

From Prevention to Protection: Policy,
Practice and Pitfalls of Surgical Sterilization
in California, 1910–Present.

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Abstract

From Prevention to Protection: Policy, Practice, and Pitfalls of Surgical Sterilization in California, 1909-Present.

In the history of involuntary sterilization in the United States, California stands out. Under the Asexualization Act (1909), a law which permitted the surgical sterilization of certain “defectives,” over 20,000 developmentally disabled and mentally ill people were forcibly sterilized. Although legal changes in 1951 all but halted the practice, the issue of the use and misuse of sterilization did not disappear. Subsequent policies concerning voluntary contraceptive sterilization (1969), and the sterilization of the developmentally disabled (1980), saw flagrant abuses of reproductive freedom capture public and political attention in the state. Traditionally, scholarly accounts advancing ideological justifications for how and why involuntary sterilization occurred in California have dominated the historiography. This dissertation contends, however, that this intellectual-cultural approach fails to fully explain the complexities of how legislation was developed and practiced. Instead, this dissertation explores the process through which eugenics, population control, racism, sexism, and other similar ideas, found expression through political, legal, and clinical institutions. By examining the inner workings of these various state and sub-state institutions, the dissertation develops a more nuanced approach, highlighting the continuities and discontinuities in the way that these ideas were incorporated into policy aims; and how policy, in turn, was translated into sterilization practice at the institutional level. In doing so, this dissertation presents novel findings about both the functional development and practice of sterilization in California, as well as extending the temporal focus traditionally applied to the state's history of sterilization policy. In particular, important new contributions about disability and the practice of sterilization by substitute consent in the 1970s and 1980s are presented. These findings are directly connected to important ongoing debates about the legacies of eugenics, reproductive technologies and practices, the reproductive rights of the developmentally disabled, and the limits of state intervention in reproductive matters.

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Abbreviations

ACLU – American Civil Liberties Union.

ACOG – American College of Obstetricians and Gynecologists.

AJC – Assembly Judiciary Committee.

ARC – Association for Retarded Citizens.

AVS – Association for Voluntary Sterilization.

BKP – Barry Keene Papers.

CDH – California Department of Health.

CHA – California Hospital Association.

CITA – California Institute of Technology Archives.

CLRC – California Law Review Commission.

CMA – California Medical Association.

CMRW – Committee for the Medical Rights of Women.

CPF – Capitol People First.

CSA – California State Archives.

DD – Developmentally Disabled.

DDS – Department of Developmental Services.

DHEW – Department of Health, Education and Welfare.

DMH – Department of Mental Hygiene.

DOI – Department of Institutions.

EWP – Earl Warren Papers.

GCBF – Governor's Chapter Bill File.

HHC – New York Health and Hospitals Corporation.

HMC – Hugh Moore Collection.

JRHP – John Randolph Haynes Papers.

LACMC – Los Angeles County Medical Center.

MALDEF – Mexican American Legal Defense and Educational Fund.

NOW – National Organization for Women.

OAL – Office of Administrative Law.

OBF – Original Bill File.

PAI – Protection and Advocacy Inc.

RCSP – Ricardo Cruz Sterilization Papers.

RTP – Reporter's Transcript of Proceedings.

SFNLAF – San Francisco Neighborhood Legal Assistance Foundation.

SJC – Senate Judiciary Committee.

SSHP – Sonoma State Hospital Papers.

SUA – Stanford University Archives.

UCHLL – University of California Hastings Law Library.

UCLA-CSRC – University of California Los Angeles Chicana Studies Research Center.

UCLA-SCL – University of California Los Angeles Special Collections Library.

UCSB-SC – University of California, Santa Barbara, Special Collections.

UMSWHA – University of Minnesota Social Welfare History Archive.

VISP – Velez-Ibanez Sterilization Papers.

A Note on Language and Definitions

Throughout this thesis, historically accurate terminology is used when referring to conceptions of disability. Terms like feeble-minded, moron, mental defective, retarded, and retardation are used throughout. While not always used in quotation marks, the use of these terms is to aid historical accuracy in exploring such ideas, and in no way indicates a personal belief that such terms are acceptable or accurate. Furthermore, due to the timespan involved; the shifting social and legal concepts; and the subtleties of language, it is worth defining some terms used throughout this work.

Throughout this study, the term involuntary sterilization is used as an umbrella term to describe the use of sexual surgery to remove the possibility of procreation through the use of compulsion or coercion. While both compulsory sterilization and coercive sterilization are forms of involuntary sterilization, they are used to denote distinct approaches to involuntary sterilization in this thesis. The term compulsory sterilization is used, as it was at the time, to describe the practice of sterilizations mandated and performed through state-run programs in the first half of the twentieth century. This term reflects the legal language used at the time to describe these programs, and also foregrounds the use of state police powers to accomplish these sterilizations.

Coercive sterilization, meanwhile, is mainly used in this thesis to describe the tactics used by doctors in the 1970s when approaching poor and minority women to submit to sterilizations. Coercion describes the various deceptive methods used by these physicians seeking to sterilize unwilling or unaware patients through the use of ambiguous or misleading language, misrepresenting the purpose of operations, seeking consent of patients in altered states of consciousness, or by applying economic, social, or other pressure tactics to achieve their aims.

Abusive sterilization is a third term used in this thesis, and again, reflects language used by activists in the 1970s to describe the widespread use of coercive sterilization on poor and minority in hospitals across the country at the time. The term was often used interchangeably with coerced or coercive sterilization, but differs slightly in that it underscores the historical view that these sterilizations were extra-legal, and breached the explicitly “voluntary” nature of the programs which funded them. This further differentiates these sterilizations from those conducted under the state-run compulsory sterilization programs. While both appear abusive from a contemporary vantage point, compulsory sterilization programs operated, in most states, within a legally accepted framework, and thus were not considered abusive in the same way.

Of course, the above definitions hinge on the idea of consent, which like the terms used over the course of this work, shifted and changed throughout the twentieth century. Indeed, in the United States, the idea of a clear and uniform idea of what constituted informed consent was a fledgling one in the 1970s, and only with the revelations of the Tuskegee Experiments in 1973 and the adoption of the National Research Act which required, and laid out the standards, by which researchers had to seek informed consent was a clear framework erected detailing how informed consent should be sought in various settings. There were, however, judicial precedents which ruled on the issue of consent (see Appendix I), and which inform the definition used in this thesis. Consent, therefore, is the voluntary choice to authorize a medical procedure, based on the full disclosure of information about the procedure by the physician, and the full comprehension of this information by the patient. When voluntary sterilization, is discussed in this thesis, then, it denotes a willing choice by the patient to undergo sterilization, in the absence of social, economic, or other pressures, and with full knowledge of the purpose, benefits, and risks of the procedure.

Finally, bound with these ideas, and discussed in detail in this thesis, is the concept of substitute consent. In California, the limits of substitute consent became a central focus in discussions of sterilization in the late-1970s and 1980s, and, indeed, still remains problematic to this day. As used in this thesis, substitute consent refers to the power conferred to the parent or guardian of a developmentally disabled, or otherwise incapacitated, person, adjudged incapable of providing consent themselves.

Introduction

Outrage spread across California in 2013 when an article published by the Center for Investigative Reporting (CIR) alleged that doctors in two women's prisons had improperly sterilized 150 inmates without following informed consent protocols.¹ These protocols are laid out in Title 22 of the California Code of Regulations, and define the standards by which lawful consent may be obtained. These standards were the result of a painstaking campaign by activists in the 1970s to strengthen the informed consent process in the face of widespread evidence of involuntary sterilization occurring in hospitals across the country; a process that will be explored in greater detail in this thesis. The California Code of Regulations likewise prohibits prison physicians from performing operations that are considered not medically necessary; this includes tubal ligation and vasectomies, which serve only to render the individual sterile.²

A year later, these allegations were corroborated in a report of the State Auditor's Office which found that some women never signed informed consent documents, while others had been rushed into surgery without doctors observing the mandatory 30-180 day wait—the period allowed between giving consent and undergoing surgery established in the 1970s. Furthermore, the two Sacramento-based medical boards, required under state law to adjudicate prison sterilization petitions before any operation could proceed, found no record of such requests.³

Despite these glaring breaches of protocol, Dr James Heinrich, the senior prison physician at the head of the scandal, refuted any wrongdoing and insisted that the inmates “all wanted it done,” or were sterilized out of medical necessity. In addition to his claims of innocence, Heinrich also maintained that the \$148,000 of state money spent on sterilization surgeries over the preceding years was trivial “compared to what you save in welfare paying for these children – as they procreate more.” It also emerged that women considered recidivistic were pressured into sterilization more than others.⁴

Yet the testimony of women who had been treated by Heinrich contradicted the physician's protestations. Several women interviewed by the CIR described being

1 “Female Inmates Sterilized in California Prisons Without Approval,” Reveal News, last modified July 7, 2013, <https://www.revealnews.org/article/female-inmates-sterilized-in-california-prisons-without-approval/>.

2 California State Auditor, *Sterilization of Female Inmates: Some Inmates Were Sterilized Unlawfully, and Safeguards Designed to Limit Occurrences of the Procedure Failed* (Sacramento: California State Auditor, 2014), 2-3

3 Ibid, 19-28.

4 “Female Inmates Sterilized in California Prisons Without Approval.”

repeatedly pressured by Heinrich and other medical staff into agreeing to sterilization procedures, often while distressed, in pain, or under the influence of painkillers or anesthetic. Kimberly Jeffrey, for instance, a former inmate at Valley State Prison, described being pressed to have a tubal ligation while under sedation and bound to an operating table. Though the panicked and confused Jeffrey managed to resist the medical staff's attempts, other women in Jeffrey's position could not.⁵

The CIR article tied the events of the prison scandal to California's "ugly past" of eugenically-motivated institutional sterilization that dominated state hospital, and, to a lesser extent, prison medical practice in the first half of the twentieth century, and its link to Third Reich's own 1933 sterilization law.⁶

This link to the history of eugenics was unsurprising. The 'golden era' of eugenics during the first half of the twentieth century, wherein over 60,000 citizens were sterilized, remains the most conspicuous episode in America's long relationship with forced or coercive sterilization.⁷ It was the science of eugenics, which found fertile soil to flourish in the late nineteenth century in the minds of the influential segments of American society, that provided the justification for these operations. Armed with a rudimentary understanding of genetics, biologists, doctors, philanthropists, and others who wore the mantle of "eugenics" argued that an individual's heredity determined his or her progress in life, and, more importantly, the worth of their contribution to the nation in which they lived. Most, like Harry H. Laughlin, arguably America's most influential eugenic proponent, believed that society itself rested on the need for good genetic stock. Accordingly, it was the eugenicists' aim to promote the reproduction of individuals endowed with positive, or *eugenic*, traits, and to impede as far as was possible the reproduction of those harboring undesirable characteristics. Through pursuing this goal, eugenicists believed they held a solution to the pressing social concerns of their time, and the key to enhancing the biological strength of the nation.

Of the numerous tools wielded by eugenicists in pursuit of this goal, sterilization emerged as the quintessential method for arresting the perceived rising tide of degeneracy. During the first half of the twentieth century, over thirty states would adopt legislation that permitted institutions to sterilize undesirable citizens – often the mentally ill, developmentally disabled, and criminal – with only nominal or no consent.⁸ By 1927,

5 Ibid.

6 Ibid.

7 For full figures, see Jonas Robitscher, *Eugenic Sterilization* (Springfield: Charles C. Thomas, 1973), 118-119.

8 Robitscher, *Eugenic Sterilization*, 118-119; Julius Paul, "Three Generations of Imbeciles Are Enough: State Eugenic Sterilization Laws in American Thought and Practice," (unpublished manuscript, Walter

following the landmark decision in *Buck vs. Bell*—A U.S. Supreme Court ruling that upheld the constitutionality of Virginia's state sterilization law, and by doing so, legitimized the practice of compulsory sterilization across the United States—these state programs operated with the authority of the nation's highest court.⁹ This decision paved the way for sterilization programs to reach their peak in the 1930s, at a time when eugenic fervor was still riding high. This crest, however, was followed by a general decline in the number of operations performed during and after the Second World War.¹⁰

The state of North Carolina proved an exception to this rule. In its forty-five-year experience with state-run eugenic sterilization, North Carolina is variously estimated sterilized between 5,993-8,000 of its citizens; if we take the higher estimate, this places it second only to California in total sterilizations by state.¹¹ What made North Carolina's program unique was that it actually increased its rate of sterilization at World War II. This feature was largely due to the presence of the North Carolina Eugenics Board: a body of public health administrators, some of whom ran the state's institutions. This body held the power to decide the outcome of sterilization petitions of individuals both inside the state's institutions, and those outside its walls. This fact accounted for the acceleration of the program after the war years; indeed, as larger numbers of African Americans began utilizing New Deal welfare programs, they increasingly fell under the purview of the Eugenics Board, who used economic as well as Eugenic motives to decide on sterilizations. Whereas in 1950, only twenty-three percent of sterilizations were performed on African-Americans, by the mid-1960s, this number had jumped to sixty-five percent.¹² The link between race, welfare expenditures and sterilization seen in North Carolina portended changes in the way sterilization would proceed after the 1950s.

Indeed, it would not be long before sterilization, albeit in new clothing, would come to national attention once more. The liberalization of state laws on voluntary sterilization for contraceptive purposes, coupled with a dramatic expansion of federal funding for reproductive services enabled, for the first time, widespread access to sterilization for large segments of the population. Yet, while the changes were premised on the expansion of reproductive choice, when coupled with poor governmental oversight,

Reed Army Institute of Research, 1965).

9 Buck v. Bell, 274 U.S. 200 (1927).

10 Philip R. Reilly, *The Surgical Solution: A History of Involuntary Sterilization in the United States* (Baltimore: Johns Hopkins University Press, 1991), 128.

11 Mark A. Largent, *Breeding Contempt: The History of Coerced Sterilization in the United States* (New Brunswick: Rutgers University Press, 2011), 77; Johanna Schoen, *Choice and Coercion: Birth Control, Sterilization and Abortion in Public Welfare* (Chapel Hill, University of North Carolina Press, 2005), 82.

12 Hansen and Desmond S. King, *Sterilized By the State: Eugenics, Race, and the Population Scare in Twentieth-Century North America* (Cambridge: Cambridge University Press, 2013), 243.

they resulted in high profile incidents of widespread coerced sterilization in hospitals and clinics across the nation. Historians have argued that despite the supposed “break” with eugenic sterilization in the 1950s, the expansion of sterilization services in the second half of the century continued many of the legacies of the eugenic era. Just as eugenic sterilization was seen as a tool to solve the nation’s social problems, proponents and practitioners of sterilization in the 1960s and 1970s, too, sought to solve the pressing concerns of their day: namely, increasing poverty, illegitimacy, the hyper-fecundity of the poor, the drag of illegal immigration, and their respective contributions to the most pressing concern of all, a perceived overpopulation. Indeed, as minority and low-income women gained access to reproductive services during this period, so too did the allegations of coerced sterilization here, in what historian Elena Gutierrez has called the “most massive sterilization campaign the country had seen.” While African Americans were the most visible targets of sterilization abuse during this period, ethnic minority women across the country were targeted by physicians for sterilization.¹³

Following the revelation of sterilization abuses across the United States in the 1970s, the politics of sterilization and reproductive choice came to the fore. Outrage from these incidents mobilized activists who sought to challenge the medical profession's long-enjoyed autonomy and privileged decision-making power in reproductive choice. This process, however, opened a major and enduring fissure between women's groups, whose politics diverged largely along racial and class lines. Following a bitter struggle for abortion rights, some white middle-class feminists demanded that access to sterilization should remain unburdened from government regulations, or any other measure seen as an obstacle to complete reproductive freedom. Although such measures were proposed as a means to safeguard the reproductive choice of vulnerable minority women, and despite high profile reports of sterilization abuse across the country, white feminists continued to frown on any impingement on their right to control their own bodies. This stance chafed against the views held by sterilization victims, and their representatives, who believed that only through stringent and comprehensive government regulations could the power for true reproductive choice be returned to the health consumers themselves, while offering them a degree of legislative safeguarding. The inconvenience of mandatory waiting period prior to sterilization, they argued, paled in comparison to the life-altering consequences of involuntary sterilization. Thus, freedom of choice for these women was less focused on

13 See *Relf v. Weinberger*, 372 F. Supp. 1196 (Dist. Court 1974); *Walker v. Pierce*, 560 F.2d 609 (4th Cir. 1977). Carmen Theresa Whalen, *From Puerto Rico to Philadelphia: Puerto Rican Workers and Postwar Economies* (Philadelphia: Temple University Press, 2001), 35; Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York: New York University Press, 2003).

access to, and more on protection from coercion in sterilization decisions. As public pressure for policy changes mounted in response to the record of abuses, this battle for protections became the subject of legislative action. It also foreshadowed similar debates around sterilization that emerged in the 1980s, which shifted discussions of reproductive choice away from conceptions of race and gender, and returned once more to the criteria of disability to which the history of sterilization in the United States was inextricably linked.

The 1970s and 1980s also witnessed dramatic changes towards the treatment of people with developmental disabilities (DD) in the United States, and widespread deinstitutionalization. However, soon questions about their suitability as parents and their right to reproductive choice abounded. Thus, while activists rallied around the abuse of minority women in the 1970s, the same period witnessed an increase in the number of petitions filed by parents in local courts seeking to order the involuntary sterilization of dependents who lacked the ability to consent. This triggered heated debates between proponents of such actions, who argued that access to sterilization should be a right for people with DD, and that it aided their transition into and freedom in society by allowing them to form romantic relationships, and even marry, without the threat of falling pregnant. However, given the intense debate over racially-motivated sterilizations, and with the light thrown on the eugenic sterilization programs of earlier decades by several states' purging eugenic laws at the turn of the eighties, opponents of court-ordered sterilizations viewed the practice with concern. For them, such sterilizations carried out upon the imprimatur of the court were understood to be an updated, palatable revival of an older, discredited impulse, and an immense source of concern for future abuse. Without statutes as guidance, many judges initially refused to grant sterilization petitions, even if they originated with the individual's parents, leading to a fierce battle in the 1980s in which courts and legislatures were dragged, and which sought to balance people with DD's right to access to sterilization with their need as vulnerable individuals to be protected from coercion. These calls only grew as old eugenic sterilization laws were repealed, and parents no longer had a clear-cut method of securing sterilization for their disabled children. This would result in a total overhaul of state sterilization policies towards the developmentally disabled nationwide, and the reexamination of the eugenic past.

Aims

It is the aim of this study to examine how these national trends unfolded in California,

paying particular attention to their impact both on individuals, and on the evolution of state sterilization policy over the course of the twentieth century. California was a significant outlier in the practice of involuntary sterilization. Indeed, with over 20,000 individuals forcibly sterilized before 1950—roughly a third of all sterilizations carried out under state programs nationwide—the state eclipsed all others in the zeal and efficiency with which it carried out the mandate of the Asexualization Act.¹⁴ This fact alone has encouraged significant interest from historians eugenics, forced sterilization, disability, and biopolitics. These operations, however, are only one element of the state's relationship with surgical sterilization, and a much richer and more complex history has remained partially hidden by the gravity of the state's practice of compulsory sterilization. This thesis seeks to explore this longitudinal history, and further unpack the legislative and clinical contours of the state's experience of surgical sterilization. It seeks to understand how the legislators, judges and physicians shaped the politics and practice of sterilization in the state. This study, therefore, aims to illuminate the complex relationship between phases of involuntary sterilization in California, and the development and modification of distinct state sterilization policies. In doing so, this study will examine three periods of sterilization policy in California from 1909 to 1990:

- i. Eugenic Sterilization (1909-1952) – This refers to the development and implementation of the Asexualization Act, under which approximately 20,000 Californians were forcibly sterilized.
- ii. Voluntary Sterilization (1952-1981) – This period follows the changes after sterilization moved out of the state hospitals and into the public's hands, and centers on the policy changes initiated by *Jessin v. Shasta* (1969), the forced sterilization of minority women, and the subsequent battle for protections.
- iii. Sterilization by Substitute Consent (1973-1990) – This emerged as part of the debate about the sterilization of the people with DD by substitute consent, embodying the tortuous effort to create a new legislative framework that would ensure their safety in such petitions.

Through its exploration of specific policies, this study aims to develop a more institutional, physician-centered examination of the politics and implementation of sterilization in California than has hitherto been accomplished. It seeks to emphasize that involuntary sterilization resulted not from a direct translation of ideology into practice, but rather that

14 Largent, *Breeding Contempt*, 77.

the design of specific policies shaped the state's and patient's experience of sterilization.

Studies that foreground the role of ideology in episodes of involuntary sterilization fail to completely account for how such occurrences persisted long after eugenics fell into disrepute. While policy is not created in a vacuum, and ideological milieus form important explanatory frameworks, this study seeks to refocus attention back on the creation of the *legislative* frameworks through which those harboring these ideological prejudices operated, as well as the failures and successes of the state in response. Refocusing the lens of analysis in this way also illuminates the role of the lesser known, though no less instrumental, figures involved in crafting Californian sterilization policy. It is, therefore, an aim of this study to highlight the role of legislators, administrators, activists, and judges who have been rendered hidden from historical view by an understandable yet overwhelming focus on the perpetrators and victims of involuntary sterilization.

The useful but somewhat myopic focus on ideology and high-profile incidents of sterilization has skewed our view of more subtle episodes of involuntary sterilization. One victim of this trend has been the issue of California's battle with the principle of substitute consent sterilizations in the 1980s. While no national scandal unfolded (like that discussed in chapter two), debate in this period was no less heated, and the problems posed to legislators, judges, and parents, no less complex. In this respect, the study also aims to extend the temporal coverage of traditional histories of sterilization in California to include a detailed examination of the legislative overhaul that occurred in the 1980s with the repeal of the Asexualization Act and the crafting of the probate code that still operates to this day; and how this fits within wider national and state histories of eugenics and sterilization. It is by addressing these gaps in the history of involuntary sterilization in California that this study makes its original contribution to knowledge.

In achieving these aims, this study will interrogate four main research questions:

- i. How did successive policies shape the institutional practice of sterilization in California between 1909 and 1990?
- ii. To what extent did the agency of individual physicians in state and county hospitals shape the practice of sterilization in California?
- iii. How did ideologies of eugenics, racism, population control, disability and reproductive freedom inform the creation or alteration of successive sterilization policies?
- iv. To what extent did developmentally disabled Californians achieve reproductive freedom in the 1980s?

Historiography of Involuntary Sterilization in the United States

Pre-1950 Involuntary Sterilization

Although the debate among scholars continues over when eugenics can be said to have fallen into disfavor or disuse in the United States, the historiography can be usefully divided into two halves, one concerning the period up to the mid-twentieth century and one concerning the period afterward. The story of sterilization in the United States pre-1950 is in fact the story of eugenic sterilization laws adopted across the nation since 1907. The central tenet proffered by eugenicists that American society would be swamped by the dysgenic, feeble-minded, criminal, and various other catchall pejoratives, and that only control over reproduction could halt this degeneration, manifested in the passage of involuntary sterilization laws. From 1907, with the passage of Indiana's sterilization law, to 1917, sixteen states would pass legislation authorizing the sterilization of hereditary "defectives." By far the most active sterilization program in the nation belonged to California, which by 1921 accounted for eighty percent of the recorded 3,233 sterilizations performed.¹⁵ Over the subsequent decades, California would continue to outpace other sterilizing states, though it would begin to lose its share of the total as new states, following the "watershed event" of the *Buck vs. Bell* decision that legitimized the practice of involuntary sterilization in the eyes of legislators, enacted sterilization laws, and existing ones increased the rate of operations.¹⁶ In total, thirty-two states would eventually enact sterilization laws, under which approximately 63,000 individuals were sterilized.¹⁷ The vast majority of these sterilizations were performed in state institutions for the mentally ill or mentally deficient, and under authorizing legislation - though extrajudicial sterilizations did occur. Statistics show that sterilizations performed under state eugenic laws began to decline in the 1940s, when a combination of physician shortages brought about by the war, changes in public, religious, and scientific opinion, and revelations of the holocaust led many states to quietly disassemble sterilization programs, despite legislation often remaining on the books long after operations had ceased.

As the above illustrates, the history of sterilization is intimately bound up with the history of eugenics, so it is perhaps unsurprising that scholars of eugenics erected the intellectual framework through which this practice was to be understood. After a fallow period following the decline of eugenics as an authoritative science, scholarly attention in

15 Jonas Robitscher, *Eugenic Sterilization* (Springfield: Charles C. Thomas, 1973), 122.

16 Philip R. Reilly, "Eugenics and Involuntary Sterilization: 1907-2015," *The Annual Review of Genomics and Human Genetics* 14 (2015): 356.

17 Robitscher, *Eugenic Sterilization*, 118-119.

the history of eugenics flourished in the late 1960s.¹⁸ These intellectual histories overwhelmingly focused their attention on the genesis of eugenic ideology, its adoption by prominent eugenic proponents, and the subsequent writings and activities of these individuals. Such studies were usually temporally and geographically limited, focusing on the eugenic collectives based on America's Atlantic seaboard during the movement's heyday in the first decades of the twentieth century. When sterilization policy was discussed, it was viewed as a straightforward outcome of the eugenic thought, and only successful due to the efforts of a handful of hardline eugenicists. As Largent correctly noted, such a simplistic understanding reeked of classic "great man history," and failed to adequately explain how involuntary sterilization was so widespread, and continued for as long as it did in the United States.¹⁹ For decades, these works established an orthodoxy in the approach to the study of involuntary sterilization in the United States, planting the leading ideologues of the eugenics movement, and the science of human improvement they espoused, as the central focus of discussions on involuntary sterilization. Indeed, this approach still echoes in more sensational histories of involuntary sterilization that benefit from the ability to draw simplistic connections between sterilization laws, buoyed by eugenic ideologues in the United States, and National Socialist sterilization and extermination programs.²⁰

Attempts to extricate the history of involuntary sterilization from that of eugenics gathered momentum in the 1990s, beginning with the physician, Philip R. Reilly's, *The Surgical Solution* – the first monograph published on the subject.²¹ Though Reilly never fully examined alternative justifications for sterilization, his thorough analysis of the rise and decline of sterilization laws, and importantly for the period in which it was penned, the enduring character of such programs after 1945, nevertheless indicated that sterilization was a worthy topic of investigation in itself. Although the *Surgical Solution* failed to

18 Haller, *Eugenics: Hereditarian Attitudes in American Thought* (New Brunswick: Rutgers University Press, 1963); Donald K. Pickens, *Eugenics and Progressives* (Nashville: Vanderbilt University Press, 1968); Garland E. Allen, "Science and Society in the Eugenic Thought of H.J. Muller," *Bioscience* 20 (1970): 346-353; Kenneth M. Ludmerer, *Genetics and American Society: A Historical Appraisal* (Baltimore: John Hopkins University Press, 1972); Charles E. Rosenberg, "The Bitter Fruit: Heredity, Disease and Social Thought in Nineteenth-Century America," *Perspectives in American History* 8 (1974): 189-235; Garland E. Allen, *Life Science in the Twentieth Century* (New York: Wiley, 1975); Garland E. Allen, "Genetics, Eugenics, and Class Struggle," *Genetics* 79 (1975): 29-45; Allan Chase, *The Legacy of Malthus: The Social Costs of the New Scientific Racism* (New York: Knopf, 1977); Stephen J. Gould. *The Mismeasure of Man* (New York: Norton, 1981); Daniel J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (New York: Knopf, 1985).

19 Largent, *Breeding Contempt*, 2.

20 See Edwin Black, *War Against the Weak* (New York: Four Walls Eight Windows, 2004); Harry Bruinius, *Better for All the World: the Secret History of Forced Sterilization and America's Quest for Racial Purity* (New York: Vintage Books, 2007).

21 Reilly, *The Surgical Solution*.

challenge the orthodoxy established decades before, it placed a wedge in the histories of involuntary sterilization and eugenics which scholars would seize upon. Within a few years of Reilly's landmark work, a spate of studies emerged that evidenced alternative explanations for sterilization's appeal to legislators, physicians, and institutional heads.²² These scholars highlighted the importance of institutional, therapeutic, economic, and social forces alongside those of eugenics. One of the earliest contributions came from the psychiatrist and historian Joel Braslow.²³ Braslow's examination of patient records and physician's writings at California's Stockton State Hospital indicated that staff at the facility "rarely justified sterilization solely on eugenic grounds."²⁴ Comparing sterilization statistics at similar institutions, Braslow concluded that it was the belief among doctors at Stockton that sterilization was an effective therapy for certain psychiatrist conditions, rather than a potent eugenic tool, that accounted for the high rates of operations at the facility. Expanding this idea, Braslow posited that, contrary to the orthodox opinion, sterilization laws in themselves did not automatically "translate into mass sterilizations."²⁵ Rather, Braslow's erudite work provocatively advanced a recognition that the utility, and thus uptake, of sterilization in a particular setting was sensitive to different regional, institutional, economic, and other variable contexts.

This approach taken by Reilly, Braslow, and others, laid the foundation for a wave of nuanced and detailed studies of sterilization studies that supplanted the traditional focus on the role of eugenics and its promoters seen in earlier scholarship. Indeed, the scholarship that has emerged since these works on the minutia of sterilization practice in individual states can be said to have become an orthodoxy of its own in the approach to studying involuntary sterilization. Indeed, just as the literature on eugenics has, over time, transcended its narrow focus on the activities of the movement's east-coast intelligentsia²⁶, so too have scholars of involuntary sterilization challenged to centrality of eugenics in

22 See James W. Trent, *Inventing the Feeble Mind: A History of Mental Retardation in the United States* (Berkeley: University of California Press, 1994); Barron H. Lerner, "Constructing Medical Indications: The Sterilization of Women with Heart Disease or Tuberculosis, 1905-1935," *Journal of the History of Medicine and Allied Sciences* 49 (1994): 362-379; Molly Ladd-Taylor, "Saving Babies and Sterilizing Mothers: Eugenics and Welfare Politics in the Interwar United States," *Social Politics: International Studies in Gender, State & Society* 4 (1997): 136-153.

23 Joel T. Braslow, *Mental Ills and Bodily Cures* (Berkeley, University of California Press, 1997).

24 *Ibid*, 59.

25 *Ibid*, 70.

26 Christina Cogdell, *Eugenic Design: Streamlining America in the 1930s* (Philadelphia: University of Pennsylvania Press, 2010); Fae Braur and Anthea Callen, *Art, Sex and Eugenics: Corpus Delecti* (New York: Routledge, 2016); Tamsen Wolff, *Mendel's Theatre: Heredity, Eugenics, and Early Twentieth-Century American Drama* (New York: Palgrave Macmillan, 2009); Ann G. Winfield, *Eugenics and Education in America: Institutionalized Racism and the Implications of History, Ideology, and Memory* (New York: Peter Lang, 2007); Martin S. Pernick, *The Black Stork: Eugenics and the Death of "Defective" Babies in American Medicine and Motion Pictures Since 1915* (New York: Oxford University Press, 1996).

such programs.²⁷

Schoen's *Choice and Coercion*, for instance, which studied the entwined histories of sterilization, abortion, and birth control in North Carolina has highlighted the Janus-faced nature of state's eugenic sterilization program. Schoen attacked the commonly held view that sterilization laws worked only to diminish women's reproductive autonomy, and highlighted the context-dependent nature of the surgery. For while many women had sterilization forced on them by the Eugenic Board, the Board also believed in sterilization's ameliorating effect on poverty, illegitimacy and welfare expenditures, as well as protective value for children vulnerable to sexual abuse. Schoen also shows that many poor women sought sterilization at a time when access to effective contraception was limited.²⁸ Schoen estimates that of the 8,000 sterilization records examined, that Board received almost 500 requests for voluntary sterilization. Further surprising is that seventy percent of these voluntary sterilization requests came from African Americans, who, as a group, experienced even greater trouble accessing reproductive health services.²⁹ Schoen's work highlighted a new complexity to the way we understand the relationship between sterilization laws, their functionaries, and the citizens that come into contact with them.

Largent is one of the scholars who has contributed to this new orthodoxy through the establishment of new chronologies. In his 2008 work, Largent contended that at the end of the nineteenth century, long before influential biologists and natural scientists of the eugenics movement began popularizing the cause, physicians across America “became advocates of the use of sexual surgeries to penalize, prevent sexual crimes, treat perverts, and prevent the unfit from perpetuating their kind.”³⁰ Largent demonstrates that medical professionals agitated for sterilization laws in legislatures and medical journals without the scientific framework and organizing influence brought later by the eugenics movement. While these factors ultimately led to the widespread adoption of sterilization laws, Largent hints at a reversed causality in the uptake of sterilization, noting that “eugenicists were as much influenced by their cultures in which they operated as they were capable of influencing it.”³¹

27 Johanna Schoen, *Choice and Coercion*; Largent, *Breeding Contempt*; Ian R. Dowbiggin, *The Sterilization Movement and Global Fertility in the Twentieth Century* (Oxford: Oxford University Press, 2008); Rebecca Kluchin, *Fit to be Tied: Sterilization and Reproductive Rights in America, 1950-1980* (New Brunswick: Rutgers University Press, 2011); Alex Wellerstein, “States of Eugenics: Institutions and Practices of Compulsory Sterilization in California,” in *Reframing Rights: Bioconstitutionalism in the Genetic Age*, ed. Sheila Jasanoff (Cambridge: MIT Press, 2011); Randall Hansen and King, *Sterilized By the State*.

28 Schoen, *Choice and Coercion*, 79.

29 Ibid, 113.

30 Largent, *Breeding Contempt*, 13.

31 Ibid, 3.

An important work that has highlighted the multifactorial nature of involuntary sterilization in the United States to its fullest is Ladd-Taylor's recently published examination of Minnesota's sterilization program. As with Ladd-Taylor's previous works, *Fixing the Poor* highlights the historic durability of sterilization for both state officials in charge of addressing social problems, as well as medical superintendents facing institutional pressures.³² While other works have set eugenic justifications on an equal footing with such motivations, the role of the science and its proponents is largely sidelined in Ladd-Taylor's account. Indeed, despite the vociferous lobbying from the Minnesota Eugenics Society for a eugenically-focused sterilization law, the form, which made no mention of heredity, and eventual operation of Minnesota's sterilization program indicates that "the loudness of a political campaign is not necessarily an indication of its effectiveness."³³ Instead, Ladd-Taylor argues, "above all, sterilization was a surgical fix for the economic and behavioral problems of the poor," designed and administered by social welfare bureaucrats troubled by spiraling welfare dependency, illegitimacy, and their associated social problems.³⁴ Alongside these salient findings, Ladd-Taylor's study should be highlighted for driving home the lesson that there is "no single sterilization story in the United States."³⁵ Despite highlighting Minnesota as "ordinary" among state's that adopted the practice, particularly when compared to well-known outliers like North Carolina and California, Ladd-Taylor's work in fact serves to highlight peculiar elements of Minnesota's law that would be overlooked but for focused regional examination.³⁶ In doing so, Ladd-Taylor's work adds to a growing list of state-specific studies of sterilization.³⁷

32 Ladd-Taylor, *Fixing the Poor: Eugenic Sterilization and Child Welfare in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 2017); Ladd-Taylor, "Saving Babies and Sterilizing Mothers," 136-153; Molly Ladd-Taylor, "'Fixing' Mothers: Child Welfare and Compulsory Sterilization in the American Midwest, 1925-1945" in *Child Welfare and Social Action*, eds. Jon Lawrence and Pat Starkey (Liverpool: Liverpool University Press, 2001), 219-234; Molly Ladd-Taylor, "The 'Sociological Advantages' of Sterilization: Fiscal Politics and Feeble-minded Women in Interwar Minnesota," in *Mental Retardation in America: A Historical Anthology*, eds. Steven Noll and James W. Trent (New York: New York University Press, 2004), 281-299.

33 Ladd-Taylor, *Fixing the Poor*, 82.

34 Ibid, 130.

35 Ibid, 128.

36 Ibid, 120.

37 See: Edward J. Larson and Leonard J. Nelson, "Involuntary Sexual Sterilization of Incompetents in Alabama: Past, Present and Future," *Alabama Law Review* 43 (1992): 399-444; Edward J. Larsen, *Sex, Race, and Science: Eugenics in the Deep South* (Baltimore: Johns Hopkins University Press, 1996); Joel T. Braslow, "In the Name of Therapeutics: The Practice of Sterilization in a California State Hospital," *Journal of the History of Medicine & Allied Sciences* 51 (1996): 29-51; Nancy L. Gallagher, *The Eugenics Project in the Green Mountain State* (Hanover: University Press of New England, 1999); Johanna Schoen, "Between Choice and Coercion: Women and the Politics of Sterilization in North Carolina, 1929-1967," *Journal of Women's History* 13 (2001): 132-156; Mark A. Largent, "The Greatest Curse of the Race': Eugenic Sterilization in Oregon, 1909-1983," *Oregon Historical Quarterly* 103 (2002): 188-209; Alexandra M. Stern, "We Cannot Make a Silk Purse out of a Sow's Ear': Eugenics in the Hoosier Heartland," *Indiana Magazine of History* 103 (2007): 3-38; Gregory N. Price

The aforementioned works, representative of the current trend in empirical studies of sterilization, have sought to transcend traditional ideological explanations for the operation of such laws and programs, have made the literature on involuntary sterilization more complex, but also more far more compelling. California has been one such state to benefit from this increasingly granular approach to the study of sterilization.

Since Richard Fox's 1978 examination of insanity in California³⁸, a number of studies have explored diverse elements of the Golden State's pre-1945 history of sterilization, including its disproportionate focus on Hispanics³⁹, institutional practices⁴⁰, role in the juvenile justice system⁴¹, and current calls for redress for survivors.⁴²

Alongside these fine works, the major account of eugenics' influence in California continues to be Stern's *Eugenic Nation*. Originally published in 2005, *Eugenic Nation* explores eugenics in California as a “multifaceted set of programs aimed at better breeding that have straddled many social, spatial and temporal divides.”⁴³ Stern's account of eugenics in the Golden State stretches both long—examining the period between the 1915 Panama-Pacific exhibition, and the repeal of eugenic legislation in 1979—and broad—considering the impact of eugenic thought on topics such as immigration, marriage counseling, and environmentalism. At times, Stern stretches the limits of what could definitively be considered “eugenic,” and this applies to her examination of sterilization. In its initial release, sterilization was given marginal consideration, placed into a chapter alongside discussions of immigration and intelligence testing of juveniles. However, in the 2nd edition, a new chapter included a novel statistically-focused account that “explored the patterns and experiences of eugenic sterilization in state institutions,” as gleaned from a set

and William A. Darity Jr, “The Economics of Race and Eugenic Sterilization in North Carolina: 1958-1968,” *Economics and Human Biology* 8 (2010): 261-272; Alexandra M. Stern, “From Legislation to Live Experience: Eugenic Sterilization in California and Indiana, 1907-79,” in *A Century of Eugenics in America: From the Indiana Experiment to the Human Genome Era*, ed. Paul A. Lombardo (Bloomington: Indiana University Press, 2011), 95-116.

38 Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978);

39 Natalie Lira, “Of Low Grade Mexican Parentage: Race, Gender and Eugenic Sterilization in California, 1928-1952” (PhD diss., University of Michigan, 2015); Nicole L. Novak et al., “Disproportionate Sterilization of Latinos under California's Eugenic Sterilization Program, 1920-1945,” *American Journal of Public Health* 108 (2018): 611-613.

40 Braslow, “In the Name of Therapeutics.”; Wellerstein, “States of Eugenics: Institutions and Practices of Compulsory Sterilization in California.”; Wendy Kline, *Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom* (Berkeley: University of California Press, 2005).

41 Miroslava Chavez-Garcia, *States of Delinquency: Race and Science in the Making of California's Juvenile Justice System* (Berkeley: University of California Press, 2016).

42 Alexandra M. Stern et al., “California's Sterilization Survivors: An Estimate and Call for Redress,” *American Journal of Public Health* 107 (2017): 50-54.

43 Alexandra M. Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (Oakland: University of California Press, 2016), 16.

of 8,000 sterilization records.⁴⁴ Yet, despite a number of studies questioning the eugenic nature of sterilization in California and elsewhere, Stern remained unequivocal that all such sterilizations carried out in California were eugenic. Stern justified this claim by stating that such sterilizations “were made possible in legal and administrative terms by state laws which[...]were firmly rooted in eugenic theories of hereditary improvement.”⁴⁵ Even therapeutic sterilizations, Stern believes, could not be separated from other eugenic sterilizations as they were carried out “under the parameters of eugenic policies.”⁴⁶ For Stern, alternative justifications like these made sterilizations no less eugenic. This thesis argues this to be an overstatement of the connection between state sterilization policy and practice, and aims to highlight this disconnect between policy and practice more thoroughly throughout.

Importantly, in conjunction with other researchers, Stern has done much to shed light on the discernible racial focus of California's state-run sterilization program, and has aided a growing body of scholarship that has focused on the experiences of Latinx patients that came under the purview of the hospital superintendents.⁴⁷ Stern, along with Natalie Lira, Nicole Novak, and other researchers have produced detailed statistical examinations of sterilizations carried out under the Asexualization Act that highlight a clear racial bias among hospital staff, both in how they treated Latinx patients, and in the disproportionate rate at which Latinx patients were sterilized.⁴⁸ Indeed, Stern and her colleagues show that Latinx men were twenty-three percent, and Latinx women fifty-nine percent more likely to be selected for sterilization than their non-Latinx cohort.⁴⁹ In highlighting these features, these researchers have drawn out more important contours of California's sterilization program, and encouraged researchers to reassess the forces that propelled California sterilization policy.

However, perhaps the greatest contribution of Stern's work, especially at the time of its initial release, was the broadening of the chronological focus typically halted by studies of eugenics and sterilization around the second world war. Stern's exploration into themes stretching into the 1960s and 1970s includes an examination of the sterilization of minority women in Los Angeles Hospitals that formed part of a wave of racially-motivated

44 Ibid, 24.

45 Ibid, 114.

46 Ibid, 115.

47 Natalie Lira and Alexandra Minna Stern, “Mexican Americans and Eugenic Sterilization: Resisting Reproductive Injustice in California, 1920-1950,” *Aztlán: A Journal of Chicano Studies* 39 (2014): 9-34; Alexandra Minna Stern, “Eugenics, Sterilization, and Historical Memory in the United States,” *História, Ciências, Saúde-Manguinhos* 23 (2016): 195-212; Lira, “Of Low Grade Mexican Parentage.”

48 Novak et al., “Disproportionate Sterilization of Latinos under California's Eugenic Sterilization Program,” 611.

49 Ibid, 612.

surgeries during this period.⁵⁰

Sterilization post-1950

Eugenic sterilization programs within state institutions in the United States fell into virtual disuse by 1950. In that year, 1,526 individuals were sterilized, mostly in North Carolina, down from 2,500 operations in 1939.⁵¹ This precipitous decline was sparked at least partly by mounting revulsion towards eugenics in the wake of World War II. Despite this decline in state-enforced sterilization within institutions, the 1960s witnessed the expansion of voluntary contraceptive sterilization in hospitals and clinics across the country. Between 1970 and 1973, the annual number of sterilizations performed outside state institutions jumped from 200,000 to over one million.⁵² This dramatic increase in surgeries was carried by liberalizing attitudes towards birth control, clarifying and loosening of state laws around the legality of sterilization, and the significant expansion of federal funding for family planning services, and sterilization in particular, broadened access to the procedure. While these advances were heralded as delivering unprecedented reproductive choice to women across America, it became apparent that for many, they served as a novel means to control and limit choice in certain groups. Reports during the period highlighted that across the United States, poor women of color, the main recipients of federally-funded birth control programs, were being sterilized at a disproportionate rate, and often, in the absence of rigorous informed consent procedures, through coercion. In 1970, for example, African American women were sterilized at a rate more than double for white women, leading critics to label the government's family-planning activities an attempt at "black genocide."⁵³ Similarly for the Native American women, between 1973–1976, some 3,400 Native women were sterilized by IHS staff on reservations, and was seen as an effort by the government to eradicate minorities.⁵⁴ These patterns of abuse directed at minority women were seen across the country, from Puerto Rico to Alabama, to California. Such episodes of abuse in the 1960s and 1970s have been a point of focus for scholars of forced sterilization, who have explored how the new sterilization programs, now removed from the state institutions, were harnessed by individuals looking to curb the interlinked crises of the day—poverty, illegitimacy, and overpopulation.

50 Ibid, 222-233.

51 Philip R. Reilly, "Eugenics and Involuntary Sterilization," 359.

52 Marlene H. Prendergast, "Sterilization Regulation: Government Efforts to Guarantee Informed Consent," *Santa Clara Law Review* 18 (1978): 971.

53 Andrea P. Mackay et al., "Tubal Sterilization in the United States, 1994-1996," *Family Planning Perspectives* 33 (2001): 164; Nelson, *Women of Color*, 86; See Stephen Trombley, *The Right to Reproduce: A History of Coercive Sterilization* (London: Weidenfeld and Nicolson, 1988), 177.

