Chapter 3

Sterilizing "Unfit" Women

The practice of involuntary sterilization existed throughout the twentieth century, but it changed over time, with a critical transition occurring in the late 1950s and early 1960s, during the shift from eugenics to neo-eugenics, and another occurring in the late 1960s concurrent with the development of federal family planning. In both moments of transition, region and race intersected to create distinct trends. First, physicians, social workers, and members of state eugenics boards exploited existing eugenic statutes to sterilize poor black women with the specific intention of reducing the number of blacks eligible to receive public assistance. Some southern physicians performed what black women colloquially referred to as "Mississippi appendectomies," or the secret sterilization via hysterectomy of poor black women who entered hospitals for abdominal surgeries—like cesarean sections and appendectomies—and left, unknowingly, without their uteruses. Women of color in other regions came under scrutiny during the second transition. The establishment of federal family planning functioned as a catalyst for this change but was not the only factor responsible for it. Neo-eugenic attitudes and policies also contributed. Physicians who treated patients receiving government aid benefited from the legitimization of contraceptive sterilization and the absence of hospital policies governing informed consent. Physicians recorded forced sterilizations as voluntary, and rising rates of female sterilization in the 1960s and 1970s "hid" their coercion. As contraceptive sterilization gained legitimacy and as federal family planning brought together poor women, especially women of color, and physicians who sought to control their reproduction and funded these interactions, forced sterilization increasingly occurred during childbirth.

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The exact number of women involuntarily sterilized between roughly 1950 and 1980 remains unknown. Neither medical institutions nor federal agencies collected the necessary statistics—perhaps an impossible task, as physicians recorded most coercive sterilizations as voluntary, and many women chose not to file formal complaints. Few sterilizations appear suspect when read through the official medical record. Consequently, the burden of verifying abuse fell to victims, an especially difficult task during a decade of rapidly evolving definitions of informed consent and consent policy. Many victims believed their coercive sterilizations to be isolated incidents, and cultural stigmas attached to infertility shamed other victims—especially Native American and Hispanic women—into secrecy.[1] The threat of racial violence prevented still more victims from demanding recourse. “Me? Getting a white lawyer to go against a white doctor?” civil rights leader and sterilization abuse victim Fannie Lou Hamer exclaimed. “I would have been taking my hands and screwing tacks into my own casket.”[2] Although exact statistics are not available, experts and contemporary activists have estimated that the total number of forced sterilizations ranged between a few thousand to several hundred thousand.[3]

Images of and Policies to Control the “Welfare Queen”

In the first half of the century, racial segregation created a semiprotective barrier between many poor black women and eugenicists.[4] Largely excluded from state and federal aid and institutions because of their race, many black women escaped eugenicists’ grasp. But once civil rights activists threatened to integrate state facilities and the law mandated the inclusion of minorities in the welfare state, some opponents of integration seized sterilization as a weapon to combat racial equality and drew upon neo-eugenic ideas to do so. Integration proved to be bittersweet for victims of sterilization abuse. The Civil Rights Act of 1964 granted people of color full access to federal programs and services such as welfare, public housing, and occupational training, but it also brought them into intimate contact with social workers, physicians, lawyers, welfare workers, and judges who provided family planning services, some of whom who took it upon themselves to sterilize “defective” women in order to reduce their dependence on welfare.

As ideas about reproductive fitness changed, so, too, did images of the “unfit.” Women continued to receive the majority of attention because of their ability to bear children, but the ethnicity and race of those targeted changed as Cold War society struggled to accept civil rights, Mexican immigration, an expanding welfare system, and a rise in illegitimacy. Two new stereotypes directly linked ideas about reproductive fitness to poor women of color: the “welfare queen” and the “pregnant pilgrim.” Together, these images solidified links between women of color, dependency, lack of reproductive fitness, and single motherhood in the public mind. These stereotypes promoted and reinforced postwar standards of reproductive fitness designed to privilege the reproductive capabilities of white middle-class women. They also affected welfare policy.

The image of welfare recipients changed in the 1950s from that of a sympathetic white widow who had lost a male breadwinner through no fault of her own to a licentious, single black woman who chose welfare over work and bore additional children out of wedlock in order to collect more money from the state. Female recipients of welfare have historically been seen as less deserving of public assistance than men who lost their ability to work because of injury, illness, or old age, but the stereotypes of women on welfare did not become profane until welfare expanded and black women gained access to the rolls.[5] Between 1940 and 1960, Aid to Dependent Children (ADC, renamed Aid to Families with Dependent Children [AFDC] in 1962) expanded from 372,000 to 803,000 families (although the numbers dropped briefly during World War II), and its budget escalated from $133 million to $994 million. By the mid-1950s, unwed mothers and minority women had displaced white widows as the primary recipients of federal aid, and blacks had become overrepresented on the case rolls. Normal population growth and high fertility rates coupled with increasing rates of divorce and desertion among all Americans had caused the number of single women across race seeking aid to rise. On top of these national trends, black families faced high rates of unemployment that stressed household resources, especially among families in the South, where mechanized agriculture displaced workers and segregation pushed blacks into the lowest-paying jobs or out of the market altogether. The intersection of these factors caused black women to become overrepresented in the ADC caseload, although whites remained the largest group receiving aid.[6]

These trends accelerated in the 1960s. Between 1961 and 1967, the total number of recipients jumped from roughly 3.5 million to 5.0 million, and by 1967 single women constituted three-quarters of all AFDC cases. The cost of AFDC grew as well, from $994 million in 1960 to $2.2 billion in 1967.[7] Three factors caused this expansion. First, Congress inaugurated President Lyndon B. Johnson's Great Society, and the Johnson administration actively recruited eligible citizens to enroll in these new programs. Second, civil rights victories, most notably the Civil Rights Act of 1964, granted blacks access to federal aid, which automatically increased the number of black women eligible for AFDC. Third, the Supreme Court dismantled discriminatory state welfare practices such as midnight raids, residency requirements, home checks, and man-in-the-house policies in 1966 and 1967. As a result, by 1970 the number of welfare recipients had increased by 35 percent.[8]

Conservative white Americans, especially those upset by integration, ignored these factors and instead blamed recipients' "immorality" and "irresponsible" reproduction for the increased enrollment. Many worried that their tax dollars were being used to support an underclass of dependent women who rejected the values they endorsed as central to maintaining a strong nation during the Cold War. A Gallup Poll conducted in 1964 reflected these concerns. Pollsters asked, "What proportion of persons do you think are on relief for dishonest reasons—most, some, hardly any, or none?" Sixty-one percent of respondents believed "at least 'some' dishonesty" existed among welfare recipients.[9] This suspicion is connected to the development of the "welfare queen" image that portrayed welfare recipients as conniving and deceitful.

The media chronicled this suspicion. A 1966 *Wall Street Journal* article depicted white animosity against welfare recipients. "I know of young Negro girls who get themselves deliberately pregnant so they can go on welfare," a Philadelphia secretary reported. A Fall River, Massachusetts, garage owner proclaimed, "The only ones benefiting from the way they're running things now are bums, deadbeats, and people who just don't give a darn about earning a living." The Catholic magazine *America* ran an article on "welfare backlash" the same year. This piece defended welfare programs as "one of the most humane features of American society," but conceded that "there are, of course, malingers on the relief rolls. There are pitiable people who make a vocation of welfare—men and women congenitally allergic to honest toil." Even this article, written in defense of welfare and of the "honest and helpless poor," expressed the neo-eugenic notion that some people were "inherently" "unfit," dishonest, and unworthy of government support.[10]

Public ideas about the purpose of welfare changed during the baby boom years. Once a program of child aid used by respectable mothers caught in difficult circumstances, in the 1950s welfare became characterized in popular discourse as a program of mothers' aid exploited by "welfare queens." The city of Newburgh, New York, sparked the first national debate about welfare, which solidified the association between black illegitimacy, welfare, and immorality in the public mind. In 1961, the city enacted a thirteen-point plan to overhaul its welfare system with the intention of expelling the "undeserving" from its rolls. Other northern cities followed. The plan's author, City Manager Joseph Mitchell, infused his welfare policy with the politics of race by accusing blacks, especially migrants, of enrolling in public assistance programs in order to avoid paid labor. Linking dependency to illegitimacy and accusing poor black women of deliberately becoming pregnant in order to extort government subsidies, Mitchell held that the city's welfare system encouraged a "culture of welfare" that bred violence and criminality.[11] The term "culture of welfare" referenced common neo-eugenic ideas about reproductive fitness that cited culture as the way in which "unfit" women reproduced their immorality and defects. Mitchell and his supporters did not want their government to support the reproduction of "defective," "lazy" citizens who they assumed would raise their children with the same values of shiftlessness and immorality.

Mitchell's policy drew upon existing strategies used by Congress and the states to reduce the welfare rolls, shame recipients, and force single women into nuclear family households. In 1951, Congress passed the Jenner Amendment, authorizing states to publicize the names of welfare recipients under the guise of curbing welfare fraud. States took even more drastic action during the next decade. They removed thousands of women and children from the rolls by reducing their welfare expenditures and shrinking public services. Nearly half of all the states also employed man-in-the-house, suitable home, or substitute father policies, which assumed that recipients' boyfriends provided for their children and hence such families no longer required public aid. In theory, "suitable home" policies sought to ensure that poor children resided in nurturing, safe environments. In practice, they punished illegitimacy by withholding aid from unwed mothers, especially women of color. Most states employed a single criterion to define an "unsuitable home": illegitimacy. These policies targeted black women, who constituted a disproportionate number of unwed mothers enrolled in federal programs. For example, in Louisiana in 1960, 66 percent of children receiving ADC were black, and 98 percent of these children were born out of wedlock.[12]

These policies reflected the belief that women who received state aid should relinquish reproductive self-determination as a condition of receiving assistance. In legislators' and supporters' minds, the "privilege" of reproductive decision making resided with the government and the taxpayers who financed the welfare system: poor women had no right to bear children whom they could not support. The welfare system itself institutionalized this assumption. Between 1910 and 1920, mothers' pensions provided poor single women with stipends on the condition that they submit to government regulation of their private relationships and family life.[13] Their successors, ADC and AFDC, advanced similar stipulations, such as requiring recipients to submit to unscheduled home visits. The Supreme Court struck down especially intrusive practices like midnight raids in 1967 and man-in-the-house policies in 1968, but the neo-eugenic notion that middle-class taxpayers held a direct investment in, and thus the right to determine, the reproductive choices of welfare recipients continued to gain favor as the decade progressed and America entered the 1970s.

