (West 2013) (prohibiting the use of non-medical reasons in determining whether to sterilize a patient), and TENN. CODE ANN. § 68-34-108 (West 2013) (prohibiting insurance companies from refusing to cover a sterilization due to its non-therapeutic nature), with KAN. STAT. ANN. § 65-446 (West 2013) (stating that no person shall be required to perform medical procedures which result in the sterilization of a person, and no person can be held civilly liable or be fired for refusing to take part in a sterilization procedure), N.J. STAT. ANN. § 2A:65A-3 (West 2013) (allowing persons to refuse to perform, assist in the performance of, or provide abortion or sterilization procedures without facing civil or criminal liability, disciplinary action, or discriminatory treatment), 43 PA. STAT. ANN. § 955.2 (West 2013) (providing immunity and protection against discrimination to hospitals, facilities, doctors, nurses, and other personnel that refuse to perform, participate in, or cooperate in an abortion or sterilization procedural on moral, religious, or professional grounds), and W. VA. CODE ANN. § 16-11-1 (West 2013) (allowing hospitals/facilities to refuse to admit patients for sterilization procedures and providing persons with immunity from civil liability for refusing to perform, accommodate, or assist in a sterilization procedure).

7. The Essure method is a non-surgical sterilization procedure in which a health care provider implants a "microinsert" into each of the fallopian tubes. See *Sterilization for Women (Tubal Sterilization)*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/health-topics/birth-control/sterilization-women-4248.htm> (last visited Oct. 15, 2013). The implant causes natural tissue to grow around the implant and this tissue permanently blocks the tubes. *Id.* Essure sterilization is reported to be safer and more convenient than surgical methods, because an incision is not required, general anesthesia is not necessary, and recovery is much faster—most women can return to normal activities the same day. *Id.*

conscientious objection exceptions has essentially preserved a coercive regulation scheme that has existed since the eugenic sterilization practices of the 1920s.

Most of the research conducted on voluntary sterilization regulations is over thirty years old,<sup>8</sup> even though most states' sterilization policies have changed since then.<sup>9</sup> This Note builds upon the existing scholarship by reexamining state sterilization restrictions in light of the ACA's contraception mandate and analyzing whether these laws afford women adequate choice and autonomy in their reproductive healthcare.

As presently written, many state policies pose obstacles that have made obtaining sterilization procedures unnecessarily

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8. See, e.g., Susan L. Bloom, *A Woman's Right to Voluntary Sterilization*, 22 BUFF. L. REV. 291, 304 (1972) (analyzing legal impediments to certain methods of contraception, especially voluntary sterilization, in light of population issues and widespread acceptance of contraception); see also Linda K. Champlin & Mark E. Winslow, *Elective Sterilization*, 113 U. PA. L. REV. 415, 419 (1965) (surveying prevalent medical provider attitudes toward elective sterilization for the purpose of family limitation, whether sterilization is widely available, why providers restrict access for that use, legal consequences of elective sterilization, and proposing legislation that would relieve providers' concerns regarding legal consequences); James F. McKenzie, *Contraceptive Sterilization: The Doctor, the Patient, and the United States Constitution*, 25 U. FLA. L. REV. 327, 329 (1973) (arguing that legislative advocacy for sterilization as a viable contraceptive method would increase productive use of the service and alleviate physicians' fear of liability); W. Douglas Myers, *A Constitutional Evaluation of Statutory and Administrative Impediments to Voluntary Sterilization*, 14 J. FAM. L. 67, 68 (1975) (analyzing statutory and non-statutory limitations on access to voluntary sterilization and the constitutional issues that such limitations raise); Angela Roddey Holder, *Voluntary Sterilization*, 225 J. AM. MED. ASS'N 1743 (1973) (examining the legal issues involved with performing voluntary (nontherapeutic) sterilization, including constitutional, statutory, spousal, and physician liability issues involved with the performance of voluntary, nontherapeutic sterilization).

9. During the 1960s, in some states, a physician could have been held criminally liable for performing or promoting sterilization operations unless she or he performed the procedure in accordance with a eugenic statute or could show "medical necessity." See Champlin & Winslow, *supra* note 8, at 419–27. Now, states providing for legal voluntary sterilization often protect physicians from criminal and civil liability for performing a sterilization operation. See, e.g., TENN. CODE ANN. § 68-34-109 (West 2013) ("[N]o physician or surgeon licensed by this state shall be liable civilly or criminally by reason of having preformed [sterilization] . . ."). Despite this progress, women still face obstacles, such as hesitancy to provide sterilization based on age stereotypes. See, e.g., Champlin & Winslow, *supra* note 8, at 419 (writing in 1965 that "there is much more hesitancy to sterilize a younger woman, regardless of the number of children she has."); Pamela Paul, Q: *Just How Hard Can It Be to Avoid Getting Pregnant? A: Much Harder than You'd Think*, 202 VOGUE 122, 122 (2012) (writing in 2012 regarding reproductive injustices which women still face); Telephone Interview with Sofia, Attorney on the West Coast (Oct. 19, 2012) (discussing her personal struggle in getting a surgical sterilization, in part due to her age).

restrictive.<sup>10</sup> A number of factors have combined to create obstacles for women seeking sterilization voluntarily: 1) the legacy of legal eugenic and neo-eugenic involuntary sterilization programs in the United States has resulted in various restrictions on doctors and clinics attempting to offer the procedure; 2) there is a lack of legislation and case law guaranteeing access to the procedure; and 3) cultural attitudes about fertility and motherhood have kept these obstacles from rising to the same level of public concern as abortion or assisted reproductive technologies.

Part I of this Note introduces the narratives of several women who have voluntarily sought sterilizations as a means of permanent contraception and encountered frustrating obstacles. These narratives illustrate the ways in which sterilization policies have moved from one form of coercion in their potential for allowing forced sterilizations, to another form of coercion in which women voluntarily seeking the procedure are denied access. Part II of this Note contextualizes these contemporary stories of coercion by providing a brief overview of the social and legal history of sterilization in the United States and suggests that this historical legacy is one of the primary reasons for existing obstacles to voluntary sterilization. Part III provides a survey of current state regulations regarding voluntary sterilizations and various types of restrictions that will inhibit the effectiveness of the ACA's preventive care mandate. Part IV of this Note calls to increase access to voluntary sterilization for *all* women, including women on Medicaid and childfree women, by including the following key components in state legislation: 1) a guarantee that complete information will be accessible to all women by requiring physicians to provide referrals for procedures they refuse to provide through conscientious objection; 2) a prohibition on nonmedical qualifications; and 3) enforcement of the ACA's mandate to provide coverage for contraceptive sterilizations without discrimination based on ability to pay.

### **I. Sterilization Stories: Childfree Women & Coercion**

Sterilization through tubal ligation is the preferred method for many women seeking permanent contraception.<sup>11</sup> Indeed, the Guttmacher Institute reports that surgical sterilization is the

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10. For an in-depth discussion of these restrictions, such as instituting a thirty-day waiting period, see *infra* Part IV(C).

11. See PLANNED PARENTHOOD, *supra* note 7.

second-most popular form of contraception in the United States.<sup>12</sup> The majority of tubal ligations occur immediately after labor so that women do not have to extend a normal hospital stay, and so the recovery for the tubal ligation and the birth take place during the same period.<sup>13</sup>

As a “safe, convenient, easy, and highly effective birth control method for the long term,” sterilization is also an increasingly attractive option for women who have never had children and are certain they do not want children.<sup>14</sup> Doctors often greet childfree women’s requests for sterilizations with hesitation.<sup>15</sup> The reasons physicians provide for not sterilizing childfree women frequently have nothing to do with physical health. Rather, they are manifestations of several different fears: fear that a woman will change her mind later, fear of the inherent risk of “unnecessary” surgical procedures, and fear that a woman might have been coerced in some way.<sup>16</sup> The first reason, that a woman might change her mind, is problematic in several ways. It assumes, first, that childbearing should be the default for women of a certain age and social status. It also assumes that a woman cannot be fully informed about her decision to undergo sterilization, because she has not experienced the “biological urge” to have children.

Elaine Tyler May, a historian who studies changing cultural expectations of marriage and reproduction in the United States,

12. *Fact Sheet: Contraceptive Use in the United States*, GUTTMACHER INST. (Aug. 2013) [hereinafter *Contraceptive Use*], [http://www.guttmacher.org/pubs/fb\\_contr\\_use.pdf](http://www.guttmacher.org/pubs/fb_contr_use.pdf) (detailing the results of its 2012 study, which found that sterilization in the form of tubal ligation was second only to the birth control pill in terms of popularity within the United States).

13. Carolyn Westhoff & Anne Davis, *Tubal Sterilization: Focus on the U.S. Experience*, 73 *FERTILITY & STERILITY* 913, 914–16 (2000).

14. Deborah Bartz & James A. Greenberg, *Sterilization in the United States*, 1 *REV. IN OBSTETRICS & GYNECOLOGY* 23, 24 (2008) (endorsing sterilization for both males and females, and citing that sterilization is the most common contraceptive method used by couples in the United States (either relying on female sterilization or a vasectomy)).

15. Briana Rognlin, *Offspring Off Limits: The Real Reasons Doctors Won't Sterilize Women*, BLISSTREE (Mar. 21, 2011), <http://www.blisstree.com/2011/03/21/sex-relationships/childfree-debate-limits-why-doctors-won't-sterilize-women/>.