54 Stern, *Eugenic Nation*, 225.

While differing from sterilization patterns in the first half of the twentieth century, scholars have assessed the role of eugenic thought in this period. In doing so, most have highlighted the continuity of individuals and groups from the eugenic heyday, and their attempts to modify their ideas to suit the different post-war social climate. In *Intended Consequences*, for instance, Donald Critchlow demonstrates that eugenics, alongside other reform movements, fed ideas into the population control lobby, which in turn exerted significant pressure on the creation of federal family-planning programs in the 1960s.⁵⁵ Among others, Critchlow discusses the involvement of *American Eugenics Society* (AES) president Frederick Osborn, and his attempts to re-codify the group's aims in the 1950s.⁵⁶ However, beyond this, Critchlow provides little support for eugenics contribution to later birth control programs, and argues that it was a combination Malthusian fears of overpopulation, and women's calls for legalized birth control, that were primary drivers of family planning legislation under which the involuntary sterilizations in question were carried out.⁵⁷

Thomas Shapiro provides more evidence, highlighting the ideological links between the eugenics movement and later population control efforts in *Population Control Politics*. In Shapiro's study, eugenics serves as an important ideological bedrock and touchstone that advocates of population control in the 1950s necessarily distanced themselves from, while still retaining vestiges of the, by then, largely unpopular discipline. In particular, Shapiro highlights the *Association for Voluntary Sterilization*, a direct outgrowth of its eugenic progenitor the *Sterilization League of New Jersey*, which would tirelessly advocate for family planning and sterilization programs throughout the second half of the twentieth century, primarily as a means of curbing overpopulation and "undesirable" fertility.⁵⁸ Shapiro's work is also praiseworthy for its sophisticated statistical examination of sterilization in the 1970s, which proved that "the pattern of who [was] sterilized [was] slanted systemically toward the poor and those on welfare."⁵⁹

However, the most significant treatment of the question over the role of eugenic thought in post-1950 sterilization explosion is Kluchin's *Fit to be Tied*. Here, Kluchin uses the term "neo-eugenics" to describe the attitudes and practices held by an array of powerful individuals that translated into episodes of involuntary sterilization.⁶⁰ In

55 Donald T. Critchlow, *Intended Consequences: Birth Control, Abortion, and the Federal Government in Modern America* (New York: Oxford University Press, 1999), 15-16.

56 Ibid, 24-25.

57 Ibid, 3.

58 Thomas M. Shapiro, *Population Control Politics: Women, Sterilization, and Reproductive Choice* (Philadelphia: Temple University Press, 1985), 45-63.

59 Ibid, 107.

60 Kluchin, *Fit to be Tied*, 3.

Kluchin's account, neo-eugenics replaced *true* eugenics after the latter's fall from popularity at the close of the baby boom era. While both eugenicists and neo-eugenicists viewed sterilization as an effective tool for solving social problems, Kluchin acknowledges that the two branches of thought “differ significantly” in other regards.⁶¹ For instance, while eugenicists bemoaned the soaring costs associated with the institutionalization of hereditary criminals and mental defectives, “neo-eugenicists took issue with an expanding welfare system, established during the Great Depression in the 1930s and strengthened in the 1960s under ‘the Great Society.’” A more significant divergence highlighted by Kluchin lay in the two groups understanding of the etiology of these problems. While eugenicists concerned themselves with a biological taint transmitted through generations in unit characters, neo-eugenicists instead believed that “reproductive fitness” lay in culture. That is, deleterious traits such as poverty or illegitimacy descended through families via a transmission of culture from mother to child. Sterilization thus served as a “biological solution” to this “cultural phenomenon,” and single mothers and poor women of color became major targets for surgical correction.⁶²

Broadly speaking, historians have approached sterilization in the latter half of the twentieth century through three major lenses (though there exists a porous border between these approaches, and a significant cross-pollination of ideas can be discerned). The first is the *feminist approach*, which highlights the women's movements struggle for reproductive self-determination in the 1960s.⁶³ Access to birth control became a major demand for women in this period, and the change of attitudes and laws towards these technologies is viewed as a result of this demand. Within this context, population controllers are viewed as “antifeminists” who hijacked the achievements of the women's movement to push their anti-choice agenda, resulting in episodes of involuntary sterilization.⁶⁴ The second is the *population control approach*. This approach emphasizes the role of the population control movement—primarily inspired by the neo-Malthusian concerns gripping America in the 1960s and 1970s—in the passage of family planning and sterilization legislation, with the ultimate goal of defusing the “population bomb” and eradicating poverty. Within this interpretation, the involuntary sterilizations of poor and minority women that occurred under such federal family planning programs are viewed as a logical consequence of the

61 Ibid.

62 Ibid 4.

63 Linda Gordon, *The Moral Property Of Women: A History of Birth Control Politics in America* (Urbana: University of Illinois Press, 2002); Linda Gordon, *Woman's Body, Woman's Right: Birth Control in America* (New York: Penguin Books, 1990); Ruth Dixon-Mueller, *Population Policy & Women's Rights: Transforming Reproductive Choice* (Westport: Praeger, 1993); Rosalind P. Petchesky, *Abortion and Woman's Choice: The State, Sexuality, and Reproductive Freedom* (London: Verso, 1986);

64 Gordon, *Moral Property of Women*, 401.

involvement of population controllers in their genesis.⁶⁵

The third and final major approach to post-1950 sterilization emphasizes the racial aspects of these operations. These histories tend to portray sterilization as a tool wielded by governmental and medical administrators for the attempted control or outright eradication of ethnic minority groups. The majority of this scholarship has focused on the experiences of African American women, but has since grown to include studies of other groups including Puerto Rican⁶⁶, Native American⁶⁷, and Mexican-American women.⁶⁸ While it is difficult to separate these approaches to the topic entirely, sharper lines are drawn by focusing on regional manifestations of sterilization abuse. As Kluchin noted: “region and race intersected to create distinct trends of forced sterilization in the second half of the twentieth century.”⁶⁹ In the case of California, historical accounts bring into focus the sterilization of Mexican-born women.

These accounts focus on the high-profile sterilization abuse scandal at the *Los Angeles County Medical Center (LACMC) Women's Hospital* in the early 1970s. Following a damning report from a former OBGYN resident of the facility, which primarily served the region's poor Chicana women, detailing coercive tactics used by doctors to trick or pressure vulnerable patients into tubal ligations, it was revealed that 140 women had been improperly sterilized by doctors at the hospital between 1970 and 1974. These victims shared striking similarities: all were Chicana, had a poor command of the English language, and were often approached for “consent” while in the deep stages of labor. Historical studies of this episode have examined two major themes: the first focuses on the abuse itself, and explores the motivations of the perpetrating physicians, as well as the patterns of abuse that resulted in sterilization. Such accounts are primarily told through the lens of *Madrigal v. Quilligan*, a lawsuit brought against the Chief of Obstetrics at the

65 Ian Dowbiggin, *The Sterilization Movement*; Shapiro, *Population Control Politics*; Critchlow, *Intended Consequences*; Randall Hansen and Desmond King, *Sterilized by the State: Eugenics, Race, and the Population Scare in Twentieth-Century North America* (New York: Cambridge University Press, 2013).

66 Iris Lopez, *Matters of Choice: Puerto Rican Women's Struggle for Reproductive Freedom* (New Brunswick: Rutgers University Press, 2008); Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico* (Berkeley: University of California Press, 2003).

67 Jane Lawrence, “The Indian Health Service and the Sterilization of Native American Women,” *American Indian Quarterly* 24 (2000): 400-419; Sally J. Torpy, “Native American Women and Coerced Sterilization: On the Trail of Tears in the 1970s,” *American Indian Culture and Research Journal* 24 (2000): 1-22; Myla Vincenti Carpio, “The Lost Generation: American Indian Women and Sterilization Abuse,” *Social Justice* 31 (2004): 40-53.

68 Jessica Enoch, “Survival Stories: Feminist Historiographic Approaches to Chicana Rhetorics of Sterilization Abuse,” *Rhetoric Society Quarterly* 35 (2005): 5-30; Alexandra Stern, “Sterilized in the Name of Public Health: Race, Immigration and Reproductive Control in Modern California,” *American Journal of Public Health* 95 (2005): 1128-1138; Elena R. Gutierrez, “Policing 'Pregnant Pilgrims': Situating Sterilization Abuse of Mexican-Origin Women in Los Angeles County,” in *Women, Health, and Nation: Canada and the United States Since 1945*, eds Georgina Feldberg et al. (Montreal: McGill-Queen's University Press, 2014), 379-403.

69 Kluchin, *Fit to be Tied*, 6.

facility by ten women who had suffered involuntary sterilization at LACMC. The second major theme that emerges is of the subsequent grassroots Chicana activism that arose in response to sterilization abuse. Histories highlight how Chicana women fought for more rigorous protections in the wake of the scandal, connecting to broader national discussions around racially-motivated sterilizations, and ultimately challenging the narrative that minority women were powerless in the face of such abuse.

The most convincing work on this topic is Elena Gutierrez's *Fertile Matters*, based on research for her 1999 PhD thesis. Gutierrez's work provides a significant insight into the sterilizations at LACMC, as well as the subsequent campaign by activists to put an end to sterilization abuse, which she highlights as an “unprecedented moment in Chicana history.”⁷⁰ The true strength of Gutierrez's work, however, is its elucidation of the ideological underpinnings of these events. In doing so, Gutierrez traces the historical construction of Mexican-origin women's fertility as excessive, aberrant, and in need of control. Indeed, to highlight how deeply entrenched these “stereotypical narratives” were, Gutierrez provides examples as far back as the 1800s, when California was still a Mexican territory, of discussions of Mexican women's alleged fecundity. This narrative became increasingly alarmist as the twentieth century dawned. By this point, Gutierrez contends, “growing nativist sentiment blamed Mexican immigrants for society's ills and commonly bemoaned their fertility.”⁷¹ She highlights how an array of professionals, including eugenicists concerned with differential fecundity of arriving Mexican immigrants grappled with and reinforced negative stereotypes surrounding these women's fertility.⁷² By the 1970s, while these early fears gave way to the new concerns of overpopulation and spiraling welfare costs, this pathologized image of the “hyperfertile” Chicana women remained at the heart of such concerns. Gutierrez contends that it was these deeply held conceptions of Mexican-origin women's fertility as something that needed controlling that ultimately manifested in involuntary sterilizations at LACMC, arguing that “race and reproductive politics are fundamentally intertwined.”⁷³ Indeed, given how central ideas of race, language, and culture figured in the proceedings of *Madrigal v. Quilligan*, Gutierrez's thorough research provides critical context to this incident of involuntary sterilization and its fallout.

While both Gutierrez and Kluchin have explored the activism that emerged after the LACMC sterilization, focusing mainly on the role of activists in public hearings on

70 Elena R. Gutierrez, *Fertile Matters: The Politics of Mexican-origin Women's Reproduction* (Austin: University of Texas Press, 2008), 107.

71 Ibid, 10.

72 Ibid, 12.

73 Ibid, 9.

sterilization protections, the issue of Chicana activism forms a central part of Virginia Espino's thesis, *Women Sterilized As They Give Birth*. As Espino states: "viewing the issue of forced sterilization against the backdrop of social activism helps to shift the story from one of social control and victimization to one of dialectical relationships of power and possibility."⁷⁴ Challenging the notion that Chicana women were powerless, Espino highlights how health activists organized community action in Los Angeles throughout the 1960s and 1970s. This began as measures to improve access to health care for local women in the 1960s through Med-8. It was a sterilization scandal at LACMC, and across the nation, however, which truly galvanized activism in the 1970s and that "evolved into a 'cause' that united a complex and diverse group of political activists whose ideologies ranged from middle class oriented liberal policies to revolutionary Maoism."⁷⁵ Using interviews with the activists themselves, alongside archival material, Espino presents a historical resume of the various activist groups who coalesced to challenge the abuse practices at LACMC by publicizing cases, educating women, organizing marches, and aiding lawsuits. Crucially for this study, while presenting their triumphs, such as the high-profile march on LACMC in 1974 that led to the *Los Angeles Times* coverage of the scandal, Espino also documents their troubles, noting how the ideological, racial, and gender differences of the diverse groups that gravitated towards the sterilization issue chafed against each other in the formation of an agenda to stop abuse.⁷⁶ Unlike other studies, Espino also does not distance the *Madrigal* plaintiffs from this activist activity that followed the sterilizations, and argues that although these ten women didn't organize marches or other grassroots campaigns, "their role in a legal battle to challenge their unwanted sterilizations turned them into activists."⁷⁷ Ultimately, Espino provides rich insight into how sterilization served as a focal point in a period of "blossoming" political activism with which legislators would have to contend in 1970s California, and foregrounds the centrality of race, class, and gender in discussions of reproductive rights.⁷⁸

The preceding works address important elements surrounding the issue of involuntary sterilization in 1970s California, but they also overlook key details that exerted significant influence on the state's policy and practice of sterilization at this time. This thesis seeks to correct these oversights, beginning with an examination of the largely ignored *Jessin v. Shasta* case. This 1969 legal challenge had far reaching ramifications for

74 Virginia Rose Espino, "Women Sterilized As They Give Birth: Population Control, Eugenics, and Social Protest in the Twentieth-Century United States (PhD diss., Arizona State University, 2007), 23.

75 Ibid, 19.

76 Ibid, 232-242.

77 Ibid, 22.

78 Ibid, 179.

California's sterilization policy moving into the 1970s; it clarified the legal position that California doctors were permitted to perform voluntary contraceptive sterilizations, and removed the fear of prosecution that hung like a cloud around the issue sterilization outside those performed within the bounds of the Asexualization Act. While the literature on involuntary sterilization in the 1970s has overwhelmingly focused on family planning legislation at a federal level, this thesis attempts to reorient attention to specific policy changes at a state level. Doing so, reveals how concerns about overpopulation, welfare rolls, and state expenditure were operative from the outset of the policy formation process, in the 1970s, and would ultimately translate into the involuntary sterilizations performed at LACMC.

Secondly, using novel records from the California State Archives, this thesis seeks to correct the almost totalizing focus on women activists in the period after the sterilizations at LACMC. While critically important, this singular focus on the campaigns of women activists comes at the expense of meaningful analysis of the other side of sterilization regulations story in the 1970s: the role of the state government, in the form of the California Department of Health (CDH). An examination of key internal records of the CDH at this time highlights how the state first reacted to and addressed the problem of involuntary sterilization unfolding in California in the 1970s. It provides crucial insight into the agency's attempts to negotiate with, on the one hand, women activists demanding stringent informed consent standards in sterilization decisions; and, on the other hand, the medical profession and other activists who viewed government attempts to regulate the practice of sterilization in response to significant evidence of abuses as overstepping their regulatory authority. This under-explored debate is key to understanding how and why sterilization policy changed as it did in the 1970s, and will be examined in detail in chapter three of this thesis. In doing so, it adds an original contribution to knowledge to the literature focused on involuntary sterilization during this period.

Sterilization and Disability After 1950

As previously highlighted, there exists a wealth of literature documenting the patterns of sterilization carried out in institutions under eugenic statutes, but considerably less attention has been paid to the sterilization of the people with DD after the institutions were emptied and eugenic statutes expunged. While attempts have been made, largely by bioethicists and sociologists, to unpack the legal and ethical features of the sterilization of people with DD after deinstitutionalization, it remains largely a hidden history.⁷⁹ Few

79 Ellen A Brantlinger, *Sterilization of People with Mental Disabilities: Issues, Perspectives and Cases*

historians have attempted to address this “roaring silence” as Tilley et al. have termed it.⁸⁰

Philip Reilly was the first historian of involuntary sterilization and eugenics to address the “right to choose” argument of the 1970s and 1980s, and five pages of his seminal *Surgical Solution* are spent surveying the legal landscape of sterilization petitions during this era.⁸¹ However, chronologically not far removed from the petitions themselves, Reilly's work is understandably brief. A more complete examination on this subject comes from Molly Ladd-Taylor. Her 2014 article, *Contraception or Eugenics* highlights how a “largely one-dimensional focus on race and poverty has impeded meaningful examination...” of how disability functioned as a justification for sterilization in the 1970s.⁸² Ladd-Taylor reorients disability to the heart of her study, examining how traditional histories have downplayed the role of disability in the often-cited sterilization of Minnie Lee and Mary Alice Relf in Alabama, and outlines the development of the national legal battles over sterilization by substitute consent—the power conferred to a parent or guardian to consent to the sterilization of developmentally disabled, or otherwise incapacitated, person, adjudged incapable of providing consent themselves—during the 1990s, highlighting the disparate positions taken by judges. A key decision in the development of substitute consent was that of *In Re Guardianship of Hayes* (see appendix I) in which a Washington court, while denying the sterilization of a women with a developmental disability, voiced that there were “rare and unusual circumstances” under which such sterilizations were appropriate. Though courts would later disagree about which circumstances warranted sterilization, and what evidence would be required, there remained a belief that persons with disabilities should have access to sterilization. The criteria used in *Hayes* would be central in the crafting of California's 1986 statute which added to the state probate code regulations governing sterilization via informed consent (see Appendix II).

In doing so, Ladd-Taylor calls for further historical examination of how disability intersected with sterilization practice during this period in order to gain a more complete

(Westport: Auburn House, 1995); Field and Sanchez, *Equal Treatment for People with Mental Retardation*; Allison C. Carey, *On the Margins of Citizenship: Intellectual Disability and Civil Rights in Twentieth-Century America* (Philadelphia: Temple University Press, 2010); Thomas E. Elkins and Frank Andersen, “Sterilization of Persons with Mental Retardation,” *Journal of the Association for the Severely Handicapped* 17 (1992): 19-26; Kathleen S. Skullney, “The Tyranny of the Best Interests: Sterilization and the Retarded Adult,” *University of Baltimore Law Forum* 23 (1993): 13-20; Douglas Diekema, “Involuntary Sterilization of Persons with Mental Retardation: An Ethical Analysis,” *Mental Retardation and Developmental Disability Research Reviews* 9 (2003): 21-26.

80 Elizabeth Tilley et al., “‘The Silence is Roaring’: Sterilization, Reproductive Rights and Women with Intellectual Disabilities,” *Disability and Society* 27 (2012): 423.

81 Reilly, *The Surgical Solution*, 152-157.

82 Molly Ladd-Taylor, “Contraception or Eugenics? Sterilization and ‘Mental Retardation’ in the 1970s and 1980s,” *Canadian Bulletin of Medical History* 31 (2014): 195.

understanding of the history of involuntary sterilization, and avoid a “silencing” of the experiences of DD people as scholars look outside the walls of the institution.⁸³ Beyond these studies, however, there exists a glaring gap in the literature on this important subject, and despite California's prolific history of institutional sterilization people with DD, there has been no historical attention awarded to the experience of these individuals and the troubled development of state sterilization policy after the repeal of the Asexualization Act.

This study seeks to correct this gap by highlighting the convoluted tale of sterilization in late-1970s and 1980s California, and in doing so, will examine a number of important features of the story of sterilization in California that have heretofore been overlooked. For instance, it will delve into the problems faced by legislators and judges during this period in seeking to develop a new sterilization policy that was at once sensitive to the state's past sterilization of over 20,000 institutional patients, while also attempting to preserve freedom of choice. The repeated reversals of legal decisions and state positions that are underscored by this study highlight the complexity of the issues faced. Using numerous case studies of sterilization petitions as a roadmap through this period, it also aims to foreground the very real ramifications of policy readjustment on a human level. Underlining the quandary faced by the state, it shows both how the denial of sterilization brought anguish to parents and restricted the personal freedom of disabled children, while also showing how even the best legislative protections are not enough to prevent abuse in such cases. Additionally, this study seeks to highlight how the shadow of eugenics operated in policy decisions during this period. The threat of a resurgent eugenic spirit permeated virtually every sterilization policy discussion during this period, and the distinct course that policy travelled during this period reflected the court and legislature's struggle with its own past. Finally, it also brings to the fore the role of self-advocacy groups in this process. Groups like People First, run by DD individuals themselves, challenged traditional views of the disabled, and argued forcefully in the courts, legislature and press that they had the right and ability to make their own decisions regarding reproduction, and exerted a significant contribution in the crafting of state's sterilization laws that related to them. In highlighting these various factors, this study seeks to establish a more comprehensive understanding of involuntary sterilization and reproductive rights in California, while connecting to ongoing debates, both in California, where the examined policy remains in place to this day, and internationally about the viability of substitute consent in sterilization decisions, the equal treatment of DD persons, and the limits of

83 Ibid, 208.

reproductive freedom.

Argument, Methodology, and Sources

As discussed, the literature on involuntary sterilization in California is rich, and touches on many features of its operation in the state. This literature is, however, not without its shortcomings. In particular, historians have perhaps uncritically honed in on the more visceral accounts of involuntary sterilization and the pernicious ideologies associated with them, resulting in an analytical neglect of the more subtle, though no less important, political and legal frameworks that underpinned them.

This narrow focus on the more spectacular and visceral elements has led to an over reliance on “eugenic” ideology as an explanatory cause of what propelled involuntary sterilization. As the literature on eugenics has expanded, however, the term has become used in increasingly elastic and imprecise ways, to the point that many common health practices have been placed alongside state-run genocide programs under the umbrella of “eugenics.”⁸⁴ In its analysis of sterilization in California, this study challenges this expansive view of eugenics, and instead proposes to proceed with a narrower and demarcated definition. As this study proceeds, eugenics strictly refers to the application of the theories of heredity as an *effort* to improve the gene pool. For this definition, both a collective genetic improvement, and a direct intention of promoting the former, must be present to satisfy the eugenic minimum established. Secondly, the exclusive concentration on pre-1950 accounts of sterilizations in state institutions and county hospitals has obscured later and no less important developments in the California's history of involuntary sterilization.

In an effort to reveal a more complete, nuanced, and grounded understanding of how sterilization functioned in California, this study excavates and knits together successive efforts to reshape sterilization policy in the Golden State over the course of the twentieth century, and the real impact that these efforts would hold for the bodies of patients. One might characterize this as a medico-legal approach. However, the following examination is neither solely concerned with the legislation itself, nor does it, as medico-legal histories traditionally have, portray the transition of sterilization policy in California as a linear story of progress and enlightenment. Nor again, on the other hand, is it solely concerned with ideological forces behind sterilization practices.

It is instead focused on the structures which made such forces operable in both

84 Mark A. Largent, “On Daniel J. Kelves's *In the Name of Eugenics*,” *Historical Studies in the Natural Sciences* 44 (2014): 520; Diane B. Paul, *Controlling Human Heredity: 1865-Present* (Amherst: Humanity Books, 2003), 2-4.

policy and practice. In particular, the core unit of analysis for the following study is the institution. This thesis examines a number of national, state, and sub-state institutions as the key mediums through which personal and ideological ambitions transited into political and medical practices. Indeed, just as historians of science have demonstrated how universities, learned societies, and other research bodies “shaped the nature of scientific inquiry” in the United States, this study holds that a similar claim can be made about the medical and legal institutions of California and their influence on the practice of sterilization.⁸⁵ In its analysis of the sources relating to these institutions, this study employs a loosely-framed bipartite classification that divides organizations into (a.) policy developers, or (b.) policy practitioners.

As a study of policy developers, it focuses largely on government bodies and the political pressure groups who sought to influence their decisions on sterilization policy. The former includes groups like the California Department of Health, the Department of Developmental Services, and a number of legislative committees responded to the issues of involuntary sterilization in the 1970s and 1980s. Using extensive documentation from the California State Archive's legislative records program, and specifically the individual bill and committee files housed therein, this approach provides a glimpse into the inner workings of such bodies during critical moments in the policy creation process, and illuminates the interpersonal dynamics and political machinations that shaped the resulting policies. This is critical to this study, as it highlights many utilitarian, as opposed to ideological reasons, for why sterilization policy transformed as it did over time. It also highlights both interdepartmental dynamics *within* the institutions, as well as their relationship with NGOs, again revealing how both individual and institutional power shaped sterilization policy decisions. These provide important findings when compared against the internal records of these influence groups—a number of which are examined throughout this study. The records of the *Human Betterment Foundation* (HBF), for instance, highlight the forceful role of the Foundation in encouraging both doctors (implementors), and legislators (developers), to extend the practice of involuntary sterilization in the first half of the twentieth century. At the other end of the spectrum, the records of activist groups like the *Mexican American Legal Defense and Educational Fund* (MALDEF), held at the Stanford University Archives, has provided insights into the relationship between not only women's groups and the government in the formation of regulations designed to prevent sterilization abuse in the 1970s, but also between other ideologically-distinct women's groups. Used together, governmental legislative records

85 Sally G. Kohlstedt, “Institutional History,” *Osiris* 1 (1985): 17.

and the records of pressure groups highlight both the institutional relationships that shaped California's sterilization policy over the century, and displays the individual motives, aims, and frustrations in their endeavors.

When examining how policy directives were translated into medical practice, this study foregrounds the inner workings of the hospital as the key site of policy implementation. In the opening chapter, this study examines the network of state institutions charged with implementing the directives of the eugenically-inspired Asexualization Act. Historical accounts have generally viewed involuntary sterilization in these institutions as a monolithic practice, despite significant quantitative differences in the sterilization rates between them. Using a combination of institutional documents, and personal writings and correspondence of superintendents who marshaled these institutions, this study takes a closer look at the peculiarities of sterilization inside. This approach highlights both the power of individual interests in such institutions, and the potential for discrepancy between the stated aims of policy, and its implementation. In the following chapters, the focus shifts to a study of involuntary sterilization at LACMC. Utilizing the reports and sworn testimony of staff, including that of departmental head Edward Quilligan, as well as the declarations of victims, the author again examines the institutional practice of involuntary sterilization, noting its disparity from state policy aims, premised on enhancing reproductive freedom, and deeper connections with the ideological forces that were operative in policy development.

This divide between policy developers and practitioners, however, is not always rigid, and some institutions straddle the border between the two roles. The Department of Institutions, for instance, whose administrators were responsible for developing the Asexualization Act, and subsequent revisions to the policy in 1950 that saw sterilization numbers fall, retained ultimate control of who was sterilized by requiring the head of the hospital system to sign off on all requests from superintendents. The same is true of the state's courts in later decades. In the 1970s, these courts served as key instruments of policy in defining the legality of non-therapeutic sterilizations. However, by the 1980s, as the issue of sterilization by substitute consent of people with DD became a pressing issue, the courts became implementers of policy in deciding the outcomes of sterilization petitions.

Through this institutionally-grounded approach, examining both the developers and implementers of policy, several overlooked aspects of involuntary sterilization in California are brought into focus.

For instance, despite serving as a focal point for histories of involuntary

sterilization in California after 1950, studies of the sterilizations in Los Angeles have lacked critical attention to the development of sterilization policy both preceding and following these events. This study seeks to correct this oversight through an analysis of the policy creation process in both the courts and legislature of California, in order to provide a new appreciation of how involuntary sterilization arose and faded during the 1970s. Breaking with a scholarship focused on changes at a federal level towards contraception and sterilization, this study also examines how institutions within the state exerted a significant influence on involuntary sterilization in California.⁸⁶ Turning attention to the 1969 case of *Jessin vs Shasta*, which legalized contraceptive sterilization in California, it is revealed how piercing social concerns around welfare expenditure and overpopulation became directly translated into sterilization policy at a local level. Through previously unused documents, this study seeks to highlight an unappreciated step in the state's drift towards involuntary sterilization in the 1970s, and highlights the role of the AVS as instrumental in this process.

This policy-centered institutional approach adds unprecedented depth to the legislative fallout in the aftermath of the LACMC sterilizations. As stated, most accounts of this period have focused on the grassroots campaigns by Los Angeles-based women's activist groups, and their subsequent participation in public hearings on the proposed regulations. This has, however, been to the exclusion of insight into the critical role played by the state government in this process. This study reorients the focus on this period away from Los Angeles and towards Sacramento, the seat of state government, and intertwines the role of the *California Department of Health* (CDH), alongside the story of women's activism in order to provide fresh insights into the factors that shaped state sterilization policy after the LACMC scandal. Utilizing previously ignored legislative records from the California State Archive, this study will highlight the intricacies faced by the CDH in forming a policy that offered both protection against future abuses, while avoiding restrictions that would unduly burden access to sterilization.

Likewise, such records have facilitated a look into Californian sterilization policy beyond the major scandals of the 1970s, where scholarship has assumed an almost totalizing focus on categories of race, class, and poverty as indicators of reproductive fitness. This has, however, concealed the arguably most complex and sensitive struggle faced by the legislature regarding sterilization policy, both for the legal, and very real ramifications it had for DD individuals and families in the state. Indeed, for while the

⁸⁶ See both Kluchin, *Fit to be Tied*, and Gutierrez, *Fertile Matters*. Both focus solely on policy change at a federal level in the lead up to sterilization at LACMC.

repeal of the Asexualization Act in 1979 has been treated as a bookend in examinations of forced sterilization in California, a policy-centered approach reveals how, from the late-1970s, fierce debate around the reproductive rights of people with DD gripped the courts and legislature of California, as each grappled with questions of whether DD individuals should have access to sterilization; and if so, how was that choice to be made? by whom? and using what criteria? Using rich archival sources from the California legislature and courts, this study sheds fresh light on this hidden episode in the state's struggle with involuntary sterilization.

Overview of the thesis

This study, then, examines the evolution of sterilization policy and practice in California from its beginning in 1909 with enactment of eugenic sterilization legislation, to the development of state policy for people with DD in 1986. Following a chronological path, this story is told over four main chapters.

Chapter one surveys the development and implementation of the Asexualization Act, under which over 20,000 institutionalized patients would be sterilized. Scrutinizing both policy and practice within *Department of Institutions* (DOI), this chapter highlights that while the language and aims of policy became increasingly eugenic in the years following its creation, the same cannot be said of the practice of sterilization within the state hospitals. Emphasizing this separation between policy and institutional practice, this chapter explores how doctors regularly ordered sterilizations for a number of non-eugenic reasons. Examining the practice of sterilization within several state hospitals, it is shown that not only did the practice of sterilization vary significantly between institutions, but that it was also tied to the beliefs of the superintendents who oversaw these hospitals. What is clear is that while eugenic concerns were indeed operative, equally important were therapeutic, social, and institutional pressures. Returning to a focus on policy, this chapter also unearths the transition away from institutional sterilization in the 1950s, and uncovers how legislative changes that led to a sharp decrease in the number of sterilizations from 1950 on were in fact tightly controlled by the state to allow institutions to keep sterilizing people.

Chapter two explores sterilization's transition from state institutions to public hospitals. Set around the scandal at LACMC, where Chicano women were targeted by doctors to undergo sterilizations that they neither understood nor wanted, this chapter examines both the policy developments that led to this abuse, as well as the experiences of those on the receiving end. While outlining federal policy changes regarding the funding

of sterilization services, this chapter also delves into the development of sterilization policy in California through the case of *Jessin v. Shasta*. Arguing that it was not so much eugenic ideas, as it was Malthusian concerns of overpopulation and welfare expenses that prompted the sterilizations at LACMC, this chapter highlights how these concerns were operative from the outset of policy discussions in the 1960s, and when combined with doctors harboring prejudiced views of Chicana fertility, made the sterilizations that followed seem inevitable. The focus then turns to how these concerns manifested in practice, describing the patterns of abuse suffered by women at the facility. The stories of these women led to a campaign to reshape state sterilization policy to prevent further violations, discussed in chapter three.

Chapter three goes behind the closed doors of the government policy making process in the wake of the Los Angeles sterilization scandal. The role of the government in the labyrinthine campaign to erect informed consent regulations that arose as a result of the events at LACMC has received little attention from historians to date. This chapter will highlight the state's struggles in this process, as it designed a sterilization policy that aimed at preventing abuse, while avoiding impinging on the freedom of both the medical profession, and women's reproductive autonomy. Highlighting the contested nature of these aims, this chapter explores the government's response to the California Medical Association's challenge of state regulations, and the battle between women activists, the majority of whom believed strict regulations were necessary, while others prioritized access to sterilization unencumbered by government intrusion. This chapter takes an in-depth look at how the government responded to these pressures, in a battle that lasted more than six years. In doing so, it sets the scene for a discussion of an equally impassioned debate the government would tackle in the 1980s—sterilization by substitute consent of the developmentally disabled.

Chapter four, then, centers on the purging of the Asexualization Act from California law. Prior to its removal, the law permitted parents to have their DD dependents operated on. However, with its repeal in 1979, a legal struggle over whether people with DD should have access to non-therapeutic sterilization gripped the courts and legislature of California. The state initially responded by flatly prohibiting sterilization in an attempt to safeguard rights. That was, however, until the parents of Valerie Nieto, who suffered from Down's syndrome, overturned the ban. Thus, the state was once again drawn into complex policy decisions that would have a very real impact on disabled Californians and their families. While this chapter primarily explores this period of policy adjustment through Valerie's case, it looks at a number of other sterilization petitions, some of whom would be

sterilized without adequate protections. It also highlights how the specter of eugenics was invoked both in these cases, and in the policy crafting process, and argues that it served ultimately as an obfuscating rather than clarifying factor in such decisions.

The policy-centered institutional approach presented above provides a new framework through which to view involuntary sterilization in California. It creates a stronger link between the more subtle cultural, social, medical, economic, and political concerns that motivated surgical intervention, and the specific structures which enabled it. In doing so, it expands the traditional contours of historical examination of the state's prolonged and complex relationship with involuntary sterilization, which dawned at the beginning of the twentieth century.

Chapter I

Eugenic Sterilization: Policy and Practice in California, 1909-1952

The various state departments, the public welfare organizations of the state and the public in general have become interested in this very important subject and have been supporting it, and with this combined support I am of the firm belief that sterilization in California has come to stay.¹

July, 30, 1910, on a remote ranch near Marsh Creek, California, the bodies of four infants lay lifeless, submerged in water at the bottom of a large washtub. Their mother, Isabel Mello, gazes calmly at the scene. Despite warning relatives of her intentions, Mello had drowned her four children in a psychotic episode. With “remarkable lucidness,” Mello explained her motive for committing the heinous crime to the authorities. Faced with the “the isolation” of her husband’s ranch, she began to ruminate that she too was afflicted with the same mental illness that ran in her family. Mello's mother, aunt, and sister—a patient at the nearby Mendocino State Hospital—were all adjudged to be insane. Fearing that her children shared this “hateful heritage,” and would lead lives blighted by insanity, Mello chose to pre-emptively end their suffering. “I simply had to do this dreadful thing,” she told the local sheriff, “there was no help for me.”² After an insanity hearing at the Contra Costa Superior Court, Mello was declared insane and was committed to the Stockton State Hospital on August 12, 1910. While Mello felt that her condition was hopeless, doctors Clark and Morton at Stockton had a more optimistic diagnosis. They had recently been empowered to use a new treatment that they believed could release Isabel from her hereditary burden, and permit her to lead a relatively normal life under supervision. Joseph, her grieving husband, gave his consent for the operation to proceed and on November 6, Morton, assisted by Smyth, severed Isabelle's fallopian tubes, thus constituting the first recorded instance of sterilization under the Asexualization Act, and initiating what was to become the most prolific eugenic sterilization program in American history.³

In 1909, California had become the third of thirty-two American states to enact legislation permitting the involuntary surgical sterilization of institutionalized individuals over the course of the twentieth century. The fact that California did not initiate these proceedings does not diminish its role as a pioneer on this front; for although the state was

1 F.O. Butler, “Sterilization Procedure and its Success in California Institutions” (address given at the National Conference of Juvenile Agencies, Jackson, Mississippi, November 1925).

2 “Insane, She Drowns Her Four Children,” *the American Weekly*, August 3, 1910; “Mother Drowns Four Children,” *San Francisco Call*, July 31, 1910, 49.

3 Sterilization Record No. 3722, Box 43, Folder 3, HBF, CITA; *Second Biennial Report of the Department of Institutions of the State of California* (Sacramento: California State Printing Office, 1924), 101.

not the first to enact sterilization legislation, it was the first to apply the statute to its population in a significant manner. Indeed, the energy with which the Golden State doggedly implemented eugenic sterilization policy in its State Hospitals and Homes for the Feeble-minded eclipsed all others. By 1921, and without the imprimatur of the Supreme Court, California had already sterilized 2,558 individuals, accounting for eighty percent of sterilizations performed nationwide. Even by 1930, when emboldened legislatures began passing new laws and utilizing old ones, California continued to account for sixty percent of the 10,887 operations performed that year.⁴ These statistics demonstrate how, in the words of Julius Paul, the American experience of eugenic sterilization was “essentially Californian sterilization.”⁵ Both nationally and internationally, the State’s “splendidly” functioning and intelligently administered policy served as a beacon for supporters of sterilization who would inundate the Department of Institution’s Sacramento office with requests for information on the renowned statute.⁶ As the numbers of sterilizations performed in its institutions continued to climb, the State served as eugenic laboratory from which countless scientific papers, written by medical and eugenic advocates, eulogized the Californian experience of sterilization, and implored other legislatures to follow suit.⁷ The extent to which California led the nation in the practice of eugenic sterilization was perhaps best characterized by the Superintendent of the Southern California State Hospital, John A. Reily in 1921. With Proudful indignation, Reily noted how California, in her efforts to halt the “dreadful avalanche of defectives, delinquents, and criminals,” had stood “very largely alone in this progressive effort.”⁸

These comments and statistics, however, evoke an oversimplified abstraction of how sterilization functioned in California. Sterilization policy was not based on one inviolable statute, but rather a patchwork of several loosely framed Acts, the development and genesis of which remain intimately tied to one prominent figure.⁹ Dr F. W. Hatch

4 Largent, *Breeding Contempt*, 79-80.

5 Julius Paul, “Three Generations of Imbeciles Are Enough: State Eugenic Sterilization Laws in American Thought and Practice,” (unpublished manuscript, Walter Reed Army Institute of Research, 1965), 260.

6 “Sterilization Attracts Worldwide Attention,” *The Evening News*, February 26, 1929, 8; Laughlin, *Eugenic Sterilization*, 128.

7 The Human Betterment Foundation were the foremost promoters of eugenic sterilization in California. See Ezra S. Gosney, *Sterilization for Human Betterment: A Summary of the Results of 6000 Operations in California, 1909-1929* (New York: Macmillan Company, 1929); The Human Betterment Foundation, *Collected Papers on Eugenic Sterilization in California: A Critical Study of Results in 6000 Cases* (Pasadena: The Human Betterment Foundation, 1930); Cora B.S. Hodson, *Human Sterilization Today: A Survey of the Present Condition* (London: Watts and Co, 1934). Robert L. Dickinson, “Sterilization without Unsexing: Surgical Review with Especial Reference to 5,820 Operations on the Insane and Feeble-minded in California,” *Journal of the American Medical Association* 92 (1929): 373-9.

8 John A. Reily to Harry H. Laughlin, January 1921. Letter. From Harry Laughlin, *Eugenical Sterilization in the United States*, (Chicago: Psychopathic Laboratory of Chicago, 1926), 59.

9 “Memorandum of Some of the Defects of the Sterilization Laws of California Which Are Realized By

(1850-1924), as General Superintendent of the Commission in Lunacy, acted as steward to the California state hospital system for over twenty-seven years, and in this role drafted the text and oversaw the operation of California's sterilization policy. Passed in 1909, the Asexualization Act functioned ostensibly as a therapeutic rather than eugenic measure, and sterilizations were ordered upon the potential curative value they held for cases of chronic insanity, and the improvement of their "physical, mental, or moral condition."¹⁰ While this therapeutic focus would be retained in subsequent revisions, the passage of two subsequent laws, in 1913 and 1917 respectively, expanded operations and foregrounded explicitly eugenic rationales in their text, emphasizing the benefit that sterilization held for future generations.¹¹ Highlighting this gravitation from therapy to heredity as the primary motivation of sterilization policy, some historians have suggested that the initial therapeutic focus of California's sterilization policy served merely as a disingenuous facade designed to safeguard the program and those implementing it.¹² While Hatch, the policy's architect, certainly displayed an interest in heredity prior to the law's passage, to say that eugenic motives guided the formation of the law would overstate their significance. It was only after several years of experience with the sterilization program that a concerted hereditarianism came to the fore.

The question remains then if Hatch's eugenic thought underpinned California's sterilization law from the start? Or whether his experience of sterilization prompted his calls to include eugenic motives? One must also consider the discernible racial dynamics at play in the Californian experience of sterilization. In recent years, a growing body of scholarship has focused on the experiences of Latinx patients that came under the purview of the hospital superintendents and the Asexualization Act.¹³ Notably, in a sophisticated statistical analysis of sterilizations under this legislation, Novak et al. noted that while race never functioned as an *explicit* category for sterilization, "existing taxonomies that constructed whites as superior" operated behind hospital walls as they did in Californian and American society more broadly.¹⁴ The researchers found that clear evidence of racial hostility and biases against Mexican-American patients in the state hospital system, which,

A Very Few, and Should Be Corrected At Once," Box 15, Folder 5, HBF, CITA.

10 California Statutes of 1909, Chapter 720, 1093.

11 California Statutes of 1913, Chapter 363; California Statutes of 1917, Chapter 489.

12 Fox, *So Far Disordered in Mind*, 29; Reilly, *The Surgical Solution*, 36; Larson, *Sex, Race, and Science*, 36; Aubrey Milunsky, *Genetics and the Law III* (New York: Plenum Press, 1985), 231.

13 Natalie Lira and Alexandra Minna Stern, "Mexican Americans and Eugenic Sterilization: Resisting Reproductive Injustice in California, 1920-1950," *Aztlan: A Journal of Chicano Studies* 39 (2014): 9-34; Alexandra Minna Stern, "Eugenics, Sterilization, and Historical Memory in the United States," *História, Ciências, Saúde-Manguinhos* 23 (2016): 195-212; Lira, "Of Low Grade Mexican Parentage."

14 Novak et al., "Disproportionate Sterilization of Latinos under California's Eugenic Sterilization Program," 611.

they demonstrate, ultimately led to disproportionate rates of sterilization among this group. Indeed, Novak et al. show that Latinx men were twenty-three percent, and Latinx women fifty-nine percent more likely to be selected for sterilization than their non-Latinx cohort.¹⁵ Alongside these notably racialized concerns, it is clear that by the second decade of the twentieth century, eugenic motives, at a policy level, came to the fore in the California, and justified the sterilization of the insane and feeble-minded upon the threat their tainted heredity posed for a shared racial gene pool.

While State-level sterilization policy, then, displayed a growing, though not absolute, coherence in its intent in the first decades of the twentieth century, it remains crucial to recognize how this policy was manifest in institutional practice. Given the decentralization that, from the beginning, characterized California's system of care for its insane, feeble-minded, and delinquent persons, recognizing this distinction becomes all the more important. Within this system, each institution acted more or less as an autonomous unit, imbuing the superintendents in charge of them with tacit omnipotence.¹⁶ It was this administrative devolution of authority, coupled with a sterilization policy that encouraged the discretionary power of hospital administrators, which engendered an equally flexible set of notions regarding the appropriate administration of this policy. Implemented within this individualistic system, the putatively hereditarian concerns encoded in the Asexualization Act formed but one amongst a series of competing, though not necessarily conflicting, rationales upon which sterilizations would be performed in the State. This variance centered chiefly upon the distinction being made increasingly clearer in policy; namely, whether sterilization should be ordered chiefly upon the benefit it held for *society* or the *individual*. Accounts of the practice of sterilization in State hospitals suggest that this distinction was more nebulous for hospital administrators than it was for policy makers, with operations regularly being justified upon both rationales. Not only this, but the idea of precisely what "benefit" sterilization could offer the patient proved to be an adaptable concept too, depending, once again, on the interests and authority of the respective superintendents. Both patient files and superintendents' writings highlight a marked divergence between the public policy and institutional practice of sterilization in the first half of the twentieth century, a discrepancy that would shape the marked statistical contours that characterized the "California experiment."¹⁷

Highlighting this policy-practice divide offers a more complex picture of eugenic

15 Ibid, 612.

16 Elsey Hurt, *California State Government: An Outline of its Administrative Organization from 1850 to 1936* (Sacramento: California State Printing Office, 1937), 104.

17 Robert C. Dexter, *The Case For and Against Sterilization* (Girard: Haldeman-Julius Publications, 1928), 37.

sterilization in California, and an important analytical framework through which to approach later instances of involuntary sterilization. This chapter, then, will chart the rise and fall of eugenic sterilization policy in California as a touchstone for later events. It will illuminate how notions of fitness in this period, as framed by sterilization policy, were couched in biological terms i.e. an individual's potential contribution to society's shared gene pool. It then unpacks instances of institutional practice, where policy directives merged with individual convictions to create a mutable and expansive interpretation of these biological concerns. Finally, this chapter will demonstrate how the demise of eugenic sterilization policy in the mid-century signaled a reorientation rather than repudiation of the ideological core that underpinned its birth, foregrounding its translation into succeeding policy developments in the years that followed.

F. W. Hatch: The Architect and His Policy

For over a quarter of a century, Frederick Winslow Hatch Jr sat at the helm of the State Commission in Lunacy, first as Secretary, and later as General Superintendent of State Hospitals. Hatch's work in the State hospital system did not go unnoticed, and in 1910, Governor James N. Gillet attributed the "high standards" of California's care for the insane to Hatch's tireless efforts over the previous thirteen years. It was also largely upon Hatch's tireless efforts that eugenic sterilization assumed the prominence that it did in California, and during his reign as General Superintendent, which lasted until his death in early 1924, approximately 3000 insane and feeble-minded patients would be sterilized in the network of hospitals under his jurisdiction.¹⁸ It was upon this record that Californian eugenicist, Paul Popenoe, described the State's sterilization program as a "permanent monument" to Hatch's legacy in the hospital system. Popenoe's statement was not hyperbolic, as Hatch was directly responsible for drafting the legislation that formed the backbone of California's sterilization machinery in 1909. Senate Bill 941—An Act to permit asexualization of inmates of the State hospitals and the California Home for the Care and Training of Feeble-minded Children—was formulated by Hatch, and was presented to the legislature by his political ally, W. F. Price, a senator from Santa Rosa, California. Contrary to popular opinion, SB941 was not the first sterilization bill to be received by the California legislature. In 1899 and 1901, the Committee on State Hospitals and Asylums—the body charged with drafting legislation related to the State hospitals—submitted two sterilization bills worded virtually identically to Hatch's. The first passed several committees before being pocketed by Governor Henry Gage, while the latter was quickly

18 Ian R. Dowbiggin, *Keeping American Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca: Cornell University Press, 1997), 121.

tabled after one reading.¹⁹

What makes the success of Hatch's bill all the more significant is the antagonistic political relations that it seemingly managed to unify. For in the first decade of the twentieth century, California was in the midst of a political revolution.²⁰ Since 1907, there had been concerted efforts by progressive politicians, in the form of the Lincoln-Roosevelt League, to oust the formidable Southern Pacific Railroad political machine from its enduring hegemony over California politics. "The Railroad had so long been in control," wrote the Chairman of the Republican State Central Committee in 1910, "that it was generally considered invincible."²¹ By the 1909 legislative session, the Railroad's days in power seemed numbered. Yet, while they had lost their majority in both the senate and assembly to anti-machine forces, the machine managed to retain control of key individuals in the legislature. Weakened, though not defeated, the small machine element blocked or "mutilated beyond recognition" reform after reform.²² On top of this, further factionalism occurred within anti-machine forces, with partisan members of the resistance unable to put aside their differences marked by party lines. Despite this bitter sectarianism that divided the legislature of 1909 on several levels, when Hatch's sterilization bill came before the Senate, it would pass with only one dissenting vote. In the assembly it fared even stronger, receiving forty-one votes in favor, and not a single against it. Passing through both houses and several committees, not a single attempt was made to block or alter the bill.²³ In a legislature characterized by infighting and partisanship, conservatives, progressives, and machine men all appeared to agree on one point—that sterilization was a measure worth setting aside their differences for.