The welfare queen stereotype chastised poor black women for "choosing" to engage in "deviant" sexual behavior while simultaneously suggesting that their "inherent" promiscuity and hypersexuality drove this behavior. In this way, the myth integrated biological, moral, and economic determinism. This synthesis of eugenic and neo-eugenic logic reflected contemporary scientific trends; by the 1940s social and biological scientists had resolved the nature-nurture controversy by declaring genetics and the environment to be interdependent variables.[14] By naturalizing black women's "deviant" sexuality, neo-eugenicists ensured that this behavior could only be attributed to black women. White women could never be accused of possessing the same "vulgar" sexual appetites and "inherent" licentiousness as black women because they would never be black. With the number of illegitimate births rising (the illegitimacy rate tripled between 1940 and 1957), neo-eugenicists used the fixed variable of race to distinguish between white and black unwed mothers and to reinforce a social hierarchy that preserved white supremacy during a period when white women's illegitimacy rates rose faster than those of black women.[15]

In the post–baby boom era, poor black women, especially unwed mothers, were considered "unfit" by definition. Neo-eugenicists placed poor black women in a double bind: they criticized them for their lack of reproductive fitness while simultaneously upholding standards of fitness based upon race and class that prevented these women from ever achieving an "acceptable" level of fitness. The myth of the welfare queen ensured that poor black mothers could never be "fit" so long as they remained poor and black—and because women could not change their race and punitive welfare policies and a lack of economic opportunities prevented many recipients from rising out of poverty, this population became "destined" to exemplify the "pathological" behavior ascribed to their race and poverty. In the 1960s, unwed black mothers came to represent the "pathologies" of the black family and community. The myth of the welfare queen nurtured this association, as did Senator Daniel Patrick Moynihan's infamous 1965 report on the black family, which blamed black crime, unemployment, single motherhood, and other social "pathologies" upon black "matriarchs."[16] Both stereotypes naturalized race and class differences by grounding these differences in a language of cultural deficiency that could be reproduced across generations.

In the late 1950s, lawmakers began to introduce bills designed to control the reproduction of "welfare queens," to use public policy to regulate "unfit" women's behavior and punish them for bearing children out of wedlock. State legislators proposed bills that criminalized illegitimacy among welfare recipients and sentenced "unfit" women (and occasionally men) to sterilization. Across the nation, but especially in southern states, legislators drafted bills to punish welfare recipients who bore two or more illegitimate children with incarceration, sterilization, a fine, or a combination of all three. In 1960, the Maryland Senate debated a bill that would subject any woman convicted of bearing two or more children out of wedlock to a fine of up to $1,000 or a prison term of under three years, or both. Under this bill, a woman convicted of the crime of illegitimacy would be declared unfit to parent and would lose custody of her children. The Maryland bill passed the senate by a vote of twenty-three to three, but suffered defeat in the House of Delegates.[17] Two years earlier, the Mississippi legislature debated "An Act to Discourage Immorality of Unmarried Females by Providing for Sterilization of the Unwed Mothers." The act read, "The birth of a second illegitimate child to any unmarried female shall subject her to the provisions of this act and a proceeding to have the unmarried female temporarily or permanently sterilized."[18] The bill died in the house, but in 1964 another Mississippi legislator took up the cause and introduced a similar bill, but with a few crucial differences. Under the second bill, parents convicted of being involved in the birth of an illegitimate child could be subjected to incarceration for one to three years. This bill was distinctive because, unlike the others, it aimed to punish both women and men for illegitimacy. Parents convicted of illegitimacy a second time would face between three and five years of jail time, but they could "submit to sterilization in lieu of imprisonment." The house approved the bill by a vote of seventy-two to thirty-seven, but public backlash caused Mississippi lawmakers to modify the bill significantly. They dropped sterilization altogether, reduced the jail time to between thirty and ninety days, and decreased the fine to less then $250.[19]

Numerous states proposed similar bills, but only two states succeeded in criminalizing out-of-wedlock births—although neither law included sterilization penalties. Several bills intended to punish illegitimacy with sterilization passed both houses only to be killed by a governor. Others passed only a single house, and still others died in committee. All, however, generated public debate about "proper" standards of reproductive fitness and whether the government held the right to legislate the reproduction of citizens receiving welfare. Politicians on both sides of the debate campaigned on the issue, local and national newspapers reported on the progress of proposed illegitimacy bills, and activist groups like the American Civil Liberties Union (ACLU) and Student Nonviolent Coordinating Committee (SNCC) vocalized their dissent through press releases and publications like SNCC's *Genocide in Mississippi* (1966) that brought the debate to a national level. The ACLU's criticism of the proposed bills is consistent with its commitment to civil rights, begun in the 1950s.[20] Although the ACLU would later commit to defending American women's reproductive freedom when it formed the Reproductive Freedom Project in March 1972, in the early-to-mid-1960s the organization had not yet established a clear position on women's reproductive rights, and thus its opposition centered on racial discrimination rather than women's rights. This is not surprising, as *Griswold v. Connecticut* (1965), legalizing contraception for married couples, had just been decided, and both the second-wave feminism and abortion rights movements were in their infancy.[21]

Debates about legislators' ability to regulate the reproduction of welfare recipients extended beyond the introduction of bills aiming to punish poor Americans who bore children out of wedlock. In 1965, *U.S. News and World Report* published an interview with Stanford physicist and Nobel Laureate William Shockley titled, "Is the Quality of U.S. Population Declining?" Basing his claim on his statistical analyses, Shockley suggested that whites were inherently more intelligent than blacks and urged his fellow scientists to take up the study of race and intelligence in an effort to evaluate the effectiveness of President Johnson's antipoverty programs.[22] Shockley's interview and subsequent scholarship on the topic set off national debates about genetic differences between whites and blacks that reinforced the prejudices inherent in the welfare queen stereotype and lent "scientific" authority to this bigotry. The physicist spent the next decade actively promoting his theory of dysgenics, or "retrogressive evolution," which held that the unrestrained reproduction of the poorest and least intelligent citizens would eventually lead to the "unfit" out-"breeding" the "fit."[23] Shockley was not alone in his musings about the role of genetics in shaping social dynamics. One year earlier, Dwight J. Ingle, a University of Chicago physicist, published an article in *Science* in which he declared that "the very high birth rate among indolent Negroes is a threat to the future success of this race."[24] Both scholars continued the eugenic tradition of employing scientific evidence to support their claims of inherited differences between the races. Richard J. Herrnstein and Charles Murray used a similar framework in *The Bell Curve: Intelligence and Class Structure in American Life*, published in 1994.[25]

A few years after President Johnson inaugurated his Great Society, some scholars began to assess the program's impact, and a minority began to use claims of genetic difference to support their rejection of antipoverty initiatives, especially when used to bolster the socioeconomic status of blacks. These scholars questioned Johnson's efforts to link civil rights and antipoverty initiatives by suggesting that blacks were inherently less intelligent than whites and therefore unable to effectively participate in federal programs designed to raise their socioeconomic status. In 1969, Arthur Jensen, a professor of educational psychology at the University of California, Berkeley (who met Shockley in 1968 when he accepted a fellowship at Stanford's Center for Advanced Study of Behavior Sciences), published a controversial article in the *Harvard Educational Review* titled "How Much Can We Boost IQ and Scholastic Achievement?" in which he intended to explain why the War on Poverty was not more successful. Jensen suggested that the inferior intelligence of black Americans could account for the relative failure of many programs. "But such a hypothesis," he maintained, "is anathema to many social scientists. The idea that the lower average intelligence and scholastic performance of Negroes could involve not only environmental, but also genetic, factors has been strongly denounced. But it has been neither contradicted nor discredited by evidence."[26] Shockley proved to be one of the few scholars who supported Jensen's thesis.[27] If in fact blacks were not as intelligent as whites, he repeatedly postulated, then Head Start and other Great Society programs designed to improve the socioeconomic status of black Americans must be rethought since environmental changes could not alter genetic "deficiencies."

As noted scientists working at premier universities and publishing in respected journals, Shockley and Jensen possessed the status necessary to have their work taken seriously by their colleagues and the media. Shockley's ideas grew increasingly radical as the 1960s gave way to the 1970s. "We fear that 'fatuous beliefs' in the power of welfare money unaided by eugenic foresight may contribute to the decline of human quality," he insisted in March 1970, the same year he established the Foundation for Research and Education on Eugenics and Dysgenics (FREED).[28] FREED boasted several prominent scientists as members as well as connections to the few individuals and organizations that remained committed to traditional eugenic ideas and practices. R. Travis Osborn, a member of the Executive Committee of the International Association for the Advancement of Ethnology and Eugenics, who served as an expert witness for segregationists attempting to overturn *Brown v. Board of Education* (1954), assumed the role of adviser to the organization.[29] One of FREED's major sources of financial support was the Pioneer Fund, created in 1937 by Wycliffe P. Draper to fund eugenic-related research. In 1977, the *New York Times* found that the Pioneer Fund contributed over $179,000 to Shockley. Remaining traditional eugenicists felt invigorated by Shockley and attached themselves to his organization, as did segregationists and members of

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the Ku Klux Klan (KKK) and the Citizens' Council, who appropriated "scientific" ideas that validated their racial prejudices.[30]

All three scientists—Ingle, Jensen, and Shockley—challenged the effectiveness of welfare and other government programs to improve the socioeconomic status of the poor, especially of poor blacks. If intelligence is largely determined by genetics, they maintained, then alternative solutions to poverty, illegitimacy, criminality, and joblessness must be identified. Two of the three—Ingle and Shockley—recommended sterilization as a plausible alternative, and in doing so followed the lead of state legislators working to criminalize illegitimacy in order to shrink the welfare rolls. Ingle believed sterilization to be appropriate for "all who, either because of genetic limitations or poor cultural heritage, are unable to endow children with a reasonable chance to achieve happiness, self-sufficiency, and good citizenship." He proposed the quarantine of "defectives" in what psychologist William Tucker calls "low IQ housing."[31] Shockley advanced several sterilization proposals, which he called "thinking exercises," that drew upon fears of overpopulation. His first plan called for government regulation of reproduction. In this system, citizens would be issued "deci-child" certificates that could be used for a pregnancy, or bought or sold on the market or through members of the New York Stock Exchange. The consequence of this plan (which he outlined in detail) would be that "only people who want and can afford children will have them."[32] This plan clearly intended to reduce the welfare "burden" and to appeal to those offended by "welfare queens." In a second plan, Shockley proposed to pay "a bonus rate of $1,000 for each point below 100 I.Q.," and again linked his proposal to anxiety about overpopulation. "We have to deal with [the] population explosion," he implored. To ensure that those not "bright enough to learn of the bonuses on their own" would be reached, Shockley actually suggested using bounty hunters to track down the "unfit."[33]

Scientists who linked race to intelligence and who argued that blacks were inherently less intelligent than whites and therefore needed to have their reproduction controlled for them represented a minority opinion in this era of civil rights and black nationalism. Jensen faced considerable backlash from his colleagues, the public, and students who picketed his office and demand that he be fired. Shockley's talks met with frequent protests from university students.[34]

Although Shockley's radical theories constituted a minority perspective, they continued to draw audiences and controversy for over a decade because Shockley tapped into neo-eugenic sentiments within the general population. Letters written to Shockley by nonacademics, by people who had seen him on television or read about his ideas in the papers, indicate that his concerns resonated with many whites at the grassroots levels, especially those attracted to the conservative politics of the era. Many conservative working- and middle-class whites viewed integration as a direct assault on their social and economic status; Shockley's theories provided them with a "legitimate" defense of the privileges of whiteness they sought to protect. Several writers used Shockley's ideas to reinforce their own prejudicial ideas about differences between the races. "As a white female employee of one of America's leading airlines I have daily encounters with the black race at Detroit Metropolitan airport," one woman wrote in 1973. She continued, "perhaps knowing 'why' would help me better understand the stupidity, ignorance, and harassment which I must contend with each day."[35] A man from Inglewood, California, wrote in 1973, "I am by no stretch . . . a racist, but I have been a student of history throughout most of my life. . . . I have been at a loss to explain the lack of progress in history by the Black populace throughout the world. My professors could not, or/nor would not, explain the Blacks' apparent lack of development compared to other racial groupings."[36] This man believed that Shockley had provided such an explanation. Similarly, a white substitute teacher of biology and science in Wichita, Kansas, wrote that Shockley's findings confirmed her own experiences in public schools. She claimed to have witnessed "the inability of almost all black students to grasp complicated concepts."[37] An Oklahoma City woman wrote to Shockley in 1974 to inform the professor that his theories reinforced her own ideas about inherent intellectual and cultural differences between blacks and whites. "I have lived around two generations of Negroes & while I am very fond of the man who has worked for me for years, & his college-educated children," she wrote, "I can't help but believe they just have a different culture or something inherently different from that of the white man."[38] This woman's use of Shockley's theories to explain her own prejudices reflects a powerful and popular trend in neo-eugenic thought: it did not really matter whether differences between the races were ascribed to genetics or environment, what mattered was that a difference could be "scientifically" identified and used to legitimize ideas of racial difference.