16. R. E. Lawrence et al., *Factors Influencing Physicians' Advice About Female Sterilization in USA: A National Survey*, 26 *HUMAN REPROD.* 106, 108–11 (2010). In this study, up to seventy percent of physicians would attempt to dissuade a woman from sterilization, depending on age, parity, and spousal agreement; the sex of the physician had no significant effect on advice about tubal ligation. *Id.* at 106–07. One doctor explained that, though risks during tubal ligation are low, he has seen at least one patient die from complications during the surgery; therefore, with their availability, effectiveness, and long duration, an IUD may be a safer and less risky choice). See Rognlin, *supra* note 15.

chronicles the social history of childfree women and argues, “[a]lthough procreation is a profoundly private experience, reproductive behavior takes place in a society that is deeply concerned about who becomes a parent and under what circumstances.”<sup>17</sup> May’s point rings true today, as women’s reproduction continues to be a matter of public debate at the state and national levels.<sup>18</sup> May suggests that the social necessity of becoming a mother (as opposed to only the biological necessity) might have originated in the early post-World War II era, in which “[p]arenthood conferred not only full adult status, but also evidence of socially sanctioned heterosexuality and patriotic citizenship.”<sup>19</sup> Being childfree, voluntarily or involuntarily, was, and arguably still is, an aberration.<sup>20</sup>

Because of the perceived social responsibility attached to parenthood, May argues that “the infertile have become more desperate and the voluntarily childless have become more defensive.”<sup>21</sup> Such sensitivity and defensiveness appear even within the terms women use to describe their lifestyles: calling a woman “childless,” versus “childfree,” versus “barren” all trigger different connotations and are often points of dissidence among women who do not become parents.<sup>22</sup> One voluntarily childfree woman told May that she was tired of being viewed as an “odddity.”<sup>23</sup> The woman explained, “[i]t’s [easier] to sympathize with the woman who spends a fortune on fertility treatments that

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17. ELAINE TYLER MAY, *BARREN IN THE PROMISED LAND: CHILDLESS AMERICANS AND THE PURSUIT OF HAPPINESS* 2 (1995). See Elaine T. May, UNIV. OF MINN. AM. STUDIES DEP’T, <http://americanstudies.umn.edu/people/profile.php?UID=mayxx002> (last visited Oct. 14, 2013).

18. See e.g., Lisa Brown, Op-Ed., *Lisa Brown: Silenced for Saying (Shock!) ‘Vagina,’* CNN (June 21, 2012, 11:14 AM), <http://www.cnn.com/2012/06/21/opinion/brown-kicked-out-for-saying-vagina/index.html> (recounting the story of Lisa Brown, Republican Representative from Michigan, who was banned from speaking on the House floor after using the word “vagina” to comment on the overbearing interest the men in the House of Representatives have in women’s reproduction); Paige Lavender & Nick Wing, *Tampons Confiscated, Guns Still Allowed at Texas Capitol Ahead of Abortion Vote*, HUFFINGTON POST (July 12, 2013, 7:00 PM), [http://www.huffingtonpost.com/2013/07/12/tampons-confiscated-texas\\_n\\_3588177.html](http://www.huffingtonpost.com/2013/07/12/tampons-confiscated-texas_n_3588177.html) (reporting on the Texas legislature’s vote on a controversial anti-abortion bill, at which feminine hygiene products were confiscated as “potential projectiles”).

19. MAY, *supra* note 17, at 3.

20. See *id.* at 13.

21. *Id.* at 16–17.

22. See *id.* at 13.

23. *Id.* at 183.

ruin her health and destroy her marriage than it is to understand a woman who says, 'I'm doing other things with my life.'<sup>24</sup>

A. *Sofia, Denied a Sterilization in Missouri in 2004*

*When a woman says she wants to have a child, no one asks her if she's really ready to commit to being a parent for the rest of her life. Why are they so concerned with my decision to never have a child for the rest of my life? In my mind, it's the same type of decision.*<sup>25</sup>

Sofia chooses to live childfree for ethical, ideological, and personal reasons.<sup>26</sup> First and foremost, she is concerned about overpopulation and its effect on the environment.<sup>27</sup> She believes that parents who do not seriously consider adding to the population and the high level of consumption that childrearing entails are irresponsible.<sup>28</sup> In addition to her ethical reasons for remaining childfree, Sofia recalls babysitting as a teenager for families in which the mother shouldered the entire burden of childrearing.<sup>29</sup> Sofia bemoans the expectation that women have to first undertake all the risk to their bodies that accompanies pregnancy, and second, assume the primary responsibility of raising the children.<sup>30</sup> Finally, Sofia has never liked children very much, and she has known for a long time that she never wanted them for herself.<sup>31</sup> Because Sofia has never wanted children of her own, because she disagrees with socially constructed responsibilities of motherhood, and because she believes that the world is already overpopulated, she sought sterilization at the age of twenty-four.<sup>32</sup>

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24. *Id.*

25. Telephone Interview with Sofia, *supra* note 9. This Author interviewed Sofia via telephone. During the interview, Sofia asked for her real name and current location to be kept private, because Sofia has not told her parents or other immediate family about her decision to remain childfree.

26. *Id.*

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.* Though it has been eight years since Sofia sought sterilization, the Planned Parenthood Clinic she visited still does not offer the procedure. See *Patty Brous Health Center - Kansas City, MO*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/health-center/centerDetails.asp?f=2628&a=90740&v=details#!service=birth-control> (last visited Nov. 11, 2012).

In 2004, Sofia was twenty-four and living in Kansas City, Missouri.<sup>33</sup> She talked to her local Planned Parenthood about surgical sterilization for permanent contraception.<sup>34</sup> “[The nurse] basically laughed at me,” Sofia said, “and she told me that no doctor in Kansas City would do that for me, even if Planned Parenthood approved it.”<sup>35</sup> Sofia, dissatisfied with the nurse’s response, e-mailed a complaint to the regional administrative offices and received a similar response.<sup>36</sup> Sofia sought out several more physicians to perform the procedure; they all denied her request.<sup>37</sup> The most cited reasons for refusing to perform a tubal ligation on Sofia were her age and the fact that she had no children.<sup>38</sup> One doctor even told Sofia that her “future partner” might want children, and it would be best if she waited to have the procedure done.<sup>39</sup>

Sofia argues that she presented her reasons for wanting the procedure as a rational, well informed, educated young woman, and she was treated with much more skepticism than if she had been asking for plastic surgery or fertility treatment.<sup>40</sup> “It’s as though we view the decision to have or to not have children differently from any other decision that will significantly impact our lives.”<sup>41</sup> Finally, after almost a full year of seeking the procedure, Sofia obtained a referral for a tubal ligation in California.<sup>42</sup> She has never regretted having the procedure.<sup>43</sup>

### *B. Other Childfree Women Denied Sterilizations Across the Country*

Though many women utilize surgical sterilization (usually in the form of tubal ligations),<sup>44</sup> too many women, like Sofia, face

33. Telephone Interview with Sofia, *supra* note 9.

34. *Id.*

35. *Id.*

36. See E-mail from Becki Brenner, Vice Pres. for Clinical Services, Planned Parenthood of Kan. & Mid-Mo., to Sofia (Apr. 16, 2004, 02:58 CST) (on file with author) (“The medical providers in the areas that we serve and where we have a referral relationship would question your desire for permanent sterilization at your age.”).

37. Telephone Interview with Sofia, *supra* note 9.

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

43. *Id.*

44. See Paul, *supra* note 9, at 122–23 (identifying tubal ligation as “the most common form of surgical female sterilization” and explaining that 643,000 tubal ligations were performed in the United States in 2006).



undue obstacles when trying to obtain the procedure. Cultural media is rife with examples of middle-class, married women with insurance who have come forward to talk about the difficulty they faced when trying to get sterilized.<sup>45</sup> Gynecologists repeatedly denied Erin Iwamoto-Galusha, a voluntarily childfree woman, the tubal ligation she requested.<sup>46</sup> She began seeking sterilization at age twenty, but was forced to ask a different doctor every year for five years, until one finally agreed.<sup>47</sup>

For Monica Trombley, getting a tubal ligation was a “fight” despite the odds she considered to be in her favor: she lived in New York City, she was married to a man who also didn’t want children, she worked as an attorney (a field she thought most people understood to be unfriendly to mothers), and it was the twenty-first century, after all.<sup>48</sup> She said she encountered multiple paternalistic doctors who said they wanted to “talk [her] out of it,” but the worst experience came when one doctor “outright lied to [her] about his willingness to respect [her] reproductive rights and [her] right to make decisions for [her] own family.”<sup>49</sup> This doctor changed his mind about doing the surgery at the last minute.<sup>50</sup> She was only able to get sterilized after she lied to a specialist in Manhattan about her reasons for wanting the procedure.<sup>51</sup> “As a lawyer,” she wrote, “I proposed to sign paperwork [that would excuse my doctors from liability] every single time I asked about getting a tubal and still had doctors trying to talk me out of it.”<sup>52</sup>

As these women’s stories illustrate, denying sterilization procedures to childfree women is not really “conscientious objection” in the traditional sense—in which moral convictions

45. Women also continue to struggle for access to even temporary forms of contraception. See Stephanie Mencimer, *Holding Birth Control Hostage*, MOTHER JONES (Apr. 30, 2012, 3:00 AM), <http://www.motherjones.com/politics/2012/04/doctors-holding-birth-control-hostage?page=1> (“Doctors still require women to submit to cancer screenings and pelvic exams to get birth control pills. Scientists say that shouldn’t happen.”); see also Maddie Oatman, *Why Don’t More American Women Use IUDs?*, MOTHER JONES (Sept. 26, 2012, 3:00 AM), <http://www.motherjones.com/blue-marble/2012/09/why-are-iuds-unpopular> (revealing that physicians have been denying IUDs to women who are “not in ‘relationships’”).

46. See, e.g., Paul, *supra* note 9, at 122 (explaining how Erin Iwamoto-Galusha was repeatedly denied access to sterilization by her doctors).

47. *Id.*

48. Monica Trombley, *No Kids for Me, Thanks: I Tied My Tubes at 26*, SLATE (June 13, 2012, 3:00 PM), [http://www.slate.com/blogs/xx\\_factor/2012/06/13/choosing\\_to\\_be\\_child\\_free\\_tubes\\_tied\\_at\\_26.html](http://www.slate.com/blogs/xx_factor/2012/06/13/choosing_to_be_child_free_tubes_tied_at_26.html).

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.*

from religiously held beliefs prevent physicians from performing certain procedures, like abortions<sup>53</sup>—because this context more closely resembles a physician opposing a procedure based on a consciously held belief that a woman should want to be a mother.<sup>54</sup> This is particularly problematic, because when a physician—someone a woman depends upon and trusts for reproductive health care and advice—expresses personal concern about a woman’s decision to never have children, it takes the form of “medical advice” that is really not based on any medical indications.