Hatch's aims were realized when on April 26, 1909, the unpopular governor James N. Gillet signed SB 941 into law, legalizing the sterilization of California's "defectives." From the outset, Hatch proceeded with caution. The operative section of the new policy read:

Whenever in the opinion of the medical superintendent of any State hospital, or the superintendent of the California Home for the Care and Training of Feeble-minded Children[...]it would be beneficial and conducive to the benefit of the physical, mental, or moral condition of any inmate[...]to be

19 AB994, February 24, 1899. OBF, CSA; *Final Calendar of Legislative Business*, Thirty-Fourth Session, California Legislature, 1901, 326.

20 For further information see: Edgar Kaskla, *California Politics: The Fault Lines of Power, Wealth, and Diversity* (Washington D.C.: CQ Press, 2008); J. Casey Sullivan, "Way Before the Storm: California, the Republican Party, and a New Conservatism, 1900-1930," *Journal of Political History* 26 (2014): 568-594.

21 Franklin Hitchborn, *Story of the California Legislature of 1911* (San Francisco: James H. Barry Company, 1911), 12-13.

22 Benjamin P. De Witt, *The Progressive Movement: A Non-Partisan, Comprehensive Discussion of Current Tendencies in American Politics* (Seattle: University of Washington Press, 1968), 64.

23 John Randolph Haynes to Paul Popenoe, October 22, 1929. Letter. From Box 77, Folder 6, JRHP, UCLA-SCL.

asexualized[...]then they may perform the same.²⁴

Notably absent from the text of the 1909 Act is any reference to heredity, degeneracy, gene pool, or other eugenically-imbued terms. Indeed, while eugenic sterilization acted as a socially therapeutic intervention, ridding society of poor heredity, California outwardly concerned itself solely with the benefit that sterilization held for the individual. This wording appeared to be a calculated move by Hatch, who consciously foregrounded this singular concern in his first report on the law's operation. In an analysis of the eight sterilization statutes passed by 1912, Hatch noted how seven operated on upon a "proposition of eugenics," that is, a "cutting off of the inheritance lines."²⁵ The sole exception, and in marked distinction, was California, who reportedly sterilized solely for the physical, mental, or moral welfare of its patients. Hatch, having already approved the sterilization of 288 patients by this point, reported much success in this therapeutic endeavor, noting not only a general improvement in the health of those operated on, but also a considerable and shared sense of satisfaction with the beneficial results.²⁶ Given the legislative revisions that would soon refocus Californian sterilization policy away from its curative mandate, and towards one focused on controlling the reproduction of the genetically defective, the therapeutic wording of California's first sterilization statute has been viewed as disingenuous.²⁷ Yet, while certainly invested in the subject of heredity, a look at Hatch's reports prior to 1912 suggest that it was practical and not eugenic concerns that would shape his formulation of the 1909 Act.

At the turn of the twentieth century, the hereditary basis for insanity became a central concern for Hatch, as it did for many of his medical colleagues in California. Since the 1870s, the State had been recognized as the insanity capital of North America, consistently surpassing all other States with its annual commitment rates.²⁸ Historically, psychiatrists had attributed this prevalence to the uniquely unsettling social and physical environment that characterized life on America's Western frontier. Here settlers, enticed by the prospect of riches, were often met by extreme social dislocation, economic hardship, and the general shock of the "newness" of the frontier, all of which combined to

24 California Statutes of 1909, Chapter 720, 1093.

25 *Eighth Biennial Report of the State Commission in Lunacy* (Sacramento: California State Printing Office, 1912), 21.

26 Ibid, 23.

27 Richard W. Fox, *So Far Disordered in Mind*, 29. Philip R. Reilly, *The Surgical Solution: A History of Involuntary Sterilization in the United States* (Baltimore: John Hopkins University press, 1991), 36; Edward J. Larson, *Sex, Race, and Science: Eugenics in the Deep South* (Baltimore: John Hopkins University Press, 1995), 36; Aubrey Milunsky, *Genetics and the Law III* (New York: Plenum Press, 1985), 231.

28 Fox, *So Far Disordered in Mind*, 18-19.

promote mental breakdowns.²⁹ However, from the 1890s, this view was gradually supplanted by another that blamed the high rate of insanity on the number of *inherently* defective individuals migrating to the State. As Hatch averred in 1906, the “ideally normally constituted man” would retain his mental integrity “in spite of stress, strain, grief, shock, worry, or less of fortune.” It was only those in possession of inherited mental “instabilities and incompetencies” who ended up as State charges.³⁰ For Hatch, heredity served as predisposing cause for insanity, and rather transmitting specific “diseases,” such as insanity or feeble-mindedness, individuals inherited an inborn weakness from their ancestors that only under “favorable conditions” would find outward expression in individual pathologies.³¹ Although the specifics of its methods of transmission still eluded Hatch, he was certain that heredity, along with alcoholism, drug abuse, and syphilis, played a leading role in the production of insanity in California.³²

Yet, the arrival of increasing numbers of settlers bearing inborn defects did not trouble Hatch upon any potential threat to the wellbeing of California's future racial stock. Instead, Hatch proved to be more concerned with the consequences that these impure interlopers held for the already overburdened hospital system. In each biennial report of the first decade of the twentieth century, Hatch reported a rapidly expanding insane population of the State hospitals, and a steady swelling of costs associated with their care. “Our state,” wrote Hatch in 1902, “receives high numbers of immigrants of unstable nerve organizations, who break down under the stress of circumstances and become inmates of our hospitals.”³³ Admission data proved this statement to be true. In 1900, Hatch reported that of the 251 admissions that year, 195 were born outside of California.³⁴ This trend continued throughout the period, with out of state patients continuing to account for approximately forty percent of all admissions.³⁵ By 1910, Hatch reported an “unprecedented number of commitments to the state hospitals.”³⁶ The continuation of this trend was to be expected, according to Hatch, for California was now “dealing not only with the first, but second, and third generations, with all the weaknesses and instability that

29 Dowbiggin, *Keeping American Sane*, 121; John W. Robertson, “Prevalence of Insanity in California,” *American Journal of Insanity* 60 (1903): 75-88. See Asa Clark, “The Number of the Insane in California,” in *Third Biennial Report of the State Commission in Lunacy* (Sacramento: California State Printing Office, 1902), 30.

30 *Fifth Biennial Report of the State Commission in Lunacy* (Sacramento: California State Printing Office, 1906), 41.

31 *Third Biennial Report of the State Commission in Lunacy*, 29.

32 *Seventh Biennial Report of the State Commission in Lunacy* (Sacramento: California State Printing Office, 1910), 20-21.

33 *Third Biennial Report of the State Commission in Lunacy*, 33.

34 *Ibid*, 34.

35 *Sixth Biennial Report of the State Commission in Lunacy* (Sacramento: California State Printing Office, 1908), 9.

36 *Seventh Biennial Report of the State Commission in Lunacy*, 10.

have descended.”³⁷ With an inefficient legal mechanism for returning disordered settlers to their State's or countries of origin, and an “exceedingly liberal” admissions policy which committed all individuals in the state who were unable to support themselves, despite being “doubtful cases for the restraint of an insane asylum,” the outlook for the California hospital system looked dire.³⁸ While Hatch's writings, then, were devoid of any eugenic overtones, securing the legality of an operation which proffered to “cure” cases of chronic and acute insanity, and thus legitimize the discharge of large numbers of patients, may have led to his foregrounding of sterilization as a therapeutic endeavor

The second practical concern, which continued throughout the program's history, was that of legality. Prior to *Buck vs. Bell* in 1927, a great degree of uncertainty existed over the legality of sterilization statutes, and by 1918, seven of the twelve existing statutes had been declared unconstitutional.³⁹ That this was an overriding concern of Hatch's can be seen in the operation of the statute. While the act was in effect compulsory, Hatch insisted that superintendents gained “consent” in every case as far as was possible—a policy directive (one of the few) which generated “much disagreement” among the institutional heads.⁴⁰ Once consent was gained from the patients, both Hatch and the Director of Public Health had to approve the procedure before the patient could be operated on. The statute's security, then, was paramount to Hatch. In October 1909, Hatch wrote to California's attorney-general, Ulysses Webb, requesting clarification on the legal position of his new statute. While Webb took issue with the term “asexualization,” which he mistook to mean castration, he upheld the sterilization of patients, if by the method of vasectomy, and if used as a “health measure” and “undoubted protection to society,” as constitutional.⁴¹ Following the decision in March 1910, Hatch wrote to all of the hospital superintendents, giving them the go-ahead to begin operations.⁴² Despite the imprimatur of the state's highest legal office, however, Hatch continued to express concerns over the law's security. This hesitancy can be seen in the first attempts to apply the law in early 1910. In March that year, Hatch met with Elmer E. Stone, superintendent of Napa State Hospital, to discuss the sterilization of selected cases at the facility.⁴³ These operations, however, were

37 Ibid.

38 *Third Biennial Report of the State Commission in Lunacy*, 35; *Sixth Biennial Report of the State Commission in Lunacy*, 23.

39 Reilly, *The Surgical Solution*, 40.

40 F. W. Hatch to Harry H. Laughlin, June 21, 1912. Letter. From Eugenics Record Office, *Bulletin 10b: Report of the Committee to Study and to Report on the Best Practical Means of Cutting Off the Defective Germ-Plasm in the American Population* (Cold Spring Harbor: ERO, 1914), 83.

41 “The Attorney General’s Opinion on the Asexualization Law,” *California State Board of Health Monthly Bulletin* 6 (1911): 611-617.

42 “To Prevent Spread of Criminal Insanity,” *The Sacramento Union*, March 9, 1910, 3.

43 “Asexualization Law Put in Force at Napa,” *Oakland Tribune*, March 20, 1910, 21.

blocked in June when one of the patient's parents refused to provide their consent for the procedure.⁴⁴ Not wanting any “arbitrary action” to arise from “compelling patients to submit to the operation,” Hatch did not force the issue, and the first male sterilizations in Napa would only take place two years after the dispute.⁴⁵ It is likely, then, that Hatch's foregrounding the operations beneficial effects may have also represented a calculated attempt to assuage both legal and familial discord over the practice of sterilization.

Practical concerns, then, appear to have shaped the early form of State sterilization policy. At this stage, eugenic concerns remained absent from Hatch's thinking both in connection with the prevalence of insanity in the State, and the sterilization policy that he formulated. The year 1912, however, marked a turning point in Hatch's thinking, and the drift towards a more explicitly eugenic *modus operandi* for sterilization becomes increasingly discernible. Several years of experience with sterilization in the state appeared to have brought the potentiality for the transmission of mental illness to the forefront of Hatch's mind. While heredity had long been recognized by Hatch as a contributing factor to the growing prevalence of insanity, a growing menace became attached to those bearing inherited illnesses from 1912. Indeed, foreshadowing his own imminent policy suggestions, Hatch wrote that that the policy of sterilization was “becoming more and more generally discussed by those who look deeply into the question of the influence of heredity in the production of that permanent underlying state[...]which we commonly call predisposition.”⁴⁶

The operations of the sterilization law, which far exceeded those of any other state, had clearly given Hatch an unprecedented amount of material to work with in the development of this sentiment. As per his policy requirements, Hatch would have received medical, biographical, and as far as possible, genealogical details on each individual put forward for sterilization by the hospital superintendents. Due to the unusual demographics of those committed to California's hospitals, Hatch reported great difficulty in obtaining the latter information on patients.⁴⁷ The lack of this crucial data, however, did not stop him diagnosing cases of hereditary insanity in those presented to him. Thus of the two hundred and sixty eight individuals sterilized by December 31, 1911, Hatch reported that one hundred and nineteen, or forty-four percent, were shown to definitely carry a hereditary

44 “New Law Blocked By Parents’ Opposition, Proposed Operation in Napa Hospital Prevented,” *The San Francisco Call*, July 17, 1910, 62.

45 F. W. Hatch to Harry H. Laughlin, June 21, 1912. Letter. From Eugenics Record Office, *Bulletin 10b*, 8; “Table of Sterilizations Performed in California State Institutions for the Insane and Feeble-minded, Reported Annually from the Beginning to January 1, 1935,” Box 11, Folder 12, HBF, CITA.

46 *Eighth Biennial Report of the State Commission in Lunacy*, 21.

47 The prevalence of many single, foreign-born males made it difficult to obtain accurate patient information. *Third Biennial Report of the State Commission in Lunacy*, 33-34.

basis for their conditions.⁴⁸ In the same month that this report was published, Hatch wrote to members of the Eugenics Record Office indicating that the number of patients showing definite “insane and alcoholic inheritance” sat slightly higher at around fifty percent.⁴⁹ Given the difficulty of obtaining patient histories, Hatch did not view these figures as representative of the actual amount of hereditary taint in these patients. The implication of this statement was clear: undoubtedly more poor heredity was present than could definitely be accounted for.

Aside from his own practical research in connection with the program, Hatch’s report drew heavily on the work of the psychiatrist, and future member of the Eugenics Research Association, A.J. Rosanoff (1878-1943). Rosanoff himself would later head-up California’s sterilization program when he became Director of Institutions in 1939.⁵⁰ In 1911, the psychiatrist published an article which detailed how the “neuropathic constitution”—the innate predisposition for insanity highlighted by Hatch—followed Mendel’s laws just as other simple physical traits did.⁵¹ Rosanoff’s results not only provided an operative framework through which this taint descended down generations, but also hinted at the significant and growing prevalence of the hereditarily disordered classes in the population. Based on Rosanoff’s data, Hatch declared that one and a half to two percent of the population were actually neuropathic, with a far greater number, approximately thirty percent according to Rosanoff, “capable...of transmitting the neuropathic make-up to their progeny.”⁵²

While prior to 1912, Hatch had disregarded any threat posed by the hereditarily disordered classes, both his growing search for and identification of hereditary blight in the operation of the sterilization law, and the growing alarm from eugenicists like Rosanoff, heightened in Hatch’s mind the threat posed by the expanding “neuropathic” classes, not just for the already strained State hospital system, but now, more importantly, for the mental and physical wellbeing of future generations. Upon this growing concern, and in a move that signaled an explicit change of direction in sterilization policy, Hatch urged for the Asexualization Act to be “greatly extended in its application.” This extension was predicated not upon the benefit it held for the individual, but upon the potential “benefit to

48 *Eighth Biennial Report of the State Commission in Lunacy*, 21.

49 F. W. Hatch to Harry H. Laughlin, June 21, 1912. Letter. From Eugenics Record Office, *Bulletin 10b*, 83.

50 “News,” *California and Western Medicine* 50 (1939): 68.

51 Aaron J. Rosanoff and Florence I. Orr, “A Study of Heredity in Insanity in the Light of the Mendelian Theory,” *The American Journal of Insanity* 68 (1911): 221-261; See also Aaron J. Rosanoff, “The Inheritance of the Neuropathic Constitution,” *Journal of the American Medical Association* 17 (1912): 1266-1269.

52 *Eighth Biennial Report of the State Commission in Lunacy*, 22.

future generations” that it carried.⁵³

The architect, it seems, was persuasive in his calls for action. At the next legislative session in 1913, the original Asexualization Act was repealed, and replaced with a much more comprehensive piece of legislation. Its passage, however, was not met with the unanimous support received in 1909, and the legislation received twenty-four votes against it in the Assembly, and a bare constitutional majority of twenty one votes in the Senate.⁵⁴ The legislation brought with it several important modifications to the first. The most important among these changes was the inclusion of an explicitly hereditarian rationale for the performance of sterilization operations. Now, instead of applying merely to “any inmate” of the State hospitals, the 1913 act specifically targeted patients with clearly inherited mental illnesses. Those now targeted included patients “afflicted with hereditary insanity or incurable chronic mania or dementia,” as well as any “idiots” or “fools,” if the appropriate consent was received.⁵⁵ While the section regarding benefit was retained in the new legislation, it sat subaltern to this new hereditarian focus. With this addition, superintendents no longer had to attest that sterilization would benefit their patients if they affirmed the presence of a stipulated hereditary disorder. The second important modification provided statutory protection to all members of the State Commission in Lunacy involved with the program, shielding them from any civil or criminal action. While this provision was included conceivably to embolden officials to increase the sterilization work done in the State, its inclusion did not abate fears of potential legal action directed at them or the statute itself, as can be seen by this exchange by two doctors at Mendocino State Hospital:

Doctor #1: Is there any way possible we could force sterilization?

Doctor #2: We can’t do it unless she and her brother give written consent. The law has never been tested and there is some question as to whether it is constitutional, and if you did it without consent you would be likely to bring trouble on yourself later.⁵⁶

The last important amendment enforced by the statute made sterilization a condition of release. This provision ensured that either by segregation or sterilization, those found to suffer from any of the stipulated hereditary illnesses would be unable to transmit their afflictions to society at large.

Reacting to these changes, the State Board of Charities, a body charged with monitoring the State's psychiatric, penal, and welfare institutions, reported that the “way

53 Ibid.

54 Hansen and King, *Sterilized by the State*, 81.

55 Landman, *The History of the Sexual Sterilization Movement*, 58; Lisa M. Matoq, *California's Compulsory Sterilization Policies, 1909-1979* (Sacramento: Senate Publications, 2003), viii.

56 Case 521, F3886:227, Case Files, Mendocino State Hospital Papers, DMH, CSA.

[was] now open[...]to prevent to a considerable extent the reproduction of the unfit.”⁵⁷ Believing that it was society's duty to prevent the insane from becoming parents, the Board decided to mail each hospital superintendent a copy of the new law in the hopes of widening its application⁵⁸. Hatch's reports following the passage of the new law highlight the extent to which the concerns over the reproduction of the unfit, shared by the Board, now steered sterilization policy. Discussions of benefit would now sit subordinate to this preventative rationale. Indeed, this had become so prominent that in 1914, Hatch even declared that “much latitude” was needed when discussing the operation's therapeutic value. Highlighting an “unselected series” of twenty-one cases, Hatch noted that while these patients showed a restoration rate of fifty percent, the operation had, in several cases, been done prior to discharge after “decided improvement” had already been shown in their conditions. With a clearing up of their conditions already shown, sterilization in these cases served solely to control reproduction, and the potential transmission of their underlying genetic defects to future generations. It was now clear that one's “potentiality for reproducing defectives” had become an explicit standard for selection to undergo the procedure.⁵⁹ According to Hatch, patients too shared a belief in this new rationale, with many expressing their “appreciation of the work done upon them by reason of their knowledge of danger of bad inheritance in child-bearing.” The same was apparently true for patient's families. While in 1912, Hatch believed that the curative effects of the operation constituted a significant factor in gaining the consent of relatives, by 1916, it appeared that the recognition of the transmission of “inherited weaknesses” informed this sentiment.⁶⁰

The extent to which heredity had by now become a leading concern for Hatch can be seen in the eugenic investigations begun shortly following the passage of the 1913 law. In an attempt to gain practical knowledge of how mental diseases passed from one generation to the next, Hatch invited Ethel H. Thayer, a field worker from the Eugenics Record Office in Long Island, to travel between the State hospitals, and trace back through several generations the family histories of their hereditarily insane and feebleminded patients.⁶¹ Due to the unusual prevalence of young, foreign-born men in California's

57 *Seventh Biennial Report of State Board of Charities and Corrections of the State of California* (Sacramento: California State Printing Office, 1916), 33.

58 State Board of Charities and Corrections to Superintendents of State Hospitals. Letter. Box 77, Folder 13, JRHP, UCLA-SCL.

59 *Ninth Biennial Report of the State Commission in Lunacy* (Sacramento: California State Printing Office, 1914), 41.

60 *Tenth Biennial Report of the State Commission in Lunacy* (Sacramento: California State Printing Office, 1916), 15.

61 *Ninth Biennial Report of the State Commission in Lunacy*, 41.

hospital system, Hatch had, for several years, noted great difficulty in obtaining patient histories.⁶² The services of an individual trained in, and dedicated to, addressing this problem represented a great boon to Hatch. Trained at Cold Spring Harbor, the home of the ERO, the almost exclusively female and college-educated field workers visited state institutions across the country, collecting and compiling pedigree data to be sent back for indexing in Long Island.⁶³ In the press, the investigations in California were promoted as a cooperative endeavor between the Eugenics Record Office and the State of California, with Hatch gaining the benefit of Thayer's expertise, and the ERO gaining vast quantities of patient data for their growing genealogical index of cacogenic individuals.⁶⁴ Taking this as a sign of progress, the front-page of the *Sacramento Union* claimed that it was "not far distant when the State government will include a department of eugenics which will[...]ensure to posterity the right of being well-born."⁶⁵ Thayer apparently saw a role for herself in this effort, and during her tenure in California, directly involved herself with the operations of the sterilization program. In a letter to Harry H. Laughlin in 1915, Thayer explained how her investigations into the family histories of two "unfit" patients in the San Jose area were "increasing the desire" of Leonard Stocking, superintendent of the nearby Agnews State Hospital, to sterilize the pair who had been "raising a large family" at county expense.⁶⁶

While the end results of Thayer's study in California are unclear, Hatch's rhetoric at this time displayed an increasingly alarmist tone, especially over the threat posed to the State by the feeble-minded. By 1914, Hatch believed that nothing was more certain than the "feeble-minded will bring forth more feeble-minded."⁶⁷ His suggestion that California had as many as eight thousand mental defectives, of which less than half were known to State officials, appeared to support this contention.⁶⁸ The problems associated with this population were far reaching, and Hatch attributed the majority of the State's socially undesirable behavior—especially inebriety, prostitution, and crime—to this unabated spring of subnormal heredity. In 1920, Hatch estimated that as many as forty percent of the State's prostitutes and twenty-five percent of its prisoners were the unfortunate products of this polluted spring.⁶⁹ Hatch was especially concerned with the higher grade defectives,

62 *Eighth Biennial Report of the State Commission in Lunacy*, 21.

63 Daylanne K. English, *Unnatural Selections: Eugenics in American Modernism and the Harlem Renaissance* (Chapel Hill: University of North Carolina Press, 2004), 141-177.

64 "To Study Heredity in Feeble-minded Cases," *Oakland Tribune*, October 14, 1914, 7.

65 "Probe of Eugenics is Turned Over to Lunacy Commission," *Sacramento Union*, December 15, 1914, 1.

66 Laughlin, *Eugenical Sterilization*, 54.

67 *Ninth Biennial Report of the State Commission in Lunacy*, 18.

68 "Defectives Problem of State Officials," *Oakland Tribune*, December 13, 1914, 37.

69 *Twelfth Biennial Report of the State Commission in Lunacy* (Sacramento: California State Printing

known as “morons,” who it was believed possessed a mental age of up to twelve years. The threat posed by this group, and especially the ‘female moron’, was acute because their ability to pass as “superficially bright,” prevented their detection, and subsequent control, by authorities.⁷⁰ As recognition of the menace posed by the hereditarily defective grew, a corresponding waning of Hatch’s belief in the power of environmental reform can be seen, with the feeble-minded shown to be unable to benefit from “all the opportunities for a better life and for education they have.”⁷¹

Controlling the reproduction of this class, then, had proven itself to be necessary. How best could this group be prevented from bringing forth more of their kind? For Hatch, long-term segregation was clearly not an option, for the State hospitals would soon be overrun with a vast class who were “unfit to bring children into the world.”⁷² Protection of both the social and mental wellbeing of future generations was a paramount concern, and in this effort sterilization represented a “greater hope.”⁷³ The necessity of the State’s sterilization program in this effort had become so self-evident, that Hatch now regarded it as “hardly profitable to discuss the question.” Undoubtedly, the concern of policy-makers over the reproduction of the genetically defective, and its concomitant evils, had from 1913 onwards come to govern Californian sterilization policy.⁷⁴

By 1917, what we may regard as the transformation of sterilization policy from putatively beneficial to eugenic was complete when Senator Edward Tyrrell, attorney for the Commission in Lunacy, submitted SB898 to the legislature. The bill made only a slight modification to the first section of the 1913 statute, substituting the law’s target from “afflicted with hereditary insanity or incurable chronic mania or dementia,” for the much broader classification of any with:

mental disease which may have been inherited and is likely to be transmitted to descendants, the various grades of feeble-mindedness, those suffering from perversion or marked departures from normal mentality or from disease of a syphilitic nature.⁷⁵

Although a relatively minor amendment to the legislation, the implications of Tyrrell’s bill for Californian sterilization policy were significant. Firstly, the inclusion of the phrase, “likely to be transmitted to descendants,” made explicit the hereditarian concerns that had, in legislation at least, until this point remained implicit. This amendment, in the words of

Office, 1920), 9.

70 *Ninth Biennial Report of the State Commission in Lunacy*, 17; See also Henry H. Goddard, “Who Is Mentally Defective – How Many Are There – And How Can They Be Detected?” (Paper presented at the Fourth International Congress on School Hygiene, Buffalo, New York, August 25-30, 1914.

71 *Ninth Biennial Report of the State Commission in Lunacy*, 18.

72 *Tenth Biennial Report of the State Commission in Lunacy*, 15.

73 *Ninth Biennial Report of the State Commission in Lunacy*, 18.

74 *Ibid*, 14.

75 Statutes of California, 1917, Chapter 489.

Joel Braslow, consolidated the “eugenic spirit” of the sterilization law, and undoubtedly placed the prevention of mental illness and other “departures from normal mentality” as its primary concern.⁷⁶ Even Harry H. Laughlin, who, in his comprehensive analysis of State sterilization laws, described the 1909 and 1913 laws as both eugenic *and* therapeutic, described the 1917 amendment as “purely eugenic” in its intention.⁷⁷ Secondly, the statute once again imbued the Commission in Lunacy, and the physicians it governed, with the power to sterilize an ever-growing number of individuals deemed unfit, based on catchall diagnoses of mental illness and the potential of the individuals to pass on these conditions to their offspring. The extent to which these seemingly technical modifications impacted sterilization policy can be seen in the annual totals of operations performed during this period. For instance, in the three years that followed the adoption of the 1913 statute, a total 381 surgeries were performed in the State hospitals. Yet, in 1917 alone, this figure reached 375 operations, and a year later would reach a high of 455 sterilizations.⁷⁸ If the 1913 law may have opened the way, to prevent “to a considerable extent the procreation of the unfit,” then the 1917 amendment inscribed this mission into law, much to the delight of State policy makers.⁷⁹

The now explicitly eugenic nature of state sterilization policy was endorsed once more by the Board of Charities and Corrections, who had for several years since the passage of the 1913 law been calling for the greater adoption of the practice throughout the State.⁸⁰ In the months following the adoption of SB898, one member of the Board, John R. Haynes had been conducting research into the use of sterilization in the State hospitals, which he published in the Board's 1918 Biennial report under the title, *The Care of the Insane*.⁸¹ Haynes' was an influential figure in California politics, having served as advisor to Governor Hiram Johnson.⁸² He was also an ardent supporter of sterilization policy, and even solicited contributions for a \$100,000 defense fund in the event of legal actions arising from the practice.⁸³ His article laid out the two obligations placed on California's superintendents: the first was to better the lives of those patients under their care; the

76 Joel T. Braslow, *Mental Ills and Bodily Cures*, 57.

77 Laughlin, *Eugenical Sterilization*, 7.

78 “Table of Sterilizations Performed in California State Institutions for the Insane and Feeble-minded,” Box 11, Folder 12, HBF, CITA.

79 *Seventh Biennial Report of the State Board of Charities and Corrections of California* (Sacramento: California State Printing Office, 1916), 33.

80 Ibid, 37. From 1914 on, the State Board of Charities and Corrections would call for the “more general adoption of the practice of sterilization.”

81 *Eighth Biennial Report of the State Board of Charities and Corrections of the State of California* (Sacramento: California State Printing Office, 1918), 61-65.

82 For an overview of John R. Haynes' career, see: Tom Sitton, *John Randolph Haynes: California Progressive* (Stanford: Stanford University Press, 1992).

83 John Randolph Haynes to Cornelia M. Stanwood, June 23, 1922. Letter. Box 77, Folder 13, JRHP, UCLA-SCL.

second, and equally heavily obligation was to protect society “against the further reproduction of unfortunates.”⁸⁴ Sterilization, for Haynes, served only the latter purpose. Indeed, in language and tone, his article was virtually indistinguishable from some mainstream eugenic jeremiads of the period, and even cited Richard Dugdale's infamous account of the Juke family as evidence of the threat posed to society by the reproduction of defectives. While practical concerns over the burgeoning hospital population figured in his support for sterilization, as they did for Hatch, it was undoubtedly the purity of California's gene pool upon which Haynes' focus was trained. “The whole stream of human life,” wrote the physician “is being constantly polluted by the admixture of tainted blood of the extremely defective.” Haynes believed that if sterilization policy was implemented as now worded, the beneficial effects to society would show in a single generation.⁸⁵ Powerful in its rhetoric, Haynes article, bringing with it the tacit support of the State's ombudsman over the hospital system, served partly to underline the eugenic imperative of the State's sterilization policy, and partly to edify this policy focus in the minds of the hospital superintendents, some of whom remained irresolute on the practice.

While the 1917 amendments represented the last significant changes to state sterilization policy until 1951, in the 1930s further attempts were made to increase the statute's eugenic value. With sterilization reaching its zenith during this period, the state received no less than five comprehensive sterilization bills designed to update and expand the policy.⁸⁶ It is likely that the establishment of the Human Betterment Foundation in 1928 by Ezra Gosney (1855-1942), who remained critical of the vague language and piecemeal legislation governing sterilization, prompted the attempts to enlarge operations in the state.⁸⁷ Pursuing this mission, each bill suggested the creation of a “State Board of Eugenics,” staffed respectively by the Directors of the DOI (formerly the Commission in Lunacy), Department of Public Health, and Department of Social Welfare.⁸⁸ This body would be charged with deciding on appropriate cases of eugenic sterilization, and the maintenance of all administrative records connected therewith. The bills expanded the scope of operations too, with a broadening of the type of institutions in which sterilization could be performed. A bill submitted in 1931 by Assemblymen Biggar and Zion even permitted the State Board to decide on “voluntary” eugenic sterilizations outside of the

84 *Eight Biennial Report of the State Board of Charities and Corrections*, 61.

85 *Ibid.*, 62.

86 AB917, January 22, 1931. OBF, CSA; AB918, January 22, 1931. OBF, CSA; AB211, January 9, 1933. OBF, CSA; AB1607, January 26, 1935. OBF, CSA; AB2590, March 1, 1937. OBF, CSA.

87 “Sterilization in America,” *The Eugenics Review* 25 (1933): 106; “Memorandum of Some of the Defects of the Sterilization Laws of California Which Are Realized By a Very Few, and Should Be Corrected At Once,” Box 15, Folder 5, HBF, CITA.

88 See, for instance, AB 1607, January 26, 1935.

State institution system if it was believed that individuals would produce offspring “likely to become public charges because of physical or mental disease or defect.”⁸⁹ However, while none of these suggestions were adopted by the legislature, this is not necessarily indicative of reluctance towards the possibility of an expanded state eugenic machinery. Instead, while each bill still immunized state officials from prosecution, the addition, at the behest of the State’s “legal minds,” of an appeal clause designed to give additional protection to patients worried those involved with the program. “A good many of us,” wrote Fred Butler, superintendent of the Sonoma State Home, “did feel that it would probably slow up our working program due to the fact that we would probably have many contests.”⁹⁰ Thus, it appears that the concern for keeping sterilization running smoothly in the state hospitals overrode the potentially problematic impulse to expand the practice beyond institutional walls.

Following Hatch’s intellectual drift and that of his associated policy makers towards eugenic tenets, reproductive “fitness” in California, for much of the first half of the twentieth-century, became circumscribed by law in explicitly biological terms. For these policy makers, stemming the perceived rampant growth of mental illness and deficiency in the State by cutting off the transmission of impure genetic material came to override all other concerns justifying the use of sterilization legislation. The effort, undeniably, became one of, in the words of Pacific State Hospital superintendent, George Tarjan, stopping society from “going to the pot” genetically.⁹¹ Upon this premise, and despite the death of the policy’s architect in 1924, California’s annual rate of sterilizations would continue to climb as the decades wore on, reaching an annual peak of 848, and cumulative total of 13,402, surgeries performed in 1939.⁹² However, as John R. Haynes’ report to the legislature in 1918 suggested, while the principles that were to underpin sterilization policy seemed to have been settled in the minds of the State’s lawmakers, the implementation of these principles in the hospitals reputedly under their charge appeared more problematic. Hospital superintendents, operating within an elastic legal and administrative environment, one which *permitted* them to sterilize, though in no way mandated it, led to marked discrepancies between both institutional rates of sterilization, and the justifications for operating which underpinned them. Given these dynamics, noting where the institutional practice of sterilization diverged from, and conformed to, State policy expectations, then, represents a critical approach to understanding the operation of

89 AB 918, January 22, 1931.

90 “Memo on So-Called Model Sterilization Bills,” Box 11, Folder 12, HBF, CITA.

91 George Tarjan Interviewed by Michael S. Balter. 1998. UCLA Neuropsychiatric Institute and Hospital Oral History Transcript, 1997-1998, UCLA-SCL, 208.

92 Matoq, *California’s Compulsory Sterilization Policies*, 8.

eugenic sterilization in California.

Sterilization in Practice: A Plurality of Perspectives

California's state hospital system was one characterized by guarded individualism. For much of the nineteenth century, following the creation of the first asylum at Stockton in 1851, State hospitals were established and operated in almost complete isolation, each being supervised by individual boards of managers and a medical superintendent therein. As was common with the "board system," this group of managers was made of lay volunteers, who, while acting as watchdogs over institutional operations, granted considerable discretion to the medical superintendent in charge of the executive staff.⁹³ These individuals were wholly responsible for setting institutional policy, therapy methods, and liaising with Sacramento over legislation and appropriations related to the hospital. The state hospital was "just like an individual person in many ways," later professed the superintendent of the Sonoma State Home.⁹⁴ In this system, then, the State of California dissevered the care of the insane and feeble-minded into a number of "uncorrelated independent units."⁹⁵ Attempts were made by the State, however, to establish a system of "uniform government" over the loosely organized hospitals, beginning with the creation of the Commission in Lunacy in 1897.⁹⁶ The Commission was charged with examining the care of the insane in the State hospitals, and acted broadly as a unified point of contact between the hospitals and the legislature. While courting acrimony from the institutional staff, administratively, the insanity law and the Commission that arose from it was to change little, with the boards of managers and, more importantly, medical superintendents, continuing to operate as the driving force behind institutional policy and practice.⁹⁷ By enacting chapter 610 of the political code in 1921, the State would make a more concerted effort to reign in the power of hospital superintendents with the creation of the Commission in Lunacy's successor, the Department of Institutions. This department succeeded all of the "duties, powers, purposes, responsibilities and jurisdiction" of the individual hospital boards, and designated them with a new, and far more limited advisory role in the hospital system.⁹⁸ Despite the State's vigorous efforts,

93 See David Prescott Barrows, *Reorganization of State Administration in California* (Berkeley: University of California Press, 1915), 11-14.

94 Fred O. Butler, "Radio Script, Station KFBK, November 13, 1942." F3501:139, DMH, SSHP, CSA.

95 Barrows, *Reorganization of State Administration in California*, 12.

96 *First Biennial Report of the State Commission in Lunacy for the State of California* (Sacramento: California State Printing Office, 1898), 5.

97 Ibid, 6. The commission noted that at times "managers have sometimes felt that their functions were being usurped and their opinions overridden."

98 *First Biennial Report of the Department of Institutions of the State of California* (Sacramento: California State Printing Office, 1922), 3.

institutional autonomy persisted under the Department of Institutions. This was perhaps due to the structure of the department itself, which, unlike other branches of government, contained no administrative subdivisions or bureaus. The individual hospitals acted, in effect, as individual departments within a department, thus preserving the “identity, character, and internal organization” of these hospitals in the face of expanding state control.⁹⁹ Just as California’s liberal policy for governing the State hospitals devolved considerable power to the superintendents who reigned over them, so too did California’s loosely drawn sterilization policy in the application of its prescriptions within the State’s eleven hospitals for the insane and feeble-minded.

Indeed, while the phraseology of California’s sterilization law changed with successive amendments, growing increasingly eugenic as it did so, one element retained throughout was an emphasis on the discretion of the medical superintendent. Three characteristics of California’s sterilization granted medical superintendents a virtual free hand in the performance of their duties. Firstly, expansive categories of transmissible disease, and the retained element of benefit in justifying sterilizations meant that virtually the entire population of the State hospitals could conceivably be ordered to undergo surgery if “in the opinion of the medical superintendent” it would be valuable to do so.¹⁰⁰ Secondly, aside from requirement that the Director of Institutions and the Director of Public Health approve sterilization requests, medical superintendents performed sterilizations with little to no oversight. Sonoma Superintendent Fred Butler signaled this feature of the law out as particularly conducive to the operation of the program:

While our law is considered unsafe from a constitutional standpoint, yet we have never been attacked on this basis. Legal minds say there are some of the other states which have a better law from this standpoint but some of the states claim the law is so technical and it takes such a long time to get the case to the operating table, that it slows them up so very much by court proceedings and the law’s delay, that sometimes it hardly seems worthwhile.¹⁰¹

It was precisely this flexibility granted by a lack of patient protections that made California’s law practicable for the superintendents, and granted them a wider remit within which to operate. The final element enhancing the discretion of superintendents was a gaping chain of mandates that permitted the institutional heads to sterilize, but in no way forced this duty on them. Very dissatisfied with California’s law from this perspective, Harry Laughlin wrote that the law in this sense did not “require” the performance of sterilization, with performance in fact being “optional on the part of the executive

⁹⁹ Hurt, *California State Government*, 104-105.

¹⁰⁰ California Statutes of 1909, Chapter 720, 1093.

¹⁰¹ Fred O. Butler, “Sterilization” (Paper presented before a group on Education at the University of California, Berkeley, September 11, 1941), 2. F3501:139, DMH, SSHP, CSA.

agents.”¹⁰² Given this permissiveness then, as Paul Popenoe would highlight to John R. Haynes in 1929, the amount and nature of sterilization work done in each hospital depended “largely on the attitude of the superintendent.”¹⁰³

Thus, while the central hospital administration noticeably altered the concerns of sterilization policy away from the individual and towards society, and more specifically, its future generations, a lack of oversight both in the administration of the State’s hospitals and the operation of sterilization therein did not compel institutional superintendents to follow suit. This system led not only to the statistically erratic distribution of the procedure in these hospitals, but also to an equally diverse set of institutional practices. To be sure, sterilization requests sent to Sacramento for approval almost always included an attestation to the presence of a mental affliction that was “likely to become transmitted to descendants.”¹⁰⁴ Yet, a look at the expansive beliefs held by superintendents about the potential value of sterilization surgery suggests that in many cases, the formulaic identification of dangerous and disordered heredity in sterilization requests served as an administrative accelerant to securing the imprimatur to operate, rather than as a legitimate concern. This is not to say that eugenic concerns were absent from the minds of California’s superintendents. Indeed, most superintendents professed a belief in the principles of eugenics to differing degrees. Rather, it is to say that eugenic concerns—those over the future of the collective gene pool—constituted but one rationale amongst a cluster of individual, patient-focused justifications which composed the mutable practice of sterilization in Californian hospitals. In these terms, sterilization served as a versatile tool to be used by institutional physicians in the betterment of the physical, psychological and social condition of the patients under their care. These rationales for sterilization found expression to more or lesser degrees in different institutional settings in line with the interests of those who sat at their helm.

Sterilization as Experimental Gerontology

One of the more tangible claims to benefit, aimed exclusively at male patients, centered on the restorative effects associated with the vasectomy. Growing in popularity during the 1920s, this belief originated from the work of the Austrian endocrinologist Eugen Steinach (1861-1944), who, since 1912, had been experimenting with the restorative effects of

102 Laughlin, *Eugenical Sterilization*, 114.

103 Paul Popenoe to John R. Haynes, October 7, 1929. Letter. Box 77, Folder 13, JRHP, UCLA-SCL.

104 This can be seen in the sterilization requests included in Mendocino State Hospital’s case files. Even where no poor heredity existed in the family, this stock phrase would be included in requests sent to the Director of Institutions. For a look at this practice in Stockton State Hospital, see Braslow, *Mental Ills and Bodily Cures*, 57-59.

vasectomy, first in animals, and by 1918, with human subjects. Steinach postulated that by severing the vas deferens, the leydig cells, responsible for the production of sex hormones in the testicles, underwent a hypertrophic response, increasing the generation and release of hormones and, correspondingly, blood flow within the body.¹⁰⁵ Steinach believed that these physiological changes reinvigorated patients, and staved off premature senescence. While Steinach, despite being nominated for a Nobel Prize in 1922, remained wary of overstating the operation's beneficial effects, his followers in California lacked the same reserve.¹⁰⁶ Indeed, not only did Californian superintendents highlight the Steinach operation's ability to improve patients mental and physical conditions, some would also attest to its ability to cure the manifestations of mental illness altogether.¹⁰⁷ Given this value, Steinach's ideas were followed in several institutions across the State. Reporting to the Human Betterment Foundation in October 1926, physicians from Stockton, Sonoma, and Patton State Hospital professed their belief in the remedial nature of sterilization for their male patients, attributing the patients' success to the absorption of "glandular secretions" and "products of the testicle."¹⁰⁸ Another follower of this method was Leonidas Stanley, chief surgeon at San Quentin Prison. Stanley, a disciple of another European endocrinologist, Serge Voronoff (1866-1951), became notorious for his goat gland experiments with San Quentin's prisoners.¹⁰⁹ Stanley, however, was not tied to one master, and much to the chagrin of the Human Betterment Foundation's leadership, concerned over the constitutionality of sterilization in prison, "voluntarily" sterilized six hundred inmates at least partially upon the operation's potential for physical rejuvenation.¹¹⁰

A striking piece of evidence that highlights the extent to which sterilization, underpinned by Steinach's theory, was used as a therapeutic tool can be seen in the report of the Brock Committee in the United Kingdom. This committee, tasked with evaluating the utility of statutory voluntary sterilization in decreasing the prevalence of hereditary

105 See Eugen Steinach, *Verjungung durch experimentelle Neubelebung der alternden Pubertatsdruse* (Berlin: Verlag von Julius Springer, 1920); Eugen Steinach, *Sex and Life: Forty Years of Biological and Medical Experiments* (New York: Viking Press, 1940).

106 Ilia Stambler, "A History of Life-Extensionism in the Twentieth Century" (PhD thesis, Bar Ilan University, 2011), 35.

107 *Second Biennial Report of the Department of Institutions*, 102.

108 "Questionnaire for Emil W. Meyer," Box 11, Folder 12, HBF, CITA; "Questionnaire for Fred P. Clark," Box 11, Folder 12, HBF, CITA; "Questionnaire for Fred O. Butler," Box 11, Folder 12, HBF, CITA.

109 "Strange Gland Magic Makes Young Men from Old," *San Francisco Chronicle*, December 10, 1922, 6F; "Gland Scandal in San Quentin," *Los Angeles Times*, May 14, 1928, 2; "Old Timers Race in Prison," *The New York Times*, November 30, 1923, 2; "Surgeon Works Magic in Secret Experiments in Transplanting of Glands," *San Francisco Chronicle*, December 9, 1922, 13.

110 "Sterilization Requested by 100 at San Quentin," *Los Angeles Times*, September 12, 1935, 1; Fred O. Butler and Leonidas L. Stanley, "Bedside Medicine: Human Sterilization," *California and Western Medicine* 39 (1933): 200-201; Ezra S. Gosney to Elmo R. Smith, October 9, 1941. Letter. Folder 9, Box 6, HBF, CITA.

mental illness, drew heavily on evidence obtained from the practice in foreign states, including California, which it identified as the “protagonist” in America’s sterilization campaign.¹¹¹ While the committee found the operation of California’s sterilization program to be satisfactory, one feature, the continued confinement of patients in institutions subsequent to sterilization, was highlighted as “profoundly unsatisfactory.”¹¹² Showing that forty-seven percent of the male insane, and thirty-four percent of the male feeble-minded patients were retained in custody despite being rendered sterile, the Committee concluded that sterilization cases were not being selected upon their “fitness for community care.” The committee linked this peculiarity to the “experimental operations” being performed in the State hospitals, “in the hope that the patient’s mental condition would be benefited.”¹¹³ Three years earlier, a report from California’s leading eugenic propagandist, Paul Popenoe, shed further light on this custom of postoperative custody. Popenoe wrote that the belief in the Steinach method held by a number of institutional heads had “led to the sterilization of many chronic patients,” particularly those suffering from dementia praecox, “who are still in the hospitals and will undoubtedly be there as long as they live.”¹¹⁴ The sterilization of indefinitely institutionalized patients, who, while sequestered, posed no threat of transmitting their defective genes to society, suggests that superintendents truly believed in the operation’s therapeutic value. At its core, this is where eugenic sterilization differed from therapeutic intervention via sterilization; whereas eugenically motivated sterilization procedures were executed upon their potential to effect a population-wide improvement in society’s genetic stock, therapeutic operations were squarely targeted at improving the physical or mental constitution of the *individual* patient. Whether this be its benefit in improving the symptoms of dementia Praecox (what we today call schizophrenia), as the above example shows, the effects of aging, or “nervousness” in female patients, there was a demonstrable belief among California’s superintendents that this somatic intervention held therapeutic, and for its most ardent proponents, even curative value in addressing some mental and bodily afflictions seen in patients under their care.