Shockley and his likeminded colleagues and supporters focused most of their attention on antipoverty initiatives related to education, but their sterilization theories extended into the realm of welfare. Shockley, in particular, explicitly used the language of overpopulation and eugenics to urge Americans to take action to reduce an "inevitable" drag on the nation's genes by large poor families, especially black ones. In this way, Shockley's ideas intersected with popular stereotypes like the welfare queen that suggested that poor black women could not manage their reproduction "responsibly" and that their failure to do so would have profound consequences on American society. “Our society is being profoundly irresponsible,” he declared. Linking this “irresponsibility” to welfare, he warned that “our nobly-intended welfare programs may be encouraging dysgenics.”[39]

The stereotype of the welfare queen caused so much resentment among white middle-class conservative Americans for the same reason: because it was the antithesis of the values they sought to embody. Postwar prosperity brought an unprecedented number of white Americans into the middle class. Roughly ten years after the conclusion of World War II, nearly 60 percent of Americans had achieved middle-class status (as opposed to only 31 percent of Americans before the Depression).[40] Many of these newcomers to the middle class had advanced economically because of government subsidies in the form of the GI Bill, which financed education and supplied homeowner and business loans for veterans. But the new middle class distinguished itself from other classes that received government aid. Most of its members believed themselves to be “worthy” and “deserving” of these benefits, which they viewed as very different from welfare and other “handouts.”[41]

Politicians who employed the image of the welfare queen pitted the interests of white middle-class families against those of poor black women and declared the latter to be undeserving of federal support while simultaneously reinforcing the deserving nature of the former. In addition, Cold War conservatives had already linked the preservation of the white nuclear family to national security by declaring the family to be a bulwark against Communism.[42] The welfare queen stereotype took this one step further by suggesting that preventing the “undeserving” from “leaching” onto the welfare system for support was an act of patriotism, a reaffirmation of the postwar democratic values of thrift, hard work, and the nuclear family. In this context, sterilization, as suggested by Shockley and conservative politicians, appeared to be an effective means of protecting white middle-class values and their attendant privileges.

Racializing Reproductive Fitness: “Pregnant Pilgrims”

The “welfare queen” became a popular stereotype in the 1960s that paved the way for other racially constructed negative images of poor women of color to emerge in the 1970s. Although it never became a national image to the extent that the “welfare queen” did, the “pregnant pilgrim” became a popular image in California in the 1970s, especially in southern cities like Los Angeles that witnessed a rise in Mexican immigration. Conservative Californians, concerned about overpopulation, the expansion of welfare, and changing ethnic demographics, began to accuse new immigrants of deliberately fleecing the state welfare system. A 1973 study found 8 to 9 percent of welfare recipients to be undocumented immigrants who received $100 million a year in social services. Los Angeles County commissioned a special report to investigate the "fleecing" of local services by these "undeserving" immigrants. The results conflicted with popular sentiment: the study reported that a "negligible" number of "aliens" received welfare. This disconnect characterized the public debates surrounding the issue of whether illegal immigrants could receive state aid. In general, public anger far exceeded the actual "problem."

One specific stereotype emerged from these discussions: the "pregnant pilgrim," which described a pregnant Mexican woman who crossed the border in order to give birth in an American hospital to an American citizen eligible for welfare. Newspapers like the *San Antonio Express*, *El Paso Times*, and *Arizona Republic* published a host of articles about this "problem" in the mid-1970s. One such article claimed that 45 percent of women who delivered in a Los Angeles County hospital "involve illegal alien women giving birth to brand new U.S. citizens."[43] Letters written by "concerned citizens" to the Sierra Club and Zero Population Growth (ZPG) echoed similar sentiments. In personal correspondence to the leader of ZPG, one man linked issues of immigration to those of population control and environmental preservation when he complained that Mexican immigrants "cancel the benefits of conservation." "The foreigners raise large families and defeat the birth control program," he proclaimed, adding, "Besides, there are many in our jails, mental institutions, and on welfare which cost us millions."[44] In 1973, California's Social Welfare Board weighed in on the debate when it reported that "aliens in California are getting at least $100 million in services to which they are not entitled."[45]

At the core of these editorials, news stories, and the debates they ignited was the issue of who should be able to legitimately access public services. Like criticisms of "welfare queens," debates about "pregnant pilgrims" featured the voices of white middle-class Americans who believed that the payment of taxes granted them the authority to determine how their contributions would be spent. These critics insisted that "if you worked hard you would be a success." Many social conservatives in Southern California and the Sun Belt, where the conservative movement developed in the postwar years, felt strongly that citizens should bear responsibility for their own welfare and believed that if recent immigrants and the poor would only adopt a Protestant work ethic, they, too, would succeed. They challenged the government's efforts to redistribute wealth and expressed anger that local and state governments expanded welfare programs without consulting middle-class taxpayers, whose money funded public assistance programs.[46]

In California and other border states experiencing a wave of Mexican immigration during the 1970s, issues of ethnicity and class also shaped the discussion, as did fears of overpopulation. The "pregnant pilgrim" constituted a threat not only because critics believed her to be "unethical" in her pursuit of American welfare (that is, getting paid for not working) but also because they believed her to be hyperfertile as well (her "contributions" to society were negative and detrimental). The two issues were linked in the public mind: hyperfertility contributed to the dependence of a "pregnant pilgrim" on welfare because she chose to have more children than she could support on her own. Like eugenicists decades earlier, social scientists of the era produced research, especially population-related studies, that reinforced the popular notion that Mexican women were dangerously hyperfertile, and this scholarship lent a scientific legitimacy to immigrant opponents' calls to close the border and deny Mexican immigrants access to public services. Despite claims of objectivity, some of this scholarship reflected researchers' own racial assumptions about Mexican women and their fertility.[47]

Social scientists and politicians were not alone in their evaluations of Mexican women's fertility and the demographics of Mexican families. Population controllers and environmental groups also expressed concern about the negative consequences of Mexican immigration. The Sierra Club wanted to restrict Mexican immigration as a means of preventing overpopulation, but chose not to lobby for federal legislation for fear of appearing racist. ZPG had the same fears, but approved a platform seeking an end to illegal immigration and a huge reduction in legal immigration in 1974. The following year, the organization made immigration a central issue and drew upon the expertise of population control expert and activist Paul Ehrlich to elicit public support for the cause. Ehrlich cautioned that Mexicans were immigrating in families, sometimes with pregnant members, with the intention of settling permanently. He warned about the economic consequences of this trend, estimating that illegal Mexican immigrants were "costing American taxpayers an estimated $10 to $13 billion a year in lost earnings and taxes, in welfare benefits and public service."[48] Ehrlich's message was clear: those who allowed illegal immigration to continue did so at their own financial risk. The threat of pregnant immigrants added another dimension to the issue, as those women who bore children in the United States produced citizens legally eligible for welfare. The president of the Los Angeles chapter of ZPG reiterated this concern when she maintained that California was overflowing with "Mexican immigrants with a baby-producing culture that won't quit."[49]

ZPG's derogatory attitude toward Mexican immigrants sheds light on its contraceptive sterilization-related activism in the early 1970s. In 1971, the

Association for Voluntary Sterilization (AVS), ZPG, and the ACLU joined together to launch a series of lawsuits designed to overturn restrictive hospital policies and make contraceptive sterilization available on demand (which will be discussed later). A few years after opposing punitive sterilization legislation, the ACLU had begun to develop a position on reproductive freedom, and it undertook these suits in the interest of defending women's right to contraception without arbitrary interference. The AVS and ZPG, however, sought to open access to sterilization in order to increase its prescription for poverty, dependence on welfare, and illegitimacy. For California-based ZPG and its founder, biologist Paul Ehrlich, Mexican women constituted the population most in need of permanent contraception, and ZPG members believed they had the academic evidence to prove it. They fought for sterilization on demand not to expand women's reproductive freedom, but instead to promote the surgery among the poor in the interest of reducing the threat of a population explosion and the cost of welfare.

As they had with the "welfare queen," critics viewed sterilization as a potential solution to overpopulation, a way to ensure that "hyperfertile" women could not "fleece" the welfare system and receive benefits that they did not deserve and that taxpayers did not want them to receive. Ten years passed between the appearance of these two images. In the late 1950s and early 1960s, critics of the "welfare queen" put forth formal legislative proposals for sterilization. In the late 1960s and early 1970s, physicians at public hospitals undertook their own sterilization plans, using the opportunities provided by the development of federal family planning and the legitimization of permanent contraception. Lawmakers in the early 1960s attempted to establish a system that would bring women into contact with public health providers and fund their sterilization. By the 1970s, such institutions were already in existence, and forced sterilization flourished.

When Legislation Fails, Try the Courts

In the late 1950s and early 1960s, state legislators failed to pass laws that punished illegitimacy with sterilization, but judges proved more successful in forcing the "unfit" to accept permanent contraception. In 1959, three grand juries in Georgia considered recommending sterilization for mothers of illegitimate children. In the early 1960s, California judges actually implemented similar plans.[50] Two California cases merit closer inspection because they expose the social engineering imperatives that drove these judges to overextend their prescribed authority and sentence "unfit" men and women to sterilization.

The first case involved Miguel Vega Andrade, a father of four who in 1960 injured his back, lost his job, and separated from his wife. For the first two years after his injury, he received $200 a month in medical compensation and paid $120 of that to his wife in child support. When these payments ceased, in the fall of 1963, his wife charged him with nonsupport. Andrade pleaded guilty in December, and the county prosecutor recommended probation. Pasadena Municipal Court Judge Joseph A. Sprankle ignored this recommendation and instead offered Andrade the choice of sterilization and marriage to his current girlfriend or jail. Andrade chose the first option, got married, had a vasectomy, found a job washing dishes, and resumed child support payments. In February 1964, Sprankle granted him probation. Later that year, Andrade decided to have children with his new wife. His lawyer petitioned the California Supreme Court for a writ of habeas corpus and asked the U.S. Supreme Court to hear the case, but both courts denied the appeal. Judge Sprankle expressed surprise at Andrade's regret, telling *Time* magazine that, until he met Andrade, he had "counseled" vasectomy in several hundred nonsupport cases without complaint.[51] Apparently, this judge believed that men who were unable to pay child support should lose the ability to bear children and that he held the authority to compel those who came before him to "choose" surgery. Sprankle's logic reflects neo-eugenic attitudes of the era, but his policy is distinctive because it targeted men, not women. Most other judges and physicians involved in punitive sterilization directed their actions at women because of their ability to become pregnant.