## II. Coercion in Eugenics & Prevalent Sterilization Abuses Throughout the Twentieth Century

Public concern with women’s reproductive capacities began to come to the forefront of domestic politics starting in 1905, during Theodore Roosevelt’s preoccupation with “race suicide.”<sup>55</sup> Committing “race suicide” was the idea Roosevelt used to incite fear of declining fertility rates and Americans’ tendency toward smaller families.<sup>56</sup> Historian Linda Gordon describes the concept of race suicide as evolving to encompass several concerns about the changing American demographic landscape in the early twentieth century.<sup>57</sup> First, many people objected to birth control in general because it was “sinful.”<sup>58</sup> Second, many feared limiting family size because of the widely held belief that, in order to prosper, the United States needed a steadily growing population.<sup>59</sup> There was also fear that if wealthy, educated White people continued to have the lowest birth rate in the nation, the United States would become overrun with immigrants, non-Caucasians, feeble-minded

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53. See Thaddeus Mason Pope, *Legal Briefing: Conscience Clauses and Conscientious Refusal*, 21 J. CLINICAL ETHICS 163, 169 (2010); see also Sy Kraft, *More Docs Refusing Abortions; Religion and Location Named Factors*, MED. NEWS TODAY (Aug. 24, 2011, 10:00 AM), <http://www.medicalnewstoday.com/articles/233282.php>.

54. See Rognlin, *supra* note 15 (revealing that some doctors refuse to sterilize women based on the presumption that they will eventually desire to become pregnant).

55. Lasting approximately until 1910, the “race-suicide alarm” fundamentally attacked women and their reproductive health choices: Roosevelt coined women who tried to limit family size as “criminal against the race[,] . . . the object of contemptuous abhorrence by healthy people.” LINDA GORDON, *THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA* 86 (2002).

56. *Id.*

57. *Id.* at 87.

58. *Id.*

59. *Id.*

people, and poor people; these groups had much higher birth rates at the time.<sup>60</sup> Finally, some viewed birth control as a “rebellion of women against their primary social duty—motherhood.”<sup>61</sup> All of these concerns were based on fear of women’s reproductive autonomy and women’s ability to control the future of the dominant race.<sup>62</sup>

Roosevelt’s “race suicide” panic ultimately played into later movements to manipulate women’s (and men’s) reproductive choices and abilities in the formal eugenics movement that lasted into the 1950s,<sup>63</sup> the later neo-eugenic practices of the era of welfare reform in the 1950s–1970s,<sup>64</sup> and the “new pronatalism” that emerged in the late 1980s.<sup>65</sup>

The following section briefly provides some background on the ever-shifting role women’s reproduction has played in the public’s perception of social ills. This section also provides some insight as to why sterilization restrictions have developed so heavy-handedly. From “race suicide” to neo-eugenics, this history is important to understanding the view that sterilization regulation should err on the side of over-protection rather than under-protection.

#### A. *Eugenics & Legal Involuntary Sterilizations Against Feeble-minded People & Institutionalized Individuals*

At the same time the panic over “race suicide” pressured White, middle-class women to have children, states ordered forced

60. *Id.*

61. *Id.*

62. *See id.* According to those perpetuating these concerns, “[s]in and small families weakened social cohesiveness and moral fiber, which encouraged and enabled women to stray from their proper sphere—home and children. Women’s wanderings weakened the family, which in turn led women to stray farther, in a vicious cycle of social degeneration.” *Id.* at 87.

63. At its height between the years of 1901 and 1935, the formal eugenics movement consisted of two tiers: “negative eugenics,’ the prevention from reproduction of those regarded as ‘unfit,’ and ‘positive eugenics,’ the encouragement of reproduction of those considered to be ‘fit.’” Kenneth M. Ludmerer, *American Geneticists and the Eugenics Movement: 1905–1935*, 2 J. HIST. & BIOLOGY 337, 338 (1969).

64. *See* DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 209 (1997) (stating that “[t]he major goal of some welfare reformers [was] to reduce the number of children born to women receiving public assistance”).

65. *See* MAY, *supra* note 17, at 213 (describing “new pronatalism” of the 1980s as coming in “[o]n the heels of the childfree movement of the 1970s,” being a “renewed push toward parenthood [taking] the form of a media blitz aimed at educated career women, warning them that if they delayed childbearing, they were likely to find themselves infertile”).

sterilizations of institutionalized women and men as part of the American eugenics movement.<sup>66</sup> During the height of eugenics policies, eugenicists advocated that “poverty, criminality, illegitimacy, epilepsy, feeble-mindedness, and alcoholism (among others) were inherited traits that could not be altered.”<sup>67</sup> Typical eugenic theory and practice during this time was to encourage reproduction of White, middle-class, native-born U.S. citizens, and discourage reproduction of non-White, poor immigrants.<sup>68</sup> The idea was that the undesirable traits that non-White, poor immigrants would pass on to their children would be “tempered over time,” and ultimately eliminated from society.<sup>69</sup>

In the 1920s, imprisoned criminals and feeble-minded or “genetically defective” women and men were forcibly sterilized.<sup>70</sup> The constitutionality of these involuntary sterilization programs remains ambiguous: the Supreme Court affirmed the constitutionality of involuntary sterilization programs in *Buck v. Bell*,<sup>71</sup> yet struck down a similar statute fifteen years later in *Skinner v. Oklahoma*.<sup>72</sup>

In *Buck v. Bell*, the superintendent and board of directors at State Colony for Epileptics and Feeble Minded (“State Colony”) ordered Carrie Buck, an eighteen-year-old feeble-minded girl residing in the institution, to be sterilized because she had recently given birth to an “illegitimate” child (born outside of marriage).<sup>73</sup> The policy at issue allowed the superintendent of State Colony to petition a special board for Buck’s sterilization; the superintendent had to believe sterilization was in “the best interests of the patient[] and of society,” and the patient must have been “afflicted with hereditary forms of insanity, imbecility, [etc.]”<sup>74</sup> In the board’s deliberations, it could consider whether the

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66. “Eugenics” technically refers to the “[p]ractices and policies, as in mate selection or sterilization, which tend to better the innate qualities of progeny and human stock.” *STEDMAN’S MEDICAL DICTIONARY FOR THE HEALTH PROFESSION AND NURSING* 589 (7th ed. 2012). However, this Note will generally discuss eugenics in terms of its rise in popularity in the United States in the early twentieth century.

67. REBECCA M. KLUCHIN, *FIT TO BE TIED: STERILIZATION AND REPRODUCTIVE RIGHTS IN AMERICA 1950–1980*, at 1 (2011).

68. *Id.* at 2.

69. *Id.*

70. *See id.* at 14–15.

71. 274 U.S. 200 (1927).

72. 316 U.S. 535 (1942).

73. *Buck*, 274 U.S. at 205. Carrie Buck’s mother, also feeble-minded, lived in State Colony as well. Buck’s mother and daughter were all implicated in the decision, because the belief at the time was that “heredity play[ed] an important part in the transmission of insanity, imbecility, [etc.]” *Id.* at 206.

74. *Id.* at 206.

patient would become a menace if, after being discharged, he or she retained the ability to procreate.<sup>75</sup> If the board concluded that depriving a patient of her or his reproductive capacity would facilitate safe discharge and increase the patient's chances of being able to support her or himself, the board could authorize or order sterilization.<sup>76</sup> After the board reached a decision, the patient had the opportunity to appeal to the Circuit Court of the County.<sup>77</sup> The superintendent recommended Buck's sterilization, and the board approved and ordered it.<sup>78</sup> Buck's guardian appealed the sterilization order to the Circuit Court of Amherst County, but the court affirmed the sterilization.<sup>79</sup> Buck's appeal made it all the way to the U.S. Supreme Court, where the guardian argued that State Colony's sterilization policy violated the Fourteenth Amendment by violating Buck's due process rights and denying her equal protection under the law.<sup>80</sup>

In *Buck*, the Court held that Buck received all the process necessary under the Fourteenth Amendment; Justice Holmes, writing for the majority, explained that sterilizing patients like Buck was sound public policy.<sup>81</sup> Holmes' words shock the modern conscience: he characterized Buck, her mother, and her child as "those who already sap the strength of the State," and asserted that sterilizing Buck and other women like her would "prevent [society from] being swamped with incompetence."<sup>82</sup> Holmes further argued that Buck's sterilization was beneficial for society:

It is better for all the world . . . [I]nstead 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 . . . Three generations of imbeciles is enough.<sup>83</sup>

*Buck* set a precedent that has never been overturned. Some states continue to rely on the rationale that sexual sterilization can promote the "best interests" of the individual and the public.<sup>84</sup>

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75. *Id.* at 205–06.

76. *Id.*

77. *Id.* at 206.

78. *Id.*

79. *Id.* at 205.

80. *Id.*

81. *See id.* at 207. Justice Pierce Butler was the single dissenter in *Buck*, though he never wrote a dissenting opinion. *See* Phillip Thompson, *Silent Protest: A Catholic Justice Dissents in Buck v. Bell*, 43 CATH. LAW. 125, 125 (2004).

82. *Buck*, 274 U.S. at 207.

83. *Id.*

84. *See, e.g.*, HAW. REV. STAT. § 560:5-608(a) (West 2013) (allowing for sterilization of a ward of the state if the court finds by "clear and convincing evidence" that "sterilization is in the best interests of the ward"). For a more

However, in *Skinner v. Oklahoma*, in which the sterilization of a male criminal was at issue, the Court struck down a sterilization statute and described depriving someone of his or her right to procreate as "a sensitive and important area of human rights."<sup>85</sup> Jack T. Skinner alleged that Oklahoma's Habitual Criminal Sterilization Act<sup>86</sup> violated his substantive due process rights under the Fourteenth Amendment.<sup>87</sup> Skinner fell within the statute's definition of a "habitual criminal," which included people who had been convicted of two or more "felonies involving moral turpitude."<sup>88</sup> Once a habitual criminal was imprisoned, the Attorney General could petition the Oklahoma courts "for a judgment that such person shall be rendered sexually sterile."<sup>89</sup> The statute also required the individual to receive "[n]otice, an opportunity to be heard, and the right to a jury trial" to go through with the proposed sterilization.<sup>90</sup> If a judge or jury found that the individual could be sterilized without posing a danger to her or his general health, the court could approve the sterilization petition.<sup>91</sup>

Skinner's three crimes of "moral turpitude" included stealing chickens and twice committing a robbery with a firearm.<sup>92</sup> The Attorney General began proceedings for Skinner's sterilization in accordance with the Oklahoma statute, and upon notice of the proceedings, Skinner answered by posing the Fourteenth Amendment challenge.<sup>93</sup> Despite Skinner's challenge to the law, the petition proceeded to a jury, who decided that a vasectomy could be performed on Skinner without danger to his health.<sup>94</sup> On Skinner's appeal, the Supreme Court of Oklahoma affirmed the jury's decision.<sup>95</sup> Ultimately, the Supreme Court of the United States overturned the Supreme Court of Oklahoma and agreed with Skinner, characterizing the Oklahoma statute as "depriv[ing] certain individuals of a right which is basic to the perpetuation of

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detailed discussion of Hawaii's and other states' laws allowing for involuntary sterilization, see *infra* Part IV(A).