Sterilization in Stockton State Hospital

One institution where the Steinach method, and indeed sterilization itself, took hold powerfully was Stockton State Hospital. Along with performing California’s first reported

111 Laurence George Brock, *Report of the Departmental Committee on Sterilisation* (London: H.M.S.O., 1934), 35.

112 Ibid, 36.

113 Ibid.

114 The Human Betterment Foundation, *Collected Papers on Eugenic Sterilization*, 263.

eugenic sterilization, physicians at Stockton would lead the early practice in the State, and by 1916 had performed forty percent of all operations reported in the State hospitals. This early adoption of sterilization at Stockton was due largely to the interest of long-serving superintendent, Fred P. Clark. Writing in 1920, Clark professed belief that “the sterilization of the insane [was] the most important thing that the State [had done] for these people and those that come after us.” With a dark humor, Clark concluded, “(not those who come after our sterilization cases), but the general public.”¹¹⁵ While Clark clearly harbored eugenic inclinations, his experience of sterilization at Stockton made him the most adamant of the superintendents over sterilization’s therapeutic potential.

In an early institutional report in 1916, Clark had noted how male patients at Stockton, unresponsive to any other form of treatment, demonstrated a “marked improvement” both physically and mentally following sterilization. Citing Brown-Sequard’s nineteenth-century experiments with the xenotransplantation of testicular secretions in humans, Clark was clearly aware of the processes at work. Yet, in contrast to positive results produced in Brown-Sequard’s subjects, whom Clark believed were “evidently due to suggestion,” the observable improvement in his own patients following vasectomy increased his belief in the “definite beneficial effect” of these secretions.¹¹⁶ Despite an admitted difficulty in obtaining follow-up reports from discharged patients, subsequent reports show that Clark maintained this belief in the operation’s curative power for over a decade. Clark’s most complete report on the progress of sterilization in Stockton came in 1924, in which he again foregrounded the beneficial effects of the operation, even including three “success” stories of sterilized patients.¹¹⁷ One such case was that of “J.T.,” a manic depressive patient committed to the hospital in 1914. In the three years that followed his internment in Stockton, J.T. was paroled on a number of occasions, only to be returned each time following a recurrence of his mental disturbance. By 1917, in an attempt to break this cycle, Clark had J.T. sterilized. Recovering “in a very short time” following the operation, J.T. was discharged and never returned to Clark’s institution. Around three years later, Clark met with J.T. again, who reported that he had “no further mental trouble” and was “in perfect health.”¹¹⁸ In each of the cases cited in Clark’s report, sterilization was ordered solely on the therapeutic value that it held for the individual. While it would be difficult to divorce eugenic motives from any of the sterilization’s

115 Fred P. Clark to John R. Haynes, July 21, 1920. Letter. Box 77, Folder 13, JRHP, UCLA-SCL.

116 *Tenth Biennial Report of the State Commission in Lunacy*, 52-53; Charles-Edouard Brown-Sequard, “The Effects Produced on Man by Subcutaneous Injections of a Liquid Obtained from the Testicles of Animals,” *The American Medical Journal* 17 (1889): 416-423.

117 *Second Biennial Report of the Department of Institutions*, 100-103.

118 *Ibid.*, 103.

carried out in California's hospitals, the distinct practice of sterilization in Stockton, guided by the therapeutic beliefs of Fred Clark, highlights the dispensable nature of heredity as a rationale in the performance of sterilization. Indeed, it appears from J.T.'s report that the patient's future wellbeing served as the operative concern in the decision to sterilize.

Even this, however, presents perhaps an oversimplified view of the attitudes held by physicians in the State hospitals in California towards sterilization. The institutional variance that characterized the practice of sterilization in California appears to manifest at a sub-institutional level too, and there existed disagreement over the effect of sterilization among Clark's staff. The most apparent example of this departmental dissonance can be seen in the responses of Stockton physicians Fred Conzelmann and S. P. Tuggle's responses to a Human Betterment Foundation survey on the issue. Tuggle, a long-serving assistant physician believed that other than inducing sterility, no mental or physical changes came from sterilization. For Tuggle, sterilization was a wholly eugenic practice. "I firmly believe," his response stated, "that every person who has been insane or committed a felony should be sterilized before being allowed to leave." "I believe in Eugenic sterilization," he concluded.¹¹⁹ Marked by its antithetical view is the response of Stockton's clinical director, Fred Conzelmann. Not only did Conzelmann believe wholeheartedly in the therapeutic qualities of sterilization, he also, in contrast to Tuggle, stated distrust towards eugenics as a rationale for operating. "Eugenics is still a theory," he wrote, "and on that theory according to your letter 5,000 people have been rendered incapable of producing children... it is often said that 'blood will tell,' but men and women cannot be bred like rabbits."¹²⁰ These dissenting opinions suggest that while institutional practices of sterilization may have indeed depended largely on the interests of superintendents, the official reports coming from institutional heads did not necessarily imply a complete coherence of this message in the staffs under their charge.

The possibility of rejuvenation then, given its source within the testicles, was limited to male patients. Despite Steinach's claims that women's fallopian tubes, if ligated or irradiated, exerted similar beneficial physiological process as shown by the testicles, this appeared to Californian superintendents to push his theories too far.¹²¹ While not agreeing on this point, this is not to say, however, that superintendents only believed sterilization's beneficial results applied to males. Indeed, on the contrary, the responses to the Human Betterment Foundation's survey on the matter highlight a belief among the

119 "Questionnaire for S. P. Tuggle," Box 11, Folder 12, HBF, CITA.

120 "Questionnaire for Fred J. Conzelmann," Box 11, Folder 12, HBF, CITA.

121 Stambler, *A History of Life-Extensionism*, 35.

State's superintendents, perhaps more widely held than the advocates of male rejuvenation, that sterilization could benefit disturbed female patients. For these women, this benefit did not arise from any internal, physiological changes, but rather sterilization's ability to alleviate the social and psychological pressures associated with childbirth. Physicians from virtually every institution in the State attested to the beneficial aspects of surgery, noting how the "dread of conception" or the told of "excessive childbearing" exerted a detrimental effect on their female charges, often prompting breakdowns or recurrences of mental trouble that landed them back in the institution.¹²² In 1925, Dr. Edwin Wayte, Superintendent of Norwalk State Hospital, noted this pattern in his institution in a letter the Human Betterment Foundation's Director:

Many women during the childbearing period vibrate back and forth between an institution and their homes. They are suffering from a mental trouble and apparently become cured at the hospital, then return to their homes and become pregnant. This assures another breakdown. If these Women were always operated upon before returning to their homes, we find it would assure them a longer remission and in many cases it has been found they remain at home apparently recovered.¹²³

Sterilization for women, then, acted not only as a prophylactic against further troubles, but also, by removing the worry of future pregnancies, aided in the patient's recovery while in hospital. Dr Wayte's assistant, who saw sterilization as "aid to recovery and also a permanent help to maintain health", reiterated this view.¹²⁴ Even Leonard Stocking, superintendent at Agnews State Hospital, who showed a reluctance to sterilize generally, and admitted that "very little medical value" could be seen in the operation, nonetheless supported the "enforced suspension of reproduction" for its beneficial effects "both physically and mentally" in women who experienced rapid repeated pregnancies.¹²⁵ Sterilization, and indeed the idea of "therapy," was versatile. It is clear that physicians operated on female patients for the greater mental stability it was purported to provide. These were, once again, individually targeted interventions aimed at improving the wellbeing of the patient, rather than society's genetic make-up. The most systematic implementation of this rationale for sterilization, however, appears at the Sonoma State Home, where, alongside obvious eugenic motives, the operation served as part of a broader system of care designed to buttress both the mental and social stability of patients released from the institution.

Sterilization at the Sonoma State Home

The Sonoma State Home looms large in California's history of forced sterilization. Nestled

¹²² "Questionnaire for A. E. Kiser," Box 11, Folder 12, HBF, CITA.

¹²³ Edwin Wayte to E.S. Gosney, September 21, 1925. Letter. Box 11, Folder 12, HBF, CITA.

¹²⁴ Questionnaire for Mary V. Church," Box 11, Folder 12, HBF, CITA.

¹²⁵ Questionnaire for Leonard Stocking," Box 11, Folder 12, HBF, CITA.

in the picturesque hills of Eldridge, California, the institution began life as a private enterprise, before being taken over the State in 1891 to provide for the custody and “limited rehabilitation” the State’s feeble-minded patients.¹²⁶ Although starting operations later than several others, more patients were sterilized at this institution than any other under the State’s eugenic sterilization law, accounting for approximately thirty per cent of all the operations performed.¹²⁷ The prolific practice of sterilization at Sonoma undoubtedly arose from the convictions of its medical superintendent, Fred Otis Butler, who guided institutional policy and practice for over thirty years. Butler initially arrived at the institution as an intern in 1913, but was quickly promoted to the position of assistant superintendent just one year later. Butler’s role in the use of sterilization in the institution was significant. Prior to his appointment as Superintendent in 1918, following the death of Doctor William Dawson, only twelve operations had been performed in the facility, and following his retirement in 1949, his replacement M.E. Porter added a further 191 operations to the total.¹²⁸ In the intervening decades, Butler, who has been described by Hansen and King as “the most productive sterilizer in the democratic world,” oversaw the sterilization of 5,520 patients in the institution, one thousand of which he would perform himself.¹²⁹ So extensive was the practice of sterilization at the hospital that it became a virtual personal laboratory for Paul Popenoe where much of his data used for papers extolling the virtues of sterilization in California originated from. This institution attracted international visitors too, including the secretary of the British Eugenics Society, C.B.S. Hodson.¹³⁰ Butler was undoubtedly the most pro-sterilization of all the superintendents in the State hospital system, who, upon his retirement, joined the *Human Betterment Association of America*, later the *Association for Voluntary Sterilization*, as its medical director, where he provided support for the practice of sterilization across the country.¹³¹

Given Butler’s perennial embrace of sterilization that transcended his career at Sonoma, it is perhaps unsurprising that the “heartly, wise old doctor,” as he was affectionately labelled by the *Sonoma Tribune*, held an expansive view on the operation’s utility.¹³² Indeed, contained within the uncompromising Superintendent’s vast collection of

126 “History of the Sonoma State Hospital,” *Sonoma Index Tribune*, November 22, 1966, 10.

127 Matoq, *California’s Sterilization Policies*, 98.

128 “Table of Sterilization Performed at the Sonoma State Home During the Years 1910-1935,” Box 11, Folder 12, HBF, CITA; “Minds in Custody III: Sterilization of Mental Patients? Some Doctors Say Yes, Some No,” *Santa Rosa Press*, October 15, 1961, 1.

129 Hansen and Desmond King, *Sterilized by the State*, 174.

130 Hodson, *Human Sterilization Today*, 22-25; Earl E. Jensen, *California State Department of Institutions Report to the Governor’s Council*, December 29, 1930 (Sacramento: Government Printing Office, 1930).

131 Dowbiggin, *The Sterilization Movement*, 78.

132 “History of the Sonoma State Hospital,” 17.

scientific papers is a wide array of justifications for sterilization, based upon economic, therapeutic, institutional (i.e. overcrowding) and, of course, eugenic grounds. This latter concern, focused on California's "unsound hereditary qualities," concerned Butler greatly, and he would become the chief liaison between the State hospitals and California's various eugenic organizations.¹³³ This concern can be seen in one of his many attempts to "sell" the practice of sterilization in which, using classic alarmist eugenic rhetoric, Butler implored a solution to the unchecked reproduction of the State's mental defectives:

It is the opinion of most authorities that heredity is an important causative factor in mental deficiency. This we have found confirmed in our own institution, where we have whole families, including parents, children and grandparents. In the face of such evidence are we to withhold sterilization? We, who have had any farming experience, know that you cannot get good crops from poor or uncertain seed. The same obtains in human relations. If we expect normal or average children we need normal instead of subnormal parents.¹³⁴

Butler estimated that anywhere from fifty to seventy-five per cent of the patients at Sonoma were the product of and held the potential to transmit further this hereditary taint. The remaining minority, called "secondary cases," Butler attributed their conditions to accidents or childhood illnesses that "retarded mental development."¹³⁵ Yet, while the protection of the gene pool provided an important impetus to the practice of sterilization at Sonoma, the superintendent's papers also explicitly make clear that reasons other than eugenics guided his decision to sterilize. Hereditary concerns aside, Butler believed that his feeble-minded patients were constitutionally incapable of effectively raising children, and to do so would only invite "untold trouble and unhappiness" for all. In this regard, Butler believed sterilization served as an important tool for the individual patient, easing their path to "normal" lives outside of the institution, and preventing them from having children they would be unable to care for.¹³⁶

A policy of training and parole remained central from the outset of Butler's career at Sonoma. His pursuit of this policy was perhaps unsurprising given an institutional waiting list that rarely dipped under a thousand, and perennial overcrowding, which was heightened during the depression years. Yet, Butler viewed parole as more than a tool to remedy institutional congestion. Indeed, he believed extramural care served an important role in the happiness and wellbeing of Sonoma's patients—a view he held before taking

133 F.O. Butler, "Sterilization" (Paper presented at the State Medical Society, Riverside, California, April 1934), 2.

134 F.O. Butler, "Opening Discussion of a paper on sterilization by Dr. Bronson Price, Department of Psychology, Ohio State university, and Mr. Sidney S. Halperin, Research Department, State Institution for the Feeble-minded, Columbus, Ohio." F3501:139, DMH, SSHP, CSA.

135 F.O. Butler, "Broadcast on KSRO, Santa Rosa, by Adele Gluck and Self," F3501:139, DMH, SSHP,, CSA.

136 F.O. Butler, "A Review of Twenty-Five Years in the American Association on Mental Deficiency," (Paper Presented at the Pacific States Regional Meeting of the American Association on Mental Deficiency, Eldridge, California, January 31, 1949).

charge of the institution:

During my surgery, I recommended to the superintendent that we start sterilization because I thought it was so important for the training of these individuals and getting them out of the institution. My philosophy that not patient of any kind belongs in a State institution if they can be cared for properly and educated at home or in the community [sic].¹³⁷

In line with this philosophy, Butler instituted a comprehensive system of training for Sonoma's patients aimed at stabilizing them before re-entering society under close supervision. Alongside academic and vocational training, and a degree of "persuasive discipline," the institution made sure that parolees were placed in jobs, had their financial affairs managed, and reported monthly to their assigned social workers, all in the attempt to "bring order out of disorder."¹³⁸ Butler boasted of the institutions success in this endeavor, claiming a "very high" successful discharge rate of seventy-five per cent of those on parole. For Butler, sterilization formed a central part in this stabilizing system. "Chiefly, he wrote, "[sterilization] would give them the opportunity to have a normal life, extramurally without the burden of children."¹³⁹ Indeed, Butler viewed the increased economic and social burden of raising children, for which his patients were "unfitted" to meet, as destroying the delicate order upon which successful reintegration rested. Especially given Butler's observation that the mentally deficient often raised families twice or three times the size of "normal" individuals, this stabilizing tool was seen as all the more necessary.¹⁴⁰

Sterilization's "stabilizing" quality was discussed particularly in connection with the institution's novel policy of permitting patients to marry. Approximately three hundred patients were given Butler's blessing to marry, either one another, or partners outside the institution, following a rigorous screening process by Sonoma's "flourishing matrimonial bureau."¹⁴¹ Butler believed that marriage "assisted materially" in stabilizing patients on parole, and that those who were wed, "as a rule," fared better outside the institution than single patients.¹⁴² The marriage program was held up as one of Sonoma's greatest successes, and Butler lauded the longevity of unions formed at the institution, declaring them to be on the whole one hundred per cent more successful than the average marriage formed outside the institution. "We find many of them," wrote Butler, "have their own

137 F.O. Butler Interviewed by Margot W. Smith, *Rough Transcript of Interview on Mental Health and Mental Retardation*, 1970. Berkeley: Regional Oral History Office, Bancroft Library, 3.

138 F.O. Butler, "Care and Training of the Feebleminded," (Paper presented at the California Conference of Social Workers, San Francisco, May, 1927), 5; Butler Interview, 8-9.

139 F.O. Butler, "Broadcast on KSRO," 5; Butler Interview, 3.

140 F.O. Butler, "The Present Status of Sexual Sterilization, its Technique, its Advantages and Disadvantages, and its Relation to Mental Deficiency" F3501:139, DMH, SSHP, CSA.

141 Robert C. Elliot, "20,000 Minds in Retreat," *The San Francisco News*, March 20, 1936, 24.

142 F.O. Butler, "Utility of Sterilization for the Mentally Deficient," 2. F3501:139, DMH, SSHP, CSA.

homes and that they conduct and fit into communities far better than many of our so-called normal people.” Butler was certain that these results could not obtain without first sterilizing patients—a necessary precondition of marriage at Sonoma. Indeed, according to Butler, many patients ended up in the institution following the dissolution of marriages, “on account of their inability to care for children.”¹⁴³ Sterilization, then, removed the threat of children, which the superintendent believed to be an unsettling burden, and also stabilized the union, which in turn exerted a similar effect on the parolee. Advocating this program, Butler wrote: “If you could visit some of their homes and see how happy and contented they are, I believe you would all agree that it is a step in the right direction.”¹⁴⁴ To be sure, making sterilization a precondition of marriage was not devoid of eugenic concerns, for Butler believed that permitting patients to wed, while still fertile, would be “against all eugenic practices.” However, Butler’s avowed concern over the capacity for his patients to care for children, regardless of the hereditary nature of their affliction, suggest that eugenics may have not formed the primary motivation in this policy.¹⁴⁵

Indeed, Butler appeared to couch his justification for operating more in what Hansen and King have characterized as the “language of parental responsibility,” than he did eugenics.¹⁴⁶ For Butler, the feeble-minded patients under his care were not necessarily “unfit” to bear children on account of their hereditary endowment, but rather on their fundamental incapacity to effectively raise a family. This belief can be seen in the superintendent’s decision to sterilize the institution’s “secondary” cases alongside the hereditarily disordered:

The public probably realizes the importance that heredity plays with the mentally deficient – in fact, some authorities say as high as eighty per cent...However, I personally feel that specially [sic] the mentally deficient, whether hereditary or secondary, should be sterilized because while the secondary cases might have some normal children yet they are no more able to care for them than the hereditary type.¹⁴⁷

In 1941, Butler reiterated his commitment to sterilizing both the “familial as well as the secondary type,” despite the fact that the latter class were likely to bear normal children, in a presentation before at the University of California, Berkeley. Butler reported that this conviction arose when a “normal” child broke down in horror upon visiting her defective mother at his institution.¹⁴⁸ This “tragedy” convinced Butler that “unless a child can be

143 F.O. Butler, “Marriages Among the Mentally Retarded,” 2-3. F3501:139, DMH, SSHP, CSA.

144 F.O. Butler, “The Success of Marriage With Those Paroled and Discharged from the Sonoma State Home,” (Paper presented at the Superintendents’ Conference, Patton, California, March, 1929), 4. F3501:139, DMH, SSHP, CSA.

145 Butler, “The Success of Marriage,” 1.

146 Hansen and King, *Sterilized by the State*, 174.

147 F.O. Butler, “Sterilization Law as it Operates in California,” (Paper presented at the Pacific Railway Surgeons’ Meeting, Los Angeles, California, October 7, 1938), 6. F3501:139, DMH, SSHP, CSA.

148 Fred O. Butler, “Sterilization,” 1.

born to a normal parent, it is better that he not be born at all.”¹⁴⁹ The superintendent’s policy of sterilizing Sonoma’s “secondary” cases—one he would hold as late as 1970—who posed no threat to the nation’s genetic stock, suggests that Butler’s concern for the protection of the “defective,” and any potential child they may have borne, may have served as a genuine concern in his decision to sterilize. Even for Butler, then, who presided over the most prolific sterilization regime in the California State hospital system, the principles of eugenics, codified in State policy, appear to have been dispensable in the practice of sterilization at Sonoma.

Observations of the Practice of Sterilization in Californian Institutions

The “flexible” nature of California’s law, highlighted in Butler’s presentation at Berkeley in 1941, permitted the unique institutional practices of sterilization at Sonoma and other institutions to flourish across the State. Operating with minimal administrative oversight and complete judicial immunity, superintendents were given a free hand to institute institutional policies of sterilization that were shaped by their own medical interests, institutional concerns, and conceptions of who they considered “fit” to bear the responsibility of children. The case studies of sterilization at Stockton and Sonoma, each of which were governed by powerful superintendents whose careers spanned over three decades, are demonstrative of both the virtual omnipotence and divergent understandings of sterilization held by these institutional heads. While Fred Clark’s institutional reports focused on the mental and physical therapeutic effects derived from patients’ physiological response to sterilization, for Fred Butler, they appeared to revolve more around sociocultural concerns over the individual’s right and ability to bear children. What remains fundamentally important to note in both cases is that individual, not collective, concerns steered these superintendents to sterilize, and that identification of poor heredity was not a necessary factor for either man in undertaking this duty. It is also important to note, however, that while omnipotent in setting institutional policy, the understanding of sterilization held by superintendents did not necessarily indicate a similarly unified belief among the medical staff under their control.

The permissiveness shown towards superintendents by California’s sterilization policy, allowing these individuals to select who and how many patients to sterilize, coupled with a legal shield that guaranteed their right to do so, was undoubtedly the main factor in the monumental uptake of the practice in California in the first three decades of the twentieth century. This institutional discretion, however, granted towards the hospital

149 Elliot, “20,000 Minds in Retreat,” 23.

administrators—a feature which made the Asexualization Act so “practicable” —may have ultimately undermined the original letter of the law. As the foregoing has demonstrated, the eugenic rationale for sterilization—the central concern of California's sterilization policy—was often cast aside in favor of alternative rationales chosen by the individual superintendent.

However, while strong and stable for much of its existence, the Asexualization Act was not completely impervious to the changing climate around sterilization around the mid-point of the twentieth century, and by 1942, an appreciable decline in the annual total of operations being performed can be seen. From this point on, the number of patients being sterilized in California's hospitals would never reach the high levels of the 1930s. By 1952, the practice would be all but dead. While the revelations of the mass extermination of Jews in Europe exerted a profound effect on the public and legislators alike, this along cannot account for the gradual dismantling of eugenic sterilization in California. Instead, it appears that a combination of institutional and philosophical changes in the approach to the treatment of patients may have acted as the impetus for the decline of sterilization. As we shall see, however, the story of the decline of sterilization in Californian state hospitals was more complex than has been appreciated.¹⁵⁰

The Decline of Involuntary Sterilization in State Hospitals

On April 5th, 1938, Andrea Garcia, an eighteen-year-old Mexican-American girl was declared a ward of the Juvenile Court of Los Angeles County, thus setting in motion the only legal challenge to California's eugenic sterilization law. Andrea was the youngest of nine children, all of whom were raised by their mother, Sara, following the death of their father. While the reasons for Andrea's initial committal remain unclear, on 11th December, 1939, Judge W. Turney Fox of the Superior Court of Los Angeles County declared Andrea to be feeble-minded and had her committed to the Pacific Colony, the Sonoma State Home's sister institution in the south of the State. By doing so, Andrea's ability to reproduce now fell under the authority of the Asexualization Act. Yet, five days later, in an extraordinary move, Andrea's mother filed a writ of prohibition to prevent what she believed was an attempt to sterilize her daughter. In a move to protect the Department of Institutions, Emmet Wilson, presiding judge of the superior court, blocked Sara's application. Undeterred however, and with the assistance of David C. Marcus, an attorney attached to the Mexican consulate, Sara filed another writ of prohibition with the district court of appeals. In it, Marcus argued that “each and every provision” of the

¹⁵⁰ Fred O. Butler, “Sterilization,” 2.

Asexualization Act was unconstitutional and void, attacking it for its violation of the fourteenth amendment. Marcus believed that the State, in contravention of federal laws, was denying Andrea her constitutional right to “life, liberty, or property” without the equal protection or due process of law. This latter point, in particular, was stressed, with Marcus noting that the law rested solely on “the discretion vested in the non-judicial body of persons contemplating said sterilization operation,” and that Andrea “will have no remedy or method of redress” to the “evil sought” by this board.¹⁵¹

Despite Marcus highlighting the inadequacies of the sterilization law, long recognized by its proponents, the court, in a two to one decision, upheld Andrea Garcia’s commitment to the Pacific Colony, and by extension, her sterilization. The dissenting opinion of Judge J. White, however, was scathing of the inadequacies brought to light by Marcus, and is worth quoting at length:

It seems to me that the legislature is without authority to authorize a purely administrative board to deprive a person of the right of procreation without the opportunity of having the finality of such action passed upon by a court of law, and that in doing so there is probable violation of the due process clause of the federal Constitution. It is to be noted that without notice to the inmate upon whom the operation is to be performed and without notice to his next of kin the State department of Institutions is clothed with *absolute unrestricted power to sterilize*. In my opinion, the grant of such power should be accompanied by requirements of notice and of hearing at which the inmate might be afforded an opportunity to defend against the proposed operation. To close legislative agencies with this plenary power, without as it does any opportunity for a hearing or any opportunity for recourse to the courts, to my mind partakes of the essence of slavery and outrages constitution guaranties.¹⁵²

Judge White believed that Andrea’s constitutional rights had been invaded, with them being placed “at the mercy of administrative officials,” and in contravention to “the security inherent in our judicial safeguards.” Despite White’s strongly worded opinion, records indicate that Andrea was sterilized at the Pacific Colony in 1941.¹⁵³

Judge White’s opinion fired a shot across the bow of State sterilization policy, and laid bare the legal inadequacies that would eventually contribute to sterilization’s rapid decline in the early-1950s. At the time of the decision, however, when the practice of sterilization had reached its zenith, the dissension failed to shake the resistant edifice of the Asexualization Act. Yet, within five years of the Garcia decision, the annual rate of sterilizations performed in the State hospitals fell by approximately fifty per cent, amounting to an average of 400 operations per year in the mid-1940s.¹⁵⁴ This decline would continue until operations virtually ceased with a legal overhaul in 1951. Given the immovability of the State in the Garcia decision, however, it remains important to note the

151 Brief for Sara Rosas Garcia vs. State Department of Institutions, Civ. 12533 (1939), 1-8. Microfiche, Los Angeles Law Library.

152 *Garcia vs. State Department of Institutions*, 36 Cal. App.2d (1939), 153-154.

153 Lira, “Of Low Grade Mexican Parentage,” 129.

154 Matoq, *California’s Sterilization Policies*, 98.

intellectual and structural changes that surrounded the treatment of the mentally ill and feeble-minded in California before successful legislative opposition to the policy could be achieved.

The reasons for the slow decline in the number of operations performed in the 1940s are unclear, yet, testimony from former members of the Department of Institutions, rebranded once again in 1943 as the *Department of Mental Hygiene* (DMH), offers possible insights into the factors which prompted this tailing off.

The most commonly cited factor in this trend has been the evaporation of support for mainline eugenics and the hereditary thought that underpinned the science. By the 1930s, the hereditarian arguments that had propped up advocacy of eugenic and its legislative solutions developed significant resistance in the scientific community.¹⁵⁵ Representative of this criticism was the 1936 report by the American Neurological Association's *Committee for the Investigation of Eugenical Sterilization*. The committee, while not against sterilization, seriously disputed the overemphasis placed on heredity in justifying the sterilization of the insane, feeble-minded, and other "socially undesirable" classes, and foregrounded the relative ignorance, not only of "over-dogmatic" eugenicists, but the scientific community as a whole surrounding the transmission of most hereditary characters in man.¹⁵⁶ Indeed, an article written by Frank Thone for the *Oakland Tribune* highlights the extent to which, by 1940, eugenics had become almost a point of ridicule. Interviewing Doctor Knight Dunlap, Chair of the UCLA Department of Psychology, Thone humorously attacked the "heredity ghosts" evoked by the eugenics movement. Quoting Dunlap heavily, who declared the entire science of eugenics as "bunk," Thone pointed out that:

Nothing is really known about human heredity, except that certain traits such as red hair, haemophilia, and Presbyterianism 'run in families.' That for most traits, we do not know how they 'run'; the traits for which the principles of inheritance are known, even vaguely, being very few. And that hasty inference from traits of fruit flies and potatoes to human traits has not been useful.¹⁵⁷

Eugenics and the simple hereditary explanations that once made its principles so appealing were clearly on the retreat. Correspondingly, when these simplistic, organic understandings of mental illness began to subside in the scientific community, new psychotherapeutic methods for explaining the complexities of human behavior began to take hold across the country. Though it would take until after World War II for these

155 Kevles, *In the Name of Eugenics*, 251-268; Dowbiggin, *The Sterilization Movement*, 28-29; Matthew Connelly, *Fatal Misconception: the Struggle to Control World Population* (Cambridge: Harvard University Press, 2008), 55.

156 The Committee of the American Neurological Association for the Investigation of Eugenical Sterilization, *Eugenical Sterilization: A Reorientation of the Problem* (New York: The Macmillan Company, 1936), 60.

157 Frank Thone, "Puts Kibosh on Hereditary Ghosts," *Oakland Tribune*, May 12, 1940, 82.

understandings to dominate the American Psychiatric Association, there was, nevertheless, a growing movement in the 1930s for what Ian Dowbiggin has termed the “more benign forms of preventative psychiatry.” “Psychiatrists,” Dowbiggin claims, “were feeling more and more optimistic.”¹⁵⁸ When discussing this broad shift away from the alarmist eugenic point of view of mental illness, one cannot ignore the impact that the revelations of the Holocaust in Europe exerted on this paradigm shift, which, according to Daniel Kevles, “all but buried the eugenic ideal.”¹⁵⁹ While these factors have been linked to the nationwide retreat of sterilization laws by the late-1940s, to what extent did they affect the practice in California?

While not enough to unseat sterilization in California, it does appear that these intellectual forces were present in the DMH. Speaking retrospectively, Fred Butler and George Tarjan, superintendents in the State’s two hospitals for the mentally deficient, both noted the erosion of belief in the hereditary basis that underpinned the practice of sterilization in the State hospitals. Asked about this changing philosophy, Butler replied, “Oh, it changed materially.”¹⁶⁰ The chief opposition, Butler identified, came from the new professional classes that began to populate the ranks of the Department in the mid- to late-1940s, most notably from social workers in the new Department’s Bureau of Social Work, and psychologists who began to become a common feature in the department at the end of the decade.¹⁶¹ Speaking specifically in reference to the knowledge of heredity, Butler reported that these newcomers “thought that we didn’t have enough information as a basis for sterilization.”¹⁶² Similarly, Tarjan identifies the limitations of hereditary knowledge in the period as one of the factors that attracted criticism of the law. Tarjan reported that while advances in genetics had proven that *some* types of “mental retardation” were genetically transmissible, “most of the retardation for which sterilization was recommended, namely socio-cultural mental retardation, was not clearly genetically transmitted. As a result, a growing emphasis on environmental factors was recognized in the production of what Tarjan labelled “psychosocial mental retardation.” For Tarjan, sterilization was too simple and singular of an approach to solve the “complex phenomenon” of mental retardation. Interestingly, Tarjan also notes that the conspicuous use of sterilization for social reasons, i.e. a patient’s ability to parent, in the absence of a

158 Dowbiggin, *Keeping America Sane*, 111.

159 Kevles, *In the Name of Eugenics*, 251.

160 Butler Interview, 14.

161 Nathan Sloate Interviewed by Alden B. Mills and Michael T. Savino, *Mental Health in California, 1939-1967*. Berkeley: Regional Oral History Office, Bancroft Library, 54-55. For the role of psychologists, see Dr. Trent Bessent Interviewed by Alden B. Mills, *Psychologists in Department of Mental Hygiene Hospitals, 1949-1967*. Berkeley: Regional Oral History Office, Bancroft Library.

162 Butler Interview, 14.

“clearly genetically transmissible condition,” was increasingly viewed as an “outmoded” feature of the sterilization law.¹⁶³

This change in philosophy noted by both Butler and Tarjan manifested at a Departmental level too. Around 1940, the Department drifted from a policy of custody, to what Alden Mills describes as a “new philosophy that had more hope in it.” During this period, the DMH grew in both size and quality, and began to develop a system of dynamic care that placed a greater emphasis on social work, recreation and occupational therapy, and extramural care for patients.¹⁶⁴ Speaking on this transition, Nathan Sloate, who served as Chief of Social Service during this period, noted a corresponding positive outlook in the prognosis for the State’s mentally ill population. “Our knowledge about what to do with patients increased,” said Sloate, “we felt more confident about what could be done.” Coupled with growing numbers of psychiatrists entering the State hospitals, and a general “upgrading” of staff, these changes signaled a philosophical shift in the Department from “hopelessness to optimism.”¹⁶⁵ The specific manifestations of this evolving philosophy can be seen at a meeting of the Mental Hygiene Committee in September 1944. Headed by Dora Shaw Heffner, Director of the Department of Mental Hygiene, the assembled members sought to address the “cultural lag” in respect to California’s treatment of the mentally ill, especially in relation to the “responsibility of a state jurisdiction.”¹⁶⁶ Present at the meeting was Walter Treadway, formerly of the United States Public Health Service, and advisor to the DMH, who specifically raised the “problem of human sterilization” in the State. While, reminiscent of the 1936 ANA report on eugenic sterilization, Treadway advocated the use of selected sterilization based on its “individual application to the individual patient,” he did caution against the “wholesale application” of the procedure in the State hospitals. According to Treadway, the revelations coming from Nazi Germany had demonstrated to him how a piece of legislation may be “tremendously abused,” when “enacted for the solution of problem.”¹⁶⁷

Treadway’s statements are telling. While sterilization’s fate was by no means sealed, and administrators still saw utility in the procedure, the wide-scale practice, based on the biological “unfitness” of the mentally ill was clearly receding by the 1940s. Yet, just as eugenics alone did not justify the practice of sterilization in California’s hospitals, nor could its nationwide repudiation alone account for the decline of sterilization in the

163 Tarjan Interview, 227-230.

164 Sloate Interview, 56. For changes post-World War II, see Braslow, *Mental Ills and Bodily Cures*, 128.

165 Ibid, 59.

166 “Mental Hygiene Committee Meeting, Sacramento, California, September 8, 1944,” 2-3. F3640:2398. EWP, DOI, CSA.

167 Ibid, 13.

State. Indeed, alongside the growing ethical concerns around sterilization predicated upon eugenic reasoning, there was a waning belief in the operation's therapeutic power. From 1935 onwards, in the face of growing professional ridicule, a lack of verifiable evidence, and developments in the chemical isolation of artificial androgens, the work of Steinach and other "rejuvenists," who had provided a powerful "therapeutic" basis for sterilization in California's State hospitals, had lost much of its legitimacy and vogue.¹⁶⁸ The science that had once seemed cutting edge and promised much hope for aging, senile patients had become increasingly viewed as faulty and anachronistic. Joel Braslow has argued that more so than changing philosophies or developments in genetics, it was the undermining of sterilization's therapeutic properties that ultimately served as the practice's "fatal flaw." Indeed, according to Braslow, "a 'therapy' based solely on the prevention of parenthood had little to recommend it when compared to a burgeoning number of somatic interventions[...]and psychological treatments."¹⁶⁹ At a time when support for sterilization was already beginning to ebb, a series of new and more efficacious therapies entered the department. Indeed, when the controversial Polish-born psychiatrist Jakob Frostig (1896-1959) joined the Department in the 1939, insulin shock therapy enjoyed a powerful yet short-lived vogue. So popular was the treatment, which had shown "very favorable results," that the 1939 Department of Institutions Statistical Report included a thirteen-page feature on the practice.¹⁷⁰ By 1942, insulin therapy had been replaced by the more popular electroshock therapy, the results of which proved to be "very dramatic and important," and gave physicians in the department "a lot of hope."¹⁷¹ Lobotomy, too, became practiced in several of the State hospitals by 1947.¹⁷² As physicians' eyes increasingly turned towards these more potent remedies, sterilization increasingly fell by the wayside.

While sterilization's days seemed numbered, and with support receding on all fronts, the DMH remained either hesitant or unwilling to take definite action on the policy. This despite the escalating modernizing impulse in the Department under Governor Earl Warren, who famously vowed to take California "out of the asylum age and put it into the

168 Michael A. Kozminski and David A. Bloom, "A Brief History of Rejuvenation Operations," *The Journal of Urology* 187 (2012): 1134; "Steinach at Eighty," *the New York Times*, January 27, 1941, 14.

169 Braslow, *Mental Ills and Bodily Cures*, 68.

170 "Technique of Insulin Shock Therapy," by Jacob P. Frostig in Statistical Report of the Department of Institutions of the State of California for the Year Ending June 30, 1939 (Sacramento: California State Printing Office, 1939), 6-19; Sloate Interview, 31.

171 Portia Bell Hume Interviewed by Alden B. Mills, *Twenty-Five Years in California Psychiatry*. Berkeley: Regional Oral History Office, Bancroft Library, 13-14.

172 Statistical Report of the Department of Mental Hygiene for the Year Ending June 30, 1948 (Sacramento: California State Printing Office, 1948), 107; Also see Braslow, *Mental Ills and Bodily Cures*, 125-151.

hospital age.”¹⁷³ In many ways, Warren’s reforms continued programs already in motion aimed at shortening hospital stays, developing alternatives to hospitalization in the first place, and increasing community understanding towards the mentally ill. Where Warren differed, in attempting to affect change, and with the help of his new head in the DMH, Frank Tallman, was to increase the central power over the State hospitals, attacking the “parochial and isolated attitude” of the superintendents.¹⁷⁴ According to Tallman, Warren felt that the superintendents “needed encouragement in realizing the helpful importance of a central governing body.” Those who didn’t either retired, as Fred Butler would in 1949, joining Birthright Inc. shortly thereafter, or were “encouraged” to seek employment elsewhere.¹⁷⁵ Yet, despite a modernizing impulse that stood opposed to the antiquated practice of sterilization, and a further erosion of the power traditionally granted to superintendents, precisely where the procedure stood in Warren and Tallman’s enlightened overhaul of the mental health system appears problematic. While historians have credited the Warren-Tallman regime with dismantling the sterilization program, sources suggest that perhaps more than being hesitant to act, the DMH actively resisted attempts to halt sterilization when they arose.¹⁷⁶ Sterilization, it seems, would not disappear without pressure, and the DMH needed an impetus to act before this change would come.

The impulse for change came primarily from a freshman legislator in the assembly, Richard J. Dolwig (1908-1992). The legislator did not shy away from controversy, and Dolwig perhaps remains better known for his real estate fraud conviction in 1975, or his proposal to divide California into two separate states, than he does for the issue of sterilization.¹⁷⁷ Dolwig, however, held a deep and enduring interest in the field of mental health, especially in regard to the rights of the mentally ill in the State hospital system. In the face of perennial government disinterest in the field of mental health, which legislators viewed as an overextension of power, Dolwig used funds from his own district of San Mateo County to establish a mental health commission in order to address the abuses and shortcomings he identified in the State’s treatment of the insane. Dolwig and the Committee created a “bill of rights for the insane,” the proposals of which would later form an integral component of the Short-Doyle Act in 1957.¹⁷⁸ Speaking in 1986, Dolwig

173 Ed Cray, *Chief Justice: A Biography of Earl Warren* (New York: Simon & Schuster, 1997), 144.

174 Frank F. Tallman Interviewed by Gabrielle Morris, *Dynamics of Change in State Mental Institutions*. Berkeley: Regional Oral History Office, Bancroft Library, 19.

175 Ibid, 20.

176 For an example of this point of view, see Alexandra Minna Stern, “From Legislation to Lived Experience”, 102; Wellerstein, “States of Eugenics,” 51.

177 Seymour Korman, “Bid to Split California is Nipped in the Bud,” *Chicago Tribune*, June 21, 1965, 11; Bernard Hurwitz, “Ex-Senator, 5 Others Get Fines, Prison in Fraud Case,” *Independent Press-Telegram*, October 11, 1975, 4.

178 Richard J. Dolwig Interviewed by Carole Hicke. Sacramento: CSA Oral History Program, 1987, 31.

said: “I took them [the legislators] into the mentally ill field. That had been shoved under the rug.”¹⁷⁹ Nowhere was this truer than in the issue of sterilization, which the conservative Dolwig, crusading for reform, brought before the legislature in 1947. Along with five co-sponsors, Dolwig submitted AB2002: *An Act to Amend Section 6624 of the Welfare and Institutions Code, Relating to Sexual Sterilization*. The Dolwig bill, while leaving unchanged the conditions for which a patient could be sterilized, stipulated that in each case, the DMH obtain a supreme court order proving that a patient’s condition was hereditarily transmissible prior to performing the operation.¹⁸⁰ The bill attacked the long-held discretion afforded to both the hospital superintendent and the head of central agency in these decisions. Furthermore, given a growing legal reticence to the practice, and the difficulty involved in proving the hereditary nature of many conditions, Dolwig’s bill would have all but stopped sterilization. However, in the face of enduring legislative resistance, especially in the state senate, AB 2002, and an identical bill submitted the following year, failed to pass.¹⁸¹

Undeterred, Dolwig began drafting a follow-up bill in early 1950, which he submitted to the Assembly in January 1951. While still requiring a court order in every case, this bill differed in that it loosened the requirement that the court prove the patient’s illness was hereditary, if the sterilization was “medically beneficial to such person.” While still stringent in its requirements, the bill proved more popular than earlier attempts and quickly passed the Assembly.¹⁸² However, in the Senate welfare committee, the bill was blocked at the request of Lawrence Kolb, Deputy Medical Director of the DMH. At the hearing, Kolb implored the Senators to reject the bill, telling them that its passage “would stop our whole program.”¹⁸³ The retired Butler was present too, and followed Kolb’s lead in convincing the senators to reject the proposed legislation. Clearly upset by the Department’s attempts to block the new safeguards, Dolwig asked the assembled Senators: “are we going to go ahead and protect the fundamental right of individuals or are we going to keep a law for the convenience of the mental hospitals?”¹⁸⁴ Clearly then, as had been demonstrated in the Garcia case years prior, the main criticism of the law centered on its lack of constitutional safeguards for the rights of the individual. Upon this rationale, a

179 Ibid, 12.

180 California Legislature. Assembly. *An Act to amend Section 6624 of the Welfare and Institutions Code, relating to sexual sterilization* (AB2002), February 3, 1947. OBF, CSA.

181 Dolwig Interview, 41; For information on 1948 bill see F.O. Butler, “Summary Report of Eight Months’ Work,” 3. Box 4, Folder 32, AVS, UMSWHA.

182 California Legislature. Assembly. *An Act to amend Section 6624 of the Welfare and Institutions Code, Relating to Sexual Sterilization* (AB2505), January 22, 1951. OBF, CSA.

183 “Senate Bans Bill on Sterilization,” *The San Mateo Times*, June 28, 1949 4.

184 “Non-Sterilizing Bill Refused, Legislation Would Stop State Program,” *San Bernadino County Sun*, June 28, 1949, 2.

concerted legislative attempt to block sterilization, something the department had feared since the program began, was now before them. A memorandum from a meeting held between Kolb, Butler, and Edward Nichols, a DMH lawyer, indicates that they were feeling pressure to act even before Dolwig's latest bill passed the Assembly. "There have been attempts made in the last two sessions to amend the law," the memo intended for Tallman indicated, "and each time our department has been successful in resisting the proposals because they were of such a nature as to have practically stopped sterilization in our State hospitals."¹⁸⁵ In what was undoubtedly a move to retain a modicum of discretion over sterilization procedures, the Department chose to sponsor their own competing bill, which was submitted by Harley E. Dillinger in April 1951.

The Dillinger bill, along with updating the terminology of the Asexualization Act, and deleting perversion and syphilis as conditions warranting sterilization, added a notification and appeal process to sterilization proceedings.¹⁸⁶ Yet, the "double and triple safeguards," listed in the proposal that were adulated in the DMH's 1952 biennial report, while certainly improving the protection afforded to patients, were designed to exclude the court as far as possible from the program.¹⁸⁷ The proposed safeguards dictated that patients selected for sterilization be given notice of an impending sterilization, and thirty days to appeal the order. If no opposition was raised, the Department may proceed. However, if a patient did object, the matter went to the Department Director. If still objecting, patients then had thirty days to file their objection with the court.¹⁸⁸ While the new protections rendered the court as a last resort, Dolwig was apparently satisfied with the Department's counter-argument, and agreed to withdraw AB 2505 in favor of it.¹⁸⁹ With Dolwig's bill withdrawn, Governor Warren signed the Dillinger bill into law. That this had been the Department's intention all along can be seen in reactions to the bill. At a department-wide conference in February 1951, Walter Rapaport, then superintendent at Agnews State Hospital, pointed out that the Dillinger bill was introduced "to counteract the proposal that all sterilizations be taken through the court."¹⁹⁰ This was affirmed by legislative secretary Beach Vasey, who, recommending the bill to Warren, stated that "it undoubtedly prevents the passage of a much more stringent bill which has been suggested by many."¹⁹¹ Contrary

¹⁸⁵ "Legislation Concerning Sterilization Law, August 22, 1950," Box 47, Folder 50, AVS, UMSWHA.

¹⁸⁶ See GCBF, 1951, MF 3:2(4), CSA.

¹⁸⁷ *Biennial Report of the California Department of Mental Hygiene, 1950-1952* (Sacramento: California State Printing Office, 1952), 39.

¹⁸⁸ Wallace G. Colthurst to Earl Warren, GCBF, 1951, MF 3:2(4), CSA.

¹⁸⁹ "Sterilization Curb Measure Approved," *The Bakersfield Californian*, April 13, 1951 12; Frank F. Tallman to Earl Warren, GCBF, 1951, MF 3:2(4), CSA.

¹⁹⁰ "Conference of the Superintendents and Medical Directors, Clinical Chiefs, and Administrative Staff, February 23, 1951, Sacramento, California" F3640: 2723, EWP, DMH, CSA.