Andrade's case received brief national attention, but failed to spark considerable public debate about the ethics of sterilization sentences and the boundaries of citizens' reproductive rights. Nancy Hernandez's case did. Her story remained national news for days, and immediately after newspapers announced her sentence, more than 300 people offered to sign a petition in protest.[52] In May 1966, Santa Barbara Municipal Court Judge Frank P. Kearney found Hernandez guilty of a misdemeanor for occupying a room that contained marijuana. Estranged from her first husband with whom she had a daughter, Hernandez, age twenty-one, had been living with her boyfriend, Joseph Sanchez, and their daughter. When police raided the drug dealer's apartment, they found Hernandez in the same room as Sanchez's marijuana stash and charged her with the misdemeanor.[53]

Judge Kearney offered Hernandez a choice between probation with permanent sterilization or a six-month jail term. At her probation hearing, before her attorney arrived, Hernandez accepted sterilization and probation. "I was shocked and didn't want to go to jail and leave my children," she later explained.[54] A local priest, a physician, and several family members intervened and convinced Hernandez to reverse her decision. Judge Kearney, in turn, revoked her probation and sentenced Hernandez to three months in jail effective immediately.

Hernandez's lawyer quickly submitted a writ of habeas corpus and petitioned for her client's release from the court order she described as "unreasonable, capricious, illegal, and unconstitutional," and designed "to shock the moral sense of the community."[55] Describing Judge Kearney's decision as "arbitrary and outside the law," Superior Court Judge C. Douglas Smith granted both petitions and reprimanded Kearney. "Judges may not ignore a law simply because they do not like it or believe in it."[56]

Municipal Court Judge Kearney based his decision on neo-eugenic principles. He assumed that because Hernandez lived with a drug user, committed adultery, and bore an illegitimate child, she would inevitably descend into the criminal world of drugs and illicit behavior. "It seemed to me she should not have more children because of her propensity to live an immoral life," Kearney maintained.[57] Similarly, like physicians who coercively sterilized their patients, the judge extended his professional authority to advance his own social welfare agenda. Rather than enforcing established policy through his legal interpretations as the law required, Kearney designed and implemented his own public policy in the courtroom. He sentenced Hernandez to sterilization in the interest of reducing the state's welfare expenditures and preventing the reproduction of subsequent generations of "unfit" citizens, something he considered "inevitable" given Hernandez's lifestyle. He also never questioned his authority to dictate Hernandez's reproductive decisions, a trait he shared with physicians who performed forced sterilizations. Evaluation of Hernandez's maternal fitness lay far beyond the bounds of the case—which involved the defendant's proximity to marijuana, not her parenting skills—yet Kearney located it at the center. Superior Court Judge Smith acknowledged this when he overturned Hernandez's sentence. He reminded Kearney that while "law-abiding taxpayers" may resent supporting the poor with "their hard-earned tax dollars," the issue of Hernandez's reproductive fitness was entirely unrelated to the drug-related misdemeanor she faced.[58]

Yet even after Kearney's ruling was overturned, the judge insisted that he had acted within his jurisdiction. Kearney claimed Hernandez's sentence represented "nothing novel, legally, medically, or sociologically," and noted that he did not order Hernandez to be sterilized; instead, he had offered sterilization as an alternative to incarceration.[59] The logic underlying his offer remains fuzzy. Even conservative social critic William F. Buckley Jr. criticized the incongruity between the crime and punishment in Hernandez's case. Writing for the *National Review*, Buckley editorialized, "the act of sterilization is no more symmetrical to the charge of drug-taking, than, say, a frontal lobotomy is to drunken driving." Further ridiculing Kearney's ruling, Buckley snidely predicted that "it would only be a matter of time before he [Kearney] started offering, in lieu of stiff jail sentences, the rack, or the whipping post."[60] Judge Kearney defended his order by arguing that California law gave courts "the right to place a defendant on probation on terms aimed at the reasonable rehabilitation of the defendant."[61] Exactly how sterilization would have rehabilitated Hernandez for occupying a room with marijuana remains a mystery. But for Kearney, as well as other neo-eugenic judges and lawmakers, establishing congruity between the crime and the punishment was not the critical issue; preventing "unfit" women like Hernandez from bearing children was of primary importance.

Andrande's and Hernandez's cases serve as a bridge between eugenics and neo-eugenics in American judicial practice. They involve judges developing their own punishments for "deviant" social behavior that raise questions about citizens' private rights. Eugenic statutes were premised on the idea that the state's interest in the health of its citizens and the reproduction of a healthy society granted it the right to revoke certain citizens' ability to reproduce, specifically citizens "shown" to have been physically "defective" in some way. But neither case followed established eugenic law; instead, they involved judges operating outside of established legal boundaries to inscribe their personal politics on the bodies of "unfit" individuals who appeared before them for unrelated matters. The concept of reproductive rights did not enter public discussion until the late 1960s, after the Supreme Court identified a constitutional right to reproductive privacy in *Griswold v. Connecticut* and after feminists began to demand the legalization of abortion. Yet the extent to which the state could legally interfere in its citizens' reproductive decisions and to which citizens could protect themselves from such interference was contested in these early cases. In subsequent years, doctors would replace judges as the experts who sentenced the "unfit" to sterilization.

Early Sterilization Abuse

Changing images of "unfit" mothers coupled with changing welfare and family planning policies contributed to changing sterilization practices. The number of sterilizations performed under eugenic statutes fell dramatically during World War II and never returned to the prewar levels. But although the number of eugenic sterilizations decreased after the war, the practice of forced sterilization did not end; rather, it transformed to reflect new social and cultural anxieties and respond to new technologies like the laparoscopy. The surgeries performed in the 1950s and early 1960s represent a transition from the eugenic surgeries of the first half of the century to the neo-eugenic surgeries of the late 1960s and 1970s. In the 1950s and early 1960s, forced sterilization was confined largely to the South and assumed two forms: use of existing eugenics laws to sterilize poor unwed black mothers, and "Mississippi appendectomies." By the 1970s, new trends in forced sterilization had spread from the South to the rest of the country through federal family planning, and forced sterilization was increasingly performed under the guise of voluntary contraceptive surgery.

In the late 1950s, southern neo-eugenicists opposed to integration and resistant to the civil rights movement began to employ existing state eugenic statutes to force poor black women to undergo unwanted and unnecessary tubal ligations. North Carolina was one of a few states to continue its eugenic sterilization program in the postwar years. Designed to reduce welfare rolls and prevent the reproduction of "feebleminded" citizens "destined" to dependency on the state, North Carolina's eugenic laws remained active and in use in the 1950s. But in the 1960s, the target demographic changed from poor white women to poor women of color, who were increasingly labeled "unfit," as welfare expanded and the previous barriers to public aid for people of color were lifted. Blacks constituted 23 percent of those sterilized by the state in the 1930s and 1940s. By 1966, blacks made up 64 percent of those sterilized under North Carolina's eugenic code.[62]

Determining the boundary between consent and coercion can be very tricky as historically it has been murky and flexible. Indeed, women have not always been victims of eugenic sterilization; some have been active agents in a complex process of negotiation involving themselves, welfare workers, and medical authorities in which women used public health services for their own purposes. From the 1930s through the early 1970s, some women "willingly accepted—and in some cases, even sought out—eugenic sterilization as a form of contraceptive control."[63] They manipulated their state eugenics boards to gain access to the one form of effective contraception they could obtain: sterilization. This was true even after the Pill emerged on the market in 1960 and before the creation of federal family planning later in the decade, especially for poor rural women who lacked access to reproductive health services for both financial and geographic reasons.[64] White middle-class women were not the first American women to conceive of sterilization as a legitimate method of contraception. Unlike their poor sisters, however, middle-class women could not have themselves sterilized under eugenic statutes because they could not point to poverty as a "symptom" of lack of reproductive fitness. When they bumped up against restrictive hospital policies prohibiting contraceptive sterilization in the late 1960s and early 1970s, middle-class women turned to the courts, not the state eugenics boards. Some poor women took their cases to the courts at this time, but increasingly they did not need to because although sterilization might not have been available, contraception now was, thanks to the creation of federal family planning. Fewer poor women needed to manipulate the system to obtain the sterilization once highly effective methods of temporary contraception became available.

While North Carolina appears to have been the only state to employ its eugenics statute so forcefully against healthy, noninstitutionalized women, it was not entirely alone. Other southern states also employed their existing eugenics codes to achieve neo-eugenic goals, albeit less frequently. Although the vast majority of forced sterilizations occurred in the South, neo-eugenicist policy makers, social workers, and physicians in other states also exploited existing eugenics laws. Washington State so heartily embraced the association between illegitimacy, mental incompetence, and poverty among black women that it sterilized one woman twice. The state ordered a tubal ligation for her at age fifteen after her first pregnancy. The surgery failed. When she became pregnant again at nineteen, the state mandated the pregnancy be aborted and forced her to undergo a hysterectomy.[65]

Social workers, physicians, and members of state eugenics boards identified poverty and unwed pregnancy as “symptoms” of “feeblemindedness” and used these “symptoms” to justify the sterilization of poor unwed black mothers under eugenics laws. Sometimes their patients welcomed this advocacy; other times, as the instance of Nial Ruth Cox indicates, they did not. In these latter instances, sterilization abuse occurred. On November 24, 1964, Cox, barely eighteen, gave birth to a child out of wedlock. Shortly thereafter, a North Carolina welfare worker threatened to discontinue her family’s welfare payments unless she consented to sterilization. Cox later insisted that the social worker described the surgery as reversible.[66] Living with her mother and eight siblings (her father died when she was six) in a home without running water, electricity, or a stove, the teenager could not risk noncompliance and submitted to the surgery—although she never provided her consent. As a minor, under twenty-one years old, Cox could not legally consent to her own surgery. Instead, a social worker obtained the mother’s consent, which Cox’s mother provided because she was also under the impression that the surgery was temporary. Years later, Cox recalled her experience: “I got pregnant when I was 17. I didn’t know anything about birth control or abortion. When the welfare caseworker found out I was pregnant, she told my mother that if we wanted to keep getting welfare, I’d have to have my tubes tied—temporarily. Nobody explained anything to me before the operation. Later on, after the operation, I saw the doctor and I asked him if I could have another baby. He said that I had nothing to worry about, that, of course, I could have more kids. I know now that I was sterilized because I was from a welfare family.”[67]

Kluchin, Rebecca M.. Fit to Be Tied : Sterilization and Reproductive Rights in America, 1950-1980, Rutgers University Press, 2009. ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/pccol/detail.action?docID=871480.