85. *Skinner v. Oklahoma*, 316 U.S. 535, 536 (1942).

86. OKLA. STAT. ANN. tit. 57, § 171 (1942).

87. *Skinner*, 316 U.S. at 536.

88. Tit. 57, § 173 (1942). Concerning "moral turpitude," many definitions are possible, but virtually all courts at least construct the term as "embracing every form of stealing." Editorial Board, *Notes*, 43 HARV. L. REV. 99, 119 (1929).

89. *Skinner*, 316 U.S. at 536 (referencing tit. 57, §§ 176, 177 (1942)).

90. *Id.* (referencing tit. 57, §§ 177-81 (1942)).

91. *Id.* at 537.

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.*

a race—the right to have offspring.”<sup>96</sup> The Court also held that the statute failed to provide equal protection under the law.<sup>97</sup> The statute allowed sterilization only of convicted felons, while other men and women who “committed intrinsically the same quality of offense,” though not amounting to felonies under Oklahoma law, were not punished through sterilization.<sup>98</sup>

The Court, though it found sterilization laws applied in a criminal context unconstitutional, did not overturn *Buck v. Bell*.<sup>99</sup> Justice Douglas, writing for the Court, specifically distinguished *Buck* from *Skinner*: “unlike the act upheld in *Buck v. Bell*, the defendant [was] given no opportunity to be heard on this issue as to whether he is the probable potential parent of socially undesirable offspring.”<sup>100</sup> Though the Court did note the “opportunity to be heard” in the Oklahoma statute earlier in the opinion,<sup>101</sup> this opportunity apparently did not convince Justice Douglas that the statute was constitutional.

The Court further distinguished the Oklahoma statute from the Virginia statute by pointing out that the Oklahoma statute, when enforced as intended, did not produce equitable outcomes.<sup>102</sup> The *Skinner* Court wrote that the statute at issue in *Buck* passed muster because State Colony intended the sterilizations to prepare patients to transition out of the institution and back into society: “so far as the operations enable those who otherwise must be kept confined to be returned to the world, and thus open the asylum to others, the equality aimed at will be more nearly reached.”<sup>103</sup> The Court appears to have viewed the sterilizations under the Virginia statute as rehabilitative in nature, liberating the sterilized individuals by facilitating their integration back into society, free from fear that they would bear children.<sup>104</sup>

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96. *Id.* at 536.

97. *Id.* at 541.

98. *Id.*

99. *See id.* at 538 (distinguishing criminal and civil sterilization statutes by the amount of process due to the individual); *see also id.* at 542 (distinguishing the statutes by their desired public policy outcomes).

100. *Id.* at 538 (internal citation omitted).

101. *Id.* at 536 (“Notice, an opportunity to be heard, and the right to a jury trial are provided.”).

102. *Id.* at 542.

103. *Id.* (citing *Buck v. Bell*, 247 U.S. 200, 208 (1927)) (internal citations omitted).

104. *See Buck*, 247 U.S. at 208 (arguing that the policy was equitable for institutionalized individuals because it allowed them to be released).

Justice Douglas took a different view than Justice Holmes on the inability to procreate.<sup>105</sup> Justice Douglas wrote:

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 [sic] and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear.<sup>106</sup>

The rhetoric used in each opinion suggests the *Skinner* Court feared the very thing the *Buck* Court desired—the gradual removal of certain types of individuals with “undesirable” characteristics over time through an inability to reproduce.<sup>107</sup>

Though the Oklahoma law that ordered sterilizations was declared unconstitutional after *Skinner*, the legality of coercive sterilizations across the country is still unclear. *Skinner* and *Buck* potentially complicate the legal status of sterilizations because *Buck* upheld the public policy reasons for involuntary sterilizations, while *Skinner* denounced those reasons.<sup>108</sup> After *Skinner*, sterilization abuses continue to occur, but the Supreme Court has never heard another sterilization case.

*B. Neo-Eugenics, Welfare Reform, & Sterilization Abuses  
Against Poor Women & Women of Color from the 1950s  
to the 1970s*

Though formal eugenic policies, like those in *Buck* and *Skinner*, fell out of fashion by 1950, “eugenic ideas and practices remained embedded in American society, culture, and politics.”<sup>109</sup> Rebecca M. Kluchin, who writes about post-1950s sterilization,

105. See *Skinner*, 316 U.S. at 541 (opining that the loss of one’s ability to procreate is akin to losing the ability to carry on one’s race).

106. *Id.*

107. Even though Justice Douglas ultimately defended an individual’s ability to procreate in general terms, one key reason the Oklahoma statute was struck down was because it did not let *Skinner* defend himself against the Attorney General’s presumption that he might be the potential father of “socially undesirable offspring.” *Id.* at 538.

108. *Id.* at 541; *Buck*, 247 U.S. at 207. It is tempting to make the argument that the differing results of these cases can be chalked up to latent gender bias. While there might be some truth in that argument, the Court stated its reasons for distinguishing the cases were related to broader public policy objectives. Compare *Buck*, 247 U.S. at 207 (“It would be strange if [the public welfare] could not call upon those who already sap the strength of the State for these lesser sacrifices [such as sterilization], . . . in order to prevent our being swamped with incompetence.”), with *Skinner*, 316 U.S. at 541 (“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.”).

109. KLUCHIN, *supra* note 67, at 10.



describes the form of eugenics that evolved into the 1960s as “neo-eugenics.”<sup>110</sup> Kluchin argues that in the United States, neo-eugenics evaluated reproductive “fitness” by considering a number of factors: “economic status, race, ethnicity, criminality, illegitimacy, intelligence, and sexual deviance.”<sup>111</sup> The predominance of neo-eugenic thinking led many doctors, social workers, and members of hospital boards to exploit existing sterilization statutes and sterilize poor women (who were disproportionately Black).<sup>112</sup>

Major welfare reforms in the 1950s<sup>113</sup> reinforced public perceptions that women who received public assistance should lose the right to their “reproductive self-determination.”<sup>114</sup> It is important to note that public images associated with welfare recipients during that time were almost exclusively those of Black, unmarried women.<sup>115</sup> As a result, poor and Black women were primary targets for eugenics activists who committed sterilization abuses.<sup>116</sup> Teaching hospitals in the southern United States often performed hysterectomies on Black women without their consent or any necessary medical reason, simply “for training purposes.”<sup>117</sup> The abuse was so widespread that people referred to a hysterectomy as a “Mississippi appendectomy.”<sup>118</sup> By 1973, a study

110. *Id.* at 11.

111. *Id.*

112. *Id.* at 73.

113. For example, the Revenue Act of 1951 (Jenner Amendment), 42 U.S.C. § 1306(a) (1950), allowed states to publish the names of all welfare recipients, suggesting that the American public had a right to know who received its tax dollars. KLUCHIN, *supra* note 67, at 77.

114. KLUCHIN, *supra* note 67, at 77. Additionally, Kluchin’s assumption is supported by Justice Holmes’s justification of sterilization policy, when he explained that it should not be a major sacrifice for women who already “sap the strength of the State” to relinquish their right to procreate. *Buck v. Bell*, 247 U.S. 200, 207 (1927).

115. See KLUCHIN, *supra* note 67, at 77 (citing RICKIE SOLINGER, *WAKE UP LITTLE SUSIE: SINGLE PREGNANCY AND RACE BEFORE ROE V. WADE* 49–53 (2000)) (“For example, in Louisiana in 1960, [sixty-six] percent of children receiving [public aid] were [B]lack, and [ninety-eight] percent of these children were born out of wedlock.”).

116. *Id.* at 78–79.

117. See ROBERTS, *supra* note 64, at 90; Judith A.M. Scully, *Eugenics, Women of Color and Reproductive Health: The Saga Continues*, 1 *AFROLOGICAL PERSP.*, Jan. 2004, at 167, 171. One particular famous case is the 1961 example of civil rights activist Fannie Lou Hamer, who had undergone surgery to have a small uterine tumor removed. She realized later that the physician had performed a full hysterectomy without her knowledge and rendered her sterile. See HARRIET A. WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* 189–90 (2006).

118. ROBERTS, *supra* note 117, at 90.

revealed “that ‘doctors in some cities [were] cavalierly subjecting women, most of them poor and Black, to surgical sterilization without explaining either potential hazards or alternate methods of birth control.’”<sup>119</sup>

Images of women who were “socially inadequate” to procreate also inspired several eugenic experiments throughout the 1960s and 1970s.<sup>120</sup> During these sterilization campaigns, women who were Black, Native American, and poor were sterilized disproportionately in comparison to other groups.<sup>121</sup> For instance, it was estimated that a program in Puerto Rico sterilized over one-third of the childbearing-age women on the island between 1937 and 1968.<sup>122</sup> The procedure was so common that it was (and still is) referred to colloquially by Puerto Rican women as simply, “la operación.”<sup>123</sup> Native American women were also sterilized in large numbers—four Indian Health Service Hospitals performed over three thousand sterilizations without obtaining proper consent from 1973 to 1976.<sup>124</sup>

### III. The Aftermath of Sterilization Abuses & Early Legal Battles for Voluntary Sterilization Rights

By the 1970s, civil rights and women’s rights groups had mobilized to challenge all forms of sterilization abuse and coercive sterilization practices.<sup>125</sup> Advocacy groups that might have originally held competing interests came to work together to ensure that coercive sterilization practices would end, but sterilization would remain a viable option for birth control.<sup>126</sup> One of these combined advocacy campaigns was called “Operation Lawsuit.”<sup>127</sup> The parties of Operation Lawsuit advocated a clear

119. *Id.* at 91 (quoting Herbert Aptheker, *Sterilization, Experimentation, and Imperialism*, 53 POL. AFF. 37, 41 (1974)).