¹⁹¹ Beach Vasey to Earl Warren, GCBF, 1951, MF 3:2(4), CSA.

to some historians' assertions, it appears that the 1951 amendments, which all but stopped sterilization in California, were not enacted by the DMH out of concern for patient's rights, nor out of disgust at the widespread use of an antiquated procedure, but actually to continue the program in a legal and ethical climate that was growing increasingly hostile to it.¹⁹² The ability to retain control over a diminished number of sterilizations was preferable to performing none. Thus, while attitudes may well have been changing in the Department, it appears that the decline of sterilization in California, may have been as disingenuous as its beginning.

Regardless of the rationale that underpinned the amendments, their impact on the program was considerable. When the revisions took effect in 1952, annual sterilization rates plummeted by eighty per cent virtually overnight. From this point on, superintendents, concerned over the "practicability" of obtaining consent from patients and mandatory waiting periods, increasingly opted not to operate.¹⁹³ To illustrate this dramatic drop, in 1951, the last significant year of eugenic sterilization in California, 251 operations were performed in the State hospitals. By the end of 1952, the annual total sat at just fifty-one procedures. While in 1960, the last recorded year of operations under the Asexualization Act, only five patients would be sterilized.¹⁹⁴ Indeed, the extent to which the function of the now conservative program changed during these years can be gleaned in a 1957 letter from Walter Rapaport, by then Director of the DMH, to Howard Hassard, Legal Counsel of the California Medical Association. Clarifying for the State's physicians the DMH's position on sterilization, Rapaport reported that "while a small degree of sterilization is still being carried out," he did "not believe that a policy of admission for sterilization only can be established under the present law." Emphasizing the rights of both patients' and their families throughout, Rapaport concluded by reminding Hassard that given changes in "medical and psychiatric thinking[...]"sterilization is more carefully scrutinized before being performed."¹⁹⁵ Rapaport's letter indicates the extent to which the State's sterilization policy by the 1950s represented, in the words of Julius Paul, a "radical departure from the halcyon days" of mass sterilization in California.¹⁹⁶

Conclusion: The Turning Tide

The importance of recognizing the complex process that contributed to this radical

192 For contrary opinions see: Stern, "From Legislation to Lived Experience," 102; Wellerstein, "*States of Eugenics*," 51.

193 "Minutes of Superintendents' Conference, October 9 and 10, 1951" F3640: 2729, EWP, DMH, CSA.

194 Matoq, *California's Sterilization Policies*, 98.

195 Walter Rapaport to Howard Hassard in "Information," *California Medicine* 87 (1957): 61.

196 Paul, "Three Generations of Imbeciles Are Enough," 285.

departure extends beyond understanding why sterilization all but ceased in California in the 1950s. For the mid-century constituted a watershed for the sterilization movement in the United States, and California serves as an example of a broader transition that took place during this period. Indeed, the stagnation of the California program, the most active, and, for a long period, unassailable of the state-run sterilization regimes, signaled a wider downfall of forced institutionalized sterilization across the country.¹⁹⁷ While many sterilization statutes were retained on the books, legislatures and institutional heads unwilling or unable to utilize them due to excessive red-tape or fear of legal reprisal, rendered most toothless. Not only did the professional and scientific hostility towards the doctrine of eugenics, and legal opposition to the constitutional weaknesses inherent in these laws, present since the war years continue to mount, but more concerted opposition from other groups emerged during this period. Catholic opposition, for instance, now at their apex of influence in the United States, crystallized in Pope Pius XII's denunciation of eugenic sterilization in 1953. Upon good moral sense, and more importantly, Christian morality, the Pope urged that eugenic sterilization, and the racialism inherent to the doctrine, must be rejected "both in principle and in practice."¹⁹⁸ Alongside Catholic opposition, the mid-century saw disability advocacy groups enter the sterilization debate too, most notably in the form of the *National Association for Retarded Citizens* (NARC). Formed by parents of mentally retarded children, NARC worked to erode not only the belief that the retarded only begat other retarded, but also the bigoted view that retarded citizens constituted a menace to society and civilization at large.¹⁹⁹ This rights-based discourse and growing enmity towards state-supported discrimination would find vocal expression in the civil rights movements developing in the mid-1950s.²⁰⁰ To be sure, the decline in State sterilization practice was not uniform, and several Southern States, particularly North Carolina, Georgia, and Virginia continued, and even increased sterilization rates during this period. By 1960, these three States accounted for eighty per cent of the annual sterilizations being performed. Yet, as Milunsky writes, these outliers must be viewed as "a local eddy in a tide of decline," and by and large, the fate of state-mandated sterilization was sealed.²⁰¹

197 See Dowbiggin, *The Sterilization Movement*, 73; Kluchin, *Fit to be Tied*, 21; Reilly, "Involuntary Sterilization in the United States," 165.

198 "Pope Denounces Sterilization and Racialism," *Albuquerque Journal*, September 9, 1953, 26; For Catholic arguments against eugenics see Rosen, *Preaching Eugenics*; Sharon M. Leon, *An Image of God: The Catholic Struggle with Eugenics* (Chicago: University of Chicago Press, 2013).

199 Eleanor Kirkby, "National Movement to Aid Mentally Retarded Children," *Valley News*, December 13, 1956, 70.

200 Stern, *Eugenic Nation*, 10.

201 Milunsky, *Genetics and the Law* III, 237.

However, the shrewd political machinations of DMH officials to ensure that decisions regarding sterilization remained firmly in their grasp, underscores the belief that the surgical procedure was still viewed as a valuable tool. Indeed, the decline of institutional sterilization in California by no means signaled the end of involuntary sterilization in the Golden State, nor the existence of the beliefs over who should, and who should not reproduce, that underpinned it. Indeed, in the drift towards the 1960s, advocates of sterilization increasingly sought to extricate the operation from the now unpopular mandatory state-run programs. Instead, sterilization during the 1960s and 1970s was increasingly repackaged by proponents as a reproductive choice that would help liberate women from unwanted pregnancies and provide them with greater self-determination in reproductive matters. Indeed, just as the *Food and Drug Administration's* approval of the oral contraceptive pill in 1960 was heralded as a prime mover in the contraceptive revolution, proponents of sterilization desired paint the operation in much the same way.²⁰² However, while white, middle-class women were the overwhelming recipients of the Pill, handing them greater control of their reproductive lives, sterilization and the intrauterine contraceptive device—technologies that handed this control of reproduction to doctors—were the preferred options for poor and minority women across the country.²⁰³ On this note, concealed within the expansion of “voluntary” sterilization legislation, which constituted part of the broader development of state family planning programs in the 1960s, was the enduring belief that sterilization served as an effective remedy for the piercing social concerns of the era. As sterilization, then, moved out of the state hospitals, and into the public hospitals and county clinics, poor and minority women became the victims of these changing dynamics of sterilization. These women would soon find out that the increased push for “voluntary” sterilization in the late 1960s and 1970s, promised as a boon to reproductive freedom, would, in fact, generate perfect conditions for involuntary sterilization to flourish once again in California. This will be examined primarily through the involuntary sterilizations at LACMC.

202 Charles F. Westoff and Norman B. Ryder, *The Contraceptive Revolution* (Princeton: Princeton University Press, 2015).

203 Kluchin, *Fit to be Tied*, 51-52.

Chapter II

The Fallout of (Reproductive) Freedom: Voluntary Sterilization Policy and the Abuse of Chicana Women in Los Angeles County Hospital, 1965-1978

People pollute and too many people crowded too close together may cause many of our social and demographic economic problems. As physicians, we have obligations to the society of which we are a part. The welfare mess, as it has been called, cries out for solutions; one of these is population control¹

When Rebeca Figueroa, 35, arrived at the Santa Marta hospital, a small Catholic medical center based in East Los Angeles that provided services to the neighborhood's primarily Mexican-origin population, on October 18, 1971, she was in great pain and bleeding profusely.² Ill-equipped to cope with the bleeding patient, the nuns who ran the ward called for an ambulance to take the mother-to-be to the larger and more modern LACMC. Upon arrival at the medical center, Figueroa was told that her baby was transverse and that, for the sake of her and her baby's life, she would need to undergo an emergency cesarean section.³ Scared, bleeding, and already under the influence of a sedative, a consent form was shoved into Figueroa's hand by a nurse without explanation. The nurse then called Figueroa's husband and, reiterating the necessity of the life-saving operation, secured his consent to operate. "Look," Figueroa recalled her husband telling her, "they are going to operate on your because they tell me that the baby is transverse and that you or the baby can die."⁴ Ultimately, what both Figueroa and her husband thought was a form authorizing doctors to perform a cesarean operation on the distressed mother was actually a form giving their consent to Rebeca's sterilization. At no point during prior to the operation had doctors discussed sterilization with Figueroa, nor, as a monolingual Spanish speaker, could she understand the consent forms that were written solely in English.⁵ Following the successful delivery of her son, Ricardo, Figueroa left the hospital unaware that she could no longer procreate. Indeed, both she and her husband had expressed their desire to have more children following Ricardo's birth. Even when she returned to the hospital a month later for her post-natal check-up, doctors dismissed Figueroa without

1 H. Curtis Wood, "The Changing Trends in Voluntary Sterilization," *Contemporary Obstetrics and Gynecology* 1 (1973): 31-39.

2 "Findings of Fact and Conclusions of Law re Rebeca Figueroa," 52. *Madrigal v. Quilligan*. Box 4, Folder 27, VISP, UCLA-CSRC.

3 Antonia Hernandez, "Chicanas and the Issue of Involuntary Sterilization: Reforms Needed to Protect Informed Consent," *Chicano Law Review* 3 (1976): 8.

4 *Madrigal v. Quilligan*, RTP, May 30, 203. Box 7, Folder 1, VISP, UCLA-CSRC.

5 "Findings of Fact and Conclusions of Law re Rebeca Figueroa," 53.

informing her of her sterilization.⁶

It was only several years later, having been experiencing dizzy spells, blurred vision and pain in her abdomen, and after repeated attempts to conceive that Figueroa began to suspect something was wrong. She sought advice from her neighbor, who herself had almost become a victim of coercive sterilization practices at County General, who suggested that she may have been sterilized during childbirth.⁷ It took until 1975—four years after doctors had permanently terminated her ability to bear children—that Figueroa learned of her sterilization during an examination by a physician in Tijuana.⁸ The effects of the sterilization resulted in more than just the destruction of her reproductive capacities, and Figueroa developed a number of health problems, including nervous seizures, and suffered abuse at the hands of her husband, angered at her inability to provide him with more children.⁹ Although shocking, Figueroa's experiences were typical of the abusive practices faced by hundreds of minority women who gave birth at LACMC during the early-1970s.¹⁰

While California may have been home to one of the more high profile incidents of sterilization abuse in the late 1960s and early 1970s, the practice was hardly unique to the region, and the period in question witnessed widespread revelations of abusive sterilization practices—targeting mainly poor women, the overwhelming majority of whom belonged to racial minorities and were recipients of government assistance programs—surface across the nation.¹¹ The numbers of women sterilized without their consent during this period is estimated to be in the hundreds of thousands, and amounted, in the words of one historian, to “the most massive sterilization campaign the country had seen.”¹² While, due to several high profile lawsuits, African Americans have come to represent the most visible targets of sterilization abuse during this period, ethnic minority women across the country were targeted by physicians for sterilization.¹³ Indeed, by 1965, one third of Puerto Rican women had been sterilized under government-financed birth control programs on the island.¹⁴ Native American women too were targets of coercion, and in 1976, the *General Accounting Office* (GAO), congress's unofficial “watchdog,” reported that over

6 RTP, May 30, 211.

7 Ibid, 213.

8 Ibid, 215-216.

9 “Findings of Fact and Conclusions of Law re Rebeca Figueroa,” 54.

10 The documents of Ricardo Cruz, a Los Angeles-based attorney, contain the records of 190 women who were coerced into sterilizations at LACMC. See Boxes 15-16, RCSP, UCSB-SC.

11 Shapiro, *Population Control Politics*, 89-94.

12 Gutierrez, “Policing 'Pregnant Pilgrims,’” 379.

13 See *Relf v. Weinberger*, 196; *Walker v. Pierce*, 560 F.2d 609 (1977). See also Nancy Hicks, “Sterilization of Black Mother of 3 Stirs Aiken, S.C.,” *The New York Times*, August 1, 1973, 27.

14 Erica M. Gibson-Rosado, *The Sterilization of Women in Puerto Rico*.

3,000 women served by the Indian Health Service had been pressured by physicians into accepting sterilization operations between 1973 and 1976.¹⁵ Connie Uri, a Native American physician, has suggested that as many as one-fourth of Native American women may have been sterilized during this period.¹⁶ And, relevant to the analysis of California's emergent "voluntary" sterilization policy in the late 1960s, *the Committee to End Sterilization Abuse* (CESA), an activist group formed in 1974 in response to the instances of coercive and uninformed sterilization noted above, claimed that twenty-two percent of Chicana women of child bearing years nationwide had been sterilized, primarily under federal family planning programs, during the 1970s.¹⁷ What, one may ask, created the conditions for the eruption of sterilization abuse during this period?

The simplest answer is that access to sterilization was made significantly easier—at least for certain groups—during this period. While eugenic sterilization at been practiced en masse since the beginning of the twentieth century, prior to the 1960s, government regulation of birth control, and especially contraceptive sterilization, was seen as anathema to the state's interest.¹⁸ Indeed, paradoxically, eugenic sterilization laws, while curtailing the reproductive autonomy of many, in some cases provided a woman's only access to the procedure, and indeed, to contraception more broadly.¹⁹ However, by the mid-1960s, a reversal of the federal government's stance towards the issue of family planning, and the growing liberalization of attitudes towards sterilization, removed the traditional barriers that had stymied women's access to the procedure.²⁰ The state's involvement in family planning and sterilization policy was premised upon the goal of enhancing reproductive freedom for women, particularly those from disadvantaged backgrounds, across the nation, and providing them with the ability to control "the number and spacing of their children within the dictates of individual conscience."²¹ However, as this chapter will explore, government regulation of sterilization policy highlights the contested and politically polarizing nature of reproductive freedom. For while many white women struggled to access sterilization in the late-1960s and early-1970s, federal legislation actively privileged sterilization as the ideal contraceptive method for minorities, while

15 Lawrence, "The Indian Health Service," 400-419.

16 John Elliot, "Genocide Charged by Indian M.D. Investigator," *Medical Tribune*, August 24, 1977, 1; 8.

17 Dick Grosboll, "Sterilization Abuse: Current State of the Law and Remedies for Abuse," *Golden Gate University Law Review* 10 (1980): 1153.

18 Critchlow, *Birth Control, Abortion, and the Federal Government*, 3.

19 Schoen, *Choice & Coercion*, 78-80.

20 Hansen and King, *Sterilized by the State*, 244-246.

21 Family Planning and Population Research, 1970. *Hearings before the Subcommittee on Health of the Committee on Labor and Public Welfare. 91st Congress, First and Second Sessions, December 8, 9 1969; and February 19, 1970, 22.*

simultaneously curtailing access to other forms of birth control.²² This contradiction, plus pre-existing distrust of government-directed birth control programs, especially from within the African American community, led many to view state involvement as, at best, a disingenuous attempt to reintroduce national stability in the wake of the social upheaval that accompanied the civil rights era, and at worst, a concerted program of genocide against the nation's minority population.²³ Instances of sterilization abuse in the 1970s would lend further support to the latter position.

These instances highlight how state involvement in family planning actively structures the delivery of birth control to society in a way that serves a social purpose. In the 1960s, government programs structured sterilization—a terminal reproductive technology—as the primary choice for the poor and minorities out of the belief that their reproduction was both excessive and, ultimately, harmful to the nation.²⁴ While not new by any means, this belief garnered increased intensity in the 1960s and '70s when Malthusian-inspired fears of overpopulation gripped American society.²⁵ These fears were rooted in the work of the British-born economist and cleric, Thomas Malthus, who, in 1798, published *An Essay on the Principle of Population*. Malthus's theory of population posited that the inexorable growth of the world's population was destined to outstrip its ability to feed itself, leading, if left unchecked by any other means, ultimately to mass starvation. Malthus heaped particular scorn on relief measures like the Poor Law, which he viewed as enabling and even encouraging excessive reproduction among society's poorest individuals. The paradoxical outcome, he argued, was an increase in poverty, and further draining of public funds and food supplies.²⁶ The neo-Malthusian population controllers of the 1960s, however, differed from the doctrine's founder in a critical respect. While Malthus's recommended solution to the population problem called for greater moral restraint and theologically-inspired industriousness, government-directed contraception proved to be the most attractive and efficacious solution to his disciples in the 1960s.²⁷ As this chapter will outline, these fears of overpopulation and its deleterious outcomes were not the exclusive domain of a few influential individuals, but represented a cultural obsession in this period. Despite this ubiquity of such ideas in popular culture and

22 Gordon, *The Moral Property of Women*, 343-344; Premilla Nadasen, *Welfare Warriors: The Welfare Rights Movement in the United States* (New York: Routledge, 2005), 216.

23 Robert G. Weisbord, *Genocide?: Birth Control and the Black American* (Westport: Greenwood Press, 1975); Littlewood, *Politics of Population Control*, 69.

24 Shapiro, *Population Control Politics*, 89.

25 See Thomas B. Robertson, "The Population Bomb: Population Growth, Globalization, and American Environmentalism, 1945-1980 (PhD diss., University of Wisconsin, 2005).

26 Thomas R. Malthus, *An Essay on the Principle of Population* (London: Routledge, 1996).

27 Shapiro, *Population Control Politics*, 31.

legislative action, the impact of neo-Malthusian thought in the development of California's first “voluntary” sterilization policy in 1969 remains overlooked. Given the momentous reshaping of federal sterilization policy that occurred during this period, and its direct link to the nationwide sterilization abuse of the poor, this oversight is unsurprising. Yet, while the existence of Malthusian-inspired attitudes in favor of population control have been taken for granted in the physicians that carried out the sterilizations at LACMC, such studies have overlooked the presence of these ideas in the shaping and formation of California's first voluntary sterilization policy, which was heralded as a victory for reproductive freedoms nationwide.²⁸

As has been established in the previous chapter, policy is rarely translated into practice without some variance from its original intention. This chapter, examining the development of both California and federal voluntary sterilization policy, highlight how both instances, premised ostensibly on egalitarian aspirations to increase reproductive freedom, resulted incongruously in the forced sterilization of women at LACMC, and indeed, thousands of others nationwide. The author will highlight how both policies assimilated, and provided a potential solution to, the dominant fears of the social climate of the 1960s in which they were formed; that being the perceived expansion of a hyperfertile minority underclass and its disproportionate contribution to the ruinous consequences of overpopulation. Using the events at the Los Angeles Medical Center as a case study, this chapter will examine how these policy developments provided a framework for and reinforced the impulse to curtail minority fertility held by physicians. It will then examine the subsequent legal battle that unfolded, in which the presence of neo-Malthusian attitudes inimical to minority fertility by physicians, and the willingness of the legal system to reinforce them, was laid bare. Finally, contrary to the claims of Stern that *Madrigal*—the pivotal legal case in California sterilization history in which ten women challenged their improper sterilizations at the hands of doctors, including the head of Obstetrics, at LACMC—represented the “concluding link in the history of forced sterilization in modern California,” this chapter will foreshadow the tremendous impact that this legal action was to have on Californian sterilization policy for years to come.²⁹

The Framework of Abuse

In the final years of the 1960s, sterilization as a method of birth control was experiencing a meteoric rise in popularity across the United States. Newspapers across the country eulogized the operation and the couples who submitted to it, highlighting their

28 “Voluntary Vasectomy Held Legal in Landmark Ruling,” *Ontario Report*, July 18, 1969.

29 Stern, “Sterilized in the Name of Public Health,” 1128.

emancipation from more rudimentary forms of birth control like the Pill or IUD, and more importantly, from unwanted pregnancy³⁰. Buoyed by the promise of enhanced reproductive freedom, the number of individuals opting to undergo sterilization jumped from approximately 200,000 in 1970 to two million by 1973.³¹ Yet, from that point, the complimentary glow surrounding the procedure acquired a darker edge, and several high profile legal cases and publications in the years that followed evinced an “epidemic” of sterilization abuse unfolding nationwide.³² The Los Angeles County Medical Center, a large teaching hospital serving the city's urban poor was identified as a center of abuse during this period. Disturbed by an alarming increase in the rates of tubal sterilizations and hysterectomies performed between 1968 and 1970, Bernard Rosenfeld, a resident physician at the hospital discovered that many Mexican-origin women were being “actively pushed” into the operation without fully informed consent and often while in the later stages of labor.³³ The full extent of the abuses at LACMC would be revealed in 1975 when eleven women who had been coercively sterilized by physicians filed a class-action lawsuit against the hospital.³⁴

The abuse faced by women at LACMC was set in motion by pivotal policy changes towards family planning in the late-1960s, both at the federal level and in California. Nationally, the federal government under the leadership of Richard Nixon reversed its traditional position of nonintervention in matters of reproduction, and began disseminating vast sums of money for birth control services to the poor through the skeletal infrastructure of Lyndon Johnson's War on Poverty programs.³⁵ Concurrently, *Jessin v. Shasta*, a landmark court decision in California, declared sterilization to be a legitimate method of family planning, initiating a new permissive policy towards the procedure within the state, and aided in the liberalization of regulations on a national level.³⁶ However, while these expanded services were sold as enhancing women's reproductive autonomy, the development of family planning provision, centered around sterilization, also served Malthusian-inspired policy objectives aimed at mitigating the linked social crises of a

30 “Sterilization: Simple New Surgery,” *The New York Times*, April 9, 1972, 7; “Couples Over 30 Prefer Sterilization to the Pill,” *The Pantagraph*, August 4, 1972, 12; “Sterilization: Popular Birth Control Method,” *Pittsburgh Post-Gazette*, May 9, 1972, 35; “Sterilization Popular for Contraception,” *Arizona Republic*, August 6, 1972, 15.

31 Chase, *The Legacy of Malthus*, 18.

32 Bernard Rosenfeld et al., *A Health Research Group Study on Surgical Sterilization: Present Abuses and Proposed Regulations* (Washington: Health Research Group, 1973), 9.

33 Narda Zachinno and Kris Lindgren, “Plaintiffs Lose Suit Over Sterilizations,” *Los Angeles Times*, July 1, 1978, B1.

34 Robert Rawich, “11 Latin Women File Suit on Sterilization,” *Los Angeles Times*, June 19, 1975, 41.

35 See Critchlow, *Birth Control, Abortion, and the Federal Government in Modern America*.

36 *Jessin v. County of Shasta*, 274 Cal. App.2d 737 (1969).

feared demographic explosion and the ever-increasing rates of welfare dependency; concerns that prompted hostility towards the “irresponsible” and profligate reproduction of the poor.³⁷ With their fertility pathologized, the advent of new policies governing reproduction would irreversibly intersect with the lives of poor minority women across the country.

Federal Government and Funding of Family Planning

On December 26 1970, Richard Nixon signed the “landmark” *Family Planning and Population Research Act* into law, marking the capstone of a dramatic turnabout in the federal government's traditional hands-off position in the reproductive lives of its citizens.³⁸ While the government's involvement in the field of family planning had indeed been growing since the mid-1960s, as a component of Lyndon Johnson's War on Poverty, the Johnson administration never fully committed to the provision of these services.³⁹ Indeed, contrary to Linda Gordon's view that subsidized family planning represented a “centerpiece” of Johnson's anti-poverty initiative, governmental efforts prior to Nixon's involvement were characterized by limited funding submerged within a “confusing mix of fiscal arrangements and service activities.”⁴⁰ Nixon's presidency, in contrast, marked an explicit commitment to, and dramatic expansion of federal provision for birth control, premised upon the goal of providing “adequate family planning services[...]to all those who want them but cannot afford them.”⁴¹ Estimating that approximately five million women needed, yet did not have access to, these services, the 1970 Act authorized \$382 million to be spent over the next three years on family planning services, as well as research, training, and educational activities related to contraception and reproduction.⁴² The “birth curb bill,” or “Congress's blank check for birth control,” as the legislation was variously dubbed used existing government agencies, such as the *Office of Economic Opportunity* (OEO) and the *Department of Health, Education and Welfare* (DHEW) as vehicles for disbursing funds and implementing family planning programs authorized by Title X of the Public Health Service Act, which, alongside Medicaid would become the large source of public funding for birth control.⁴³ Conscious too of the fragmented

37 *Relf v. Weinberger*, 1204.

38 “President Signs Birth Curb Bill,” *The New York Times*, December 27, 1970, 1.

39 Littlewood, *Politics of Population Control*, 53.

40 Gordon, *The Moral Property of Women*, 51; Leslie Corsa, “United States: Public Policy and Programs in Family Planning,” *Studies in Family Planning* 1 (1968): 3.

41 Richard Nixon, “Special Message to the Congress on Problems of Population Growth,” July 18, 1969, in *Public Papers of the Presidents of the United States: Richard Nixon* (Washington D.C: G.P.O, 1971), 521-530.

42 Hansen and King, *Sterilized by the State*, 247.

43 Martha C. Ward, *Poor Women, Powerful Men: America's Great Experiment in Family Planning* (Boulder: Westview Press, 1986), 40; Gregory Michael Dorr, “Protection or Control? Women's Health,

provision of such services under the former administration, Nixon's policy expansion also created the *Office of Population Affairs* and the *National Centre for Family Planning Services*, charged with coordinating these activities⁴⁴. Nixon's ascendancy to the White House in 1969, then, not only triggered a phenomenal increase in government financial support for family planning, it also marked the codification, centralization, and rationalization of these services upon the concerted aim of substantially expanding access to birth control for the nation's poor citizens.

Propelling the legislation's popularity, in a period when reproductive rights—one component within a broader “rights explosion” emerging in the 1960s—held a prominent position in political discourse, was the plank of equal access upon which it rested.⁴⁵ The professed “egalitarian aspirations” of Nixon and his supports, premised on the extension of family planning services to previously underserved women, enhancing their ability to exercise reproductive autonomy, were foregrounded in discussions over the legislation, winning the support of both the women's and nascent welfare rights movement.⁴⁶ Senator Joseph Tydings of Maryland, for instance, supported the legislation, arguing that it promised poor women “the same fundamental right the affluent now enjoy of access to the safest and most effective family planning methods.”⁴⁷ Another senator, George McGovern, welcomed federal intervention in “making access to family planning services the universal human right that it should be.”⁴⁸ While cautious of the potential for coercion in federal family planning programs, Bobby McMahan of the *National Welfare Rights Organization* (NWRO), lent her organization's support believing that the program's emphasis on widening access to family planning services was necessary for poor women to have true reproductive freedom; itself an important topic of welfare rights discussions around this time.⁴⁹ This emphasis on liberating poor women from unwanted pregnancies won broad support for the legislation, yet, also masked other motives for its development. Elected at a time of “epidemic disorder,” Nixon sought strategies to promote stability in the nation.⁵⁰

Sterilization Abuse and Relf. Weinberger,” in *A Century of Eugenics in America: from the Indiana Experiment to the Human Genome Era*, ed. Paul. Lombardo (Bloomington: Indiana University Press), 167.

44 Littlewood, *Politics of Population Control*, 55.

45 Judith A. Baer, *Historical and Multicultural Encyclopedia of Women's Reproductive Rights in the United States* (Westport: Greenwood Press, 2002), xv.

46 Shapiro, *Population Control Politics*, 10.

47 *Family Planning and Population Research*, 1970, 26.

48 Ibid, 297.

49 Ibid, 277; Premilla Nadasen, “Mothers at Work: The Welfare Rights movement and Welfare Reform in the 1960s,” in *The Legal Tender of Gender: Law, Welfare, and the Regulation of Women's Poverty*, ed. Shelley Gavigan and Dorothy Chunn (Oxford: Hart, 2010), 113.

50 Dorr, “Protection or Control,” 163-164; Kevin L. Yuill, *Richard Nixon and the Rise of Affirmative Action: The Pursuit of Racial Equality in an Era of Limits* (Lanham: Rowman and Littlefield, 2006), 98.

For many, including those close to Nixon, these tensions were the first signs of a demographic crisis gripping America, which, if left unabated, would develop into a full-blown Malthusian nightmare⁵¹. In this light, the expansion of family planning provision was seen as the most effective apparatus for combatting this crisis.

The late-1960s were a time of uncertainty for many Americans. The economic prosperity that had characterized the mid-decade fell into decline under the costly war in Vietnam and the expansion of Johnson's *Great Society* programs. Concurrently, urban violence, spurred by inner-city poverty and racial tensions, spread like wildfire across the nation to such an extent that rioting had become “something of a fad” by the end of the decade.⁵² For Nixon, these “social problems,” and others like them, were the likely result of the rapid population explosion being experienced by the nation.⁵³ Nixon's comments reflected a Malthusian-inspired cultural obsession gripping America at the time that unchecked population growth would result in widespread poverty, starvation, environmental degradation, and economic collapse.⁵⁴ A litany of monographs, including Paul Erlich's best-selling *Population Bomb*, competed with countless newspaper reports, magazine articles, and radio broadcasts for the opportunity to alarm the public over the consequences of overpopulation.⁵⁵ Whipped into a frenzy by sensationalist claims, like those of the vitriolic Hugh Moore, that the nation would be left with “overcrowded cities, polluted air and water, [and] countless unwanted and suffering children,” the public focused their ire on the “irresponsible” reproduction of the nation's poor and racialized underclass.⁵⁶ The belief that the poor were substantially outbreeding the better off, and thereby contributing disproportionately to the overpopulation problem, reached the highest levels of government, and even Nixon, in a 1967 speech before the National Industrial Conference Board, recognized the “frightening fact[...]that the poor are multiplying twice as fast as the rich.”⁵⁷ Upon this rationale, population control advocates across the country welcomed the advent of family planning programs that focused acutely on this class. True to the Malthusian doctrine that underpinned overpopulation anxieties, those on welfare, and indeed the welfare state itself became targets of great resentment—a point of irony

51 Bayard Webster, “Overpopulation Unites 2 Groups,” *The New York Times*, October 2, 1969, 49.

52 Dorr, “Protection or Control,” 164; Will Mara, *Civil Unrest in the 1960s: Riots and their Aftermath* (New York: Marshal Cavendish, 2010), 49.

53 Richard Nixon, “Special Message to the Congress,” July 19, 1969.

54 Dowbiggin, *The Sterilization Movement and*, 110-134.

55 Paul R. Erlich, *The Population Bomb* (New York: Ballantine Books, 1971); Rachel Carson, *Silent Spring* (Boston: Houghton Mifflin, 1962); E. F. Schumacher *Small is Beautiful: Economics as if People Mattered* (New York: Harper and Row, 1973).

56 Hugh Moore to “Dear Friend,” November 1966. Letter. Box 15, Folder 7, HMC, Seeley G. Mudd Library, Princeton.

57 “Don't the Fools Know There's a War On?,” *The Emporia Gazette*, September 15, 1967, 2.

considering the welfare state's forthcoming role in facilitating efforts to stem the fecundity of the poor.

While under the Johnson regime poverty was viewed as the nation's preeminent social problem; it was replaced in the 1970s by the vexing issue of welfare dependency. As a legacy of the Great Society reforms, which saw previously ineligible minorities begin to receive assistance; the government encourage uptake of welfare programs; and liberalized requirements for receiving public assistance, welfare rolls swelled.⁵⁸ In 1967, five million families received public assistance through the *Aid to Families with Dependent Children Program* (AFDC). By 1971, this figure had more than doubled, surpassing ten million families served.⁵⁹ Minority representation in these programs also grew precipitously during this period, and by 1967 almost half of all AFDC recipients were non-white, transforming, in the minds of critics, from a “widows program” to a “negro program.”⁶⁰ According to Hansen and King, while the AFDC program, originally created by the *Social Security Act* in 1935, had long been the most expensive federal welfare program administered by this legislation, the precipitous caseload increase in the 1970s saw costs for the program exceed \$4 billion.⁶¹ As both minority uptake and expenditure of welfare programs mushroomed, so did public and political hostility towards them, becoming, as it traditionally had been, focused on the supposedly deviant sexual behavior of recipients. Pejorative epithets like “brood sow” and “welfare queen” increasingly became synonymous with welfare mothers, evoking images of lazy, unmarried, wildly fecund grifters who demanded ever-greater sums of taxpayer money with the birth of each illegitimate child.⁶² Just as Malthus attacked the Poor Law for increasing births among the poor, welfare critics argued that programs like AFDC encouraged this behavior by “putting a premium on undesirable, anti-social behavior.”⁶³ As expansion of the program continued, anger over the seemingly insoluble “welfare mess” became vocalized in calls to limit the fertility of recipients to break the cycle of dependency. By the mid-1960s, bills permitting the mandatory sterilization of welfare recipients flooded state legislatures—including California's.⁶⁴ Even one of Nixon's top advisors, the controversial Daniel

58 Kluchin, *Fit to be Tied*, 74.

59 Russell B. Long, “The Welfare Mess: a Scandal of Illegitimacy and Desertion,” (paper presented before the United States Senate Committee on Finance, Washington D.C., December 14, 1971), 1.

60 Gwendolyn Mink, “Welfare Reform in Historical Perspective,” *Connecticut Law Review* 26 (1994): 879; Daniel P. Moynihan, “The Crises in Welfare,” *The Public Interest* 0 (1968), 13.

61 Richard K. Caputo, *U.S. Social Welfare Reform: Policy Transitions from 1981 to the Present* (New York: Springer, 2011), 10; Hansen and King, 247.

62 Paul J. Placek and Gerry E. Hendershot, “Public Welfare and Family Planning: An Empirical Study of the 'Brood Sow' Myth,” *Social Problems* 21 (1974): 658-673; Kluchin, *Fit to be Tied*, 74-79.

63 Roger A. Freeman, “Welfare Reform and the Family Assistance Plan,” (paper presented before the United States Senate Committee on Finance, Washington D.C., January 27, 1972), 49.

64 Julius Paul, “The Return of Punitive Sterilization Proposals: Current Attacks on Illegitimacy and the

Moynihan, argued that one solution to the problem lay in a “sharp curtailment of the freedom now by and large enjoyed by low-income groups to produce children they cannot support.”⁶⁵ While the mandatory proposals to do so failed, Title X provides a framework through which these sentiments could find expression under the guise of voluntarism and equal access.

Title X, then, represented the “magnificent culmination” of federal interest in the potentials of birth control, and committed the nation to providing family planning services for the poor.⁶⁶ Although not unanimous, the calculated presentation of the Janus-faced birth curb program won it considerable support. As Thomas Shapiro notes, family planning programs are inherently “laden with ideological assumptions,” and are necessitated by, and a response to, the perceived needs of society.⁶⁷ In this regard, Title X family planning programs reflected Nixon's, and society's belief more broadly, that the reckoned hyperfertility of the poor had become socially pathological, eroding the quality of life for the majority of Americans by this class's contribution to both the welfare mess and population explosion. To the adherents of this dogma, the check of pathological fertility implicit to the Title X programs appeared to offer the simplest and most economical solution to these pressing social problems. On the other hand, the packaging of the legislation as an unprecedented aid to the reproductive autonomy of the poor mollified much of the potential opposition to government-directed birth control programs. Indeed, even those who saw through the “phony and deceptive” rights-based rhetoric of the program conceded that to deny the potential benefits offered by the program to recipient's reproductive autonomy would be detrimental to the poor, whatever the “real motives” of its architects may have been.⁶⁸ Reconciling these interests, the government began lending rhetorical, organizational and financial support to the expansion of family planning nationwide, laying the framework upon which sterilization abuse would rest. At the time Title X was passed, however, the position of sterilization within the program remained ambiguous. While the government remained silent on the controversial procedure, the OEO expressly prohibited its service providers from offering the operation.⁶⁹ This ban reflected a wariness towards the operation held by medical bodies and state legislatures at

AFDC Program,” *Law & Society Review* 3 (1968): 78; “State Welfare Chief Rejects Plan to Sterilize Parents of Aid Children,” *The Sacramento Bee*, September 14, 1961, A10.

65 Moynihan, “The Crises in Welfare,” 10.

66 “Most Laud Nixon's Birth Control Plan,” *Waukesha Daily Freeman*, July 19, 1969, 1.

67 Shapiro, *Population Control Politics*, 9.

68 Statement of Mrs Bobby McMahan in *Family Planning and Population Research*, 1970, 276.

69 Littlewood, *Politics of Population Control*, 44-45; Jeannie I Rosoff, *Family Planning, Contraception, Voluntary Sterilization, and Abortion: An Analysis of Laws and Policies in the United States, Each State and Jurisdiction* (Washington D.C.: GPO, 1978), 7.

the turn of the 1970s.⁷⁰ This sentiment, however, began evaporating rapidly during these years, and as we shall now see, one Californian couple's fight for their right to choose the surgery as a form of contraception not only reshaped their state's policy on the issue, but also provided an impetus to the inclusion of sterilization within federally-sponsored birth control programs.

The “Legal Cloud” Disperses

In 1967, Marion and Oscar Jessin approached physicians at Shasta General Hospital, California, seeking a tubal ligation for the former. The impoverished couple already had six children and feared that the birth of any more would see them become public charges. Even though the Jessins were entitled to family planning services at county expense, physicians at the hospital, finding no medical necessity to justify the operation, refused the couple's request. Undeterred, the couple were approached by local attorney Jere E. Hurley, and began a two year legal battle for their right to be sterilized. Despite being generally overlooked by historians, the Jessin case is a critically important action in the state's history of sterilization. Not only did it definitively clarify California's position on the issue of voluntary contraceptive sterilization, it highlighted how piercing national debates over welfare, overpopulation, and the irresponsible reproduction of the poor figured in the crafting of state policy. Indeed, while California had embraced eugenic sterilization like no other in the first half of the twentieth century, a “legal cloud” continued to linger over voluntary sterilization in the state.⁷¹ Despite no explicit legislative prohibition existing on the subject, many Californian physicians remained reluctant to perform such operations out of fear of malpractice lawsuits or being charged with mayhem: a common law offense prohibiting the deliberate maiming of a person.⁷² This legal limbo, Frank C. Reid, assistant Secretary of the Human Betterment Foundation, contended in 1941, arose from the industrious spreading of reports by the “enemies of sterilization” that such operations were illegal in the state.⁷³ A more likely source of fear possibly sprang from the highly sensational 1936 Ann Cooper Hewitt Case, where mayhem charges were brought against two Californian surgeons for the involuntary sterilization of the heiress at her mother's request.⁷⁴ Despite the dismissal of charges against the two surgeons by Judge Isadore Golden, and a 1961 declaration by AMA that sterilization carried no greater risk of

70 Dowbiggin, *The Sterilization Movement*, 144.

71 Wallace Turner, “Legality Upheld on Sterilization: California Court Rules on Voluntary Operations,” *The New York Times*, July 20, 1969, 34.

72 Sarah S. Beserra et al., *Sex Code of California: A Compendium* (Sausalito: Graphic Arts of Marin, 1973), 16.

73 Frank C. Reid to Louana E. Siler, October 10, 1941. Letter. Box 6, Folder 9, HBF, CITA.

74 See Kline, *Building a Better Race*, 110.

prosecution than any other medical procedure, the legal cloud continued to loom large over the operation in the state.⁷⁵

California, in this regard, mirrored most other state's attitudes towards sterilization at this time. Indeed, by 1967, only three states—Connecticut, Kansas, and Utah—had laws regulating voluntary sterilization, all of which required evidence of “medical necessity” before proceeding.⁷⁶ In other states, the unease produced by the absence of permissive legislation was compounded by inhibitory regulations imposed from within the medical profession. The promulgation of guidelines by the *Joint Commission on Accreditation of Hospitals* (JCAH) in 1961, for instance, gave rise to the common requirement that a woman submit to review by a hospital sterilization committee before her operation was approved. These committees, usually consisting of several physicians and a psychiatrist, were often run in conjunction with therapeutic abortion committees, and thus commonly transferred the moral outrage felt towards this procedure to sterilization requests.⁷⁷ The committee requirement was further endorsed by the *American College of Obstetricians and Gynecologists* (ACOG), who added a requirement that petitioners meet an age-parity formula.⁷⁸ This seemingly arbitrary standard, which one critic scoffed “must have been devised by a Houdini,” dictated that a sterilization only be permitted if a woman's age multiplied by her number of living children equaled or surpass 120.⁷⁹ In combination, this statutory uncertainty, bureaucratic review processes, and the widespread “Rule of 120” formed a system that discouraged physicians from performing, and women from seeking sterilization as a form of birth control. The few women who persisted in spite of this opposition resorted to “doctor shopping” in the hope of finding a physician willing to perform the operation.⁸⁰ Voluntary sterilization remained a “strange beast,” and the subject of fervent and divergent opinions. It was this status that underpinned federal hesitancy towards including sterilization as part of its family planning arsenal.⁸¹ The case unfolding in California in 1968, then, deciding on the legitimacy of sterilization as a method of contraception, held great significance both locally and nationally.

75 Lawrence Lader, *Foolproof Birth Control: Male and Female Sterilization* (Boston: Beacon Press, 1972), 227.

76 Richard W. Millar, “Sterilization: A Continuing Controversy,” *University of San Francisco Law Review* 1 (1967): 174.

77 Linda K. Champlin, “Elective Sterilization,” *University of Pennsylvania Law Review* 133 (1965): 419; Peter R. Forbes, “Voluntary Sterilization of Women as a Right,” *DePaul Law Review* 18 (1969): 562.

78 Kluchin, *Fit to be Tied*, 22.

79 Naomi Rock, “Voluntary Sterilization Offers One Solution for the World's Family Planning and Population Problems,” *The Greenwood Index-Journal*, May 5, 1970, 11.

80 Jean Sprain Wilson, “Growing Number of Detroiters Seek Sterilization,” *Detroit Free Press*, April 5, 1970, 53.

81 Roger C. Wolf, “Legal and Psychiatric Aspects of Voluntary Sterilization,” *Journal of Family Law* 3 (1963): 103.

When Hurley filed the Jessins' case in late 1967, his argument centered on the financial element of the couple's complaint, contending that the county's refusal to fund Marion's operation represented an "arbitrary and unconstitutional discrimination against the plaintiffs based on their financial circumstances." Indeed, more than merely discriminating against the Jessins, Hurley claimed that by refusing to operate, and thus potentially forcing the Jessins into public dependency, they were guilty of the "unnecessary and unreasonable expenditure of public funds."⁸² The county, it turned out, proved to be "entirely sympathetic" with the Jessins' cause, but, revealing sources of legal uncertainty around the operation, believed that they could not advise the doctors at the county hospital to proceed.⁸³ The first was a 1966 statement from the *California Medical Association's* (CMA) legal counsel, which, although fully supporting sterilizations "based on solid medical grounds," warned that "economic necessities," which the Jessins undoubtedly were, "would not, under the present status of the law, support the performance of a sterilization procedure."⁸⁴ The second, more compelling evidence for proscribing the operation came from Fred N. Howser's 1950 Attorney General's opinion. Issued in response to a Department of Corrections request for clarity on the legality of sterilization prison inmates, the lengthy opinion ruled that although no clear prohibition existed, sterilization, with or without consent, remained "cloaked in illegality."⁸⁵ Howser believed that only the inmates of state hospitals, as prescribed by the Asexualization Act, could be legally operated on in California. He further drew on extant anti-contraception and anti-abortion statutes, and a 1930 legal article which declared vasectomy to be a maiming of the body, to substantiate his interdiction.⁸⁶ However, Howser's concluding statement that sterilization operations were "contrary to the established policy of this state" in that they violate "the state's social interest in the maintenance of the birth rate," reflects the almost sacrosanct status of fertility held by America's post-WWII baby-boom society, as much as it did the tenuous legal precedents upon which Howser drew.⁸⁷ The Attorney General's pronatalist message, which had stymied the use of contraceptive sterilization since the 1950, presented at interesting conflict when invoked in the radically transformed post-baby boom, and decidedly anti-natalist environment of the late-1960s. Both the

82 *Jane Doe & John Doe vs. County of Shasta, Case 36342, August 29, 1967, 3-4. Box 111, Folder 15-16, AVS, UMSWHA.*

83 Robert A. Rehburg to Donald H. Higgins, February 15, 1968. Letter. Box 111, Folder 15-16, AVS, UMSWHA.

84 "Exhibit A," *Jane Doe & John Doe vs. County of Shasta. Box 111, Folder 15-16, AVS, UMSWHA.*

85 15 Ops. Cal. Atty. Gen. 100-104.

86 Justin Miller and Gordon Dean, "Liability of Physicians for Sterilization Operations," *Medico-Legal Journal* 47 (1930): 120-123.

87 15 Ops. Cal. Atty. Gen. 104; Ronald Freedman et al., *Family Planning, Sterility, and Population Growth* (New York: McGraw-Hill, 1959), 6-7.

county and the Jessins' hoped that the court's decision would serve to dispel this legal shadow cast by Howser over the operation a decade earlier.

One interesting feature of the trial was the testimony of the Jessins' sole witness, Dr John D. Keye. Keye had served as the county's Director of Public Health until 1966, and supported the Jessins' demands for sterilization. Keye's support, however, sprang less from concern over the Jessins' reproductive rights, and more from a pervasive view in the medical community that the poor were irresponsible breeders. In supporting the couple's claim, Keye noted that indigent patients, like the Jessins, “can't follow directions on the devices and pills and other [birth] control methods.”⁸⁸ As animosity towards the reproduction of the poor grew, so did the view among physicians that they couldn't be trusted to limit their own fertility. A 1971 questionnaire sent to 132 doctors confirmed that belief that many considered their public patients neither “intelligent” nor “motivated” enough to use contraception. As a result, physicians recommended sterilization to public patients at over twice the rate of their paying patients.⁸⁹ Another survey in the same year reiterated physicians' belief that the poor could not be trusted with contraception. Thirty percent of respondents believed that welfare should be withheld from women unless they submit to sterilization following the birth of a third illegitimate child.⁹⁰ This data exemplified physicians views on the reproductive proclivities of the poor, and also their preference for contraceptive methods—sterilization, IUD—that permitted them to retain control over this area of their patient's medical life. This attitude partly reflected an engrained medical paternalism, that these physicians knew what was best for their patients, and had the right to act on it; but also the unique responsibility felt by the medical profession towards alleviating the problems associated with overpopulation.⁹¹ Doctors, by decreasing mortality through medical interventions, not only felt partially complicit in the extant demographic problems, but because these problems were “fundamentally biological and ecological in nature and pertain to the[...]well-being of human beings,” believed that it was their duty to “discourage exuberant fertility” among their most profligate patients, with sterilization serving as a key method.⁹² For a segment of these physicians, overpopulation necessitated a “new ethic” towards the reproduction of certain groups in

88 *Jessin v. Shasta*, 740.