As in many of these cases, the county director of welfare who petitioned the state eugenics board failed to produce concrete evidence of Cox's purported mental deficiency, relying instead on her poverty, race, unwed pregnancy, and family's welfare status to indicate her supposed mental incompetence. This information proved definitive enough for the state eugenics board to accept as valid. As was common practice, the eugenics board approved the petition for surgery without convening a formal hearing and without supplying a court-appointed representative to protect the patient's interests. The board also failed to offer Cox a forum in which to contest its January 25, 1965, decision. Consequently, Dr. A. M. Stanton sterilized Cox on February 10. It was another five years before Cox learned that her sterilization was permanent.[68]

Elaine Riddick Trent had a similar experience with the North Carolina Eugenics Board. On March 1, 1968, the fourteen-year-old entered a hospital in Edenton, North Carolina, to deliver her first child. During her confinement, hospital staff sterilized her without her knowledge or consent at the order of the North Carolina Eugenics Board. The board did not request that Trent undergo psychological evaluation to determine her mental status, but instead interpreted Trent's out-of-wedlock pregnancy and dark skin as evidence of her "mental incompetence" and authorized her surgery on this basis, without convening a formal hearing.[69] Hospital staff did obtain the "consent" of Trent's illiterate grandmother, who marked an "A" on a form presented to her, although it appears that the grandmother did not understand the significance of her mark. Had the grandmother understood the content of the document she signed, it is more than likely that she would have communicated this knowledge to Trent, who did not learn of her sterility until 1973.[70]

In the late 1950s and early 1960s, some southern physicians with neo-eugenic politics also began to practice "Mississippi appendectomies." Civil rights activist Fannie Lou Hamer was victimized this way in 1961 when she entered Sunflower City Hospital in Alabama to have a uterine tumor removed. Having lost the battle to preserve Jim Crow segregation, some southern whites looked for other ways to demonstrate their racial power. Performing an unwanted and unknown surgery on a black patient who had no recourse or evidence (in the form of a medical chart) to support her claims was one method that some southern physicians used to exert their influence over a black community demanding equality. Physicians frequently failed to document the sterilizations they performed, leaving women no direct evidence to link the violations of their bodies to their physicians, and sometimes leaving patients without the knowledge of their violation. A physician who performed an unauthorized surgery that terminated the fertility of an unknowing patient who lay unconscious and vulnerable on the operating table exercised considerable power over her. At a time when civil rights victories granted black women and men access to health care and other government programs that refused to serve them for so long, forced sterilization functioned as one way that the whites in charge of public health could continue to assert racial supremacy without directly challenging new policies of integration. It also functioned as a reminder of black patients' dependence upon white doctors' goodwill. Aware of these covert sterilization practices, women in need of abdominal surgery who chose to be treated by undergoing cesarean sections, having tumors removed, or undergoing appendectomies had to accept the risk of forced sterilization when seeking medical care.

Physicians performed "Mississippi appendectomies" primarily in rural communities overwhelmed by racial struggle. In the years preceding the establishment of federal family planning, sterilization abuse remained generally confined to southern states, where most surgeons operated without their patients' knowledge or informed consent. However, by offering contraceptive services through the Office of Economic Opportunity (OEO), the Department of Health, Education, and Welfare (HEW), and the Public Health Service (PHS), legislators in the Johnson and Nixon administrations unintentionally created an institutional network that encouraged new practices of forced sterilization.

Federal Family Planning: Creating the System That Fostered Abuse

The end of legal segregation, the development of federal family planning services, and the legitimization of sterilization as a method of birth control intersected to create an environment conducive to a new pattern of forced sterilization. Instead of exploiting eugenics statutes and removing women's uteruses without their knowledge or consent, in the late 1960s some physicians began to force women to consent to unwanted surgeries. Instead of secretly performing a "Mississippi appendectomy," physicians began to require their patients to sign consent forms to surgeries they did not want or did not understand. The existence of signed consent forms allowed abusive physicians to avoid administrative suspicion and protected them against litigation. When victims began to file lawsuits against their abusers, physicians submitted the signed medical consent forms as evidence of their patients' desire to undergo sterilization. In this way, they shielded themselves from liability and blamed victims for their own sterility.[71] This new pattern of forced sterilization developed and spread from the South to the rest of the country as a result of federal family planning and the absence of hospital policies governing informed consent.

Kluchin, Rebecca M.. Fit to Be Tied : Sterilization and Reproductive Rights in America, 1950-1980, Rutgers University Press, 2009. ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/pccol/detail.action?docID=871480.
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President Johnson announced his commitment to controlling overpopulation abroad in his 1965 State of the Union address, but he proved more hesitant to develop family planning initiatives at home. Over the course of his term, Johnson's administration gradually expanded existing public assistance programs to include family planning services. It was not until 1967 that Congress formally entered the realm of domestic family planning on a national level, when it amended Title V of the Social Security acts. The amendment stipulated that at least 6 percent of the monies allotted to the AFDC maternal and infant care fund be directed toward family planning services. It also required that states develop family planning programs and make family planning services available to adults on welfare. Congress also offered federal grants to private nonprofit family planning organizations like Planned Parenthood for the first time. Surprisingly, the amendment passed quietly. In part, this is because legislators considered family planning policy while debating welfare reform, and the controversy generated by the latter issue overshadowed the former. But it is also because politicians on both sides of the aisle believed that family planning offered a "solution" to the "problems" of illegitimacy and welfare.[72]

The federal government delved further into the provision of family planning services with the election of Richard Nixon in 1968. Under President Nixon, Congress not only increased funding for existing programs but also developed a host of new services.[73] Nixon based his support for family planning on cost-benefit analyses that showed that it was cheaper to fund contraception for poor women than to support their children. Congress passed the Family Planning Services and Population Research Act on December 24, 1970. This legislation provided $382 million for family planning services, research, and training, and authorized Title X of the Public Health Services Act, the second largest single source of federal funding for family planning next to Medicaid.[74] The 1970 law signaled a clear and firm federal commitment to family planning services.

Congress placed two restrictions on the use of these funds. First, attempting to guard against coercion, legislators stipulated that participation in federal programs "shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service."[75] But legislators neglected to develop actual safeguards to protect patients against coercion; they naively assumed this proclamation sufficient to deter abuse. Second, the 1970 act mandated that no federal monies be used for abortion. Earlier legislation prohibited the use of federal funds for both abortion and sterilization. In 1970, legislators lifted the restriction on sterilization for HEW and PHS programs. Operating under different legislation, however, the OEO continued to ban the procedure. Nevertheless, the ban failed to prevent some OEO providers from performing sterilizations—some voluntary, some coercive.[76]

The OEO's ban on sterilization reflected both the agency's ambivalence about providing family planning and its concern for patients' rights. A few federal agencies administered their own family planning programs prior to passage of the 1967 Social Security amendments. The OEO was one such agency. In November 1966, Sargent Shriver, the director of the OEO, published regulations for his agency's family planning project grants. Shriver's list of regulations reflected the Johnson administration's reluctance to enter the realm of family planning. Conservative in its application, the policy entitled only married women residing in two-person households to utilize OEO-sponsored programs and prohibited the use of agency funds for abortion or sterilization. The AVS and the ACLU opposed this policy, but aside from letter writing, did not take action to change the rules. Despite its cautious nature, Shriver's proposal privileged patients' rights by mandating that participation in all OEO-funded programs be voluntary and by forbidding providers from conditioning federal aid upon receipt of contraception. Shriver's attention to patients' rights suggests that at least one federal agency recognized the potential for coercion within federal family planning programs from the outset. Despite frequent and fervent objections to OEO policy by the ACLU and the AVS, the ban on sterilization and abortion remained in effect until May 18, 1971, when the OEO lifted the restriction on sterilization, but not abortion.[77]

The OEO reversed its ban on voluntary sterilization in 1971 in response to increasing pressure from state providers, who reported heavy demand for the service from their female clients.[78] A 1970 OEO survey of family planning programs found that 80 percent of respondents supported including sterilization among their services.[79] Unlike HEW, which simply expanded its programs to include contraceptive sterilization under the Family Planning Services and Population Research Act, the OEO delayed implementing sterilization services until it could develop protective guidelines. Although Shriver was no longer at the OEO, his fear of coercion continued to shape the antipoverty agency's policy. Protecting patients from coercion also proved to be a central concern of Dr. George Contis, director of the Family Planning Program, Office of Health Affairs at the OEO. In a memorandum addressed to all agencies receiving OEO family planning funds dated June 28, 1971, Contis wrote: "We are more concerned that the patients be protected and provided with high quality medical care. Therefore, we are developing a set of guidelines and clinical standards for the provision of sterilization services. . . . We plan to have these available for use by the family planning projects and comprehensive health centers by

September 1, 1971." He then instructed his affiliates, "*Please do not begin providing sterilizations until you receive these guidelines*."[80]

Despite Contis's promise, OEO affiliates did not receive the guidelines in September. Instead, they received another letter from the director of Family Planning dated November 5, 1971, stating that regional health specialists and national health professionals had reviewed the guidelines on September 7, and determined that they required further revision. Thanking providers for their patience, Contis predicted that the formal guidelines would be released within a few weeks.[81]

Finally, on January 11, 1972, the OEO printed the long-awaited guidelines, *OEO Instruction 6130–2, Voluntary Sterilization Services*. This eighteen-page document carefully outlined conditions for voluntary sterilization under OEO programs. Most important, the document reiterated Shriver's 1965 edict that all OEO sterilizations be voluntary. Specifically, sterilization was to be provided "only to those persons who request it," who "must be well informed enough to make a meaningful choice," and who held "the legal capacity" to consent to surgery. Equally as important, the guidelines mandated that "no sterilization procedure shall be conducted unless the individual patient has given his informed written consent to the procedure."[82] The guidelines included sample consent forms and standards and rules for record keeping.

Although the OEO printed the new guidelines, the agency did not distribute them due to political pressure from the White House. In late 1971, Dr. E. Leon Cooper became the new director of Health Affairs at the OEO. A physician opposed to contraceptive sterilization, Cooper objected to the now extremely delayed guidelines because of his own personal skepticism about permanent contraception and because he feared that the cost of sterilization would strain his agency's budget.[83] On January 31, 1972, one day before a press conference scheduled to announce the guidelines, Cooper suspended release of the new policy, a move sanctioned by the White House. In meetings between the OEO and the Office of Management and Budget, White House officials expressed President Nixon's concern about the political implications of an explicit federal policy condoning voluntary sterilization in an election year. Specifically, Nixon feared a Catholic backlash. The president "definitely didn't want us to go ahead" with the publication of the guidelines, OEO Deputy Director Wesley Hjornevik recalled.[84] At the combined request of the White House and Cooper, the OEO transferred 25,000 copies of the guidelines to a warehouse in northeast Washington, D.C., where they remained until news of the forced sterilization of fourteen-year-old Minnie Lee Relf and her twelve-year-old sister, Mary Alice, in the summer of 1973 prompted a federal investigation into their whereabouts.[85]

Because it never authorized the performance of sterilizations, the OEO never tabulated the number of sterilizations performed by its family planning affiliates between May 1971, when the sterilization ban was lifted, and July 1973, when it transferred its family planning responsibilities to HEW. An unpublished OEO study estimated that the department funded 2,000 sterilizations in 1972, at least 15 of which involved minors.[86] Likewise, although HEW affiliates began to provide sterilizations after Congress passed the Family Planning Services and Population Research Act in December 1970, the agency also failed to collect and maintain accurate records of its activities until 1974, when evidence of sterilization abuse forced it to implement strict record-keeping protocol. At the time, HEW could only estimate the number of sterilizations performed with its funds in the early years of its family planning activities. For example, it claimed to have funded approximately 16,000 female and 8,677 male sterilizations in 1972.[87]

It remains unclear how many OEO officials knew that their providers performed unauthorized sterilizations between 1971 and 1973. The acting director of the OEO from January through June 1973 testified at Senator Edward Kennedy's hearings on human experimentation that he had no knowledge of these practices during his tenure. However, *Medical World News* reported that Cooper, director of Health Affairs, had received two memoranda (one dated March 30 and the other April 4, 1972) that openly discussed sterilization in OEO programs, which indicates that Cooper and other administrators in OEO's Family Planning Division knew about the unauthorized surgeries. "Programs are being besieged by requests for voluntary sterilization services and some programs, we understand, are providing these services in response to popular demand," read one memorandum.[88] This memo suggests a disconnect between OEO policy and practice that was tacitly acknowledged at the highest levels of the agency but never addressed explicitly until victims publicized their abuse.