120. See Scully, *supra* note 117, at 169.

121. GORDON, *supra* note 55, at 342.

122. *La Operación* (FILM & HISTORY, 1982), <http://www.filmandhistory.org/documentary/women/operacion.php>; Scully, *supra* note 117, at 170.

123. *La Operación*, *supra* note 122.

124. See Scully, *supra* note 117, at 170.

125. See KLUCHIN, *supra* note 67, at 114–16.

126. *Id.* at 115–16.

127. *Id.* Zero Population Growth (ZPG), Association for Voluntary Sterilization (AVS) (now known as EngenderHealth), and the ACLU were involved in Operation Lawsuit. *Id.* Notably, the ACLU headquarters never committed to the campaign; the organization only participated in Operation Lawsuit to the extent that its local chapters chose to become involved. *Id.* at 121. Kluchin argues that while ZPG and AVS were ostensibly in solidarity with women who were denied voluntary sterilization, the two groups had ulterior motives for being active in Operation

position: the group was committed to ensuring a woman's right to make her own reproductive decisions without the interference of medicine or law.<sup>128</sup> The group's efforts were successful, insofar as the laws that resulted were major victories for opponents of coerced sterilization.<sup>129</sup> For women denied voluntary sterilizations, however, these outcomes failed to provide adequate protection.

Robbie Mae Hathaway was the type of woman that Operation Lawsuit intended to protect.<sup>130</sup> Hathaway's case is important because it is one of the few instances in which the courts have addressed a person's affirmative right to obtain sterilization.<sup>131</sup> Hathaway was desperately seeking a tubal ligation as permanent contraception; Worcester City Hospital in Massachusetts refused the tubal ligation surgery she asked for.<sup>132</sup> In *Buck and Skinner*, the Court examined whether a state had the authority to force an unwilling individual to undergo sterilization;<sup>133</sup> in *Hathaway*, the court determined whether a hospital had the authority to deny an individual a sterilization that she wanted.<sup>134</sup>

Hathaway was thirty-six years old, married, and raising eight children.<sup>135</sup> She also lived with numerous health problems, which made other methods of birth control unreliable and made future pregnancies dangerous.<sup>136</sup> The Worcester City Hospital, a municipal hospital, denied Hathaway's request for sterilization,

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Lawsuit. *Id.* at 120–21. Kluchin argues that ZPG and AVS represented neo-eugenic interests that were less concerned with protecting women's autonomy in reproductive decisions and more concerned with promoting population control. *See id.* at 120 ("Although the AVS used the language of women's rights to advocate the overturning of restrictive hospital sterilization policies, its continued concern with the reproductive fitness of Americans suggests that its chief motivation was to make sterilization accessible to those who 'needed' it."); *see also id.* at 121 ("ZPG also used the language of reproductive freedom to advance its population control agenda by making sterilization available on demand."). Kluchin's characterization of the movement against sterilization regulations, while important and useful, should not be taken without criticism. Accepting Kluchin's characterization that sterilization practices ultimately promote neo-eugenic agendas undermines a core principle of reproductive freedom—that women have the autonomy to make their own reproductive choices without interference from the government or physicians.

128. *Id.* at 120.

129. *Id.* at 120–21.

130. *Id.* at 132–36.

131. *See Hathaway v. Worcester City Hosp.*, 475 F.2d 701, 703 (1st Cir. 1973).

132. *Id.*

133. *See Buck v. Bell*, 247 U.S. 200, 205 (1927); *Skinner v. Oklahoma* 316 U.S. 535, 536 (1942).

134. *Hathaway*, 475 F.2d at 702.

135. *Id.*

136. *Id.* at 702–03 (listing high blood pressure, umbilical hernia, irregular menstrual flow, and risk of "psychological deterioration" among Hathaway's health problems).

even after her doctor recommended tubal ligation.<sup>137</sup> The hospital had a policy that barred doctors from using operating rooms to perform sterilizations.<sup>138</sup> The First Circuit Court of Appeals found that in light of *Roe v. Wade*<sup>139</sup> and *Doe v. Bolton*,<sup>140</sup> sterilizations involve a fundamental interest: "a decision to terminate the possibility of any future pregnancy would seem to embrace all of the factors deemed important by the Court in *Roe* . . . but in magnified form, particularly [because of the] danger to [Hathaway]'s life and the eight existing children."<sup>141</sup> The court ultimately held that the hospital's ban on sterilization operations violated the Equal Protection Clause.<sup>142</sup> Worcester City Hospital could not issue a ban on sterilization practices when the clinic offered surgeries that were similar in technological requirements, risk to the patient, and post-surgical care involved.<sup>143</sup>

The Supreme Court has never decided whether there is an affirmative right to sterilization, but there are lower court cases besides *Hathaway* that concern the "right to" sterilization.<sup>144</sup> The New Jersey Supreme Court held in *In re Grady* that "the right to be sterilized is included in the privacy rights protected by the federal Constitution."<sup>145</sup> Another New Jersey case held that

137. *See id.*

138. *Id.* at 703. The policy was adopted in light of an Assistant Solicitor's issued opinion, which stated that he was "highly doubtful" that sterilization was legal in Massachusetts, due to statutes regarding the legality of birth control in the state. *Id.* The First Circuit Court of Appeals determined that the Assistant Solicitor's concerns about illegality were no longer at issue because of the Supreme Court's decisions in *Doe v. Bolton*, 410 U.S. 179 (1973); *Roe v. Wade*, 410 U.S. 113 (1973); and *Eisenstadt v. Baird*, 405 U.S. 438 (1972) which, among other things, essentially prohibited all-encompassing anti-birth control policies. *Hathaway*, 475 F.2d at 704.

139. *Roe*, 410 U.S. at 164 (holding unconstitutional Texas statutes that prohibit abortion in all cases).

140. *Bolton*, 410 U.S. at 195 (holding unconstitutional provisions of Georgia statutes that require abortions to be conducted in hospitals); *id.* at 198 (holding unconstitutional provisions of Georgia statutes that require those seeking abortions to obtain consent by a committee); *id.* at 199 (holding unconstitutional provisions of Georgia statutes that require a two-physician confirmation of a decision to abort).

141. *Hathaway*, 475 F.2d at 705.

142. *Id.* at 706.

143. *Id.* at 701-02.

144. *See In re Grady*, 426 A.2d 467, 474 (N.J. 1981).

145. *Id.* *But see McCabe v. Nassau Cnty. Med. Ctr.*, 453 F.2d 698, 704 (2d Cir. 1971) (declining to comment on whether the constitutional right to privacy was infringed on by parity restrictions on sterilization, but holding that Ms. McCabe's claim for damages against the hospital that denied the procedure was warranted).

spousal consent requirements for sterilizations are unconstitutional.<sup>146</sup>

Until the Supreme Court speaks to voluntary sterilization, there are steps that Congress and state legislatures can take to ensure that women's reproductive rights are protected and respected when it comes to the decision of whether and when to bear children. The following section surveys state laws governing sterilization and analyzes the various restrictions across states. It will become clear that, on balance, state laws do not do enough to protect women's fundamental reproductive freedom when it comes to voluntary sterilizations. Some state restrictions affect certain groups of women more profoundly than other groups of women. Further, these restrictions will also inhibit the ACA's preventive care mandate from reaching its full potential to respect and protect women's reproductive rights.

#### IV. Current State Sterilization Laws

The legacy of the fight to end sterilization abuse, though resulting in great gains for women's civil rights, has left the law ambiguous for women who voluntarily choose sterilization as a form of permanent contraception. Specifically, women seeking sterilization surgery who have never given birth have consistently described physicians' reactions to their requests as "paternalistic," suggesting they are too young,<sup>147</sup> attempting to change their minds,<sup>148</sup> insisting on further evaluations and meeting other requirements before the surgery,<sup>149</sup> or directly refusing the

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146. *Ponter v. Ponter*, 342 A.2d 574, 577 (N.J. Ch. 1975) (holding that a woman has "a constitutional right to obtain a sterilization operation without the consent of her husband").

147. See, e.g., Interview with Sofia, *supra* note 9 (talking about being denied surgical sterilization in part because of her age); see also Lisa Belkin, *Your Kids Are Their Problem*, N.Y. TIMES MAG., July 23, 2000, available at <http://www.nytimes.com/2000/07/23/magazine/your-kids-are-their-problem.html?pagewanted=all&src=pm> (interviewing Monica Lightner, whose physician insisted that she would change her mind one day); Paul, *supra* note 9; Rognlin, *supra* note 15 (relaying the story of a woman whose physician has repeatedly told her that sterilization is "not an option" for women under the age of thirty); Trombley, *supra* note 48; *Tyra Banks Show: I Don't Need a Husband or a Baby* (The CW television broadcast May 27, 2009), available at <http://www.youtube.com/watch?v=RVkATJHLvnc> (revealing the story of Tracy, whose doctor refused to perform a tubal ligation on her at age twenty-four and again at age thirty).

148. Belkin, *supra* note 147; Paul, *supra* note 9; Rognlin, *supra* note 15; Trombley, *supra* note 48; *Tyra Banks Show*, *supra* note 147.