89 Anthony R. Measham et al., “Physicians and Contraception: A Study of Perceptions and Practices in an Urban Southeastern United States Community,” *Southern Medical Journal* 64 (1971): 499-503.

90 Morton Silver, “Survey of Private Physicians – Summary of Initial Findings” (paper presented at the annual meeting of the American Public Health Association, Minneapolis, Minnesota, October 11, 1971).

91 Kluchin, *Fit to be Tied*, 111.

92 “A New Ethic For Medicine and Society” *California Medicine* 113 (1970): 68; Hardin, “Everybody's Guilty,” 46; C. Lee Buxton, “The Doctor's Responsibility in Population Control,” *Northwest Medicine* 65 (1966): 112-116.

society, one which potentially included coercion.

Burgeoning fears surrounding overpopulation, then, were clearly active in the trial a feature illuminated further when Judge Richard Abbe handed down his decision. Declaring the Attorney General's opinion to be “archaic and illogical,” Abbe ruled that voluntary contraceptive sterilization operations were legal in California, that they constituted a legitimate and reimbursable method of family planning, and that, in some cases, the county had a “duty” to provide these services.⁹³ The reasoning behind Abbe's attack on Howser's statement was clearly influenced by his awareness of population problems:

One wonders if it is really in the social and economic interest of this state or any other state to maintain a birthrate unchecked by anything other than total abstinence from sexual activities.⁹⁴

While definitive in his ruling, the county did not feel that Abbe had the power to establish a legally-secure statewide policy governing the operation, and appealed the decision to the more powerful appellate court—the outcome of which would represent the first decision on voluntary sterilization by a court of this stature anywhere in the nation, and potentially affect its national standing.⁹⁵

This fact ushered in the involvement of the *Association for Voluntary Sterilization* (AVS). The former eugenics group, now under the leadership of ardent population-controller, Hugh Moore, spent the 1950s and 60s promoting voluntary sterilization as a solution to family and population problems.⁹⁶ The inability of the poor to control their fecundity constituted the group's bugbear, and sterilization, they argued, held the ability to attenuate the mushrooming social and economic problems linked with overpopulation through the elimination of this class's many unwanted children.⁹⁷ Success in this mission, the AVS recognized, required government acceptance and adoption of sterilization into existing family planning programs. “What is needed now,” expounded AVS executive director, John R. Rague, highlighting humanities impending cataclysm, “is action—action on a very large social and financial scale.”⁹⁸ While the AVS had spent this period privately financing couples who wished to, but could not afford to be sterilized, they recognized that

93 *Jessin v. Shasta*, 741; “Judge OK's Sterilization for Indigent,” *Honolulu Advisor*, May 2, 1968.

94 “Judge Rules Sterilization for Indigents,” *Eureka Times Standard*, April 23, 1968, 8.

95 *Jessin v. Shasta*, 742.

96 H. Curtis Wood, *Sex Without Babies: A Comprehensive Review of Voluntary Sterilization as a Method of Family Planning* (Philadelphia: Whitmore Books, 1967), 21.

97 See Dowbiggin, *The Sterilization Movement*, Chapter 5; Kluchin, *Fit to be Tied*, 26-49; H Curtis Wood, “A Prescription for the Alleviation of Welfare Abuses and Illegitimacy,” *Journal of the Kentucky State Medical Association* 61 (1963): 319-323.

98 Statement of John R. Rague, Executive Director of the Association for Voluntary Sterilization, on Voluntary Contraceptive Sterilization as a Major Method of Birth Control, Heard before the Subcommittee on Monopoly, Select Committee on Small Business, United States Senate, 1970, 7305.

scale limited their efficacy in this mission.⁹⁹ “The United States government should act now,” implored Rague, “to make government financed birth control, *especially voluntary sterilization*, freely available to every adult in the country.”¹⁰⁰ Translated, this meant extending sterilization to the poor. The “precedent-making” effect of the Jessin case, and its effect on this mission, was not lost on the population-control group, who positioned themselves as a champion of the couple's reproductive rights at the appellate trial.¹⁰¹

At the trial, the AVS's attorneys submitted an exhaustive sixty-page “Brandeis-type” brief—a form of evidentiary report that makes extensive use of scientific or social scientific evidence to support a legal position—marshaling legal precedents, evidence of public and professional acceptance, and exhaustive correspondence from religious leaders, physicians, and politicians, all supporting the practice of contraceptive sterilization. The thrust of the brief, however, contended that the operation was cloaked not in “illegality,” but rather constitutional protection, arguing that the county's refusal to operate impinged on the couple's right to privacy, equal protection, and due process guaranteed by the fourteenth amendment.¹⁰² This constitutional argument was a calculated move by the AVS who understood that, were they to be successful, grounding the right to sterilization in constitutional protection would place the practice on a solid legal footing nationally.¹⁰³ To do so, the AVS drew heavily on the landmark 1965 *Griswold v. Connecticut* decision, which declared unconstitutional a Connecticut law banning the use and sale of contraception, and ruled that the right to family planning fell within a “right to privacy older than the Bill of Rights” itself.¹⁰⁴ Drawing parallels throughout, the AVS attorneys contended that the couple's right to choose sterilization was implicit in their right to “marry, establish a home, and bring up children,” and fell within a “sensitive area of privacy” that precluded state intervention.¹⁰⁵ Furthermore, seizing on the financial issue of the case, the AVS claimed that denying sterilization to indigent citizens represented an “invidious distinction” between the poor and well-to-do, violating the couple's right to equal protection under laws.¹⁰⁶ The AVS attorneys implored the presiding justices to take judicial notice of the vast swaths of evidence presented within their brief and to legalize

99 Wood, *Sex Without Babies*, 24-25; Kluchin, *Fit to be Tied*, 37-42.

100 Statement of Rague, 7305.

101 “Shasta County California Court Case,” *AVS Progress Report*, 4. Box 111, Folder 15-16, AVS, UMSWHA.

102 “Brief as Amicus Curiae of the Association for Voluntary Sterilization, Inc.,” 23. Box 111, Folder 15-16, AVS, UMSWHA.

103 “Landmark Rule by California's Highest Court Unanimously Declares Voluntary Contraceptive Sterilization Legal,” Box 111, Folder 15-16, AVS, UMSWHA.

104 *Griswold v. Connecticut*, 381 U.S. 486 (1965).

105 “Brief as Amicus Curiae,” 22.

106 *Ibid*, 24.

sterilization in California, particularly “in light of the war on poverty and the critical threat to the survival of mankind posed by the population explosion at home and abroad.”¹⁰⁷ This statement, buried surreptitiously within the high-minded rhetoric of constitutional rights, highlights how the battle for the Jessins' reproductive autonomy provided the AVS with the perfect platform to further their mission of extending the practice of sterilization, and therein their population-control objectives.

Ultimately, the appellate trial proved to be a one-sided affair in favor of the Jessins. The presiding justices were “most sympathetic” to the couple throughout, and lauded the “thoroughly documented and brilliant brief” submitted by the AVS. After two-hours, Justice Edwin Reagan, one of California's most respected judges, whose decisions were considered “virtually unchallengeable,” declared that there did “not appear to any other good legal reason why such a voluntary operation, given consent, should not be performed.”¹⁰⁸ Therefore, Reagan concluded, “voluntary-non-therapeutic surgical sterilization operations are legal in the State of California.”¹⁰⁹ Reagan's authoritative decision not only granted the Jessins the right to surgery after a three-year legal battle, but established a new permissive policy towards sterilization as a legitimate method of family planning in California, under which doctors could operate unimpeded by a legal cloud of prosecution. The dispersion of this cloud was undoubtedly one factor contributing to the 470% increase in tubal ligations performed at LACMC between 1968-1970.¹¹⁰

Elated with the court's decision, and foregrounding its wider significance, an AVS press-release labelled the result a “victory for reason.” Positioning themselves once again as a champion of reproductive rights, “the decision,” the press-release continued, “affects freedom of choice in matters of birth control for millions of Americans[...]and those who have been denied it by hospitals that have often fallen back on the interdiction that 'It is against public policy.'”¹¹¹ Although the *Association's* concern over reproductive rights may have been overstated, their belief in the significance of the *Jessin* decision was not. For *Jessin* not only liberalized sterilization policy in California, its outcome both reflected and bolstered a broader attitudinal shift towards the procedure in the years immediately following the decision. In 1969, for instance, ACOG deleted the age-parity recommendation from its authoritative manual, *Standards for Obstetric-Gynecologic*

107 Ibid, 27.

108 “Telephone Conversation: Mr. Philip Jensen,” John R. Rague to Donald H. Higgins, Evelyn E. Bryant, and Janice Kaye, May 26, 1969. Letter. Box 111, Folder 15-16, AVS, UMSWHA; *Jessin v. Shasta*, 748.

109 Ibid, 749.

110 Rosenfeld et al., *A Health Research Group Study on Surgical Sterilization*, 1.

111 “Landmark Rule by California's Highest Court.”

Practice, and one year later, dropped its pre-sterilization consultation requirement.¹¹² Further, a circular issued by the *California Hospital Association* (CHA) indicates that by 1970, JCAH no longer required hospitals to maintain sterilization committees—“this,” the circular noted, “being the direct result from *Jessin v. Shasta*.”¹¹³ Yet, despite the broad liberalization of attitudes and guidelines concerning sterilization, the AVS, alongside population-control group, *Zero Population Growth* (ZPG), and the ACLU, launched operation lawsuit with the aim of bringing legal action against hospitals that continued to prohibit operations based on non-medical criteria.¹¹⁴ Despite isolated resistance to these changes, the removal of arbitrary barriers to sterilization in the years following *Jessin*, rendered the operation “generally available to those who seek it.” On the whole, discretion over sterilization was now delegated to physicians, and, in theory at least, their patients.¹¹⁵ As the barriers tumbled, and demand for contraceptive sterilization grew, the federal government, in a step that would open the floodgates to abusive sterilization practices, was forced to clarify its stance on the procedure.

On May 18, 1971, Wesley L. Hjernevik, Deputy Director of OEO, issued Instruction 6130-I, removing the anti-poverty agency's prohibition on funding sterilization operations.¹¹⁶ This instruction came in response to an OEO family planning project management survey, which revealed that eighty percent of service providers, many of which fielded weekly requests for sterilization, desired permission to offer the operation to indigent clients. While OEO officials expressed their eagerness to begin providing sterilization services, the Director of Family Planning Services, George Contis, concerned over the potential for coercion, issued a memo requesting that no operations be performed until procedural guidelines, scheduled to be released on September 1, were distributed.¹¹⁷ Although ready for distribution by January 1, 1972, it would take until 1974 before the OEO guidelines reached service providers. It was later revealed that the guidelines had been deliberately suppressed by the White House due to political considerations.¹¹⁸ Nixon, who had only won one-third of the Catholic vote in 1968, sought to bolster Catholic

112 Susan L. Peck, “Voluntary Female Sterilization: Attitudes and Legislation,” *Hastings Center Report* 4 (1974): 8; Christine E. Motley, “Contraceptive Sterilization: the Need for State Regulation,” *Golden Gate University Law Review* 6 (1975): 82.

113 “CHA/CMA Joint Memorandum Regarding Sterilization Procedures,” June 30, 1970. Box 48, Folder 30, AVS, UMSWHA.

114 Dowbiggin, *The Sterilization Movement*, 157.

115 Elissa Krauss, *Hospital Survey on Sterilization Policies* (New York: American Civil Liberties Union, 1975), 6.

116 Hansen and King, *Sterilized by the State*, 248.

117 George Contis, M.D., to All OEO Community Action Directors, November 5, 1971. Letter. in U.S. Congress, Senate, Committee on Labor and Public Welfare, *Quality of Health Care – Human Experimentation*: Hearings before the Subcommittee on Health, 93rd Congress, First Session, March 7 and 8, 1973, 1506.

118 Trombley, *The Right to Reproduce: A History of Coercive Sterilization*, 183.

support in the 1972 elections by presenting himself as a “moral traditionalist.”¹¹⁹ Courting the Catholic vote, the president who had launched the government's largest ever family planning initiative, attempted to distance his administration from the sterilization issue. While Nixon's efforts did halt the release of the guidelines, they did not stop government agencies from offering sterilization services. Ultimately, the guideline “snafu” as Alvin Arnett, Director of the OEO, referred to it, resulted in the sterilization of several hundred thousand individuals annually without adequate regulatory oversight.¹²⁰ This figure was amplified by DHEW, who, it turned out, had been offering sterilization services to clients without explicit government fiat since the passage of Title X.¹²¹

By 1973, it had become clear that an “indefinite number” of poor and minority women “opting” for sterilization under these government programs had done so under coercion.¹²² Many had been pressured into accepting sterilization while in labor; lied to about its irreversibility; threatened with the denial of adequate medical treatment; or simply operated on without their knowledge. Perhaps the highest profile of these cases at this time was that of sisters Minnie Lee, 12, and Mary Alice, 14, Relf. The girls' mother, Minnie Relf, had been visited by a social worker from the Montgomery Community Action Committee, and informed her that Minnie Lee and Mary Alice should accompany her to a nearby hospital for some required “shots.” The illiterate Minnie signed a form that was placed in front of her, and the girls were taken to the Professional Center Hospital, where the following day, they were irreversibly surgically sterilized. If not for the intervention of the *Southern Poverty Law Center*, their case may have faded from the historical record.

The conditions within which this rampant abuse unfolded were created by the concomitant policy developments outlined above. Nixon's contrasting commitment to the issue of family planning—providing the unequalled contributing of government financial and ideological support, yet remaining quiet on the issue of sterilization—fostered a system that provided open-ended funding for the sterilization of the poor, while offering zero protections to the reproductive autonomy of a class, understood by many, prior to the passage of Title X, as vulnerable to coercion. Policy changes in California, too, were important to these events, not just for the permissible environment it created towards

119 Gary Scott Smith, *Religion in the Oval Office: The Religious Lives of American Presidents* (Oxford: Oxford University Press, 2015), 262.

120 Statement of Alvin J. Arnett, Director-Designate, Office of Economic Opportunity, in U.S. Congress, Senate, Committee on Labor and Public Welfare, *Alvin J. Arnett to be Director of the Office of Economic Opportunity*, 93rd Congress, First Session, July 20, 1973, 123.

121 *Relf v. Weinberger*, 1196.

122 Ibid.

sterilization leading up to the events at LACMC, nor for the attitudinal changes in bolstered nationally, but in highlighting how piercing social concerns became incorporated into policy, and the individuals that served as its instruments—in this case, judges and physicians. Emerging in 1973, the revelations of sterilization abuse at LACMC would serve as a prime example of how such practices flourished under this system; the widespread permeation of the thought that underpinned it; and women's resistance against it.

Sterilization Abuse at the Los Angeles County Medical Center

On February 22, 1974, Dr Edward Quilligan, the esteemed head of Obstetrics and Gynecology at the LACMC Women's Hospital, issued a memo informing his staff that “effective immediately, patients will not be approached for the first time concerning sterilization when they are in active labor[...]This includes those individuals undergoing a caesarian section regardless of the previous number of caesarian sections unless there is a medical indication for sterilization.”¹²³ This memo represented the hurried response to widely reported allegations made by a whistleblower on Quilligan's staff that hundreds of low-income, minority women had been subjected to “11th-hour persuasion” and “cajoled, pressured, and sometimes coerced into consenting to surgical sterilization.”¹²⁴ These practices, Bernard Rosenfeld, the whistleblower, contended were the direct result of physicians taking advantage of an unregulated environment, and acting on “very strong beliefs” about population control, welfare, and race.¹²⁵ By the following year, the extent of the abuse attested to by Rosenfeld was revealed when ten Chicana women who had been pushed into accepting sterilization procedures without their fully informed consent by staff at LACMC, joined by Karen Benker, a former medical student at the facility, recounted stories detailing pervasive patterns of abuse at the facility. Their affidavits attested to an “atmosphere” engendered by hospital administrators that encouraged abuse, which, in the absence of a clear policy for gaining informed consent, resulted in widespread coercion of the largely non-English speaking, minority women who frequented the hospital into accepting operations.¹²⁶ Filed on June 18, 1975, *Madrigal V. Quilligan*, would become one of the most high-profile unlawful sterilization cases of the era, and named the hospital, Quilligan, twelve physicians, the Secretary of DHEW, and the state of California as co-

123 “E.J. Quilligan, M.D. to Obstetrics Section Full-Time Staff and All House Staff, February 22, 1974.” Box 5, Folder 21, VISP, UCLA-CSRC.

124 Rosenfeld et al., *A Health Research Group Study on Surgical Sterilization*; Robert Kistler, “Women 'Pushed' into Sterilization, Doctor Charges: Thousands Victimized at Some Inner-City Teaching Hospitals, Report Claims,” *The Los Angeles Times*, December 2, 1974, 3.

125 Ibid.

126 *Madrigal v. Quilligan*, RTP, June 6, 718. Box 7, Folder 6, VISP, UCLA-CSRC.

defendants.¹²⁷ The trial, which attracted national attention, would become significant, not only for exposing the plight of the ten plaintiffs and many others like them, but for its contribution to the wider debate surrounding reproductive autonomy and appropriate safeguards for sterilization that would characterize the mid- to late-1970s.

Immediately prior the revelations of abuse at LACMC, OBGYN services were in the ascendancy at the facility, due principally to large federal grants designated for the “expansion and strengthening” of the department. Benefitting from this money, the OBGYN department, previously located on a ward within the main hospital building, took over the newly remodeled “Unit II” building, which became the Women's Hospital in 1968.¹²⁸ The grants also attracted new staff and, in 1969, Edward J. Quilligan was hired to oversee and modernize the growing department. The arrival of Quilligan within the department, himself a nationally respected Obstetrician, who also served as head of the USC Department of Obstetrics and Gynecology, coincided with a staff turnover, with the new head bringing nine new full-time faculty with him, and several senior staff retiring.¹²⁹ With its expanded, cutting-edge facilities, and Quilligan's reputable hand-picked staff, the Women's Hospital grew to be considered “one of the finest hospitals in the world,” particularly in regard to its provision for “high-risk” patients, which included novel fetal monitoring technologies and special delivery rooms.¹³⁰ Unsurprisingly perhaps, given government focus on family planning at this time, a significant portion of these grants funded the expansion of birth control services within the new hospital. This took the form of a new staff of family planning counsellors whose role it was to approach new mothers prior to discharge in order to ensure their commitment to using birth control, including the Pill and IUD.¹³¹ These changes—open-ended federal funding; a new dedicated building; and the arrival of Quilligan and his cadre of handpicked physicians—coincided with a dramatic upsurge in sterilizations at the LACMC Women's Hospital. However, perhaps the most significant factor actuating this escalation was the complete lack of regulation surrounding sterilization practices at the hospital.

This complete lack of even minimal standards for ensuring informed consent formed a significant element of Rosenfeld's complaints against Quilligan and LACMC. While Quilligan maintained that the hospital's policy was “to do our very best to make sure

127 Espino, “Women Sterilized as they Give Birth,” 4.

128 Affidavit of Karen E. Benker, M.D., 2. Box 15, Folder 1, RCSP, UCSB-SC.

129 Helen Eastman Martin, *The History of the Los Angeles County Hospital (1878-1968) and the Los Angeles County-University of Southern California Medical Center (1968-1978)* (Los Angeles: University of Southern California Press, 1979), 328.

130 Ibid, 322.

131 Affidavit of Karen E. Benker, 2-3.

that every women [was] given informed consent before sterilizations are done,” the Women's Hospital had no official policy governing the practice of sterilization prior to 1974.¹³² Despite his apparent concern over patient protections, this deficiency lay solely with Quilligan, who, under the decentralized hospital system adopted by LACMC in 1968, had been granted complete power to develop and institute policies within his own department.¹³³ Quilligan's lack of concern for sterilization regulations became evident at the *Madrigal* trial. When asked whether any policy regarding sterilization existed prior to 1974, Quilligan hesitantly replied: “I guess I can say that the policy was the follow the standards in the [national medical] community.” Prompted to clarify his statement, the doctor stated: “Well, I think it was that the patient had a right to be sterilized, if she so requested. And, the individual physicians, residents, were to explain to the patient that it was an operation with was, in general, permanent.”¹³⁴ However, Quilligan admitted that no memo stating this position was ever issued to his staff; it was simply “discussed” on several occasions.¹³⁵ The OBGYNs at LACMC during this period, then, were effectively under no obligation from within the hospital hierarchy to ensure that their patients understood the procedure they were to undergo. In fact, the only written directive concerning sterilization at this time was a short statement contained in *Guidelines for Interns in Obstetrics*, used at the facility for guiding all admissions to the obstetrical ward. This directive, instructing interns to “ascertain the need for tubal ligation, [and] order consents and abdominal preps,” led to the aggressive “selling” of tubal ligations by physicians, and correspondingly the acquiescence of many women who did not understand what they were signing.¹³⁶ This was true of the ten plaintiffs in the *Madrigal* case, seven of whom signed their “consent” for sterilization, and was a feature, according to a former intern at LACMC, which facilitated a “consistent pattern of outrageous attempts to coerce patients to be sterilized.”¹³⁷

Benker, who served as a technician in the Women's Hospital between 1969-1970, was the only member of the hospital staff to testify against her colleagues at the trial, corroborating the stories of abuse at the facility. During her tenure at the hospital, Benker alleged to have encountered coercive practices on an almost daily basis, and never once recalled “seeing a woman counseled that the [sterilization] operation was permanent and irreversible;” that the sterilization could be done “at a later date if she wanted it;” nor that

132 Kistler, “Women 'Pushed' into Sterilization,” 28.

133 Martin, *The History of the Los Angeles County Hospital*, 503.

134 RTP, June 6, 691.

135 Ibid, 692.

136 Rosenfeld et al., *A Health Research Group Study on Surgical Sterilization*, 22.

137 Affidavit of Karen E. Benker, 4.

“there were many forms of birth control she could choose if she didn't want more children.” Once targeted by a resident physician for sterilization, mothers-to-be were simply “silently” presented with consent papers without being informed as to what they were signing.¹³⁸ Held in the hospital's active labor room, characterized, according to Benker, by “crowding, screams of pain, bright lights, lack of sleep by patients and staff, and an 'assembly-line' approach to patients,” mothers were usually approached for consent while exhausted, frightened, “in the most painful stages of labor,” and often under the influence of strong analgesic medication.¹³⁹ Thus mothers experiencing complications and requiring delivery by caesarian section were particularly vulnerable to “extremely aggressive” pressure from interns to get consent for sterilization, as the operation could be performed at the time of birth and before the mother had a chance to “change her mind.”¹⁴⁰ The efficacy with which physicians deceived or strong-armed women into sterilization was compounded by the language dynamics at the facility. With a largely Spanish-speaking clientele, Benker estimated that of all the mothers passing through LACMC, one in eight of them spoke “virtually no English.” The inverse was true of the physicians at the facility, virtually none of whom “spoke beyond a few words of Spanish.” Unable to understand the consent forms, nor the instructions of doctors, these non-English speaking women were acutely vulnerable to the coercion of physicians at the Women's hospital, and were often recommended for sterilization solely on the question, “More babies?”¹⁴¹ These were the conditions faced by the *Madrigal* plaintiffs when they entered the hospital to give birth. Their testimonies, often overlapping, provide poignant examples of the various methods employed by physicians to induce the women into being sterilized.

A common tactic used by physicians to gain consent from female patients was to deliberately obfuscate the consequences of the operation. This ranged from outright lying to patients that sterilization was reversible, to more subtle deception.¹⁴² Medical staff would often euphemistically refer to sterilization as a “tying” of the tubes in front of patients—therefore implying that tubes could be “untied” and the potential for conception restored. This was the experience of Jovita Rivera, a 28 year old Mexican woman who was unknowingly sterilized at the Women's Hospital in 1973. While preparing for the delivery of her fifth child, Rivera expressed a desire to have her “tubes tied” in order to increase the interval between the birth of her next child.¹⁴³ Despite clearly being unaware of the

138 Ibid, 6.

139 Ibid, 7.

140 Ibid, 4; Rosenfeld et al., *A Health Research Group Study on Surgical Sterilization*, 22.

141 Affidavit of Karen E. Benker, 6.

142 Sandra A. Salazar, “Fight to Stop Sterilization Abuse!,” 8. Box 51, Folder 1, MALDEF, SUA.

143 “Findings of Fact and Conclusions of Law re Jovita Rivera,” 4. Box 4, Folder 27, VISIP, UCLA-CSRC.

consequences of her request, medical staff failed to counsel Rivera, who neither spoke nor read English, about the operation; advise her regarding alternative forms of contraception; or provide her with any consent forms. It was only once Rivera was rushed for an emergency c-section following a prolapsed umbilical cord that doctors began aggressively pushing for consent, despite their being no emergency need for sterilization.¹⁴⁴ Following the successful delivery of her fifth and final child, Jorge, Rivera came to on the operating table with medical staff asking if they were going to tie her tubes. Very heavily sedated, not cognizant of the consequences, nor what she was signing, Rivera relented. The new mother recalled being too weak to sign the form independently, at which point the physician took her hand and “helped” her sign the consent.¹⁴⁵ Rivera only realized that she had been sterilized approximately a year later.¹⁴⁶

Estella Benavides, too, thought that her tubes had been “tied” after being forced in a sterilization operation while giving birth to her third child at the Women's Hospital in March, 1974. Having been in labor for over sixteen hours, physicians repeatedly approached a frightened and hemorrhaging Benavides for her consent to a tubal ligation. Medical staff told Benavides that she could die if she had any more children, and wished to sterilize the mother in order to “protect” her.¹⁴⁷ The false charge that sterilization, an elective operation, was necessary to protect the life of the mother, was pushed by physicians at the Women's Hospital. In her affidavit, Benker affirmed that this practice was widespread at the Women's hospital, and that many women who had “difficult” pregnancies were automatically approached for sterilization, even though “there were seldom grounds to say that another pregnancy was dangerous to the mother's health.”¹⁴⁸ At no time did physicians discuss alternative forms of contraception with Benavides. When Benavides rejected their arguments, saying that she desired more children, one of the doctors authoritatively replied, “well, you already have three, that's a good family plan.”¹⁴⁹ After repeated approaches by medical staff, reiterating that she may die if she did not consent to sterilization, and fearful what might happen to her daughters, Benavides signed the form. Heavily sedated, the nurses “dictated” what Benavides was to write. When asked later whether she felt pushed into the operation, Benavides replied: “I just thought that something might happen to me because I had no one to leave my girls with here.”¹⁵⁰

144 Ibid, 6.

145 *Madrigal v. Quilligan*, RTP, June 7-8, 875. Box 7, Folder 7, VISP, UCLA-CSRC.

146 “Findings of Fact and Conclusions of Law re Jovita Rivera,” 6.

147 *Madrigal v. Quilligan*, RTP, May 30, 129. Box 7, Folder 1, VISP, UCLA-CSRC.

148 Affidavit of Karen E. Benker, 5.

149 RTP, May 30, 125.

150 Ibid, 165.

Doctors similarly advised twenty-four-year-old Consuelo Hermosillo in September 1974 that further pregnancies could be hazardous to her wellbeing. Hermosillo had already delivered two children by c-section, and doctors misinformed her that any further operations could prove dangerous. As with Benavides, medical staff deliberately played on this fear in order to gain consent for tubal ligation, asking Hermosillo to consider her three children and what might happen to them in the event of any future complications.¹⁵¹ When Hermosillo continued to resist their advances, several medical staff erroneously informed her that California law limited the number of c-sections that a mother could receive to three. In fact, no such law existed.¹⁵² Doctors threatened to prolong Hermosillo's labor unless she consented to the operation. "My child," Hermosillo recalled a nurse advising her, "it is better that you sign the forms because they are going to keep you here. Not until you sign the forms will they taken you to the cesarean."¹⁵³ In great pain, and fearing for not just her own life, but her unborn child's, Hermosillo reluctantly agreed. While so weak and medicated that she had to be held up while signing, Hermosillo eventually gave written consent to be sterilized.¹⁵⁴

Just as medical staff exploited a mothers' relationships with her children in an effort to win their consent, they similarly took advantage of patients' marital relationships. As Benker attested, while it was a general policy that wives and husbands were separated during labor, "if a resident found that the woman was resisting sterilization he would sometimes have the husband come in and pressure the woman to go along with the sterilization, with false information that the mother's health would be endangered by further pregnancies."¹⁵⁵ Dolores Madrigal, who only learned that she had been permanently sterilized a month after giving birth to her third child when she heard news reports about sterilization cases at LACMC, encountered this coercion at the facility. As with the other women in the case, Madrigal was told when she entered the Women's Hospital on October 13, 1973 that she would be required to deliver her baby by c-section. Madrigal, who already had two children, recalled being repeatedly approached by medical staff for her consent to a sterilization procedure, who asked her why she refused to "take care of herself" by having pregnancies in such quick succession.¹⁵⁶ Each time Madrigal rebuffed their advances, another physician would approach and chastise her for her

151 "Findings of Fact and Conclusions of Law re Consuelo Hermosillo," 28. Box 4, Folder 27, VISP, UCLA-CSRC.

152 RTP, June 6, 667.

153 Ibid, 668.

154 "Findings of Fact and Conclusions of Law re Consuelo Hermosillo," 30.

155 Affidavit of Karen E. Benker, 5.

156 *Madrigal v. Quilligan*, RTP, June 2, 451. Box 7, Folder 4, VISP, UCLA-CSRC.

reproductive irresponsibility.¹⁵⁷ Finally, with Madrigal confined to a hospital bed in the hallway, the frustrated doctors sought to convince her husband that she should be sterilized. From her bed, Madrigal recalled overhearing a Spanish-speaking nurse tell her husband that “if I had another child, I was going to die—but that [was] not true.”¹⁵⁸ Doctors had not indicated to Madrigal any life-threatening problem, nor was there any medical indication for sterilization. Fearing that his wife may die, Mr. Madrigal gave his consent. Shortly after, Madrigal continued, “the nurse came over and told me, laughing, she said ‘your husband said yes.’” Weak, frightened, in great pain, and eager to deliver her child, a nurse threw a consent form at Madrigal.¹⁵⁹ Despite not understanding its content, she complied and was sterilized while giving birth.

As well as overstating or outright falsifying potential complications related to future pregnancies, medical staff threatened to deliberately endanger women's health by denying them adequate treatment. Benker alleged that doctors would routinely withhold pain medication from women in the “throes of a contraction,” unless they agreed to give their consent for sterilization.¹⁶⁰ During her pre-natal visits to the Women's Hospital, Elena Orzoco was persistently harassed by doctors for her consent to a tubal ligation following the birth of her sixth child. So frustrated were the staff with Orzoco's resistance that one doctor reportedly became very angry and shouted at the expected mother, insisting that she give her consent.¹⁶¹ When their approaches failed, doctors threatened to withhold treatment from the mother. Orzoco, who had been suffering from an abdominal hernia throughout her pregnancy, testified that during one visit to the pre-natal clinic, she was approached by several physicians who told her that unless she consented to tubal ligation, “they weren't going to fix the hernia right,” and that they would allow it to rupture.¹⁶² “Well,” Orzoco recalled the doctors explaining, “if I wasn't going to have a tubal ligation, they were going to fix it with less strong thread. But if I was going to have a tubal ligation, they would fix it right with the right thread so that I wouldn't have any complications later.”¹⁶³ Despite this pressure, medical staff only managed to get Orzoco's signature authorizing her sterilization on July 11, 1972, when she was admitted to the hospital for the delivery of her baby. Medical staff aggressively solicited Orzoco, now in the throes of labor, for her consent to sterilization, violently poking at her painful abdomen,

157 Ibid.

158 Ibid, 453.

159 Ibid, 454.

160 Affidavit of Karen E. Benker, 5.

161 “Findings of Fact and Conclusions of Law re Elena Orzoco,” 11. Box 4, Folder 27, VISP, UCLA-CSRC.

162 *Madrigal v. Quilligan*, RTP, June 1, 355. Box 7, Folder 3, VISP, UCLA-CSRC.

163 Ibid, 388.

and repeatedly insisting that she follow their instructions.¹⁶⁴ Believing that the operation was reversible, and wishing to stop the medical staff's harassment, Orzoco eventually signed the papers.¹⁶⁵

Physicians sometimes dispensed with the tactics entirely and simply made a unilateral decision that a woman was to be sterilized without consulting her. Doctors took this decision in the case of Guadalupe Acosta, who arrived at the medical center in August 1973 after an unusually long pregnancy. Already in the late stages of labor when she arrived, Acosta recalled receiving rough treatment from medical staff, who began pushing violently on her stomach in an attempt to induce labor.¹⁶⁶ When Acosta, in great pain and strapped to a bed, resisted, pushing one of the physicians away, she was punched in the stomach by another of the attending doctors.¹⁶⁷ Despite not being approached for her consent to a caesarian delivery, nor a tubal ligation, Acosta was taken to surgery and during the delivery of her child, was permanently sterilized. Doctors simply decided that Acosta should be sterilized, and then did so without informing her. It took eight days before Acosta learned that her child had been delivered stillborn, and even longer before she learnt of her sterilized.¹⁶⁸ It was only two months later, when Acosta returned to the hospital seeking temporary birth control while she recovered from surgery, that she was informed of her tubal ligation. On the drive to the hospital that day, Acosta and her husband spent the journey discussing potential names for a baby boy that they hoped to have following her recovery.¹⁶⁹ However, Acosta recalled a nurse telling her upon her arrival, "what do you want pills for when your tubes have been tied."¹⁷⁰ The hostile treatment experienced by, and ultimate sterilization of Acosta, and all of the women unlawfully operated on at the Women's Hospital, did not occur simply due to the lack of patient safeguards. Indeed, as the case of Rivera demonstrates, women were still vulnerable to pressure even after Quilligan's memorandum ostensibly established protections in hospital policy. While the lack of safeguards certainly facilitated abuse, the rampant coercion at the Women's hospital was symptomatic of a pervasive atmosphere of hostility towards the reproduction of minority women at the facility.

In many cases, the staff at the Women's Hospital viewed minority women simply as clinical material for interns and residents to practice surgical procedures on. This was

164 Ibid, 370.

165 "Findings of Fact and Conclusions of Law re Elena Orzoco," 13.

166 RTP, May 30, 62.

167 Ibid, 63.

168 Ibid, 75.

169 Diane Ainsworth, "Mother No More," *Reader: Los Angeles' Free Weekly*, January 26, 1979, 4.

170 RTP, May 30, 75.

the result, Rosenfeld contended, of a system that encouraged trainee surgeons to operate as much as possible during their training.¹⁷¹ Accordingly, interns at LACMC were not only encouraged to “push” women into sterilization surgeries, but actively congratulated when their efforts were successful. This practice was taught to all new OBGYN interns at the hospital, and in 1973, a resident reportedly instructed the latest crop of trainees: “I want you to ask every one of the girls if they want their tubes tied, regardless of how old they are. Remember everyone you get to get her tubes tied means two tubes for some resident or intern.”¹⁷²

Physicians also encouraged interns to push women into accepting hysterectomies over tubal ligation—privileging the more risk procedure so that trainee doctors could gain more experience. These physicians routinely abused their medical power in order to ensure that they had indigent bodies to operate on. For instance, when an intern at the Women's Hospital asked his resident how he should proceed if a woman resisted his advances to operate, the resident replied: “Talk her into it. You can always talk them into it.”¹⁷³ The reduction of the women's bodies to the status of clinical material points to what Carlos Velez-Ibanez, anthropologist, and expert witness at the *Madrigal* trial, termed the “neutralization of the minority person as human being.”¹⁷⁴ This process, which legitimized the denial of reproductive autonomy for Mexican-American, and indeed, other minority patients at the hands of LACMC physicians, was justified upon a confluence of adverse attitudes—centered around racially-driven fears of overpopulation and welfare abuse—towards the fertility of these “problematic” individuals, which, in the absence of safeguards, were allowed flourished in medical practice.

Benker attested to the “great emphasis” placed on curbing the fertility of Mexican-American patients at the Women's Hospital, which the plaintiffs' attorneys in *Madrigal* described as tantamount to a “philosophy” or hostility and distrust, fomented by senior medical staff.¹⁷⁵ Indeed, Benker recalled Dr. Quilligan, the most senior physician at the Women's Hospital, proudly tell a group of medical students that the hospital had received a two million dollar grant from the federal government “to show how low we can cut the birth rate of the negro and Mexican populations of Los Angeles County.”¹⁷⁶ Quilligan's statement was emblematic of a broader hostility towards the allegedly excessive

171 Rosenfeld et al., *A Health Research Group Study on Surgical Sterilization*, 2.

172 Ibid, 7.

173 Ibid.

174 Carlos G. Velez-Ibanez, “Se Me Acabo La Cancion: An Ethnography of Non-Consenting Sterilizations Among Mexican Women in Los Angeles,” in *Latina Issues: Fragments of Historia(ella) (herstory)*, ed. Antoinette Sedillo Lopez (New York: Garland Publishing Press, 1995), 190.

175 Affidavit of Karen E. Benker, 2; RTP, June 7-8, 828.

176 Ibid, 797.

childbearing of Mexican-American patients at the hospital, and their perceived contribution to rapid population growth and draining welfare expenses. Indeed, “it was frequently expressed,” according to Benker, the minority mothers “bred like rabbits” and “ate up money on welfare.”¹⁷⁷ Physicians told a patient at the facility that “people from Mexico are very poor and they can't support their children,” shortly before sterilizing the woman.¹⁷⁸ Another physician, justified sterilization patients, saying, “well, if we're going to pay for them we should control them.”¹⁷⁹ With these deeply engrained beliefs made operative by a lack of safeguards, physicians performed sterilizations because they were “socially desirable” rather than strictly medically necessary.¹⁸⁰ This “philosophy” reflected partly the broad permeation of neo-Malthusian beliefs into the medical profession nationally, which defined hyperfertility among the poor and minorities as problematic and burdensome. Indeed, as Benker stated, there was a “prevailing attitude” at LACMC that “one or two children were enough for any mother.”¹⁸¹ However, the treatment experienced by Mexican-American mothers at the hands of physicians at the Women's Hospital also reflected regionally-specific concerns and animosity towards the reproductive practices of Mexican immigrants.

Indeed, white Californians had long held concern over the perceived hyperfertility of Mexican immigrants and the social problems that they engendered. Since the 1920s, when concerns over immigration were at their peak, white Californians spoke of a “brown flood” of Mexican immigrants who forced “deplorable conditions[...]on our schools and social and public life.”¹⁸² In particular, the fecundity of these immigrants who “bred like rabbits and like rats” troubled these commentators.¹⁸³ By 1929, newspapers reported that almost eighteen percent of births across California were to Mexican parents, and in towns and cities closer to the border this figure reached as high as seventy percent.¹⁸⁴ The high birth-rate among poor immigrants, it was argued, placed tremendous strain on social services, with approximately twenty-five percent of all cases supported by the County Charities of Los Angeles and forty-three percent of all cases treated at Los Angeles General Hospital (Later LACMC) were of Mexican origin.¹⁸⁵ By the 1970s, the fecundity

177 Affidavit of Karen E. Benker, 7.

178 RTP, June 7-8, 902.

179 Kistler, “Women 'Pushed' into Sterilization,” 3.

180 RTP, June 7-8, 802.

181 Affidavit of Karen E. Benker, 8.

182 “Immigration Problems: Remarks Consisting of Portions of the Congressional Record and Committee Hearings for Reprinting, by John C. Box,” 2. Box 78, Folder 1, JRHP, UCLA-SCL.

183 Ibid.

184 “Tells About Mexican Influx: State Fact-Finding Committee on Immigration Problem Submits Report – Many Employed in Industry.” Box 78, Folder 2, JRHP, UCLA-SCL.

185 Frances A. Shambaugh, “Immigration and the Present Law,” *The Bulletin of the California League of Women Voters*, November 1939, 3. Box 78, Folder 2, JRHP, UCLA-SCL.

of Mexican immigrants was again brought into sharp focus as social crises surrounding welfare and overpopulation crested. During this period, the press increasingly portrayed Mexican immigrants as an opportunistic and cunning group, undeserving of the benefits rightfully owed to American taxpayers.

Reports of swathes of Mexicans illegally crossing the border in welfare funds was labelled as the “most complex and poignant social dilemma” of the 1970s.¹⁸⁶ California, which, along with other southwestern states, had traditionally experienced high volumes of Mexican immigration, and also held the highest reported rate of welfare abuse by undocumented immigrants nationally, was acutely aware of the problem.¹⁸⁷ Indeed, in 1973 it was reported that illegal immigrants in California were receiving approximately \$100 million annually in welfare payments due to lax monitoring by the Social Security Administration. Robert E. Mitchell, Chairman of the State Social Welfare Board, estimated that up to nine percent of relief rolls were populated by “ineligible recent immigrants, temporary aliens or illegal aliens.”¹⁸⁸ The increasing reports of welfare fraud by illegal immigrants in California and elsewhere prompted an *Immigration and Naturalizations Service* (INS) investigation in Los Angeles County, where it was confirmed that 2,883 illegal immigrants had been receiving public support, while another 2,960 failed to appear before investigators. Welfare payments were only part of the reported “drain” on public funds brought by Mexican immigrants, and the director of the *California Department of Health Services* estimated that Los Angeles County was spending \$10.5 million dollars annually providing health care for undocumented immigrants.¹⁸⁹ Newspapers from across the southwest voiced similar allegations of welfare abuse, and fed the image of the Mexican immigrant as an opportunistic and relentless “victimizer of the social system.”¹⁹⁰ These reports also warned that the economic impact of this “silent invasion” was not just a problem for the American taxpayer, but if left unabated, could result in a “national disaster” for the country.¹⁹¹ These popular stereotypes of Mexican immigrants as welfare grifters fueled the philosophy of distrust and hostility towards Mexican-origin mothers at LACMC, and, for the physicians responsible,

186 James Reston, “The Silent Invasion,” *The New York Times*, May 4, 1977, 23.

187 “Aliens’ Abuse of Welfare Cited: Cost is \$72 Million Yearly in Five States,” *Los Angeles Times*, November 14, 1977, b1.

188 “Aliens Reportedly Get \$100 Million in Welfare,” *Los Angeles Times*, January 27, 1973, A22.

189 John Kendall, “Influx of Illegal Aliens Termed ‘Out of Control,’” *Los Angeles Times*, January 9, 1977, 24.

190 Robert M. Lewis, “Illegal Welfare Recipients,” *Arizona Republic*, September 7, 1975; “Texas Wants Illegal Aliens Off Welfare,” *The Herald Banner*, July 27, 1972, 8; “State Welfare Abuses,” *Santa Fe New Mexican*, August 18, 1971, 6; Mike Otten, “Illegal Aliens are Costing State Taxpayers Millions,” *Ukiah Daily Journal*, November 12, 1970, 10.

191 Kendall, “Influx of Illegal Aliens Termed ‘Out of Control,’” A1.

legitimized the elimination of their childbearing potential.

While hostility was direct at Mexican immigrants as a whole, pregnant women in particular became the targets of sensational newspaper reports. These reports expressed anger over so-called “pregnant pilgrims” - Mexican women who crossed the border while pregnant in order that their children could be born in American hospitals, and receive U.S. citizenship.¹⁹² Indeed, so rife was the practice, claimed a report in the *San Antonio Express*, that forty-five percent of all maternity cases in an unnamed Los Angeles Hospital involved “illegal alien women giving birth to brand-new U.S. Citizens.”¹⁹³ Similarly, a San Diego hospital estimated that at least fifteen Mexican mothers made their “pilgrimage” across the border each month to give birth in “the most modern medical facilities” at county taxpayer expense. “The strongest lure,” claimed the report, “is American citizenship for the child born there.”¹⁹⁴ The litany of reports on “pregnant pilgrims” portrayed the women making the short to the United States as conniving menaces who waited on the border until the onset of labor, crossing into American order to “compel” public hospitals in California, Arizona and Texas to admit them as emergency patients using taxpayer money.¹⁹⁵ These articles both informed and reflected the public's fears over Mexican immigrant women's fecundity, and anger at their taking advantage of services that they, as non-citizens, were supposedly not entitled to. This attitude had clearly been accepted by medical staff at LACMC, where doctors reportedly believed that women who didn't speak English “weren't really 'American,’” and that they had “come from Mexico pregnant on the bus just so that they could have their baby born an American citizen, 'so they themselves can't be deported.’”¹⁹⁶ These beliefs, reflective of wider public hostility, rendered the fertility of Mexican mothers at LACMC to be viewed as pathological, and to doctors, legitimized controlling their reproduction upon the costs saved to the taxpayer, the state, and the nation.

Contesting these stereotypes, and seeking redress for their suffering at the hands of the county physicians, ten Mexican-American women sterilized at LACMC stepped out of one paternalistic environment, the hospital, and entered another, the courtroom. Here they were confronted by the same markedly asymmetric power dynamic that had led to their non-consenting sterilizations. Despite the considerable forces working to stymie their

192 “Mexican Women Give Birth to Americans,” *Indiana Gazette*, June 30, 1975, 40; “Women in Labor Find Open Border,” *Valley Morning Star*, June 15, 1975, 33; “Mexican Women Make Trip to U.S. To Bear Children,” *Asbury Park Press*, November 24, 1972, 10.