Minnie Lee and Mary Alice Relf

Sterilization abuse finally became a national issue in the summer of 1973 when Minnie Lee and Mary Alice Relf filed suit against the government agencies and individuals responsible for their involuntary sterilizations. The black girls, ages fourteen and twelve, respectively, had been sterilized without their knowledge or informed consent on June 14, 1973. Minnie Lee's and Mary Alice's abuse epitomizes the neo-eugenic values underlying this new practice. Family planning workers funded by the OEO identified the girls as appropriate surgical candidates on the basis of their race and class and tricked their illiterate mother into "consenting" to her daughters' sterilizations. No evidence suggested that the girls were at risk for an unintended pregnancy, and neither the girls nor their parents solicited family planning services. The Relfs' experience is not representative of sterilization abuse incidents during this era because of the extremity of their case and the publicity it generated. It is instructive, however, because it magnifies the prejudicial attitudes and assumptions about reproductive fitness inherent in forced sterilization and because it was the case that brought forced sterilization to national attention.

Minnie Lee and Mary Alice Relf lived with their parents and older sister, Katie, in public housing in Montgomery, Alabama. Local family planning agents at the Montgomery Community Action Agency, an OEO-sponsored program, approached the girls about contraception as soon as the family moved into the housing project in 1971. They predicted that because Minnie Lee and Mary Alice were poor and black, they would engage in unprotected sexual activity and bear illegitimate children, whom they would ask the state to support. No evidence suggested that the Relfs were sexually active when family planning workers solicited their consent to contraception. Community Action Agency workers had merely observed that "boys were hanging around" the girls.[89]

In 1971, the family planning agency began to administer the contraceptive injection Depo-Provera to Katie, then fourteen years old. Community Action Agency staff did not obtain parental consent for these routine injections of the controversial drug, which was in clinical trials at the time. In March 1973, again without consulting her parents, nurses took Katie to a family planning clinic and forced her to accept an IUD. Katie protested, but clinic staff dismissed her objections and inserted the device, telling the teenager that she needed it.[90]

Sometime after Katie began receiving Depo-Provera at the clinic, family planning workers began to administer the three-month injections to Minnie Lee, who was then twelve, and Mary Alice, who was then ten. Again, the staff did not obtain parental permission to perform these injections, nor did they adequately explain the injections to the girls. Most medical professionals today consider Depo-Provera to be a safe, effective, and popular method of contraception. However, in the early 1970s Depo-Provera was an experimental contraceptive in its early clinical trial phase, and clinicians administered the injections to welfare recipients like the Relfs at federally funded clinics. The Food and Drug Administration (FDA) terminated this round of clinical trials of Depo-Provera in the spring of 1973 after a preliminary study linked the drug to cancer in beagles. Rather than substitute another form of temporary contraception or simply stop administering contraception to the sexually inactive girls, family planning workers decided to sterilize them.[91]

On June 13, 1973, a family planning worker from the Montgomery Community Action Committee escorted Minnie Lee, Mary Alice, and their mother from their home to a doctor's office and then to a hospital, where the Relfs were told that the girls would receive more shots. Hospital staff obtained Mrs. Relf's consent to what she believed to be Depo-Provera injections and helped her home. Mrs. Relf, who was illiterate, had no way of knowing that the form she signed had authorized her daughters' sterilizations. "I put an X on a piece of paper, and she told me that they were going to give them some shots. That is what she told me," Mrs. Relf testified at a Senate subcommittee hearing convened by Senator Edward Kennedy in July 1973. "They didn't say anything about giving them no operation," she contended. "They told me they were going to give shots."[92] Her husband corroborated this account, testifying at the same hearing that "the girls had been getting some birth control shots for some time, and the clinic nurses come here and said they wanted to give them some more. But they just took 'em away instead and then taken the life right out of them."[93] When asked by Kennedy if she would have willingly consented to her daughters' sterilization, Mrs. Relf replied, "I would not have let them do that." Her husband reiterated his objection to the offense, "I didn't want it done and I'm still upset."[94]

Concerned about his daughters, Lonnie Relf, a fifty-six-year-old unemployed contractor crippled by a back injury, traveled to the hospital around nine or ten o'clock on the evening of June 13 to check on them. Hospital staff refused to allow Mr. Relf to see the girls, informing him that visiting hours were over and that he would have to wait until the following day to see his children. Lonnie Relf returned home puzzled about the cause of his daughters' hospitalization.

The next morning Mrs. Relf returned to the hospital where her daughters "told me they had been operated on." "That was the first I knew about it," she testified.[95] Although a nurse claimed to have explained the procedure to the girls, her competence is questionable. If she did in fact explain the surgery to the girls, she did an extremely poor job of communicating its permanence. Joseph Levin, general counsel of the Southern Poverty Law Center and attorney to the Relfs, maintained that Mary Alice did not understand that she could not bear children, and while Minnie Lee appeared to understand the consequences of her surgery, she continued to speak of reversing the procedure and having children in the future.[96]

Orelia Dixon, director of the Montgomery Community Action Agency's Family Planning Project, insisted that Mrs. Relf understood the nature of the surgery to which nurses asked her to consent. "There is no doubt in my mind that they knew what that meant," she maintained. "We explain everything and don't use words that people can't understand."[97] Unable to continue injecting the girls with Depo-Provera after the FDA terminated clinical trials, but unwilling to trust the girls to take birth control pills consistently, Dixon contended that family planning nurses determined sterilization to be an appropriate method of contraception for the young girls. When accused of racism in the press, clinic staff pointed out that "the nurses who took the girls from their home were also black."[98] This defense intended to suggest the nurses' clinical objectivity by implying that black women would not victimize other black women.

Perhaps the girls' sterilization constituted a genuine, albeit terrible, misunderstanding between the clinic staff and the Relfs. Regardless, the neo-eugenic intent of the clinic workers' actions remains clear, as evidenced by the clinic staff's insistence that sterilization constituted an appropriate alternative to Depo-Provera for two sexually inactive preteen girls. Clinic personnel identified Minnie Lee and Mary Alice Relf as "unfit" to reproduce on the basis of their race and class and sought to render them infertile before they could bear illegitimate children who would become dependent upon the state. Clinic records suggest that the staff did not confine this practice to the Relfs; they targeted other poor black girls whom they also predicted would bear children out of wedlock. In 1973, the Montgomery Community Action Agency sterilized eleven females. Ten of the eleven patients were black, and five, including the Relfs, were between the ages of twelve and seventeen.[99] These records show that in the early 1970s, forced sterilization had evolved beyond the targeting of those who had born children out of wedlock; some family planning clinics had begun to sterilize "unfit" girls who, they predicted, would become unwed mothers.

Exposing Sterilization Abuse

Although a physician sterilized Minnie Lee and Mary Alice Relf without their knowledge or consent, the majority of forced sterilization incidents in the late 1960s and early 1970s (the peak years of abuse) involved physicians coercing patients to consent to unwanted surgeries when they entered the hospital for labor and delivery. Most often, physicians, nurses, and social workers forced patients to consent to surgery by threatening to revoke their public aid if they refused, leading them to believe that tubal ligations could be reversed, or pressuring them to agree to surgery while under duress or on medication, especially during labor and delivery. In the years following the Relfs' disclosure, victims' testimonies and lawsuits, federal investigations, private studies, and congressional hearings revealed the existence of widespread sterilization abuse across the nation. New York, California, North Carolina, Mississippi, and Alabama stood out as particularly egregious offenders.

Sterilization abuse assumed multiple forms and ranged from subtle persuasion to oppressive harassment. It also bore a distinct regional and racial/ethnic pattern. In the South where blacks and whites continued to struggle with integration, black women remained targets for those who performed forced sterilizations. In California and the Sun Belt, where issues of Mexican immigration dominated, physicians and medical staff targeted Mexican and Mexican American women for sterilization as a method of reducing the population and shrinking the welfare rolls. Puerto Rican and black women in New York City became targets for physicians who endorsed the myth of the welfare queen and who believed that Puerto Rican women's "hyperfertility" and poverty made them appropriate candidates for surgery. Finally, Native American women living on reservations experienced very high rates of forced sterilization as the medical staff serving this population sought to reduce dependency by preventing their patients from bearing children.

As sterilization gained acceptance as a legitimate method of contraception and as federal family planning funded the procedure, surgeons and social workers stopped secretly sterilizing women or using eugenic statutes to sterilize poor women who bore children out of wedlock, and instead started to demand that patients consent to permanent contraception. Most physicians approached potential surgical candidates during labor and delivery, and many deceptively marketed sterilization in order to secure patients' consent to the procedure. One physician explained, "Women seem to accept the procedure more readily if the word 'operation' is not used." He routinely described tubal ligations to patients as "a stitch in the vagina" that protected against pregnancy.[100] Another physician established a policy of informing patients of the permanence of tubal ligation only if they asked.[101] Still other doctors "neglected" to inform their patients that sterilization was permanent. A San Francisco intern reported, "If the patient asked, yes she'd be told it was permanent. If there was a big rush, the staff wouldn't bother."[102] And an Ohio physician bluntly admitted, "The alternatives were rarely gone into with a black welfare patient who had two or more kids."[103]

Many Mexican, Puerto Rican, and Native American women found that physicians exploited the language barrier between them when patients did not speak English fluently. A pediatric intern at New York's Bellevue Hospital explained: "There was a large Puerto Rican population and I think a lot of women didn't know the full consequences of what was happening to them. There was a language problem. Many of them thought their tubes could be untied."[104] By referring to sterilization as the "tying of tubes," physicians suggested that surgery could be easily reversed. Elena Orozco became a victim of this type of abuse. "What I was signing, I understood it to tie my tubes, not to sterilize. If they would have put the word 'sterilization' there, I would not have signed the papers," the Los Angeles woman revealed.[105] Another woman sterilized without her informed consent at the University of Southern California, Los Angeles County Medical Center (USC L.A. County Medical Center) explained in a deposition, "We [her husband and herself] both believed that my tubes could later be untied if I desired to have more children. . . . At no time did any member of the medical center's staff inform me that my tubes were going to be cut and that I would be permanently sterilized."[106] As both women learned too late, doctors generally cauterized or cut the fallopian tubes entirely, making reversal difficult, if not impossible.