149. Belkin, *supra* note 147; Paul, *supra* note 9; Rognlin, *supra* note 15; Trombley, *supra* note 48; Telephone Interview with Sofia, *supra* note 9; *Tyra Banks Show*, *supra* note 147.

request.<sup>150</sup> Currently, state laws regarding access to or restrictions on sterilization fall into one (or more) of four categories: 1) states that do not guarantee a right to voluntary sterilization but allow for an institutionalized individual to be sterilized involuntarily; 2) states that protect hospitals' and individual physicians' rights to refuse to perform a sterilization on any individual, regardless of the circumstance; 3) states that provide an explicit right to voluntary sterilization; and 4) states that do not take any position on sterilization—neither providing protections against involuntary sterilizations nor guaranteeing access to voluntary sterilizations.<sup>151</sup>

*Figure 1* provides a geographic representation of these categories.<sup>152</sup> The following sections will briefly survey some key states' sterilization legislation and further examine policies within states that explicitly provide a right to voluntary contraceptive sterilization.<sup>153</sup>

#### A. States That Still Allow Involuntary Sterilizations

There are many states in which involuntary sterilizations still occur: Arkansas,<sup>154</sup> California,<sup>155</sup> Colorado,<sup>156</sup> Connecticut,<sup>157</sup> Delaware,<sup>158</sup> Georgia,<sup>159</sup> Hawaii,<sup>160</sup> Idaho,<sup>161</sup> Illinois,<sup>162</sup> Maine,<sup>163</sup> Nevada,<sup>164</sup> New Hampshire,<sup>165</sup> New Jersey,<sup>166</sup> North Carolina,<sup>167</sup>

150. Belkin, *supra* note 147; Paul, *supra* note 9; Rognlin, *supra* note 15; Trombley, *supra* note 48; Telephone Interview with Sofia, *supra* note 9; Tyra Banks Show, *supra* note 147.

151. The Author has created these categories based on her own survey of the sterilization laws of each state.

152. Please see Figure 1 on page 168. —Ed.

153. The Author chose to highlight the following states because their statutes best represent the categories in which they have been placed.

154. ARK. CODE ANN. § 20-49-202(a) (West 2013).

155. CAL. PROBATE CODE § 1952 (West 2013).

156. COLO. REV. STAT. ANN. § 25.5-10-233 (West 2013) (taking effect March 1, 2014).

157. CONN. GEN. STAT. ANN. § 45a-699 (West 2013). *But see id.* at § 45a-697 (providing a right of the individual to refuse the procedure despite a court's finding that sterilization is in that individual's best interest).

158. DEL. CODE ANN. tit. 16, §§ 5704–5715 (West 2013).

159. GA. CODE ANN. § 31-20-3 (West 2013).

160. HAW. REV. STAT. §§ 560:5-601–560:5-612 (West 2013).

161. IDAHO CODE ANN. § 39-3909(3) (West 2013).

162. 755 ILL. COMP. STAT. ANN. 5/11a–5/17.1 (West 2013) (providing process for the involuntary sterilization of a ward of the state or a person with a legal guardian).

163. ME. REV. STAT. ANN. tit. 34-B, §§ 7004–7012 (providing process for court-ordered sterilization when the sterilization is in the best interests of an individual who cannot provide informed consent).

164. NEV. REV. STAT. ANN. § 159.0805 (West 2013).

North Dakota,<sup>168</sup> Ohio,<sup>169</sup> Oregon,<sup>170</sup> Utah,<sup>171</sup> Vermont,<sup>172</sup> Virginia,<sup>173</sup> Washington,<sup>174</sup> and Wyoming.<sup>175</sup> These laws are most likely remnants of the prevalent eugenic sterilization practices in many states in the early 1900s.<sup>176</sup>

Of the states where involuntary sterilizations still occur, Hawaii's statute is the most comprehensive. The Hawaii statute provides procedures for the entire process of a sterilization petition, including the opportunity to appeal,<sup>177</sup> and detailed criteria for the court's evaluation of the sterilization petition.<sup>178</sup>

The Hawaii statute allows for the sterilization of "wards" after the individual is at least eighteen years old and the court has issued an order for the sterilization.<sup>179</sup> In Hawaii, the process for "any interested person" to initiate a petition for sterilization of a ward begins by filing for the procedure in a family court.<sup>180</sup> Perhaps one of the most significant pieces of the Hawaii statute is the provision regarding the hearing.<sup>181</sup> After the petition has been

165. See, e.g., N.H. REV. STAT. ANN. § 464-A:25 (West 2013).

166. N.J. STAT. ANN. § 30:6D-5(a)(4) (West 2013).

167. N.C. GEN. STAT. ANN. § 35A-1245 (West 2013) (allowing a guardian to consent to a medically necessary sterilization in limited circumstances and only after a court has authorized the sterilization).

168. N.D. CENT. CODE ANN. § 25-01.2-11 (West 2013).

169. OHIO REV. CODE ANN. § 5123.86 (West 2013).

170. OR. REV. STAT. ANN. § 436.305 (West 2013) (allowing the court to determine when sterilization is in the best interests of an individual when that individual lacks the ability to give informed consent).

171. UTAH CODE ANN. § 62A-6-105 (West 2013).

172. VT. STAT. ANN. tit. 18, § 8709 (West 2013).

173. VA. CODE ANN. § 54.1-2976 (West 2013).

174. WASH. REV. CODE ANN. § 9.92.100 (West 2013) (allowing for court-ordered sterilizations in criminal court).

175. WYO. STAT. ANN. § 3-2-202 (West 2013).

176. Susan P. Raine, *Federal Sterilization Policy: Unintended Consequences*, 14 VIRTUAL MENTOR 152, 153 (2012).

177. HAW. REV. STAT. §§ 560:5-603–560:5-609.

178. *Id.* at § 560:5-608.

179. *Id.* at § 560:5-602.

180. *Id.* at § 560:5-603.

181. The *Skinner* court used the amount of process an individual received as a distinguishing factor of constitutionality in a sterilization statute. The hearing on the petition in the Hawaii statute provides for a lengthy procedure compared to other sterilization statutes:

The ward shall be entitled to be present at the hearing, and to see and hear all evidence bearing on the petition. The ward shall be entitled to be represented by an attorney, in addition to the court-appointed guardian ad litem, to present evidence, to cross examine witnesses, including any person submitting a report. The ward may be absent from the hearing if the ward is unwilling or unable to participate.

filed, the court appoints a special guardian ad litem to represent the ward in the proceedings.<sup>182</sup> Once the hearing begins, the court may seek out “advisors” to help in the evaluation process; these advisors have expertise “regarding the reproductive rights of incapacitated adults with disabilities” within the context of one of several disciplines, including law, medicine, ethics, and theology.<sup>183</sup> These advisors make recommendations to the court on whether sterilization is “in the best interest of the ward.”<sup>184</sup> When considering whether sterilization is in the ward’s “best interests,” the court and experts consider whether the individual is likely to be sexually active, fertile, and whether the individual will suffer physical or psychological harm if he or she were to become a parent.<sup>185</sup>

These involuntary sterilization statutes implicate many reproductive rights issues for both women and men. In stark contrast to the women whose physicians deny sterilizations they seek voluntarily, the individuals covered under the involuntary sterilization statutes have the potential to be sterilized against their will. Involuntary sterilizations like these represent one kind of coercion, while women denied voluntary sterilizations represent another form of coercion.

*B. States in Which No Hospital or Doctor Can Be Required to Perform a Sterilization*

Georgia,<sup>186</sup> Idaho,<sup>187</sup> Illinois,<sup>188</sup> Kansas,<sup>189</sup> Kentucky,<sup>190</sup> Maine,<sup>191</sup>  
Maryland,<sup>192</sup> Massachusetts,<sup>193</sup> Missouri,<sup>194</sup> Montana,<sup>195</sup> New

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*Id.* at § 560:5-607. *But see* WYO. STAT. ANN. § 3-2-202 (West 2013) (establishing a much less detailed procedure for approving involuntary sterilization of a ward). Under the Hawaii statute, if all of the possible parties are utilized (the attorney, the ward, and the guardian ad litem) and the ward actually attends the hearing, this hearing might provide enough of an opportunity for the ward to be heard that the sterilization would meet the standard alluded to in *Skinner*. *See* *Skinner v. Oklahoma*, 316 U.S. 535, 538 (1942) (distinguishing the unconstitutional Oklahoma statute from the constitutional Virginia statute by pointing out that the Virginia statute provided more opportunity for the individual to be sterilized to speak on her or his own behalf).

182. HAW. REV. STAT. § 560:5-604 (West 2013). It is unclear from the statutory language how the guardian ad litem fits into the process if the ward files a petition for sterilization on her or his own behalf.

183. *Id.* at § 560:5-606.5.

184. *Id.*

185. *Id.* at 560:5-608(d).

186. GA. CODE ANN. § 31-20-6 (West 2013).

187. IDAHO CODE ANN. § 39-3915 (West 2013).

188. 745 ILL. COMP. STAT. ANN. 70/4 (West 2013).

189. KAN. STAT. ANN. § 65-446 (West 2013).



Jersey,<sup>196</sup> New Mexico,<sup>197</sup> Pennsylvania,<sup>198</sup> Rhode Island,<sup>199</sup> and West Virginia<sup>200</sup> all have sterilization statutes providing that no hospital or physician will be required to perform sterilizations. In these states physicians are also often protected from legal liability, termination of employment, and any other penalties or disciplinary action for refusing to perform sterilizations.<sup>201</sup> Most of these statutes provide no exceptions for medical emergencies—the physician can still refuse to perform.<sup>202</sup> Only a few of the states with the right of refusal require a doctor or nurse to have a previously written objection in order to be protected under the statute.<sup>203</sup>

The statute in Kansas is potentially one of the most restrictive in terms of access to sterilization.<sup>204</sup> In the Kansas statute, there is no way to hold an individual physician accountable for refusing to perform a procedure that might have been medically necessary.<sup>205</sup> Nor are physicians or medical facilities required to refer a patient elsewhere.<sup>206</sup> Notably,

190. KY. REV. STAT. ANN. § 311.800 (West 2013).

191. ME. REV. STAT. ANN. tit. 34-B. §§ 7004–7012 (West 2013) (providing the procedure for court-ordered sterilizations when the individual cannot provide informed consent and it is determined to be in the best interests of the individual).

192. MD. CODE ANN., HEALTH § 20-214 (West 2013).

193. MASS. GEN. LAWS ANN. ch. 12, § 12I (West 2013); MASS. GEN. LAWS ANN. ch. 272, § 21B (West 2013).

194. MO. ANN. STAT. § 191.724 (West 2013).

195. MONT. CODE ANN. §§ 50-5-502–50-5-505 (2013).

196. N.J. STAT. ANN. §§ 2A:65A-1–2A:65A-2 (West 2013).

197. N.M. STAT. ANN. § 24-8-6(A)(2) (West 2013).

198. 43 PENN. STAT. ANN. § 955.2(a) (West 2013).

199. R.I. GEN. LAWS ANN. § 23-17-11 (West 2013).

200. *See* W. VA. CODE ANN. § 16-11-1 (West 2013).