193 Steven Kline, “Aliens: Victims or Victimizers?” *San Antonio Express*, August 23, 1977, 13.

194 “Pregnancy Pilgrimage Offers Hope to Mexican Mothers,” *Los Angeles Times*, December 1, 1972, D16.

195 Tom Kuhn, “Aliens Give Birth at State's Expense,” *Arizona Daily Republic*, April 27, 1975, 1.

196 Affidavit of Karen E. Benker, 7.

voices, the impoverished, minority, and largely uneducated women sought to speak out against the violence perpetrated by doctors, who had robbed them of their constitutional right to procreate. They did so not just for themselves, nor the approximately \$170,000 in damages requested, but also to prevent similar abuses occurring against vulnerable women in the future. The women were aided by two attorneys two young attorneys, and a team of expert witnesses who all attested that the women, whether drugged, distressed, or deceived, could not have provided their informed consent to the sterilization operations performed on them. Their action occurred at a time of mobilization against abusive sterilization practices in California and nationally, and a search for appropriate safeguards in the future. Although they may not have appreciated the significance of their case when it came before the California Court of Appeals in 1978, the Madrigal plaintiffs would have a decisive effect on the shaping of California sterilization policy in the years immediately following the lawsuit.

The Culpability of Culture: Madrigal v. Quilligan and the Fight for Reproductive Autonomy

Following repeated appeals from Rosenfeld, the doctor who broke the allegations of abuse at LACMC to the nation, Charles Nabarette, a young attorney at the *Model Cities Center for Law and Justice*, agreed to represent the sterilized women in a suit against the hospital. Nabarette was joined by two associates at the Center, which, ironically, was funded under the War on Poverty, Antonia Hernandez and Georgina Torres-Rizk. However, the latter would leave the case before its conclusion.¹⁹⁷ Despite Nabarette's initial reluctance to take the case, the attorneys all recognized the tremendous importance of the action, not alone for its impact on sterilization policy in the state, but also on Mexican-American women's rights more broadly. Alongside this recognition, and her own outrage over the allegations, Hernandez had deeply personal motivations for taking the case. Hernandez's own mother had been misinformed by doctors at LACMC that sterilization was medically necessary to protect her life following the birth of one of her children at the hospital. Unlike the women Hernandez was to represent in court, her mother was able to refuse the doctors' advances after getting a second opinion.¹⁹⁸ Hernandez and Nabarette would receive assistance from the Comisión Femenil and the Chicana Welfare Rights Organization, who, along with raising awareness for the issue of sterilization abuse as part of a broader coalition of Chicana-rights activist groups flourishing in the 1970s, aided the attorneys in locating over

197 Espino, "Women Sterilized as they Give Birth," 218-219.

198 Ibid, 249.

one hundred women who claimed to have been coercively sterilized at LACMC.¹⁹⁹ The grassroots activism of these groups emboldened the Mexican-American community to challenge the abuses at LACMC, crystalizing in the protest march from State Street Park to the hospital by several hundred activists, and the resulting coverage of abuses in the *Los Angeles Times*.²⁰⁰ Despite this burgeoning support, only twelve of the women located by the attorneys agreed to testify in the courtroom against Quilligan and his cohort. In a case that would last for over two years, the women and their attorneys were forced not only to confront the power of the physicians who had robbed them of their reproductive ability, but also the power of the court itself. Beginning in the late 1975, the women's courage in the face of these odds was met with early and significant results.

The attorneys' aims were far-reaching, and along with financial reparations for the women, asked the court to temporarily halt sterilizations operations at LACMC, issue an injunction against the defendant doctors, and significantly modify the consent process for tubal ligation in public health facilities across the state.²⁰¹ The latter point was insisted upon by Hernandez, who believed that: "only a reform of the existing regulations can ensure voluntary and informed consent" for vulnerable patients like the plaintiffs.²⁰² Despite the women's testimony of abuse, Judge Elisha Crary ruled in favor of the defendants, accepting the doctors' argument that the women "freely and voluntarily consented to said elective surgical procedure."²⁰³ In spite of this setback, however, the Hernandez and Nabarette found reason to celebrate. In what represented a major step forward in the protection of women's reproductive autonomy in California, Crary ordered that sterilization consent forms be written in both Spanish and English, and furthermore, at a sixth grade education level of comprehension.²⁰⁴ Prior to this order, no provision existed that consent forms were legible to the Mexican-American women.²⁰⁵ At the trial, an expert witness testified that LACMC consent forms were written at an eleventh grade reading level, despite forty-five percent of the hospitals Mexican-American clientele possessing a comprehension level far below this. As a further protection, while California permitted the sterilization of patients as young as eighteen, Crary ordered that federal monies could no longer be used to fund sterilizations for those under twenty-one years old. In light of the

199 Ainsworth, "Mother No More," 4.

200 Mike Goodman, "3 Women ask \$6 Million from County in Sterilization Claim," *Los Angeles Times*, November 21, 1974, A1. Local newspaper coverage of the sterilization's at LACMC began in late-1974

201 Gutierrez, *Fertile Matters*, 50.

202 Hernandez, "Chicanas and the Issue of Involuntary Sterilization," 32.

203 Espino, "Women Sterilized as they Give Birth," 253.

204 Robert Rawitch, "State Enjoined in Sterilization Suit Filed by Women," *Los Angeles Times*, October 7, 1975, 6.

205 Hernandez, "Chicanas and the Issue of Involuntary Sterilization," 29.

protections handed down by the judge, Nabarette claimed that, except for the financial damages, his team had: “won everything we've asked for.”²⁰⁶ Importantly, a mechanism had been added in California's public hospitals that, although may have not completely halted coercive sterilization, provided greater protection to Spanish-speaking and low-income women using these facilities. Undeterred by Crary's vindication of the doctors, Nabarette and Hernandez chose to appeal the decision, and two years later the women would receive another chance at justice for the deprivation of their reproductive autonomy.

At the second trial, beginning on May 31 1978, the women's attorneys marshaled considerable evidence to prove not only that the women could not provide their consent to the operations, but that the racist attitudes of hospital staff had resulted in their unwanted sterilization. Along with the women themselves, Karen Benker, whose scathing deposition prior to the trial detailed systematic coercion at the facility, took the stand to testify. There she was joined by a number of expert witnesses who all reinforced the women's allegations. Dr. Don Sloan, a renowned OBGYN, who had experience with issues of informed consent after assisting the *New York Health and Hospitals Corporation* “revise, rewrite, and restate” acceptance consent forms for sterilization, presented evidence that, given the conditions faced by the women, none of the 'consents' given could have been acceptable.²⁰⁷ Handwriting expert William Bowman highlighted dramatic discrepancies between the women's signatures at the time of admission and those given on their consent forms hours later, indicative, he argued, of significant distress.²⁰⁸ Dr. Terry Kupers, a psychiatrist, testified to the distress experienced by the women, demonstrating that they had all suffered “irreparable psychological damage” after their coerced surgeries.²⁰⁹ Along with the women's testimonies, this evidence was presented to judge Jesse W. Curtis, who had taken over the case after Crary's death. As Nabarette and Hernandez waived their right to a jury trial, the final decision would rest with the seventy year old unabashed conservative, who was described as a “stereotype of the paternalistic figure commanding the courtroom.”²¹⁰ As the plaintiffs made their case of the two and a half week trial, Curtis's hostility towards Mexican-American women and their fertility was laid bare. Throughout the case, the judge variously criticized, disregarded, or repurposed the plaintiffs' arguments to favor the doctors. The judge's hostility is illustrative of how social

206 Rawitch, “State Enjoined in Sterilization Suit,” 6.

207 *Madrigal v. Quilligan*, RTP, June 5, 531. Box 7, Folder 5, VISIP, UCLA-CSRC.

208 Narda Zachinno, “Trial Hears Handwriting Expert: Sterilized Women Were 'Troubled,' Court Told,” *Los Angeles Times*, June 15, 1978, B30.

209 Terry A. Kupers, “10 Lose Their Fertility – and Their Case,” *Los Angeles Times*, September 28, 1978, C7.

210 Velez-Ibanez, “Se Me Acabo La Cancion,” 197.

attitudes towards overpopulation, welfare costs, and minority fertility pervaded the court room as well as medical practice. Curtis's contempt for the plaintiffs' case is highlighted in his lengthy objection to the testimony of Karen Benker.

As the only member of the Women's Hospital staff to testify against her former colleagues, Benker's damning personal observations of abuse at LACMC ostensibly provided compelling evidence for the plaintiffs. Her testimony ventured to establish that doctors at the medical center pushed Mexican-American women, seen as a "strain on society," into sterilization for social reasons, and that this notion, in turn, pervaded the entire "culture and practice" of the hospital.²¹¹ Benker's potentially pivotal evidence, however, was stymied by Curtis who did "not think there was any point" in a discussion of the hospital's atmosphere or culture.²¹² At best, Curtis considered the former intern's observations of medical staffs' attitudes as "peripheral" to the central issue of whether Quilligan and other physicians had exploited their professional power and "overridden" the women's wishes by insisting on sterilization.²¹³ Therefore judging Benker's testimony to be largely immaterial to the case, Curtis asserted that, as long as medical justification was present, and doctors had not overstepped their authority, they were, as any other individual, entitled to hold and express beliefs about the fertility of specific racial groups and conceptions of ideal family size.²¹⁴ The judge ascribed the "confusion" over this issue to a simple "clash of cultures;" pitting the pronatalist sentiment, characteristic of the Mexican-American plaintiffs, against, in his opinion, the more rational anti-natalist stance of the doctors. On this point, it is worth quoting Curtis's reductionist and patronizing opinion at length:

The plaintiffs are Mexican-Americans who have a culture they based [sic] somewhat foreign to ours. They just happened to be Mexican-Americans. There could be other people who, I think in this country, come from other ethnic backgrounds who have more or less the same culture, one which highly values the woman's ability to procreate a family, and particularly the size of the family is a matter of great concern, and also has almost a religious significance[...]

The other cultural aspect is one which exists in this country which has somewhat less regard, let us say, for large families. It does not have the religious connections with it or the religious feels about it. In fact, there is a big segment of the people in this country, and not only in this country but in the world, who believe that one of the prime causes of our social and economic problems are big families where the parents are not able to either socially or economically support them. The people who have that belief have gone out on a program to try to encourage or to persuade people who have big families to cut down and to become involved in various birth control procedures[...]

So, I do not think it is surprising that you might find a doctor who believes that people who are inclined to have big families shouldn't, and particularly for good medical reasons, undertake to persuade a person not to have a large family. And if that person agrees and is willing to be sterilized, then I cannot see anything wrong with the doctor having suggested it or having convinced the patient,

211 RTP, June 6, 783; RTP, June 7-8, 802.

212 Ibid, 812.

213 Ibid, 825.

214 Ibid, 829.

so long as he does not use his powers, his ability, his circumstances to override what would be a reasonable decision on the part of the patient.²¹⁵

Ultimately, in choosing not to recognize any link between the doctors' attitudes and the alleged non-consenting sterilization of the women, and characterizing Benker's testimony as a "waste of time," Curtis eliminated a significant element of the plaintiffs' case.²¹⁶ The racial bias at play was obvious. Dubious of whether any social justifications for sterilization were operative to begin with, Curtis nevertheless sided with the doctors, whose alleged racially-driven remarks he considered to be at most an issue for internal administrative inquiry. His adumbration of the cultural significance of fertility to Mexican-American women, and ultimate disregard of it, further highlight this bias. This issue of cultural difference would continue to play a central role in the trial, especially following the testimony of expert witness Carlos Velez-Ibanez.

Velez-Ibanez, a professor of anthropology at UCLA, was asked by Nabarette and Hernandez to testify about the "dire" social and cultural implications experienced by the women subsequent to their non-consenting sterilizations at the hospital.²¹⁷ With Velez-Ibanez's evidence, the attorneys intended to show that, given the cultural significance of motherhood within the traditional Mexican rural subculture to which the majority of the sterilized women belonged, they had suffered greatly at the hands of doctors. Yet, before Velez-Ibanez even had the opportunity to testify, Curtis applied the reductionism leveled against Benker's testimony to the anthropologist's work. Devaluing the importance of the women's culture, Curtis remarked: "everybody knows the Mexican people have strong feelings about a big family, and how they have an intense love for children and that sort of thing." "Frankly," the judge concluded, "I doubt very much whether this witness is going to be able to testify to anything that the Court cannot already take judicial notice of." Reinforcing widely-held stereotypes ("everybody knows"), about the supposed fecundity of Mexican-American mothers, Curtis believed Velez-Ibanez's expert testimony to be superfluous and self-evident. While he did not consider this testimony to be "very helpful," nor a valuable use of the plaintiffs' trial expenses, Curtis ultimately allowed Velez-Ibanez to present the findings of his 450 hour ethnographic study.²¹⁸

Following extensive communication with the sterilization women, Velez discovered that eight of the nine he worked with came from traditional, low-income agricultural settings where fertility was so prized that "social identity for such women

215 Ibid, 823-825.

216 Ibid, 815.

217 RTP, May 30, 27.

218 RTP, June 2, 393.

would be intricately related to the potential of having children.”²¹⁹ Sterilization, therefore, not only undermined the plaintiffs' identity as women, but also their social identity and standing. Velez noted how childbirth was an integral part of the women's “subculture,” and that mothers “received prestige and were recognized as valued adults because of the potential and ability to bear children.” This esteem, he argued, was reinforced by “the continued presence of small children in the household.” Indeed, so important was motherhood within the women's culture that one's status as “una mujer” (a woman) was intimately tied to having children.²²⁰ The consequences of sterilization, a “visible and permanent mark of humiliation,” for these women were far reaching, Velez-Ibanez argued.²²¹ The stigmatized women withdrew from friends and family members; isolating themselves out of shame and refusing to discuss their ordeal with siblings or parents.²²² Likewise, Velez-Ibanez concluded that significant marital tensions, including violence and abandonment, had resulted from the women's sterilization. In all, he believed eight of the women's marriages to have “suffered irreparable damage to different degrees,” with three of them ending in divorce before the conclusion of the trial.²²³ Estella Benavides described how she had separated from her husband on three occasions since her sterilization in 1974. Her husband had clearly been angered by her inability to bear children and following a heated argument, snapped that she was now “not enough of a woman.”²²⁴ Benavides also spoke of a cessation of intimacy in the relationship. In the women's culture, sexual relations were a “mechanism for bearing children,” rather than solely pleasure, thus sterilization had removed the primary motivation for these amatory relationships.²²⁵ Velez-Ibanez's thoroughgoing testimony used these severe physical, psychological, and emotional traumas to highlight the powerful cultural significance of fertility for these women.

In contrast to the plaintiffs' comprehensive case, the defense neither contested the evidence of the expert witnesses nor extensively cross-examined the women's testimony. The only witnesses called by the defense were the doctors themselves, each of whom was unable to recall treating any of the women, and declared that it was there “custom and practice” not to suggest sterilization unless it was specifically asked for, or medically indicated.²²⁶ Despite acknowledging the “great complexity” of the “social, emotional and

219 Carlos Velez-Ibanez, “The Notion of Culture,” 35. Box 5, Folder 36, VISP, UCLA-CSRC.

220 Velez-Ibanez, “Se Me Acabo La Cancion,” 191.

221 *Madrigal v. Quilligan*, RTP, June 9, 1050. Box 8, Folder 1, VISP, UCLA-CSRC.

222 Ainsworth, “Mother No More,” 5.

223 Velez-Ibanez, “Se Me Acabo La Cancion,” 193.

224 *Madrigal v. Quilligan*, RTP, May 31, 149. Box 7, Folder 2, VISP, UCLA-CSRC.

225 Velez-Ibanez, “Se Me Acabo La Cancion,” 191.

226 *Ibid*, 198.

cultural considerations” at play, Curtis accepted the doctors' claims at face value and ultimately ruled in their favor on June 30, 1978.²²⁷ In doing so, Curtis refuted what he understood to be the plaintiffs' argument that they were the “victims of a concerted plan by hospital attendants and doctors to push them, as members of a low socio-economic group who tend toward large families, to consent to sterilization in order to accomplish *some sinister, invidious social purpose*.”²²⁸ In doing so, Curtis completely undermined the plaintiffs testimony of their experiences, considering it hyperbolic and conspiratorial. Addressing each woman's claim individually, Curtis found it unsurprising that the doctors, as members of a busy inner-city obstetrics ward, failed to remember treating the plaintiffs, and ruled that in each case doctors had acted upon the “bona fide belief” that the women had wanted, and knowingly consented to the tubal ligations performed on them.²²⁹ In absolving the doctors, Curtis parroted their claims that the medical staff “would not perform an operation unless they were certain in their own mind that the patient understood the nature of the operation and was requesting the procedure.”²³⁰ The arguments employed by Curtis in absolving the doctors of fault highlight how veiled anti-immigrant sentiment, itself inexorable linked with fears of overpopulation and welfare abuse, guided the court proceedings. This was particularly apparent in the judge's manipulation of Velez-Ibanez's testimony.

Throughout his inflammatory decision, Curtis made repeated references to the women's Mexican origins, and despite his derision of Velez-Ibanez's work, heavily paraphrased the anthropologist's findings. The plaintiffs had contended that the women's minority status, and the commonplace association with harmful hyperfertility that accompanied it, resulted in their unwanted sterilizations at the hands of physicians, and, in light of Velez-Ibanez's testimony, amplified their claims for damages.²³¹ Substantively, Curtis agreed with Velez-Ibanez's work, agreeing that the decision process leading up to sterilization was “a much more traumatic event” for the plaintiffs than for “typical” patients.²³² The judge, however, reversed the causality of the plaintiffs' argument, declaring that the women's cultural differences had, in fact, “*contributed* to the problem in a subtle but significant way.”²³³ Emphasizing their atypicality, Curtis recognized that the women would have needed “great explanation, more patient advice, and greater care in

227 Ibid, 199.

228 Jesse W. Curtis, “Opinion,” in Reynaldo A. Valencia, *Mexican Americans and the Law: El Pueblo Unido Jamas Sera Vencido* (Tuscon: University of Arizona Press, 2004), 44.

229 Ibid, 46.

230 Velez-Ibanez, “Se Me Acabo La Cancion,” 199.

231 RTP, May 30, 26-28.

232 Curtis, “Opinion,” 45.

233 Ibid, 44.

interpreting her consent than persons not members of such a subculture.”²³⁴ Turning this testimony against the women, Curtis continued:

But this need for such deliberate treatment is not readily apparent. The anthropological expert testified that he would not have known that these women possessed these traits had he not conducted tests and a study which required some 450 hours of time[...]It is not surprising therefore that the staff of a busy metropolitan hospital which had neither the time nor staff to make such esoteric studies would be unaware of these atypical cultural traits.²³⁵

Curtis's statement excused whatever behavior the plaintiffs may have considered abusive as a culturally-rooted overreaction to what the judge considered ostensibly “normal” operating procedure by the doctors. With such knowledge extending beyond that required of the doctors, Curtis believed they could not be blamed “for relying on indicia of consent which appeared to be unequivocal at face value.”²³⁶

The judge made a similar shift when addressing the importance of language in the women's mistreatment by doctors. The plaintiffs' contention was that medical staff had deliberately exploited the language barrier in order to obfuscate both the necessity and outcome of the operations foisted on the women, and were aided in doing so by consent forms written solely in English. Benker's declaration that non-English speaking women, whom account for approximately sixty percent of the hospital's caseload, were “by far the most abused” patients at LACMC, spoke to the central importance of language as a facilitator of exploitative practices by primarily English speaking doctors.²³⁷ Yet for Curtis, it was not the doctors inability to speak Spanish beyond a few rudimentary OBGYN-related terms that resulted in the “breakdown in communication” that led to the women's sterilizations, but rather the inability of the Spanish-speaking patients to adequately express their objections.²³⁸ The judge claimed that the preponderance of Spanish speaking patients was “generally understood” by hospital administrators, and that staff at the facility had “acquired enough familiarity of the language to get by.”²³⁹ This statement, was based on the uncritical acceptance of testimony from physicians such as Quilligan, who claimed, again, that physicians had learned enough Spanish, what one doctors referred to as “obstetrical Spanish,” to “communicate with the patients.”²⁴⁰ Despite some of the women attesting otherwise, Curtis accepted Quilligan's claim that the hospital always provided interpreters to Spanish speaking patients if it was “thought to be a necessity” by the

234 Ibid, 45.

235 Velez-Ibanez, “Se Me Acabo La Cancion,” 199.

236 Curtis, “Opinion,” 47.

237 Affidavit of Karen E. Benker, 6.

238 Curtis, “Opinion,” 44.

239 Ibid.

240 For “Obstetrical Spanish” see testimony of James Schreiber in *Madrigal v. Quilligan*, RTP, June 13, 1433. Box 8, Folder 3, VISP, UCLA-CSRC; For Quilligan's statements see RTP, June 6, 748.

attending physician.²⁴¹ Yet, Curtis concluded, “despite even with these precautions *misunderstandings are bound to occur*” (emphasis mine).²⁴² Painting the women's sterilizations as the result of a misunderstanding, and furthermore, one which had been caused by their own inability to communicate, the judge successfully undermined the plaintiffs claim that doctors intentionally manipulated the language barrier in order to accomplish their anti-immigrant and anti-natalist ends through tubal ligation. Again, it was the atypicality of the women—in this case their language—that was alleged to have *contributed* to their loss of fertility.

Nabarette and Hernandez viewed Curtis's discriminatory closing statement as a significant setback, not only for the women, who were left completely uncompensated, but also for the many other women left open to coercion by physicians in publicly funded hospitals across state and nationwide.²⁴³ Encapsulating the reaction to the decision, Terry Kupers, the psychiatrist who had served as expert witness for the plaintiffs, stated: “the legal system treated them [the women] as shabbily as did the medical system.”²⁴⁴ Shortly after the decision was handed down, Nabarette voiced his intention to launch an appeal against the result, particularly in light of Curtis's complete disregard of expert witness Don Sloan's testimony on the issue of informed consent.²⁴⁵ While, for reasons unknown, the appeal seemingly failed to materialize, the trial was not without its positive outcomes, and the women's actions against the hospital resulted in the establishment of important guidelines designed to protect the reproductive autonomy of patients in public health facilities.²⁴⁶ For instance, as a direct result of the publicity surrounding the trial, LACMC was, in 1975, reported to be among only three out of fifty-one hospitals surveyed nationwide to be in full compliance with DHEW's federal guidelines on informed consent for sterilization released in 1974, which, among other stipulations, mandated a seventy-two hour waiting period between consent and the operation.²⁴⁷ Quilligan also reported that the hospital had opened a dedicated sterilization counseling clinic, one of only a few nationwide, and staffed by a team of “specially trained” female counsellors, to ensure that those undergoing the procedure fully understood the risk and alternatives.²⁴⁸ Alongside the affirmative relief judgement issued by Crary in 1975 that required the California

241 Ibid.

242 Curtis, “Opinion,” 44.

243 Gutierrez, *Fertile Matters*, 50.

244 Kupers, “10 Lose Their Fertility,” C7.

245 Narda Zachinno, “10 Women Will Appeal Ruling on Sterilization,” *Los Angeles Times*, July 8, 1978, A26.

246 Kluchin, *Fit to be Tied*, 173.

247 Krauss, *Hospital Survey on Sterilization Policies*, 21.

248 Claudia Dreifus, “Sterilizing the Poor,” *The Progressive* 39 (1975): 19.

Department of Health to issue all sterilization consent forms and related materials in both English and Spanish, and at an intelligible reading level, these protections constituted a material victory for the plaintiffs, addressing both the immediate abuses that had occurred at LACMC, and impairing the ability of doctors to perpetuate similar coercion.²⁴⁹

However, arguably a more important outcome of the *Madrigal* trial was its galvanizing effect on a coalition of activists unified by and opposed to sterilization abuse and the state policies that they believed permitted its occurrence. As Sandra Salazar, leader of the *Chicana Rights Project*, wrote as the trial unfolded: “Women in California have a chance to stop forced sterilizations. But we must speak up and not be ashamed to let doctors and government officials know that we value the right to have children and that we value the right to decided how many children we want to have.”²⁵⁰ For many in the fight against sterilization abuse, *Madrigal* provided this impetus to speak up. Emboldened by the plaintiffs' decision to confront the formidable power of both the medical establishment that sterilized them, and the court that effectively sanctioned it, a broad array of activists, lawyers, health professionals, and community leaders highlighted the continuing potential for coercion in sterilization decisions, and the crucial need to revise the liberal guidelines that governed the process.²⁵¹ They were aided by organizations such as MALDEF, and the *Coalition for the Medical Rights of Women* (CMRW), both of whom contributed considerable resources to the movement against abuse.²⁵² Alongside the significant newspaper coverage generated by the highly-public court proceedings, these activists forcefully put the issue of sterilization abuse before legislators and the public alike through a series of public hearings, demonstrations, lectures and press releases.²⁵³ Tackling what they understood to be the source of coercion—the issue of informed consent—this coalition launched a legal campaign aimed at negotiating, alongside legislators, the form and substance of new sterilization guidelines for California that would provide greater protection to patient rights and neutralize the problems of coercion and deficiencies in the mechanisms of obtaining consent. In the name of reproductive rights, these activists would engage in an acrimonious battle to reshape California's sterilization policy, the labyrinthine nature of which would elicit conflicts over the appropriate scope of patient rights, medical authority, and reproductive self-determination.

249 Rawitch, “State Enjoined in Sterilization Suit,” 6.

250 Salazar, “Fight to Stop Sterilization Abuse!” 3.

251 Espino, “Women Sterilized as they Give Birth,” 255-256.

252 Kluchin, *Fit to be Tied*, 199.

253 For community mobilization see Gutierrez, *Fertile Matters*, 95.

Conclusion

By the close of the *Madrigal* proceedings, sterilization rates across the country had increased threefold since the turn of the 1970s. In California, which continued to claim the largest total of sterilization operations performed annually, this precipitous increase resulted from overlapping federal and state policy developments. It would not be hyperbolic to say that the Nixon regime's foolhardy funding of a nationwide family planning system, within which sterilization was privileged as a birth control option for the poor, ushered in a chapter of pervasive abuse and the systematic contravention of reproductive rights for several hundred thousand vulnerable individuals during the 1970s. That this saturation of government funding at least partly accounted for the instances of abuse that surfaced during this period has generally been appreciated by historians. Conversely, developments during this period in California's sterilization policy have remained relatively overlooked. The *Jessin* trial not only dramatically reoriented the state's stance on the legality of the operation, emboldening medical professionals with the discretion to operate free from the fear of prosecution, it also served as a precedent for and impetus to the evaporation of restrictive guidelines to the procedure nationwide. Inseparable from the development of both policies were population control agendas—those of legislators, physicians, and much of society more broadly—that sought, by limiting problematic fertility, to abate the social crises of overpopulation and the welfare mess. Arguably nowhere amongst the numerous incidents of sterilization abuse during the 1970s was the integration of anti-natalist social attitudes into sterilization policy more apparent than in the non-consenting sterilizations of the *Madrigal* plaintiffs by medical staff at LACMC. Here long held hostility and suspicion of perceived Mexican-American hyper-fertility and irresponsible motherhood was given teeth by a lack of regulatory oversight or guidelines designed to protect the reproductive autonomy of patients, and almost open-ended funding from the federal government.

Towards the end of the decade, the “horror stories” of sterilization abuse emanating from hospitals nationwide galvanized activists to press for more protective legislation to eliminate alleged federal support for coercive and uniformed sterilizations. In late 1977, representatives from over fifty national organizations, including women's, religious, civil rights, family planning, and reproductive rights groups, assembled in Washington D.C. for a *National Conference on Sterilization Abuse* that recommended the suspension of all sterilization operations funded by DHEW while a new protective policy was implemented. As awareness of the need for new guidelines grew, California would be one of two states—the other being New York—that would draft protective procedural regulations for

sterilization of their own without waiting for the federal government to take action. This battle for, and eventually form and substance of California's new regulations, aimed at ensuring that each patient choosing sterilization in the state would be supplied with the correct information to make a decision with “legally effective informed consent,” will be the focus of the following chapter. In particular, it will chart the efforts of predominantly Chicana activists who worked with the State Department of Health in formulating a new protective policy of sterilization in the state, against continued resistance from the medical professionals seeking to reassert their traditional authority over such decisions. Importantly, it will also highlight, as the period of abuse subsided, and a new period of growing protections emerged, how the reverberation of these policy changes would significantly affect California's developmentally disabled community in the years that followed.

Chapter III

Caught in the Crossfire: The State, Sterilization Regulations, and the Competing Meanings of Reproductive Freedom in the 1970s and 1980s

Thus, we have a cycle. Originally, hospitals imposed restrictions on access to sterilizations; then they became freely available; now, these regulations attempt to impose new and sweeping restrictions—not just on voluntary sterilizations for contraceptive purposes, but on a broad range of medical treatments and procedures which may result in infertility.¹

When a patient of Dr C Alan Sevenser's arrived at the OBGYN's practice in Tulare, California in late 1977, the physician informed her that obstetrical indications necessitated that she gave birth via cesarean section, which Sevenser scheduled for a week later. During the visit, the mother-to-be and her husband requested that she be sterilized at the same time as the birth. New California sterilization regulations, designed to protect women from coercion, required that a minimum of seventy-two hours elapse after a patient consented to a sterilization operation before the procedure can be performed. Had the operation gone ahead as planned, the waiting period would not have affected Sevenser's patient. Yet, less than seventy-two hours later, the woman went into "spontaneous labor," requiring Sevenser to perform an emergency c-section. Although she had consented to a tubal ligation, the woman was denied sterilization, as seventy-two hours had not elapsed since her and her husband's consent. The patient now, wrote Sevenser acrimoniously, would be forced to return at a later date "for a new anesthetic, a new surgery, and all of the expense that goes with it." The patient's was one of several case studies used by the OBGYN, and a number of colleagues, in early 1978 before the Sacramento superior court, in order to highlight the "detrimental" effect of sterilization regulations on their patients, and hopefully, see such regulations stricken from California's administrative code.²

The inability of Sevenser's patient, a white woman, to access sterilization on demand highlights one of the problems faced by the state of California in the schismatic debate over sterilization regulations that emerged in the mid-1970s following evidence of nationwide sterilization abuse. Given that it was largely poor minority women upon which this abuse was perpetrated, the battle lines over protections assumed discernible racial and class dimensions. Broadly, White, middle-class women, would hold up the experiences of patients like Sevenser's in attacking informed consent regulations which they viewed as sexist and restrictive. Informed by the struggle for abortion rights, white feminists had maintained an aversion to government intrusion in matters of reproduction and, privileged

¹ "Appellant's Opening Brief," *CMA v. Lackner Pleadings*, 5. Box 909, Folder 5, MALDEF, SUA.

² "Testimony of C. Alan Sevenser, M.D. In Support of Plaintiffs' Motion for Summary Judgement," *CMA v. Lackner Pleadings*, 2. Box 908, Folder 7, MALDEF, SUA.

individual choice in such decisions.³ In the context of sterilization, this denoted the right to access the procedure at will. This stance would clash with that taken by minority women and their representatives, who held that only comprehensive government regulation could put power back in health consumers hands, and offer them a modicum of protection in sterilization decisions. The inconvenience of having to delay a sterilization procedure, minority women argued, paled in comparison to the irreversible and life-altering consequences of involuntary sterilization. Thus, freedom of choice, in this context, meant freedom to choose *or* reject sterilization without duress or coercion. As public pressure for protective regulations mounted in response to the record of abuses in California, this battle for reproductive freedom became the subject of legal and administrative action. The demands for government accountability over the issue placed the state uncomfortably at the center of this debate; any resolution of which was bound to prompt backlash from one party or another.

The CMRW, formed in 1974, led the charge for sterilization regulations in California. While the group recognized that regulations would not completely stamp out abuse practices, they nevertheless aimed to at least reduce the probability that events like those at LACMC would occur again. The women of the CMRW had been prompted to action by the reports of abuse emerging from LACMC, and their subsequent investigations, which revealed statewide non-compliance with federal informed consent standards, and further instances of abuse. In an attempt to push the reticent CDH to enact guarantees for the reproductive freedom of minority women, the CMRW tirelessly marshaled a campaign of letter writing, public hearings, and meetings in conjunction with other minority and women's groups, and the CDH. In doing so, the CMRW would encounter significant resistance from the *California National Organization for Women* (CANOW), the state chapter of the national women's liberation organization. In a highly public struggle, the groups divergent conceptions of freedom chafed against one another. The health department's agonized grappling with the issue of regulations, as the ultimate arbiter on the matter, during the mid-to-late 1970s serves to illustrate the issues faced by California in remaking its sterilization policy.

The debate was complicated further by the resistance of California's medical establishment, represented by the CMA, and their allies, to government regulation. Their opposition hinged not, as women activists did, on reproductive freedom, but on the freedom to practice their profession unencumbered by what they saw as stifling and

3 For an overview of the differences between white feminists and minority feminists, see: Benita Roth, *Separate Roads to Feminism: Black, Chicana, and White Feminist Movements in America's Second Wave* (Cambridge: Cambridge University Press, 2004).

intrusive government interference. Despite the rapidly growing awareness of abusive sterilization practices by the time regulations began to be seriously discussed, pointing to the inability of the medical profession to regulate itself effectively, physicians and their advocates nevertheless continued to deny claims of a systemic problem within their ranks, and challenged government attempts to impose their will in the courtroom, administrative proceedings, and through the backdoor. In undermining the struggle for patient protections, the CMA would attempt sow further discord and doubt throughout the already strained CDH leadership.

As noted in the literature review, while emotive details of the coerced sterilizations at LACMC have filled the literature on sterilization abuse, the same cannot be said of the labyrinthine campaign to erect informed consent regulations that arose as a result of press coverage and the subsequent legal battle. This has led to the neglect of a critical period in the protective reshaping of state sterilization policy, and the myriad complications encountered by the health department in the process. Gutierrez, for instance, while admirably elucidating the role played by Chicana activists in organizing the struggle for regulations, presents an oversimplified analysis of the course of events that led to the eventual adoption of protections.⁴ Kluchin, likewise, while presenting a more encompassing examination of events, is limited by the broader, national scope of her work.⁵ This chapter, then, will expand on the historiography on the period of policy development that followed revelations of abuse in the mid-1970s. It will provide a more detailed understanding of the “extraordinarily lengthy, complicated, and thorough discussion” that preceded the adoption of California's informed consent regulations for sterilization, and shed new light on the health department's role throughout.⁶ It will also provide fresh insights into the struggle of women's movements in California over the issue of protections, and the organizational infighting that gripped the state's largest feminist group as a result.

This examination will begin by exploring national attempts to regulate sterilization that preceded the sterilizations in Los Angeles. It will then focus on the early push for informed consent regulations within the state that resulted from the outrage over the LACMC sterilizations, and examine the leadership of the CDH, and the work of assemblyman Barry Keene in prompting departmental accountability. The chapter will then move to an analysis of the organizational effort carried out by the CMRW, their push

4 Gutierrez, *Fertile Matters*, Chapter 6.

5 Kluchin, *Fit to be Tied*, 198-203.

6 “Declaration of Mary Foran, On Behalf of the Intervener Coalition for the Medical Rights of Women,” *CMA v. Lackner Pleadings*, 11. Box 908, Folder 7, MALDEF, SUA.

for public hearings on the regulations, and their subsequent confrontation with CANOW, and the latter group's identity crisis over the issue. Finally, the chapter will conclude with an analysis of the medical profession's resistance to state regulation through both legal action and less overt measures, and shed light on the circumstances surrounding the final adoption of patient protections by the health department.

Disorganization and Disregard: The Early Fight for Sterilization Regulations in California

On April 18, 1974, DHEW promulgated regulations that represented the federal government's first concerted attempt to assure that hospitals were following informed consent standards where federally funded sterilizations were performed. The new departmental regulations prohibited the funding of sterilization operations for those under twenty-one-years-old or adjudged mentally incompetent, and required the signature of a consent form seventy-two hours prior to the surgery, which, among other points, explained that patient could withhold their consent without jeopardizing their entitlement to welfare benefits.⁷ These were among the stipulations ordered by Judge Gerhard Gesell who, recognizing the “uncontroverted evidence” of widespread sterilization abuse, ruled that earlier regulations published by the agency in February had failed to “implement the congressional command that federal family planning funds not be used to coerced indigent patients into submitting to sterilization.”⁸ Although the regulations released in April were intended only to be temporary, while DHEW formulated a stronger, permanent solution, they would remain in effect until 1979.⁹ While the temporary safeguards, and particularly the seventy-two hour delay, theoretically afforded vulnerable patients a modicum of protection, DHEW's inability to effectively enforce the new measures troubled Gesell.¹⁰ The judge's fears were well founded, when, almost nine months after being released, the *Health Research Group* reported that DHEW had not “made the slightest effort to inform hospitals of their obligations,” nor monitored “whether its own legal standards [were] being implemented.”¹¹ When reports of the events at LACMC broke in December, the agency's administrative negligence was laid bare by an anonymous employee. While DHEW had distributed copies of the interim regulations to state Medicaid administrators, including the CDH, “there's probably been little actual follow-up at this point,” the

7 “Sterilizations and Abortions: Federal Financial Participation,” *Federal Register* 43 (1978): 52146; Trombley, *The Right to Reproduce*, 184.

8 *Relf v. Weinberger*, 1199-1201.

9 Rosoff, *Family Planning, Contraception, Voluntary Sterilization, and Abortion*, vii.

10 *Relf v. Weinberger*, 1203.

11 Robert E. McGarrah, *Sterilization Without Consent: Teaching Hospital Violations of HEW Regulations* (Washington D.C.: Public Citizen Health Research Group, 1975), 3.

employee noted. “There usually isn’t,” the Whistleblower claimed, noting DHEW’s incompetence, “unless pressure is applied to the department from somewhere.”¹²

Continuing litigation and Gesell’s insistence on adequate protections seemingly did not provide enough impetus for DHEW to sufficiently oversee their own regulations.¹³

Cognizant of this governmental inability to safeguard their reproductive autonomy, activists began pushing for more effective sterilization safeguards at a state level.

Several months after DHEW published the regulations, a bitter battle over sterilization erupted in New York City. The newly formed Sterilization Advisory Committee of the New York *Health and Hospitals Corporation* (HHC)—the body responsible for operating the city’s public hospitals and clinics—began studying the federal regulations and investigating sterilization practices in the twenty municipal hospitals under HHC control.¹⁴ The ad hoc Committee—comprised of representatives from CESA, the ACLU, HealthPac, and local health and community organizations—found DHEW’s perfunctory regulations not only inadequate for the protection of patient’s, but also totally unenforced within the city’s hospitals, each of which continued to use its own surgical consent form.¹⁵ Recognizing that it would take a dedicated local effort to ensure vulnerable patients were protected, and with a mandate from HHC president, John Holloman, the Advisory Committee proposed regulations for the city’s public hospitals that far exceeded DHEW’s requirements. The proposed regulations stipulated that woman may not be approached for consent while in labor; that she receive counseling on alternative contraceptive methods; and that all consent forms be written in her native language.¹⁶ The most significant difference between the local and federal regulations was the lengthening of the waiting period between consent and surgery from seventy-two hours to thirty days.¹⁷ The stringent regulations unanimously passed the HHC board in September 1975, and went into effect that November. As expected, powerful opposition to the regulations came from physicians, and family planning groups like the AVS and Planned Parenthood. Another source of significant criticism came from other women’s groups, including the *National Organization for Women* (NOW), and the *National Abortion Rights Action League* (NARAL), who viewed the regulations as a hindrance to women obtaining

12 Robert Kistler, “Many U.S. Rules on Sterilization Abuses Ignored Here,” *The Los Angeles Times*, December 3, 1974, 24.

13 Rosoff, *Family Planning*, 8.

14 Barbara Caress, “Sterilization Guidelines,” *Health/Pac Bulletin* 65 (1975): 9.

15 Shapiro, *Population Control Politics*, 138.

16 Caress, “Sterilization Guidelines,” 12-13.

17 HHC Advisory Committee on Sterilization, *Why Sterilization Guidelines are Needed* (New York: Office of Quality Assurance, 1975), 6.

sterilization on demand.¹⁸

The action was an important moment in the fight against sterilization abuse nationally. With the largest municipal hospital system in the nation, HHC initiatives often served as an example for hospitals nationwide to follow. As a report from the Health Policy Advisory Center noted: “If sterilization abuse is effectively curtailed here, the result would probably be fewer sterilizations elsewhere.”¹⁹ As well as providing an impetus for action, the events in New York portended the widening chasm in the women's movement, drawn along racial and class lines, over what constituted reproductive freedom, and the significant difficulty in balancing the need for protection, against the desire to obtain treatment unhindered by government regulation. Both issues would soon come to the fore in California as the events at LACMC forced the state to act on its own regulatory negligence.

Just as the state had been pressured into revising its eugenic sterilization statute in 1952, it appears that once again the efforts on an individual legislator forced the California government to act on the issue of sterilization abuse in the 1970s. In December 1974, Assemblyman Barry Keene, author of the California Natural Death Act - the first “right to die” legislation in the United States - discovered that despite over 3,000 government-funded sterilizations being performed since the release of DHEW's regulations, the CDH was reimbursing hospitals without any evidence of compliance with federal informed consent requirements.²⁰ Indeed, far from following the federal mandate, Keene learned that the regulations had been left to “gather dust” within the halls of the CDH for eight months, providing stark confirmation of the fears of sterilization abuse activists nationwide.²¹ The response of the CDH, under the leadership of deputy director Jerry Green, exhibited a mixture of ignorance and animosity over the Keene's allegations. Green claimed that the new regulations had not been adequately brought to his department's attention, claiming that his staff got “a mass of these things [federal regulations] in continually.”²² Further countering the charges, the interim head contended that his department had been “caught off guard” by DHEW's promulgation of regulations, as it “hadn't been pointed out to any of us that there was any kind of forced sterilization program going on, and *I'm not*

18 Kluchin, *Fit to be Tied*, 192-193.

19 Caress, “Sterilization Guidelines,” 9.

20 “Hospital Officials Blaming State for Not Getting Word,” *Progress Bulletin*, December 12, 1974, 12. Between April-June California funded 3,660 Medi-Cal sterilizations. See also, Barry Keene, “The Natural Death Act: A Well-Baby Check-Up on its First Birthday,” *Annals of the New York Academy of Sciences* 135 (1978): 376-393.

21 “Keene Urges Crackdown on Improper Sterilizations,” December 9, 1974. LP311:29, BKP, CSA.

22 “State Said in Violation of Sterilization Rules,” *Daily Independent Journal*, December 11, 1974, 3.

convinced there is in California” (emphasis mine).²³ Green's defiance came despite reports breaking in the *Los Angeles Times* over the events at LACMC, and noncompliance in other hospitals.

California's noncompliance with DHEW's regulations is perhaps understandable given the turmoil gripping the state's health administration at that time. The CDH had only come into being in March 1973 after the Reagan administration ordered that the departments of Mental Hygiene, Public Health, Social Welfare, Rehabilitation and Healthcare Services be “welded” together to form one mega conglomerate department. The result of forging this “health superagency” was a state of loosely organized administrative chaos, characterized by poor departmental communication, a labyrinthine power structure, lack of centralized control, and a concomitant “deterioration in the planning, operation, and evaluation of health programs.”²⁴ Adding to the disorder, the department faced growing and acerbic allegations of Medi-Cal fraud, and by March 1975, had been without a permanent director for five months until the appointment of controversial San Jose physician, Jerome A. Lackner.²⁵ As the events at LACMC unfolded, the federal regulations sat dormant within the CDH's tortuous and dysfunctional administrative complex.

Yet, even were the regulations to have been distributed to the hospitals in a timely manner, it is unlikely, given the impotence of the CDH, and the complete lack of federal follow-up or enforcement, that it would have altered the treatment received by the Mexican women at LACMC. Recognizing this fact, Keene submitted a bill to the legislature that aimed to prevent more “outrageous” abuses in California hospitals, prompt the CDH to enforce strict compliance with DHEW's consent regulations, and provide them with the administrative teeth to do so.²⁶ Submitted on December 11, 1974 the emergency legislation required that hospitals forward sterilization consent forms to the CDH prior to reimbursement under Medi-Cal; that the department randomly follow-up on sterilization cases to ensure that patients truly understood the nature of the operation; that the CDH produce compliance reports; and, most importantly, that physicians, willfully negligent of the regulations, be removed as providers of Medi-Cal services.²⁷ In what represented a significant step forward for protective legislation, Keene's bill provided the accountability

23 “Hospital Officials Blaming State for Not Getting Word,” 12.

24 Bill Skane, “Health's Embattled Lackner – Anything But An Administrator,” *California Journal* 8 (1977): 54.

25 “Medi-Cal Costs Trigger Probe,” *The Bakersfield Californian*, August 12, 1974, 5; Carl Ingram, “Brown Tightens Up on What Medi-Cal Will Pay,” *Redlands Daily Facts*, January 15, 1975, 14; “San Jose M.D. Gets Health Job,” *The Independent*, March 12, 1975, 7.

26 “Improper Sterilization Crackdown Urged by Keene,” *Ukiah Daily Journal*, December 11, 1974, 2.

27 “Legislative Counsel's Digest, Request No. 448, December 9, 1974,” LP311:29, BKP, CSA.

to enforce regulations that Gesell identified as lacking when DHEW first proposed its regulations. The assemblyman's efforts were met with ringing endorsement from groups including the ACLU Women's Rights Project, The Western Center on Law and Poverty, and the National Association of Social Workers.²⁸ These groups lent their support out of the desire to protect vulnerable women from abusive sterilization practices, insisting that “the right to determine the fate of one's own body is basic and must be protected.”²⁹ In support of this, Keene's bill went further, and required the CDH to adopt its own set of sterilization regulations.