Pressuring non-English-speaking women to consent to surgery using English forms was another way in which physicians exploited the language barrier in order to force patients to accept sterilization. Physicians and other hospital staff made few efforts to find translators for these patients. When Dr. Bernard Rosenfeld, a resident at the USC L.A. County Medical Center, opposed the sterilization of a twenty-six-year-old Spanish-speaking woman who "spoke no English," but whose "operation consent form [was] signed in English," the physician responsible for the patient told Rosenfeld, "We're doing her a favor."[107] Sterilizing the patient was far more important to this physician than making sure she understood and consented to the procedure.

Physicians aggressively "sold" tubal ligation by repeatedly approaching women during labor and delivery and, if this proved unsuccessful, during the subsequent hospital stay. Patient records from the USC L.A. County Medical Center indicate that physicians approached women during active labor, when they were distressed and often under the influence of anesthesia or pain medication. Consent forms were frequently signed just before surgery began.[108] For example, a thirty-year-old Los Angeles woman was in labor for nineteen hours and thirty minutes before consenting to sterilization. During this time, she received the drugs Demerol and Visteril. Her last dose of Demerol was administered forty-five minutes before she signed the consent form.[109] Another woman treated at the same hospital recalled submitting to sterilization after being worn down by labor, pain medication, and her doctor's insistence. "I told the doctor that I did not want to be sterilized since my husband and I planned to have another child," she explained. "I was groggy from the drugs, exhausted from the labor, as well as from the doctor's constant pressuring. Finally, I told the doctor, 'Okay, if it's a boy, go ahead and do it.' "[110] Although she delivered a girl, this woman awoke from anesthesia to learn that she had been sterilized. She was not alone in learning of her surgery after the fact. Admitted to the hospital on

June 5, 1972, thirty-three-year-old Maria Gomez remembered that the doctor who was to perform her emergency cesarean section asked her about sterilization just before surgery began. “I don’t remember very much after this,” she explained in an affidavit, because “I was very drowsy and drugged. They gave me some funny anesthesia.” A postpartum check-up confirmed that she had been sterilized. Sterilization proved especially devastating for Gomez; her baby died twenty-four hours after birth.[111]

Some women who successfully resisted surgery during delivery were pursued by resentful physicians for the remainder of their hospital stay. Dr. Juan Nieto recalled that in the Colorado hospital where he trained, physicians harassed poor Mexican women from the moment they entered the hospital to deliver until they consented to surgery. Nieto explained, “They would get a young woman, maybe 19 or 20, who was having a baby and start right in on her in the delivery room. . . . If she said no, they would all stand around her bed every morning while on rounds and repeatedly suggest that she have the operation.”[112] Ralph Nader’s Health Research Group’s (HRG) 1973 *Study on Surgical Sterilization* confirmed this practice. Its primary author, Dr. Bernard Rosenfeld, remembered his chief resident’s instructions upon learning that a woman scheduled for a tubal ligation after delivery refused the surgery. The chief resident told him, “Go in there [the postpartum room where women stay for a few hours after delivery] and see if you can talk her into it.”[113]

Ricardo Cruz, a Los Angeles lawyer involved in litigation on behalf of Chicanas sterilized without their knowledge or informed consent, compiled a list of 190 women sterilized during labor at the USC L.A. County Medical Center between 1970 and 1974. The list also included copies of portions of these women’s medical record, most likely copied and interpreted by Dr. Rosenfeld. None of the women had any medical indication for sterilization, and few had large families. Seven of the 190 women listed had no living children at the time of surgery. Fifty-three had only one living child at the time of sterilization, and the same number of women had two living children when sterilized. Only 21 of the 190 patients had more than five children.[114]

The Cruz documents reveal several specific patterns of coercion at the USC L.A. County Medical Center, which became notorious for its forced sterilization of Chicana patients who arrived at the hospital for delivery. On several occasions, patients’ refusal to consent to surgery is charted, then followed by a second note listing the day of sterilization.[115] For example, the chart of a twenty-five-year-old reads, “No history of desiring sterilization in clinic. Admitted 6/1/71[.] Pre Op Note states, ‘Doesn’t want tubal at time of surgery.’ Cesarean section and tubal ligation done 6/2/71.”[116] Another chart of a thirty-nine-year-old woman includes a note that states, "Doesn't desire bilateral tubal ligation." This is followed by a description of a subsequent blood transfusion, indication for cesarean section, and confirmation of "cesarean section and sterilization done."[117] Notes on another patient's medical record indicate that the twenty-eight-year-old mother of four was "in hospital 3 days before labor began; not asked until labor was in progress if she desired tubal ligation even though cesarean section was known to be needed before labor began."[118] Clearly, the physicians treating her made an effort to approach her about surgery when she was most vulnerable.

Sometimes the phrase "no consents signed" was followed by a second one stating: "physician's certificate of emergency: 'This is to certify that the delay necessary to obtain complete consent for treatment would endanger this patient's life or chance of recovery. We believe emergency operation is necessary.' "[119] On the one hand, an emergency situation would warrant the bypass of consent under common standards of informed consent, which were just being developed (but not yet formalized) in the early 1970s as abuse occurred. On the other hand, sterilization is not an emergency procedure, although a cesarean section is. If a pregnant patient's health depended on immediate delivery, an emergency bypass of consent for the cesarean section would make medical and ethical sense, but not so for elective tubal ligation. Physicians preferred to perform cesarean sections and tubal ligations in tandem to minimize risks associated with infection and anesthesia, as well as to reduce medical costs. It appears that at this hospital, physicians who performed emergency cesarean sections sometimes used the opportunity to persuade a woman to accept permanent contraception.

Coercion caused by the failure of hospital staff to adequately explain the consequences of tubal ligation is evident in records in which patients questioned their fertility status after surgery. For example, notes from a patient's follow-up check-up revealed that she did not know whether she had been sterilized while undergoing a cesarean section. "Patient states she's nervous because she doesn't know if her tubes were ligated with c/s 1970," the chart read.[120] Frequently patients' lack of knowledge about their fertility status appeared in requests for contraception. One patient, described as "Spanish-American, Mexican" with one living child, was sterilized in June 1972. She returned to her family planning clinic about six weeks after delivery and requested birth control pills, but was given an IUD because her varicose veins constituted a counterindication to Pill use. A pathology report in her chart dated July 20, 1972, indicated that both of her fallopian tubes had been removed during her cesarean section. As of August 1973, however, the IUD remained inside the patient, suggesting that she did not understand the consequences of her surgery and that medical staff had failed to explain them to her. Her chart offers a possible explanation for the confusion. The patient had "signed [her consent] in markedly distressed handwriting 6/20 for cesarean section and sterilization" after she experienced a full twenty-four hours of labor, numerous doses of Demerol and Visteril, and an unsuccessful attempt at a forceps delivery.[121] Similarly, postpartum clinic notes on the chart of a twenty-nine-year-old black woman sterilized after a cesarean section on March 16, 1972, read, "Birth control method wanted—diaphragm."[122] The chart indicates that the patient consented to sterilization, but one must wonder about how well the procedure was explained to this patient given that she requested temporary contraception at a postpartum check-up.

Physicians who failed to elicit consent before surgery sometimes required their patients to sign consent forms *after* surgery to ensure that they had a signature to protect themselves against potential litigation. In one instance, a patient signed her consent forms at 9 A.M. for a cesarean and tubal ligation that occurred three and a half hours earlier. When she returned for her postpartum visit, she requested a diaphragm, indicating that she, like so many others, did not fully understand the consequences of her sterilization.[123]

The absence of official hospital protocol for obtaining patients' informed consent to surgery allowed these patterns of abuse to develop and grow. The practice of forced sterilization at delivery began in the interim period between the start of medical and public discussion of patient protections in the late 1960s and the actual implementation of these policies in the early-to-mid-1970s. In the late 1960s, consumer groups and health activists started to demand increased oversight over medical practice, the establishment of strict standards of informed consent, and the strengthening of the patient's position within the inherently unequal doctor-patient relationship. Their demands led to the creation of clear standards of informed consent and the adoption of these standards by hospitals across the country, which slowed forced sterilization upon delivery by prohibiting physicians from obtaining consent from patients under duress and the influence of anesthesia and pain medication, requiring that they explain all the risks and side effects of surgery, and mandating that non-English speakers have surgeries explained to them in their native language. In 1970, the Joint Commission on the Accreditation of Hospitals (JCAH) adopted a Patient Bill of Rights, which the American Hospital Association (AHA) endorsed in 1973.[124]

In the interim between demands for standards of informed consent and the actual adoption of these protective mechanisms, physicians devised their own sterilization policies, some more explicit than others. Rosenfeld believed that "it's mainly a question of the doctor's prejudice. Or their feeling that they have a social right to determine how many children a woman should have."[125] Physicians across the country affirmed Rosenfeld's contention. A doctor trained in North Carolina reported that his colleagues "pushed them [sterilizations] on anyone delivering their second or more child."[126] In the experience of a resident who studied at Wayne State Medical School in Detroit, the number of children a woman bore played a greater role than age in doctors' choices of sterilization candidates. "We had a lot of young girls come in . . . thirteen and sixteen and they'd have two or three children. . . . There were so many young girls and most of them had a real low mentality. We'd tell them about birth control and they wouldn't take it. It would get some of the residents real mad."[127] An intern from Milwaukee reported that she witnessed physicians sterilizing minors "if they had two kids."[128]

Another common form of sterilization abuse involved physicians persuading poor patients to accept hysterectomies instead of tubal ligation solely for the purpose of practicing a more complicated surgery. A 1973 HRG study on sterilization confirmed this practice, as did patients' own reports. Physicians who acted in this manner placed their own education over their patients' well-being, as hysterectomy involved a greater medical risk and recovery period. A 1972 *American Journal of Obstetrics and Gynecology* study found that the complication rate for hysterectomy was ten to twenty times higher than for tubal ligation. As sociologist Adele Clark maintains, "this is a classic example of professionals exercising their autonomy over and against that of patients."[129]

Residents' comments to HRG investigators revealed institutional acceptance of the practice of using poor patients to develop young surgeons' skills. One resident at Boston City Hospital reported, "We like to do a hysterectomy, its [*sic*] more of a challenge . . . you know, a well-trained chimpanzee can do a tubal ligation . . . and it's good experience for a junior resident." Another medical student at the same hospital recalled that "on many occasions, patients requesting sterilization . . . usually by tubal ligation, were talked to for several days until they agreed to hysterectomies." A staff doctor admitted to HRG investigators, "Let's face it, we've all talked women into hysterectomies who didn't need them, during residency training." Likewise, when one student questioned whether the size of a supposed fibroid tumor (a benign growth in the uterus that is sometimes an indication for hysterectomy) necessitated a hysterectomy, the presiding resident replied, "We don't know. The guy that sent her in thought there might be." Besides, he added, "She's 42 and doesn't need a uterus."[130] Likewise, a physician trained at a southwestern hospital recalled that one of his colleagues would lie to women whom he believed had too many children and tell them that they needed hysterectomies when no medical indications for surgery existed. He remembered one instance in which this colleague actively covered up his misdiagnosis, saying, " 'We're going to have to make sure the pathology report does not get back to the woman and make up a reason why she needed to have it taken out.' "[131]