201. *See* W. VA. CODE ANN. § 16-11-1 (West 2013); *see also* N.J. STAT. ANN. § 2A:65A-3 (West 2013) (prohibiting penalties for refusing to perform sterilizations).

202. *See, e.g.*, W. VA. CODE ANN. § 16-11-1 (West 2013) (lacking any language requiring physicians to perform sterilizations in medical emergencies).

203. *See, e.g.*, 43 PENN. STAT. ANN. § 955.2(a) (West 2013); R.I. GEN. LAWS ANN. § 23-17-11 (West 2013).

204. The statute reads, in relevant part:

No person shall be required to perform or participate in medical procedures which result in sterilization of a person, and the refusal of any person to perform or participate in those medical procedures shall not be a basis for civil liability to any person. No hospital, hospital administrator[,] or governing board of any hospital shall terminate the employment of, prevent or impair the practice or occupation of[,] or impose any other sanction on any person because of his refusal to perform or participate in such medical procedures.

KAN. STAT. ANN. § 65-446 (West 2013).

205. *See id.*

206. *See id.*

Kansas's statute contains language that specifically permits physicians to refuse to make a referral.<sup>207</sup>

These state statutes pose many ethical and practical problems, especially when a physician is allowed to refuse to provide a patient with a referral or information which she can use to obtain a sterilization procedure elsewhere. The American College of Obstetricians and Gynecologists (ACOG) specifically suggests that:

Although a woman's request for sterilization may conflict with the physician's medical judgment or moral beliefs, the patient's values and request cannot be dismissed or ignored . . . . [T]he physician who objects solely as a matter of conscience has the obligation to inform her that sterilization services may be available elsewhere and should refer her to another caregiver.<sup>208</sup>

While ACOG's opinion is not binding, the committee's view provides an important perspective that should be taken seriously when state legislatures consider laws relating to women's health.

### C. States That Allow for Legal Voluntary Sterilization

The following states allow or imply a right to voluntary sterilization: Arkansas,<sup>209</sup> California,<sup>210</sup> Colorado,<sup>211</sup> Connecticut,<sup>212</sup> Delaware,<sup>213</sup> Georgia,<sup>214</sup> Kentucky,<sup>215</sup> Massachusetts,<sup>216</sup> Michigan,<sup>217</sup> New Hampshire,<sup>218</sup> North Carolina,<sup>219</sup> Oklahoma,<sup>220</sup> Oregon,<sup>221</sup> Tennessee,<sup>222</sup> Utah,<sup>223</sup> Vermont,<sup>224</sup> Virginia,<sup>225</sup> and West Virginia.<sup>226</sup>

207. In other states in which the "right to refuse" policy is in place, there is no mention of an explicit right that physicians have to refuse to refer patients to other care. *Compare id.* ("No person shall be required to perform, or participate in . . . sterilization . . . ."), with MONT. CODE ANN. § 50-5-502 (West 2013) ("No private hospital or health care facility shall be required . . . to admit any person for the purpose of sterilization . . . .").

208. ACOG COMM. ON ETHICS, STERILIZATION OF WOMEN, INCLUDING THOSE WITH MENTAL DISABILITIES, COMMITTEE OPINION NO. 317 (July 2007).

209. ARK. CODE ANN. § 20-16-304 (West 2013).

210. *See* CAL. HEALTH & SAFETY CODE § 1258 (West 2013).

211. *See* COLO. REV. STAT. ANN. §§ 25.5-10-231-25.5-10-232 (West 2013).

212. *See* CONN. GEN. STAT. ANN. § 45(a)-691 (West 2013).

213. *See* DEL. CODE ANN. tit. 16, § 5702 (West 2013).

214. GA. CODE ANN. § 31-20-2 (West 2013).

215. *See* KY. REV. STAT. ANN. § 212.345 (West 2013).

216. *See* MASS. ANN. LAWS ch. 112, § 12W (West 2013).

217. MICH. ADMIN. CODE r. 400.7703 (2013)

218. *See* N.H. REV. STAT. ANN. § 460:21-a (West 2013).

219. *See* N.C. GEN. STAT. ANN. § 90-271 (West 2013).

220. This statute implies a right to voluntary sterilization for men under sixty-five. Women are not mentioned in this statute. *See* OKLA. STAT. ANN. tit. 56, § 200.1 (West 2013).

Of the states that allow for the lawful performance of sterilization, none provides a comprehensive legislative scheme to provide access for voluntary sterilization without unnecessary restrictions. Most states that provide for the lawful performance of sterilization require an individual to be at least eighteen years old and for the procedure to be performed in a hospital.<sup>227</sup> Some states also require the individual to request sterilization in writing.<sup>228</sup> These restrictions have resulted in unnecessary obstacles to obtaining voluntary sterilization in the present. It is possible for states to craft policies that can provide protections from sterilization abuse while still ensuring that women can reasonably gain access to the procedure.<sup>229</sup>

### 1. Writing Requirements & Waiting Periods

The requirement that a woman must wait for a set number of days after she submits her sterilization request in writing is most likely a result of sterilization abuses in recent history. Assuming the requirement is not overly burdensome for some groups of women (e.g., those which lack the resources, education, or ability to write an essay regarding sterilization), the writing requirement could potentially protect women who might be coerced into consenting to sterilization while under anesthesia during another medical procedure.<sup>230</sup>

221. OR. REV. STAT. ANN. § 435.305 (West 2013).

222. See TENN. CODE ANN. § 68-34-108 (West 2013).

223. See UTAH CODE ANN. § 62A-6-102 (West 2013).

224. See VT. STAT. ANN. tit. 8, § 4099(c) (West 2013).

225. See VA. CODE ANN. § 54.1-2974 (West 2013).

226. See W. VA. CODE ANN. § 16-11-1 (West 2013).

227. See N.C. GEN. STAT. ANN. § 90-271 (West 2013); see also DEL. CODE ANN. tit. 16, § 5702 (West 2013); TENN. CODE ANN. § 68-34-108 (West 2013); UTAH CODE ANN. § 62A-6-102 (West 2013); VT. STAT. ANN. tit. 8, § 4099(c) (West 2013); W. VA. CODE ANN. § 16-11-1 (West 2013).

228. See CONN. GEN. STAT. ANN. § 45(a)-691 (West 2013); KY. REV. STAT. ANN. § 212.345 (West 2013); MASS. GEN. LAWS ANN. ch. 112, § 12W (West 2013); N.C. GEN. STAT. ANN. § 90-271 (West 2013); TENN. CODE ANN. § 68-34-108 (West 2013); VA. CODE ANN. § 54.1-2974 (West 2013); W. VA. CODE ANN. § 16-11-1 (West 2013).

229. COMM. ON THE HEALTH CARE FOR UNDERSERVED WOMEN, ACCESS TO POSTPARTUM STERILIZATION, COMMITTEE OPINION NO.530 (July 2012), [hereinafter ACOG POSTPARTUM STERILIZATION], available at [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Health\\_Care\\_for\\_Underserved\\_Women/Access\\_to\\_Postpartum\\_Sterilization](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Access_to_Postpartum_Sterilization).

230. This requirement can rise to the level of being unduly burdensome if, as in some recent cases, women are forced to repeatedly “write essays” about their reasons for wanting to be sterilized. See, e.g., Paul, *supra* note 9, at 122 (relaying the story of Erin Iwamoto-Galusha, whose doctor told her to “write an essay explaining her reasons” for seeking a tubal ligation and come back in three months.)

The rationale for waiting periods is similar to the rationale for the writing requirement: the time between the consent and the procedure is supposed to allow a woman adequate time to think about her decision and to reflect on its implications. Waiting periods might also potentially provide protection to women who might be coerced into getting sterilized in exchange for monetary assistance,<sup>231</sup> whose consent might be coercively obtained during a separate medical procedure,<sup>232</sup> or who might not have received complete information regarding alternative methods of contraception.<sup>233</sup> The length of waiting periods varies among states. For example, Kentucky has a mandatory twenty-four-hour waiting period,<sup>234</sup> while Michigan has a thirty-day waiting period.<sup>235</sup> Waiting periods at some clinics, however, have become so strictly enforced that the requirement is hurting the very women it was designed to protect.<sup>236</sup> Susan P. Raine, a lawyer, medical doctor, and professor of medical ethics and health policy, has pointed out the difficulty that women who receive federal assistance encounter when trying to fulfill both the writing and the waiting requirements for postpartum sterilization.<sup>237</sup> Such policies have resulted in only fifty percent of women who ask for the procedure actually getting it.<sup>238</sup> Women either mistakenly believe the hospital will have their consent forms on file and leave the papers at home when they present for delivery; do not sign the forms thirty days in advance (and instead when they get to the hospital

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231. See, e.g., PROJECT PREVENTION, <http://www.projectprevention.org/> (last visited Nov. 1, 2013). This organization was formerly known as Children Requiring a Caring Kommunity (CRACK). In its current form, it is still providing financial incentives (in amounts of approximately three hundred dollars) to women who can prove a drug addiction and show a record of their sterilization. The website currently displays an advertisement that reads, "Attention Drug Addicts and Alcoholics: Get Birth Control Get \$300." The organization also reported that January 2012 marked a "major milestone" for the group as it reached 4,000 "severely-addicted" women. *Id.*

232. See, e.g., KLUCHIN, *supra* note 67, at 103 (relaying stories of doctors who have approached women during active labor to try to obtain their consent to sterilization after the baby is delivered).

233. See, e.g., *id.* at 92 (interviewing Nial Ruth Cox, whose welfare case manager told her that she must get a "temporary" tubal ligation because she had gotten pregnant at seventeen, and whose doctor told her she would be able to have more children later).

234. KY. REV. STAT. ANN. § 212.347 (West 2013).

235. MICH. ADMIN. CODE r. 400.7703 (2013).

236. See Press Release, *supra* note 4.

237. Raine, *supra* note 176, at 155.

238. ACOG POSTPARTUM STERILIZATION, *supra* note 229.

for delivery); or their physicians forget to tell them about the waiting period, writing requirement, or both.<sup>239</sup>

## 2. Nonmedical Qualifications

The California Health and Safety Code provides that any hospital in which a therapeutic sterilization can be performed cannot require a patient to meet nonmedical criteria when a patient seeks a contraceptive sterilization.<sup>240</sup> The specific statutory language reads:

No health facility which permits sterilization for contraceptive purposes to be performed therein, nor the medical staff of such health facility, shall require the individual upon whom such a sterilization operation is to be performed to meet any special nonmedical qualifications, which are not imposed on individuals seeking other types of operations in the health facility. Such prohibited nonmedical qualifications shall include, but not be limited to, age, marital status, and number of natural children.<sup>241</sup>

There are several ways in which this statute is among the most protective of women's freedom regarding access to sterilization.<sup>242</sup> First, the statute implicates the medical staff. Physicians are prohibited from denying women sterilizations unilaterally, veiled with the authority of medical judgment. Neither the hospital policy nor the physician in her individual capacity can require a patient to meet arbitrary criteria or force religious or moral beliefs onto patients through refusing to provide contraceptive sterilizations.<sup>243</sup> Secondly, the statute speaks directly to the problem that women like Sofia and other childfree women have faced when obtaining contraceptive sterilization.<sup>244</sup> This language specifically refers to nonmedical requirements that have been implemented at various points throughout the history of sterilization policy and practice: "age, marital status, and number of natural children."<sup>245</sup> Many hospitals utilized age and number of natural children (also known as parity) in the 1970s to prevent childfree women from obtaining sterilizations, and an age/parity

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239. *Id.*

240. See CAL. HEALTH & SAFETY CODE § 1258 (West 2013).

241. *Id.*

242. The other state whose statutes prohibit nonmedical qualifications for voluntary contraceptive sterilization is New Hampshire. See N.H. REV. STAT. ANN. § 460:21-a (2013).

243. See CAL. HEALTH & SAFETY CODE § 1258 (West 2013) ("No health facility . . . nor the medical staff of such health facility, shall require the individual . . . to meet any special nonmedical qualifications . . .").

244. See *supra* Part I; see also Paul, *supra* note 9.

245. CAL. HEALTH & SAFETY CODE § 1258 (West 2013).

formula was even recommended, at one time, by the American College of Obstetricians and Gynecologists.<sup>246</sup>

The California statutes will continue to provide important protection against hospitals and physicians who might hold patriarchal attitudes about women and childbearing. It will allow a physician to express his or her opinion regarding the fact that a woman is young, unmarried, and childfree when seeking sterilization,<sup>247</sup> but those reasons are not grounds for denying the procedure to a woman in California. In that regard, a statute like California's would have benefitted Sofia in her quest to obtain a tubal ligation in Missouri. Her youth, the fact that she was not married, and the fact that she was childfree were all reasons given to Sofia for the Kansas doctors' refusal to perform a tubal ligation on her.<sup>248</sup>

### 3. Right to Information & Referral

California has also declared that women have a right to obtain reproductive health information.<sup>249</sup> First, the California legislature provides that the statutes should be construed in favor of an interpretation that all women have the right to receive complete information regarding their reproductive health options: "[it] is the intent of the Legislature that every patient be given full and complete information about the health care services available to allow patients to make well informed health care decisions."<sup>250</sup> Additionally, the California statute provides that each health insurance provider must notify the patient that she has the right to "shop around" for a provider that covers these services.<sup>251</sup>

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246. KLUCHIN, *supra* note 67, at 22 ("The most popular hospital restriction was the 120 rule, which deemed only those women whose age and parity (number of children) multiplied together reached or exceeded the number 120 to be appropriate surgical candidates."). Some hospitals even adopted a formula that required women's age and parity, when multiplied together, to equal 150 or 175. *Id.* The ACOG endorsed the 120 rule. *Id.* at 23.

247. The provision also states, "[n]othing in this section shall . . . affect the right of the attending physician to counsel or advise his patient as to whether or not sterilization is appropriate." CAL. HEALTH & SAFETY CODE § 1258 (West 2013).

248. *See supra* Part I(A); *see also* E-mail from Brenner, *supra* note 36.

249. CAL. HEALTH & SAFETY CODE § 1363.02(a) (West 2013).

250. *See id.*

251. The following sentences must appear at the beginning of provider directories, on health plans' websites, on disclosure forms of each plan, as well as on plans' evidence of coverage:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or

Though the California statute requires insurance companies to disclose that certain plans and providers may not provide reproductive health services, the provision provides no guarantee that patients will actually be aware of that information.<sup>252</sup> Furthermore, the provision fails to protect women who, at the time of enrollment, believe they will not be in need of reproductive services. The language of the statute could be improved by directly countering the Kansas statute. The Kansas statute provides that no physician can be held liable for refusing to refer a patient who is seeking sterilization.<sup>253</sup> To counter that language, the California statute should include a provision that goes beyond a general statement that every woman should be informed of all her healthcare options. The statute should explicitly require physicians to provide patients with referrals to other doctors or hospitals who provide the reproductive services they need.

#### *D. States That Do Not Directly Regulate Voluntary Sterilization*

Many states do not explicitly address voluntary or involuntary sterilization.<sup>254</sup> A lack of legislation creates the opportunity for sterilization abuse to continue and for burdensome restrictions to remain unchecked. For example, physicians might be hesitant to perform the procedure for fear of liability or community hostility;<sup>255</sup> physicians might be able to unilaterally

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abortion. . . . Call your prospective doctor . . . to ensure that you can obtain the health care services that you need.

*Id.* § 1362.02(b).

252. The statute only requires providers to state in writing that patients have the ability to visit a doctor who provides reproductive health services. The statute does not require that patients should be verbally informed of the choice, nor does it require that doctors and providers who do not offer these types of reproductive services should tell their patients directly. See CAL. HEALTH & SAFETY CODE § 1363.02 (West 2013).

253. *Id.*

254. As of the date of publication, the following states and the District of Columbia remained silent on voluntary sterilization: Alabama, Alaska, Arizona, Florida, Indiana, Iowa, Louisiana, Minnesota, Mississippi, Nebraska, New York, South Carolina, South Dakota, and Texas.

255. Myers, *supra* note 8, at 73 (relaying interview accounts of physicians who fear community disapproval of a liberal sterilization policy because of the public's misguided comparison of sterilizations to abortions). This concern is especially relevant in conservative states like Kansas, where each physician is entitled to choose whether he or she provides the procedure, and where there has been extreme violence against abortion providers. See KAN. STAT. ANN. § 65-446 (2002) (allowing for physicians to refuse to participate in sterilization procedures); see also Joe Stumpe & Monica Davey, *Abortion Doctor Shot to Death in Kansas Church*, N.Y. TIMES, June, 1, 2009, at A1 (recounting the murder of abortion doctor George Tiller, who was shot during a Sunday morning church service in Wichita, Kansas);

make decisions regarding the contraception options available to women;<sup>256</sup> and individuals who are not able to provide informed consent could be subject to sterilization abuse.<sup>257</sup>

## V. Improving Sterilization Laws

Because of inconsistencies in statutes among states, progress toward state legislation that places women's reproductive rights first, especially regarding contraceptive sterilization, will continue to be slow and piecemeal. State legislatures must find a way to differentiate between procedures that are wrongful to impose on some from those that are wrongful to deny to others.<sup>258</sup> Rebecca J. Cook, Chairperson at the Center for Reproductive Rights and scholar of international human rights and reproductive health, has suggested that guidelines proposed by professional associations to properly practice sterilization offer the best guidance.<sup>259</sup> The objectives of any sterilization law should be "overcoming power and knowledge imbalances" in the patient-physician relationship, "making informed choice[s]," "addressing the multiple needs of individuals," and "ensuring clients' choice of method."<sup>260</sup> With these greater objectives as a foundation, this Note calls for a uniform sterilization statute that would accomplish the following: 1) guarantee access to information by requiring physicians to provide referrals for procedures they do not provide; 2) prohibit nonmedical qualifications, such as age, number of children, or marital status when considering an individual for a sterilization procedure; and 3) ensure an equal opportunity to access the procedure by enforcing the requirement in the ACA.

## Conclusion

The past two years have seen important victories and losses in women's reproductive rights. In August of 2012, the ACA

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Jenny Deam, *Doctor Struggles to Fill Role of Slain Kansas Abortion Provider*, L.A. TIMESN (Mar. 5, 2010), <http://articles.latimes.com/2012/mar/05/nation/la-na-kansas-abortion-20120305> (describing the threats Dr. Mila Means, a doctor who has attempted to re-open Dr. Tiller's abortion clinic, has received since she began the project).

256. See, e.g., Trombley, *supra* note 48 (describing doctors' refusals to perform sterilization for non-medical reasons).

257. See *supra* Part IV(A).

258. R.J. Cook & B.M. Dickens, *Voluntary and Involuntary Sterilization: Denials and Abuses of Rights*, 68 INT'L J. GYNECOLOGY & OBSTETRICS 61, 63 (2000).

259. *Id.*

260. *Id.*



mandate that provides full coverage for women's preventative health care, including contraception, went into effect. In the same year, over forty new bills were passed at the state level that limited women's access to contraception and other reproductive health care.<sup>261</sup> In 2013, women's reproductive rights advocates celebrated the fortieth anniversary of the landmark case *Roe v. Wade*.<sup>262</sup> In light of these historic events, it is obvious that increased autonomy for women in making choices about their reproductive health, whether these women choose to become mothers or not, is a desirable and worthy goal. Ensuring access to surgical and non-surgical sterilization procedures is an area of women's reproductive health policy that still leaves much to be desired. The legacy of coercive sterilization programs in the United States, the lack of legislation or case law guaranteeing access, and cultural attitudes about motherhood have all combined to impede women's access to sterilization. It is important not to minimize the experiences of childfree or unmarried women seeking sterilization voluntarily. Ultimately, *all* women and men have the *same* constitutionally protected right to reproductive freedom: having full control over the decision of whether and when to have children.

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261. CTR. FOR REPROD. RIGHTS, *REPRODUCTIVE RIGHTS IN 2012: A LOOK BACK AT THE STATES 2* (2012), available at [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/USLP\\_endofyear\\_Report\\_1.9.12.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/documents/USLP_endofyear_Report_1.9.12.pdf).

262. 410 U.S. 113 (1973).

Figure 1: Sterilization Policies by State (2013)