Native American women who lived on reservations and received health care through the Indian Health Service (IHS) also experienced an extremely high rate of sterilization abuse. Between 1970 and 1976, IHS hospitals and affiliates sterilized between 25 and 42 percent of all Native American women of childbearing age.[132] The IHS provided poor health care in run-down, underfunded, understaffed, and underequipped hospitals and clinics that could not meet the needs of Native Americans. Understaffing prevented many Native Americans from receiving health care quickly. To compensate, the IHS contracted out its services, which encouraged forced sterilization, as the IHS made no effort to regulate contract facilities. Set in the context of poor health care, which contributed to short life spans, and the decades-old practice of removing children from Native American homes and sending them to white schools to be assimilated, forced sterilization exacerbated an existing population problem that threatened the health and well-being of Native American tribes and cultures.[133]

The introduction of forced sterilization to an already dwindling population imperiled the reproduction of many tribes and tribal cultures and led some tribal advocates to accuse the federal government of using sterilization to reduce population size in order to claim more Native American land.[134] These claims bore a similarity to cries of genocide leveled against the government by black nationalists in the same era. "There are only 5,000 of us," Tribal Judge Marie Sanchez of the Northern Cheyenne exclaimed. "This is another attempt to limit our population—but this time, they're doing it in the noble name of medicine."[135] Dr. Constance Uri, an outspoken advocate of patients who had been sterilized, approached the issue from another perspective. "Zero population growth may be all right for the white man, because he's crowding this continent. But for the Indian, it's genocidal," she declared.[136]

In the early 1970s, Dr. Uri witnessed a significant rise in the number of young, sterile Native American women. She first confronted the issue in 1970 when a twenty-year-old woman asked her for a "womb transplant." "I've heard of kidney transplants," the patient said, "and I want to know if you can give me a new womb." Uri had to explain to her young patient—who was engaged and planning a family—that her uterus had been removed and could not be replaced. An IHS physician had performed a hysterectomy on her six years earlier when she struggled with alcoholism and told her that the surgery was reversible.

Although this woman sought assistance from Uri, fear of forced sterilization led many women to avoid the IHS providers: Uri and two colleagues held clinics in a tepee in order to provide services for patients in a "safe" environment.[137]

Concerned that an epidemic of abuse was under way, Uri contacted Senator James G. Abourezk of South Dakota, who requested a Government Accounting Office (GAO) investigation of sterilizations performed through the IHS and its contract facilities. The GAO studied the incidence of sterilization in four regions (Oklahoma City, Oklahoma; Aberdeen, South Dakota; Albuquerque, New Mexico; and Phoenix, Arizona). But it asked only one question: Did the sterilizations comply with the 1974 HEW guidelines? These guidelines (which will be discussed in detail later) prohibited the sterilization of individuals under the age of twenty-one, required that patients be informed of all risks and benefits of the surgery before consenting to it, and standardized the process of informed consent. The GAO study found that between 1973 and 1976, the IHS funded 3,406 female sterilizations and 142 vasectomies. Of the 3,406 female surgeries, 3,001 involved women of childbearing age. The GAO identified several violations of the waiting period and informed consent process, but ultimately concluded that most sterilizations performed through the IHS did not constitute abuse.[138] This conclusion contradicts the evidence provided by tribal leaders, some of who conducted their own studies. Had investigators broadened their study to examine the conditions under which these surgeries occurred, rather than measuring compliance with the 1974 guidelines, they would likely have uncovered the blatant evidence of abuse already documented by Native American activists and victims of sterilization abuse. Various violations of the 1974 guidelines, such as the thirty-six sterilizations of women under twenty-one years of age and the GAO's conclusion that most physicians caring for Native Americans were unaware of the new federal guidelines, suggests that abuse was common on reservations.[139]

Tribal leader Lee Brightman collected his own evidence of abuse. In 1979, he reported that during a weeklong visit to the Rosebud Reservation in South Dakota, he encountered seven women sterilized without their informed consent. Two women had entered an IHS hospital to have their appendixes removed and left without their ovaries. One sixteen-year-old awoke from anesthesia administered during delivery to learn she had been "fixed so that she wouldn't have more kids until she was eighteen."[140] Another young woman had gone to the hospital to have an ovarian cyst removed and left without her uterus. Finally, IHS surgeons sterilized a young postpartum patient by falsely informing her mother that without surgery, her daughter would die. IHS physicians later convinced the same mother that she, too, would die unless she accepted sterilization.[141]

Chief Tribal Judge Marie Sanchez also investigated sterilization abuse among Native Americans. Sanchez interviewed women in Lame Deer, Montana, and found that thirty women had been sterilized between 1973 and 1976. She found two girls under fifteen who were victims of "Mississippi appendectomies." They entered the hospital to have their appendixes removed but later learned they had been sterilized. Sanchez met another woman with severe migraine headaches. Doctors attributed her headaches to hormones and suggested a hysterectomy. Surgery did not eradicate her headaches; she was later found to have a brain tumor.[142] Sanchez found the practice of physicians pushing hysterectomies on otherwise healthy patients to be common on reservations, as it was in other public hospitals. "The doctors that come to us are young, often fresh out of medical school and they want to practice on someone," Sanchez stated.[143] Dr. Uri's investigation also uncovered unnecessary hysterectomies in patients as young as eighteen who had undergone the surgery without comprehending its permanence.[144]

The most well known case of Native American women and forced sterilization occurred off the reservation, in western Pennsylvania. In 1970, Norma Jean Serena received a visit from a welfare worker from Armstrong County Welfare Services in Pennsylvania who responded to a complaint that Serena and her two children were living in squalid conditions with a black man who was not her husband. Social workers insisted on taking the two children, a boy and a girl, both under four years old, to Children's Hospital in Pittsburgh for medical examination. After the exam, they told Serena that her children were too sick to leave the hospital, although the physician's report indicated that the children were "healthy and alert."[145] Subsequently, caseworkers placed the children in foster care, telling Serena that the arrangement was temporary, but informing the foster parents that it could be made permanent.[146]

Serena was pregnant with her fifth child at the time (the oldest two children did not live with her). The Child Welfare and Board of Assistance in Pittsburgh removed the baby from her care after birth and placed him in the foster system in August 1970, claiming that Serena was too ill to care for him. Serena was sterilized after delivery. Sources offer two conflicting stories about how and when Serena discovered her sterilization. One says that she learned about her surgery the following day when physicians approached her to sign a consent form. Another, that she found out days after the surgery when she "overheard a conversation in her hospital room."[147] Doctors recorded their motivation to sterilize this patient on her chart. "We find from observation and examination of Norma Jean Serena," they wrote, "that she is suffering from the following ailment or conditions . . . socioeconomic reasons . . . and that another pregnancy would, in our opinion, be unadvisable. Therefore, we are of the opinion that it is medically necessary to perform the sterilization."[148] The note on Serena's chart makes clear the association between poverty, illegitimacy, and women of color and highlights the authority that white physicians assumed in making the most intimate decisions on behalf of their patients without consulting the patients themselves. Her lawyer, Richard Levine, agreed, stating, "These people [the defendants—welfare officials, doctors, and so forth] wield enormous power in the name of benevolence. If this case does nothing else it will put a bridle on that power."[149]

Serena filed suit against the institutions and individuals complicit in removing her children and sterilizing her without her informed consent. She was only partially successful. In 1973, a jury ruled in her favor, determining that her children had been removed under false pretenses. It awarded her $17,000 and ordered her children released back to her. In 1979, Serena lost her case against the physicians and social worker involved in her sterilization after the doctor who sterilized her testified that he had explained the procedure carefully to her and that she demonstrated an understanding of it.[150]

Understanding Physicians on Forced Sterilization

How does one explain why physicians who practiced forced sterilization acted as they did? Were they all malicious? Did some act out of benevolence, however misguided such logic may have been? How did changing trends in the practice of medicine and the doctor-patient relationship influence physicians involved in abuse?

Most physicians appear to have operated with relatively benevolent intentions, genuinely believing that sterilization would raise their patients' standard of living and improve their quality of life. They functioned according to an outdated, paternal model of professional conduct, which granted doctors the authority to make life-and-death decisions on behalf of their patients. Medical paternalism functioned relatively effectively in the first half of the twentieth century when doctors practiced within their local communities and community members trusted their physician to act on their behalf. But by the mid-1960s, these once familiar public figures had become strangers. Postwar changes in medical practice—specifically, the consolidation of services within the hospital movement toward specialization, advances in diagnostic technology, and the migration of hospitals out of rural communities—disrupted the close relationships doctors once shared with their patients. With these changes, the doctor ceased to be a general practitioner residing within his local community and instead became a specialist operating in a large, impersonal institution.

Without a shared community, patients became estranged from their doctors and began to question these experts' ability to act on their behalf.[151] Despite patient skepticism, many physicians retained their right to make medical decisions on behalf of patients. While doctors held tight to paternalism, patients increasingly invoked their right to make their own medical decisions. Even after the courts and legislatures established formal protocols for medical decision making, many doctors stubbornly refused to concede their professional authority to patients, bioethicists, lawmakers, and judges. Many involved in forced sterilization acted according to outdated precepts, genuinely believing sterilization to be in the best interest of a particular patient, but failing to understand that they no longer controlled reproductive decision making.

A minority of doctors operated with more neo-eugenic intentions. Blaming poor minority women for the expansion of welfare, which they believed to directly threaten their own economic security, these doctors deliberately sterilized their patients in order to reduce the number of "defective" citizens and "undeserving" poor. As a North Carolina physician explained, "A doctor who had just got his income tax back and realized it all went to welfare and unemployment was more likely to push it [sterilization] harder."[152] Exploiting their professional authority, these physicians literally inscribed their politics upon their patients' bodies.

Both groups of doctors exploited the economic, gender, and racial disparities between themselves and their patients to intimidate patients and pressure them to consent to unwanted sterilization. As one physician commented, poor women "were uneducated and trained to do what the doctor told them."[153] Victims of sterilization abuse often reported being overwhelmed by physicians who embodied social power and prestige far above their own. In an extreme example, Guadalupe Acosta recounted the delivery that resulted in a forced sterilization. "There were two doctors just pushing down on my stomach and . . . I couldn't stand it. I pushed one doctor because I couldn't stand the pain. When he came back, he hit me in the stomach and said, 'Now lady, let us do what we have to.' "[154]

Having relinquished bodily control to their doctors, victims of sterilization abuse possessed few tools of resistance. Isolated from friends and relatives, without the economic resources to change providers (and for women in labor, the time to insist upon an alternate provider), many victims of sterilization abuse lacked the means to resist their abusers effectively. Those in labor could not leave the delivery room, and those who did not speak English fluently could not fully understand the surgery being pushed on them. Those under the influence of pain medication often lacked the ability to consent to permanent contraception. Those whose doctors threatened to revoke their welfare benefits if they refused the procedure conceded rather than consented, fearful that continued resistance would cause them to lose support they desperately needed. Every woman who experienced forced sterilization witnessed the incredible imbalance of power between doctor and patient. The majority understood the racial and socioeconomic politics that created the situation. A few women forcibly sterilized continued to fight their victimization after surgery by filing lawsuits in defense of their violated reproductive rights and seeking compensation for the loss of their fertility, but even the few who succeed could not retrieve their lost fertility.