In response, the CDH was unusually swift to act, announcing their intention to release emergency regulations in late January 1975. These regulations, which aside from lowering the permissible age of consent from the twenty-one to eighteen, tracked the federal regulations released the April prior, and were put into effect on February 21 after interim chief deputy director, R.K. Best, invoked the emergency provision of the Administrative Procedure Act. As with the federal regulations, the CDH regulations were only intended to be temporary while more permanent protections were formulated in Sacramento. The California regulations, however, suffered from the same deficiencies as the federal rules on which they were modeled; namely, a lack of power and initiative to enforce their requirements. The only recourse the CDH held in this regard was a “prior authorization” clause which required physicians to submit evidence of consent prior to sterilization or risk non-reimbursement for the procedure.³⁰ Unlike Keene's proposed legislation, physicians in non-compliance faced no professional repercussions. Yet, despite its inadequacies, the regulations were undoubtedly a step in the right direction from a department that had thus far shown itself to be unwilling or incapable of protecting vulnerable patients' rights.

Departmental efforts to protect patients were aided with the appointment of Jerome Lackner as CDH director in March. The San Jose-based physician had originally come to Sacramento the month prior to serve as a consultant to the flagging department, and provide guidance over the state's long-range health needs. Lackner so impressed his colleagues with his “enormous intelligence and insight,” that he was eventually offered the vacant directorship.³¹ For a department in administrative chaos, the physician-lawyer, who served as a medical volunteer during the 1964 Civil Rights marches at Selma, and as

28 Lynda Bardis to Barry Keene, April 2, 1975. Letter. LP311:29, BKP, CSA; Susan Beck to Barry Keene. Letter. LP311:29, BKP, CSA; Terrence S. Terauchi to Barry Keene, April 10, 1975. Letter. MF 1:4(27), CSA.

29 Bardis to Keene.

30 “Fact Sheet for Filing Administrative Regulations with the Secretary of State,” 1-2. MF 1:4(27), CSA.

31 “San Jose M.D. Gets Health Job,” 7.

personal physician to United Farm Workers president Cesar Chavez, was an usual choice for the role.³² A self-confessed poor administrator, Lackner would come under fire throughout his tenure at the department for his lack of effective leadership.³³ Another source of criticism stemmed from the controversial physician's "sharp focus on issues instead of programs."³⁴ Critics claimed that the director dedicated undue focus to issues of personal interest, such as family planning, to the detriment of broader concerns. The issue of abortion, for instance, which Lackner opposed on moral grounds became an area of preoccupation at the CDH when, in 1976, the department imposed restrictions on Medi-Cal covered abortions after twenty weeks of pregnancy. After this point, only life-saving abortions were authorized. For their part in restricting abortion for large numbers of low-income women without any hearing, Lackner and his department received widespread and intense criticism.³⁵

Like abortion, sterilization would become one of the issues upon which Lackner would fixate and, under his leadership, CDH activity in the regulation of statewide sterilization practices would increase. Despite the enactment of the emergency regulations, one of the director's first actions upon taking office was to impose a moratorium on Medi-Cal sterilizations, while effective protections were developed, lasting until April 1976. Despite his staunch opposition towards abortion, for which the Lackner won recognition from the Catholic Church, his desire to regulate sterilization did not stem from the same moral disposition. Indeed, Lackner openly supported government-financed sterilization, but, sensitive to claims of abuse from minority communities, only if appropriate safeguards were in place.³⁶ As negotiations over a permanent solution to California's sterilization problem intensified, the CDH's unorthodox director would become a central figure in the escalating discourse.

While the embargo on Medi-Cal sterilizations provided a temporary semi-solution to reported hospital non-compliance, debate over the state's emergency regulations did not cease, and many, including some within the CDH, viewed the department's efforts to guarantee informed consent as minimal. Days before they were released, Steven Fleisher, a legal advisor to the CDH pinpointed several recommendations to increase the regulations' protective value. While he acknowledging the haste with which the department had been forced to act, the advisor nevertheless declared that "this area [sterilization], fraught with

32 Skane, "Health's Embattled Lackner," 53.

33 "Health Chief OK'd Despite 'Failing,'" *Independent*, May 22, 1975, 18; "Brown Defends State Health Director," *Santa Cruz Sentinel*, November 24, 1976, 6.

34 Skane, "Health's Embattled Lackner," 55.

35 Ibid; "State Will Repeal Ban on Medi-Cal Abortions," *Santa Cruz Sentinel*, December 1, 1976, 20.

36 "Women Attack Sterilization," *The San Mateo Times*, February 8, 1977, 20.

abuse, is in urgent need of effective state regulation.” The advisor took issue with the department's intention to use consent forms provided by DHEW, which he believed would encourage hospitals to take “short-cuts” in the consent process as compliance would be based entirely on the provider's word. Recognizing the potential for physicians to exploit a loophole in the regulations, Fleisher suggested that non-emergency therapeutic sterilizations, too, be covered by the seventy-two hour wait period, given “the gravity and permanency of the operation, and the breadth of the term therapeutic.” Finally, citing the large number of low-income patients, who, like the Madrigal plaintiffs, were not Medi-Cal recipients, Fleisher suggested that the regulations be extended to cover all state-licensed facilities, both public and private. Along with the wait period, this recommendation would become a significant source of dissent, particularly within the medical community. While Fleisher ultimately deemed the regulations to be “acceptable,” his comments nonetheless indicate a recognition that more needed to be done to prevent abuses like those at LACMC from occurring again.³⁷ However, for a local coalition of women's rights groups, arguably more aware of the scale and impact of such abuses, both the emergency regulations, and the continued government foot-dragging that accompanied them were far from acceptable.

Enter the Coalition

Tired of governmental inactivity and foot-dragging over the regulations issue, women's groups in California launched a campaign to trigger action from the CDH. The broad-based coalition consisted of women's health, consumer, legal, and minority organizations, and was spearheaded by the CMRW. Founded in 1974, the CMRW aimed to increase the accountability of the pharmaceutical and medical professions to their female consumers. Emboldened by successful negotiations with CDH over pre-market testing of IUDs, the CMRW expanded its areas of concern, of which sterilization abuse would assume a dominating role in the 1970s.³⁸ Indicative of the importance of which sterilization abuse assumed, the CMRW formed the *Sterilization and Informed Consent Project*, an educational program chaired by social worker, Esther Talavera. Talavera provided the link between the mainly white feminists that populated the ranks of the CMRW, and the Chicana community, represented within the broader coalition primarily by members of MALDEF's *Chicana Rights Project*.³⁹ The representatives of the coalition were united both by the severity of sterilization abuse within the state, and appreciation of the potential for stricter informed consent requirements to diminish it. With the help of legal

37 Steven M. Fleisher to Robert L. Gnaizda, February 12, 1975. Letter. LP311:29, BKP, CSA.

38 *Coalition News*, March 1976. Box 53, Folder 1, MALDEF, SUA.

39 Gutierrez, *Fertile Matters*, 103.

representatives, the coalition would doggedly pressure the rudderless and ineffective CDH to enact these protections, and in doing so, fuel debate over the appropriate scope of government to regulate medical practice, and the Janus-faced impact on individual freedoms of the safeguards themselves.⁴⁰

The day that the CDH published their emergency regulations, a member of the *San Francisco Neighborhood Legal Assistance Foundation* (SFNLAF) wrote to the CDH criticizing both the time taken to promulgate their regulations, and their substance, which, while better than nothing, they considered to be “simply not enough to protect women from involuntary sterilization.”⁴¹ SFNLAF, a public interest law organization focused on issues of sex discrimination, and who represented the coalition, were primarily concerned with the exclusion of them and their clients, whom the regulations were ostensibly designed to protect, from the drafting process. “It appears,” wrote Patti Roberts, head of the Women's Litigation Unit, “that the proposed regulations have been drafted and submitted with a minimal, if any, public interest.” The letter attacked the CDH's decision to schedule a single hearing on the emergency regulations located in Sacramento, which Roberts argued was inaccessible for most and obviated “the opportunity for the majority of concerned people to be publicly heard.” As it turned out, the CMRW, who had previously asked the CDH to be kept informed of all departmental proposals in the area of family planning, had never been contacted regarding the promulgation of emergency regulations. Roberts urged that the women be given a hand in crafting the state's sterilization regulations, suggesting that public hearings be held throughout the state in order to ensure that their eventual substance would “adequately protect women, in practice, and not merely on paper.” Public evaluation, review and input was considered by the coalition to be critical in assuring that “the state will not participate or permit coerced sterilizations.”⁴²

Despite their imploring action, by April the coalition's letter was still unanswered. Represented this time by Erica Black-Grubb of *Public Advocates Inc*, the coalition bemoaned the CDH's continued unresponsiveness. “Although we thought that prior requests would ensure that our clients would be receiving direct notice of any steps taken on this issue,” Black-Grubb noted, “that has not been the case.” Indeed, now two months on, certain members of the coalition had not even received copies of the department's emergency regulations. Far more concise than their first, Black Grubb's letter of April 18 announced the coalition's intention to submit a formal rule-making petition, “in order to clarify the facts which dictate the need for new regulations, as well as the capacity of the

40 Kluchin, *Fit to be Tied*, 200.

41 Patti Roberts to Robert Gnaizda, February 21, 1975. Letter. LP311:29, BKP, CSA.

42 Patti Roberts to Robert Gnaizda.

department of health to issue them.”⁴³ The message from the coalition was clear: if the department would not work with them voluntarily on the issue of sterilization regulations, they would take matters into their own hands. For their part, the government's repeated disregard of the coalition's request for involvement should not, especially given the new director's deep concern with the issue of sterilization, be understood as deliberately hostile or insular behavior. Given the perennial bureaucratic problems experienced by the CDH, it appears more like that, as with the regulations sent from DHEW, left to collect dust within the department for eight months, the coalition's requests were overlooked by a discordant department imploding under the weight of its growing administrative responsibilities. Yet, whatever the reason, the practical result remained the same: the exclusion from the regulations drafting process of those with a concerted interest in, and experience of sterilization abuse.

This situation changed dramatically, however, on April 21, 1975, when attorneys from SFNLAF, PAI and Equal Rights Advocates filed an “unprecedented” petition on behalf of the coalition of sterilization abuse activists to submit their own model regulations to the state. The press release that accompanied this action exhibited an intensification of the coalition's resolve to end sterilization abuse, and served as a shot across the bow of the CDH that the coalition would no longer be ignored. Emphasizing that it was the department's responsibility to ensure that the hospitals under its purview did not ride “rough-shod” over patients' rights, the coalition publicly stressed the complicity of the state and the CDH in the coerced sterilizations of women through their impotent regulation of sterilization policy. “The department has failed to comply with that responsibility,” the statement continued, “and has thereby precipitated grave dangers to the health and lives of California residents.”⁴⁴ In form and substance, the model regulations submitted by the women closely followed the earlier suggestions made by Steven Fleisher, and demanded that the CDH distribute its own consent documentation; that the regulations, including a seventy-two hour wait, apply to therapeutic sterilizations; and that they be instituted in private as well as public hospitals licensed by the CDH so as to protect the full patient population.⁴⁵ The example regulations also required that an auditor-witness, chosen by the patient, be present during the consent process, unless otherwise waived. Clearly learning from the events at LACMC, the coalition recognized that the regulations would be practically useless unless subject to a strict monitoring process. With this in mind, the

43 Erica Black-Grubb to Jerome Lackner, April 18, 1975. Letter. LP311:29, BKP, CSA.

44 “Coalition of Women's, Health, and Minority Groups Petition State Department of Health to End Forced Sterilizations.” LP311:29, BKP, CSA.

45 *California Coalition for the Medical Rights of Women* et al., “Petition for Regulations to Prevent Coerced Sterilizations in All Licensed Health Facilities.” LP311:29, BKP, CSA.

coalition's model regulations contained a tracking system that required health facilities licensed by the CDH to submit quarterly monitoring reports to the department, detailing the total number of sterilizations performed in each facility; the number of sterilizations performed by each doctor; documentary evidence that the informed consent process was followed; and demographic data on all sterilized individuals. As their press release indicated, however, the coalition, despite this clause, remained concerned about CDH incompetence, and believed that community enforcement, too, to ensure compliance from hospitals and the state.⁴⁶

If prompting government action was the goal of the petition, the coalition's tenacity paid off as the remainder of 1975 was spent in negotiation with the CDH and CMA over the final form that regulations were to take. The CMA, opposed to any attempts to regulate the practice of physicians, stopped attending the negotiations shortly after they began.⁴⁷ These negotiations included public hearings, held in May, where women with intimate knowledge or and experience with sterilization abuse presented testimony in favor of government protections. Additionally, the women's efforts in foregrounding the issue of sterilization abuse before the state arguably contributed to the eventual passage of the Keene Bill in July, which provided greater protections to the state's Medi-Cal recipients through the enforcement of DHEW regulations.⁴⁸ Finally, by January 1976, after a process of "long and tedious" negotiations and redrafting, the CDH proposed the state's official regulations on sterilization. The "crux" of these regulations, according to the coalition, which provided that informed consent was uniform and extensive in all CDH licensed facilities, was a waiting period of fourteen days between consent and sterilization.⁴⁹ To the chagrin of the women's groups, the regulations allowed, upon the patient's request, for this period to be reduced to three days.⁵⁰ Nevertheless, while not exactly in line with their wishes, the CDH regulations represented a tremendous victory for the coalition, who, for over a year had requested that the CDH provide protective measures for women undergoing sterilization. Before the regulations could be instituted, however, the women still needed the approval of the physician-run *Health Facilities Advisory Board* (HFAB)—a body decidedly hostile to their mission.

At the hearing on March 31, 1976 the women activists and physicians clashed in heated debate. Representing the coalition, Sandra Salazar of MALDEF's CRP, and

46 "Fact Sheet: Sterilization Procedures Violate Patients' Rights," 2. LP311:29, BKP, CSA.

47 "Summary of the Health Facilities Advisory Board Consideration of the Sterilization Regulations March 31, 1976." Box 53, Folder 1, MALDEF, SUA.

48 "Insurance; Medi-Cal Payments – Sterilizations," *Pacific Law Journal* 7 (1976): 482.

49 *Coalition News*, March 1976.

50 "Main Points of the Regulations Now Proposed," April 6, 1976. Box 53, Folder 1, MALDEF, SUA.

Talavera of the CMRW, among others, communicated stories of abuse, and the deficiencies that prompted them, in hospitals across the state. Their compelling testimony, intended to bolster the calls for protections, was immediately attacked by the assembled physicians. One board member labelled the women's testimony a "waste of time," claiming the abuses to be perpetrated by "individual bad doctors." Another female member of the board dismissed the women's testimony as "repetitious." The members of the medical community used their platform to the utmost to attack the coalition, the CDH, and the proposed regulations on a number of fronts. Dr. John Miller, for instance, representing the CMA, attempted to undermine the activists' testimony, painted their claims as conspiratorial, and argued that their support for regulations sprang from a deep-seated "suspicion by women of men in medicine." Miller, like the majority of his colleagues, viewed the regulations as unnecessary and burdensome, and believed that the ultimate solution to the alleged abuses lay in patient education, not regulation. Similarly, Ron Davey, a hospital administrator and member of the HFAB, agreeing with the CMA and CHA's attorneys, openly questioned the authority of the department to even issue such regulations. In fact, so opposed was Davey to the state's attempts to regulate medical practice, that he boldly declared his hospital's non-compliance with the mandated federal sterilization regulations. It was this belief, that the state did not have the right to invade nor police the doctor-patient relationship, which was shown to be the central concern of the medical community at the meeting, and the grounds upon which their continued hostility to the regulations and the department would rest.⁵¹

It is important to note, however, that the vehement opposition to the regulations at the meeting from the medical community was not unanimous. Dr C.J. Wellington, a OBGYN practicing in what he described as "ghetto areas," testified to the existence of sterilization abuse. Courting the acrimony of his colleagues, Wellington agreed with the activists that, due to the prevalence of abuses, the fourteen day waiting period was "necessary in all but emergency operations to save life." While an isolated voice among his colleagues, Wellington's testimony certainly aided the women activists' cause.⁵²

Despite strong opposition, the regulations were passed by the board by a one-vote margin. With the regulations now on the verge of passed, HFAB's administrative approval of the regulations represented a "major victory" for the coalition.⁵³ Indeed, while weeks prior the CDH, in a piece of mendacious propaganda, had attempted to claim responsibility for the regulations, it would be gross unjust to view the development and progress of the

51 "Summary of the Health Facilities Advisory Board."

52 Ibid.

53 *Coalition News*, March 1976.

regulations as originating from anything other than the consistent and concentrated work of the tireless women's coalition.⁵⁴ As had been the case with the eugenics amendments of 1951, it is unlikely that the government would have acted on the regulations issue, at least for a considerable time, had it not been for the political agitation of extra-departmental actors. Yet, while HFAB's ratification served as a boon to the coalition's campaign, and signaled governmental commitment to the issue, the regulations' supporters still expected significant resistance at the required public hearings. If the coalition thought HFAB's decision would prompt a turnaround in governmental stonewalling, however, they were wrong. By late-July, Patti Roberts wrote to Lackner's office demanding to know why the government had taken no action since the April decision. To the coalition's anger, Lackner's office informed them that, despite the already considerable deliberations, the regulations were under an internal review process. Emphasizing the need for the hearings to go ahead swiftly, Roberts reminded Lackner that while the coalition had been talking "in good faith," women were still being coerced and abused in hospitals across the state.⁵⁵ Signaling once again their role as prime movers in the campaign for protections, the coalition dragged Lackner and his department kicking and screaming into regulating sterilization. However, as the HFAB meeting indicated, government paralysis on the subject emanated perhaps as much from its attempts to negotiate the splintered politics surrounding sterilization regulations and reproductive choice as it did from crippling bureaucratic inefficiency. The schismatic nature of such debates would be laid bare when, in February 1977, the public hearings eventually began.

Women Pitted Against Women: The Regulations Hearings and the Contested Nature of Reproductive Freedom

Given the importance of the potential importance of their testimony in passing protections, the coalition spent the first weeks of 1977 industriously preparing for the debate. The group had also initiated a letter-writing campaign, demanding that hearings be held statewide and outside working hours. For fiscal reasons, it had long been government policy to hold hearings during working hours.⁵⁶ This troubled SFNLAF's Patti Roberts, who believed that hearings scheduled during the week would not be "truly representative," as many poor individuals, trapped in "restrictive jobs," would be unable to attend.⁵⁷ Thus,

54 "Sterilization Patient Must Wait Three Days," *Redlands Daily Facts*, January 23, 1976, 6. The article claimed that the impetus for the regulations came from the state assuming that "if the safeguards were good for Medi-Cal patients, they merited application to all citizens."

55 Patti Roberts to Jerome Lackner, July 28, 1976. Letter. Box 910, Folder 2, MALDEF, SUA.

56 Quin Denvir to Patti Roberts, July 7, 1976. Letter. Box 910, Folder 2, MALDEF, SUA.

57 Patti Roberts to Jerome Lackner, June 15, 1976. Letter. Box 910, Folder 2, MALDEF, SUA.

Roberts and other women demanded that the hearing in San Francisco be scheduled on a Saturday. At the same time, the CMRW had begun preparations of their own, requesting testimony from any individual, family member, community group, or health worker who had personal experience of sterilization abuse.⁵⁸ Members of the coalition ran workshops to assist these women, many of whom had never testified in any capacity before, prepare their testimony, and offered translation services for the Spanish-speaking contributors.⁵⁹ This action from the coalition, ensuring that supporters of the regulations turned out in force, was borne out of the recognition that their opponents, too, would use the hearings to launch an attack on the proposals. The February issue of *Coalition News*, the CMRW's bi-monthly publication, implored supporters to show up, cautioning them that "the opposition from the medical establishment will be there. Will you?"⁶⁰

This premonition was well founded, for, in the interim, the medical community had begun a letter-writing campaign of their own. Physicians across the state wrote to the CDH Regulations Unit, voicing their strong opposition to the proposed regulations. These, they claimed, would ultimately be a "disservice" to patients by forcing all hospitals to become "policemen" of sterilization surgeries.⁶¹ A stronger worded objection came from the president of the San Diego County Gynecological Society, arguing that the regulations sounded "so outlandish, impractical, and indeed ridiculous, that we tended to laugh and shrug them off." "It now sounds," the physician wrote, "as if through some ill-intentioned, ill-informed pressure from God knows where, you have full intention of implementing these regulations."⁶² While the women activists expected this resistance from the medical establishment, enduring hostility from the state's white feminists became a point of concern.

Aware of their potential resistance, a delegation from the *Comisión Femenil*, a Chicana feminist organization based in Los Angeles, met with members of the NOW in an attempt to secure their support. Founded in 1966, NOW was the oldest and largest women's liberation organization nationally. It had been formed out of frustration towards the federal government's ignorance towards women's issues, and its lack of enforcement of gendered anti-discrimination laws.⁶³ By 1973, NOW had amassed a membership of over

58 The Coalition for the Medical Rights of Women, "Sterilization – Coercion or Choice?" LP311:29, BKP, CSA.

59 Kluchin, *Fit to be Tied*, 200.

60 "Sterilization Hearings Scheduled for Friday," *Coalition News*, February 1977, 1. LP311:29, BKP, CSA.

61 Peter C. Pavitt to State Department of Health Regulations Unit, February 15, 1977. Letter. Box 910, Folder 2, MALDEF, SUA.

62 Lawrence L. Grove to State Department of Health Regulations Unit, February 16, 1977. Letter. Box 910, Folder 2, MALDEF, SUA.

63 "National Organization for Women: What it's All About." P-140 26:37, WHCC, UC Davis Special

200,000 individuals, spread over 365 nationwide chapters.⁶⁴ Clearly, the support of such an influential organization would be beneficial at the hearings. Given prior cooperation with minority groups on other women's issues, NOW's support of the regulations had been expected.⁶⁵ However, at the meeting, NOW members voiced their hostility to the proposed regulations, arguing that a woman's right to sterilization on demand outweighed the need for a lengthy waiting period. Gloria Molina, then president of the *Comisión*, recalled her shock at the feminists' hardline stance on the issue: "we really expected to be embraced by the feminist organizations and instead were rebuffed and basically told to find other solutions[...]they just were not willing to compromise on any of it."⁶⁶ Despite the *Comisión* presenting NOW representatives with evidence of the abuses at LACMC, the group remained resolute that access to sterilization must remain open and unhindered. NOW's opposition underscored a deep rift in the women's movement between mainstream white feminists and minority women views on reproductive choice.

NOW's leadership was composed overwhelmingly by white, middle-class women.⁶⁷ From this perspective, NOW opposed sterilization regulations which they viewed as a barrier to service, and a manifestation of state-sponsored paternalism. These were seen as no different from age-parity formulas and sterilization committees that had previously foreclosed access to sterilization. Indeed, these women frowned on any legislation designed to regulate fertility-related functions, which they understood as impinging on their right to control their own bodies.⁶⁸ This defense of individual choice arose from the battle for abortion rights.⁶⁹ From this, Rosalind Petchesky claims, came their adoption of a philosophy which sought to exclude the state from the reproductive decision making process entirely, and place it firmly between the women and her physician.⁷⁰ These women, however, uncritically transplanted this approach, used in the debate over abortion, to the issue of sterilization. They did so without an appreciation of both the distinct social context and medical nature that separated the two issues.⁷¹ NOW worried too that, were they to support government sterilization regulations, they would leave their abortion rights

Collections.

64 Marion Lockwood Carden, *The New Feminist Movement* (New York: Russell Safe Foundation, 1974), 104.

65 "Interview with Evelyn Martinez," quoted in Gutierrez, *Fertile Matters*, 104.

66 "Interview with Gloria Molina," quoted in Gutierrez, *Fertile Matters*, 105.

67 James S. Baugess, *Encyclopedia of the Sixties: a Decade of Culture and Counterculture* (Santa Barbara: Greenwood, 2012), 458.

68 Geri Sherwood to Barry Keene, April 11, 1975. Letter. LP311:29, BKP, CSA. This point of view was voiced in opposition to Keene's sterilization legislation.

69 Shapiro, *Population Control Politics*, 152.

70 Petchesky, *Abortion and Woman's Choice*, 131.

71 Shapiro, *Population Control Politics*, 152.

agenda susceptible to attack.⁷² This point was felt more acutely in California, where Lackner sat openly hostile to the issue of abortion.⁷³ Praised for his insight, Lackner himself wondered how this polarized conflict between white liberal feminists, demanding convenience in sterilization decisions, and women of color, demanding safeguards, would be settled. At the HFAB meeting Lackner asked the attendees which issue they considered a more important right to guarantee: immediate access or freedom from abuse and duress? On that day, nobody could offer a solution.⁷⁴ However, with the hearings about to begin, the state would soon have to choose.

Despite NOW's staunch opposition to the *Comisión* members, the fragmented nature of the women's organization provided hope to sterilization activists. Indeed, Adele Clarke's contention that NOW has historically reflected the interests of middle-class women, and thus an opposition to the regulation of sterilization, may present an oversimplified understanding of the group.⁷⁵ For NOW was far from a monolithic organization. Since its formation, the group had recognized the importance of devolving power to regional chapters. NOW's leadership argued that having a plethora of semi-autonomous sub-groups representing its interests would garner greater publicity and authority for the group. They also recognized that state and municipal government bodies would be more receptive to lobbying pressure from local representatives than some "distant" national body.⁷⁶ While these local chapters occasionally represented an entire state, more often they were limited to individual cities, with their membership comprising of only a handful of representatives. Given this decentralization of power, it is unsurprising that local chapters, which created their own by-laws and activities, did not always tow the party line, and often chafed against the direction of NOW's central leadership.⁷⁷

By the mid-1970s, this disunity had developed into a full-blown identity crisis. The ascendancy of attorney Karen DeCrow to the presidency of NOW in 1974 brought with it a radicalization of the organization's leadership—exemplified by DeCrow's election slogan: "out of the mainstream and into the revolution"—and a developing schism with its more moderate members.⁷⁸ As NOW's organizational resources became stretched during

72 Kluchin, *Fit to be Tied*, 193.

73 "New Law May Curb Abortions," *The San Bernadino County Sun*, September 18, 1976, A1.

74 "Summary of the Health Facilities Advisory Board."

75 Adele Clarke, "Subtle Forms of Sterilization Abuse: A Reproductive Rights Analysis," in *Living with Contradictions: Controversies in Feminist Social Ethics*, ed. Alison M. Jaggar (Boulder: Westview Press, 1994), 346.

76 Carden, *The New Feminist Movement*, 105.

77 Steven M. Buechler, *Women's Movements in the United States: Woman Suffrage, Equal Rights and Beyond* (New Brunswick, Rutgers University Press, 1990), 66.

78 Barbara Ryan, *Feminism and the Women's Movement: Dynamics of Change in Social Movement*,

the 1970s, this divide grew increasingly acute, as each group vied for limited funding. Recognizing this unrest, DeCrow moved to centralize the group's leadership within a single office in Washington D.C., and establish unified state-wide chapters that were answerable to the central office. By 1976, more moderate members within the organization had formed an opposition element called *WomanSurge* to counteract the perceived radicalization of the group. "The women's movement," the leaders of WomanSurge argued, "must put forth a public image which appeals to the majority of American women."⁷⁹ Set against these acrimonious internal politics, it is unsurprising that disagreement over sterilization regulations arose within NOW. Indeed, this was already apparent in the group's intervention in the New York sterilization regulations debate.

NOW's New York chapter (NYNOW), following the central leadership, opposed the HHC sterilization regulations. It did so partly out of the defense of individual choice, and partly out of loyalty to Planned Parenthood, with which the organization was engaged in an "alliance of mutual needs."⁸⁰ When the HHC regulations were passed, sterilization activists, with the assistance of local councilman, Carter Burden, introduced legislation to extend the protections to all municipal and private hospitals in the city.⁸¹ Recognizing the tremendous importance of having NOW's support at the hearings on the Burden Bill, as it was termed, activists, spearheaded by CESA, attempted to convince NYNOW to support the regulations. CESA's attempt to convince the group to support the bill proved successful, and at the final hearing, Burden read a letter of support from the NYNOW's vice-president Luba Zimmerman:

While we are wary of government interference in matters relating to fertility, certainly a distinction must be made between laws designed to ensure freedom of choice and access to family-planning information and methods and laws which restrict choice or limit access.⁸²

NYNOW recognized that the regulations increased women's reproductive freedom, not limited it. NYNOW's defection from the national leadership represented, according to Kluchin, a "rare example of white liberal feminists adopting a broad philosophy of reproductive rights," in concert with women of color.⁸³ NOW's testimony at the sterilization hearings in California similarly highlighted an organization fractured by the struggle to balance women's individual choice with the need to protect the vulnerable from coercion.

Ideology, and Activism (New York: Routledge, 2010), 71.

79 Buechler, *Women's Movements*, 66.

80 Shapiro, *Population Control Politics*, 155.

81 Dowbiggin, *The Sterilization Movement*, 182.

82 Barbara Caress, "Freedom's Just Another Word for Having Time to Choose," *Health/PAC Bulletin* 76 (1977): 18.

83 Kluchin, *Fit to be Tied*, 194.

At the California sterilization hearings, CANOW, the official representative of National NOW, elected to oppose regulations. CANOW had been formed in 1971 at NOW's fifth annual conference in anticipation of the California legislature's vote on the Equal Rights Amendment, which guaranteed equal rights for women. The California branch became not only the largest feminist organization in the state, but also became the largest of NOW's state organizations, marshaling fifteen local sub-chapters. The organization's size correlated with impact, and along with aiding the passage of the ERA in 1972, CANOW also persuaded NOW leadership to promote a series of female-worker walkouts known as the "Alice Doesn't!" strikes.⁸⁴

Represented by Gerry Sherwood at the first hearing in Sacramento on February 8, 1977, CANOW argued that the regulations would have a "chilling effect" on sterilizations.⁸⁵ Citing the coerced sterilizations at LACMC as evidence, Sherwood viewed the adoption of additional safeguards as superfluous, and argued that only strong enforcement by the CDH of the existing federal regulations offered a solution. Predictably, the fourteen-day waiting period became Sherwood's central target of attack. CANOW claimed that doctors, either reluctant to perform sterilizations or fearful of malpractice suits, would not inform women of their right to waive the time limit to seventy-two hours, and would thereby deter many women from choosing sterilization. To be sure, CANOW objected to the imposition of waiting period full stop, including the seventy-two hour concession, which interfered, they believed, with a woman's right to choose. Indeed, CANOW not only contended that the regulations were unjust to women, but that state was acting illegally by imposing "non-medical qualifications" on the operation.⁸⁶ Several years prior, in what represented the coup de grâce for the "120 rule" in California, Senator Anthony Beilenson submitted legislation which outlawed hospitals from continuing to enforce ACOG's draconian age-parity formula, or any other non-medical restriction for sterilization.⁸⁷ Sherwood's specious contention was that the criteria of informed consent, defined by the requirements of the proposed regulations, constituted non-medical preconditions on women's access to sterilizations, and thus represented an overextension of the CDH's authority. CANOW's position at the Sacramento hearing confirmed the women's group's opposition to the regulations. However, over the coming days, testimony

84 Sarah Slavin, *U.S. Women's Interest Groups: Institutional Profiles* (Westport: Greenwood Press, 1995), 409-411; Linda Zink, "Women Strike While Iron's Unplugged," *Long Beach Independent*, October 25, 1975, 20.

85 "State Sterilization Rules Rapped by Women's Libbers," *Santa Cruz Sentinel*, February 8, 1977, 6.

86 Ibid; "Statement on the Proposed Informed Consent Sterilization Regulations by Geri Sherwood, N.O.W Legislative Committee, February 8, 1977." Box 908, Folder 3, MALDEF, SUA.

87 "Enrolled Bill Report, S.B.1358," GCBF, MF 3:3, CSA; Lynn Lilliston, "Beilenson Attacks Sterilization Game," *The Los Angeles Times*, April 10, 1972, G2.

at hearings in San Francisco and Los Angeles highlighted, once more, the divided nature of NOW.

Four days later in San Francisco, Shelley Fernandez, president of the San Francisco NOW, presented testimony on behalf of her chapter. A teacher by profession, Fernandez had joined NOW in 1970 after working with several community health and women's groups in the Bay Area. After joining NOW, Fernandez became an energetic yet criticized member of the organization, serving on committees at all levels, and twice sitting on National NOW's board. While the majority of the criticism leveled at Fernandez attacked her conservative stance—Fernandez was a high-profile member of *WomanSurge*—she in fact saw herself as a “peacemaker” between the radical majority caucus, and the more mainstream feminists like herself.⁸⁸ Fernandez's role as a peacemaker was apparent in the hearings in San Francisco, at which she repeatedly emphasized NOW's unity with the other women's groups in favor of regulations.

The thrust of Fernandez's testimony discredited media reports, largely based on Sherwood's testimony in Sacramento, that NOW stood against the regulations. Believing this to be a fabrication, Fernandez stated that she was:

Here to refute an article that appeared in the newspaper saying that the National Organization for Women took a position against the proposed regulations. This is totally, completely untrue. It was said as a very divisive kind of thing to divide us in the women's movement[...]There was nothing said at a national level, nothing ever said in the state level, and, of course, I am involved on the chapter level. And I also took a poll and called many chapter members throughout the State. There has been no statements against the proposed regulations. In fact, quite the contrary, so I want to clear that up once and for all.⁸⁹

It is unclear why Fernandez was not made aware of Sherwood's statements at the Sacramento hearings, though it is likely to do with the majority caucus of CANOW attempting to exclude *WomanSurge* members from the hearings process, out of fear that they, like Fernandez, would break ranks. Fernandez saw the newspapers allegations as an attempt sow dissent between NOW and other women's groups in the state. Whatever the reason, Fernandez, speaking in Spanish, emphasized that NOW, along with women of color, supported the regulations:

As you can see here today by the number of women that come in coalition, representing many different kinds of organizations, we women are growing stronger[...]we are developing a spirit of unity and strength and non-confrontation. And we are going to stand together against all forms of oppression.⁹⁰

“Viva las mujeres,” Fernandez proclaimed, reiterating NOW's support for the

88 Harriet Stix, “Ms. Fernandez: Will She Be the Next NOW President?” *The Los Angeles Times*, June 3, 1976, A9-10.

89 “Testimony of Shelley Fernandez,” in *State Department of Health Public Hearings on Regulations: Human Sterilization (hereafter “Sterilization Hearings”), February 12, 1977, 99-100. Box 910, Folder 9, MALDEF, SUA.*

90 Ibid, 100.

regulations.⁹¹

Fernandez was joined at the hearings by Deborah Barto, a physician and member of Fernandez's San Francisco chapter. While Barto's testimony did not pack the same rhetorical punch as her president's, it was, nonetheless, remarkable for two reasons. Firstly, it represented another voice from within NOW coming out in support of the regulations. More importantly, it undermined two of the central claims used by white feminists to oppose regulations. Firstly, attacking hostility towards the fourteen-day waiting period, Barto claimed that women could simply sign the consent forms several weeks before their intended delivery date. This would allow women an opportunity to change their mind, while also allowing women to be sterilized during delivery, and thus not requiring a dangerous or costly second operation. Thus, women, the physician argued, would not be inconvenienced in any way. Then, in a significant break with white feminist orthodoxy, Barto acknowledged the unique context of the sterilization operations as opposed to other procedures, i.e. abortion. "Sterilization operations do require special regulations by law," she claimed, "these operations are not like other operations that do not require special regulations. These procedures are more emotional. They can be interpreted politically as methods of population control, *and they involve that most important ability, the ability to reproduce ourselves*" (emphasis mine).⁹² Here Barto struck at the heart of the white feminists' opposition to regulations. The philosophy of strict government non-intervention that characterized the struggle for abortion could not be simply transplanted to the case of sterilization. While women of color had before attacked this blindness to the fundamental differences surrounding sterilization, that this statement came from a member of NOW made it all the more powerful.

Yet, while the coalition and other activists may have celebrated NOW's apparent reversal of position, it was only two days later that Katherine Carson, co-coordinator of CANOW's Human Reproduction Taskforce, restated NOW's opposition to the regulations. Despite Fernandez's insistence that NOW supported the regulations, Carson claimed that Fernandez's statement reflected only the position of the San Francisco chapter, and further, that this chapter, as a representative of WomanSurge, was not part of CANOW.⁹³ Carson's statement dealt a blow to the other women's organizations, driving an ideological wedge once more between them and NOW. Carson's testimony reinforced many of the claims previously voiced by Sherwood in Sacramento, including that they imposed non-medical

91 Ibid.

92 "Testimony of Deborah Barto," *Sterilization Hearings*, February 12, 12-13.

93 "Testimony of Catherine Carson, Co-Coordinator of the Human Reproduction Taskforce for California NOW," *Sterilization Hearings*, February 14, 130. Box 54, Folder 9, MALDEF, SUA.

criteria on the operations; that waiting periods limited women's decision making; and that further regulations would do little to prevent abuse. Furthering NOW's objections, Carson claimed that the regulations, ostensibly applicable to both men and women, in fact only applied to the latter, as vasectomies, largely performed in doctors' offices, did not fall under CDH jurisdiction.⁹⁴ These sexist regulations, Carson argued, were "based on the opinion that women do not know what they are doing when they make a decision to have a sterilization." "Women," they claimed, "are not a special class to need this protection."⁹⁵ This statement demonstrates the shortsightedness of the majority caucus of CANOW, who, uncompromising in their defense of individual choice, refused to admit that it was women exactly (especially minority women), who represented the overwhelming targets of sterilization abuse, that needed special protection. However, CANOW's message was clear, the regulations represented a barrier to service and were thus antithetical to women's freedom.

In many ways, the coalition's fight for regulations, and attempts to persuade NOW to support them, came at an inopportune moment in the women's movement's history. As Steven Buechler notes, the late 1970s saw NOW "increasingly entangled in efforts to maintain, sustain, and expand [earlier] political victories."⁹⁶ The issue of reproductive choice was one such area where resistance mounted following the 1973 *Roe v. Wade* decision—legalizing women's right to abortion in the first two trimesters. The most forceful attack came from the 1976 Hyde amendment which prohibited the use of federal funds to pay for abortions, unless it was life-threatening to withhold the procedure.⁹⁷ Against this "sustained counterattack" on its earlier success, NOW, in the late-1970s, stood more resolute on women's right to individual choice in matters of reproduction.⁹⁸ Indeed, at CANOW's 1976 state conference, the organization reaffirmed its commitment to freedom of choice, and dedicated itself to attacking both the 1976 Hyde amendment, and Lackner's attempts to tighten abortion laws in California. Grippled by the militancy of the moment, CANOW members at the conference resolved to oppose any legislation which adversely affected reproductive choice.⁹⁹ Against this background, the attempts of sterilization activists to persuade NOW to support protective regulations may have futility from the start. The organization's stance on the sterilization regulations indicated clearly

94 "State Sterilization Rules Rapped by Women's Libbers," 6.

95 "Testimony of Catherine Carson," *Sterilization Hearings*, February 14, 129-130.

96 Buechler, *Women's Movements*, 67.

97 Mary Ziegler, *After Roe: The Lost History of the Abortion Debate* (Cambridge: Harvard University Press, 2015), 121.

98 Buechler, *Women's Movements*, 67.

99 "NOW Confab Plans Action to Reaffirm Aims," *Bakersfield Californian*, December 9, 1976, 31.

that they privileged a definition of reproductive choice which denoted a freedom to access sterilization services on demand, rather than the broader freedom to choose or *resist* the operation.

Undeterred, minority women activist turned out in force at the hearings to support the proposed safeguards. Their testimony comprised a blend of legal advocacy, and evocative “flesh and blood” accounts of sterilization abuse to press home the need for regulations.¹⁰⁰ Alongside personal stories of abuse, activists recounted instances of sterilization abuse against minority women nationwide.¹⁰¹ These accounts reinforced the argument put forth by a number of attendees that sterilization abuse had reached genocidal proportions. Ricardo Cruz, for instance, a lawyer representing seven Chicana women sterilized at LACMC, noted that: “what you are seeing with the testimony and the exhibits is that we can't get around the word 'genocide.’” In the tremendous “whole-scale” push to sterilize minority women, Cruz stressed the state's complicity through its failure to enforce previous regulations.¹⁰² Others at the hearings, like Helen Abel of the *Women's Alliance to Gain Equality* (WAGE), emphasized the medical community's use of women of color as “guinea pigs” for medical experimentation.¹⁰³ WAGE, although a predominantly white feminist organization, formed out of NOW's ignorance to working-class issues, chose to side with minority women and argued that safeguards would not interfere with a woman's right to choose.¹⁰⁴ Ultimately, such testimony emphasized the failure of the government to act on the issue of sterilization abuse sooner, and the immediate need for the adoption and enforcement of the proposed safeguards.

However, the testimony of sterilization abuse activists also showed that disagreement, while not as stark as those within NOW, existed over the form of regulations among minority women too. Indeed, many believed that the regulations fought for by the coalition did not go far enough. Although the coalition itself had fought the inclusion of the seventy-two hour waiver stipulated by the CDH, several groups believed that even a fourteen-day interval was inadequate.¹⁰⁵ A group of activists from several women's groups described the proposed regulations as “extremely skeletal” and wished to see the waiting period extended to ninety-days.¹⁰⁶ This, they argued, was the perfect

100 “Testimony of Erica Grubb,” *Sterilization Hearings, February 14*, 49.

101 See “Testimony of Connie Uri,” *Sterilization Hearings, February 12*, 71-74.

102 “Testimony of Ricard Cruz,” *Sterilization Hearings, February 14*, 113.

103 “Testimony of Helen Abel,” *Sterilization Hearings, February 12*, 101.

104 Kieron Walsh Taylor, “Turn to the Working Class: The New Left, Black Liberation, and the U.S. Labor Movement, 1967-1981” (PhD diss., University of North Carolina, 2007), 15.

105 Among them were the National Coalition Against Sterilization Abuse, the Native American Solidarity Committee, and the Council of Black Nurses.

106 “Statement of Debbie Freeman, Carol Jacques and Gloria Lucio,” *Sterilization Hearings, February 14*, 70.

compromise between the proposed fourteen-day wait, and the six month interval proposed by Native American women, who, as Connie Uri testified, had been particularly hard-hit by sterilization abuse.¹⁰⁷ Directly addressing NOW's objections to the waiting period, a representative for the group asked, "what is the hurry? What is the rush?" "If you are a middle-class white woman," the representative continued, "you will have to plan three months prior to the sterilization."¹⁰⁸ The representative's comments highlight the complexity of sterilization policy, displaying a divergence of opinion not just between white women and minority women, but also between minority women themselves, over what constituted acceptable guarantees for reproductive autonomy.

While the regulations were not completely satisfactory to all, many activists viewed them as adequate, and simply hoped that they be instituted swiftly. This was typified by the response of CMRW members at the hearings who stated that: "while we have some problems with the regulations as written[...]in general we fully support the end product."¹⁰⁹ At the hearings, CMRW members were as dynamic as they had been in the lead up to them. Here CMRW members argued, contrary to NOW's claims, that regulations, in fact, empowered women's choice. The regulations "don't infringe or pose a 'chilling effect' on the exercise of any fundamental rights," claimed Eric Grubb, using the Sherwood's own language. Instead, Grubb contended, "these requirements and all informed consent procedures are designed to enhance the exercise of these fundamental rights." Grubb disputed the claim put forward by the NOW representatives that informed consent itself constituted a non-medical qualification for undergoing a sterilization operation. Informed consent, Grubb argued, was not a qualification, but a fundamental right possessed by every woman to determine what to do with her own body.¹¹⁰ That government regulation was needed to guarantee this right was proven by the lurid accounts of abuse heard at the hearings. Women, Grubb's colleague argued, "cannot rely on the goodwill or moral integrity of a physician to prevent abuse," especially considering that many physicians denied existence of abuse.¹¹¹ Thus, the CMRW argued that not only was the government ethically bound to enact regulations, it constitutionally empowered to do so under its mandate to protect public health.

Similarly, while acknowledging the difficulty in balancing unencumbered access

107 Native American Solidarity Committee, *The Systematic Genocide of Native Nations by the United States Government* (San Francisco: American Indian Treaty Council, 1977), 4.

108 "Statement of Debbie Freeman, Carol Jacques and Gloria Lucio," *Sterilization Hearings*, February 14, 71.

109 "Testimony of Dorie Wilsnack," *Sterilization Hearings*, February 12, 38.

110 "Testimony of Erica Grubb," *Sterilization Hearings*, February 12, 50-51.

111 "Testimony of Lin patternson," *Sterilization Hearings*, February 12, 52.

to, and protection from sterilization, CMRW members pointed to the testimony of abused women to argue for the necessity of the latter. The objection of white feminists to regulations, the CMRW argued, was overblown as that the time taken to schedule a sterilization, in the face of hospital waiting lists, was generally equal to or in excess of the fourteen-day interval anyway.¹¹² The CMRW's comprehensive and compelling testimony, delivered over six presentations, captured the overwhelming feeling of sterilization activists at the hearings. It pointed to the urgency felt over the need for regulations, and, based on the testimony of hundreds of women health consumers and providers, the need to primacy protections over convenience in sterilization.

The government agreed, and, in a major victory for the activists, the regulations as were passed as originally promulgated. Acknowledging the women's input in a memo to hospital administrators following the passage of the regulations, Lackner wrote that the protections represented the “synthesis of many thoughtful comments obtained by letter, public testimony, and public meetings with[...]lay groups and individuals.”¹¹³ Lackner's comment certainly understated the significant work of sterilization activists in pushing his reluctant department through an extraordinarily complicated struggle to institute patient protections. Throughout this process, the CDH had shown itself to be reluctant and reactionary, and had it not been for the consistent pressure of the CMRW and its allies, it's unlikely that protections, other than those required by the federal government, would have existed. The department's paralysis stemmed from the inherent difficulty in regulating sterilization—a fact acknowledged in Lackner's memo. “While perhaps not perfect, admitted Lackner, “the regulations come as close as I could imagine towards reasonably accommodating the various viewpoints we heard and carefully analyzed.” “Ideally,” the director continued, “they strike a balance between undue restriction on the availability of sterilization services, optimum protection of patient rights, and the interests of the medical profession in the expedient, yet humane, practice of their profession.”¹¹⁴ Lackner's last line was undoubtedly an attempt to placate the physicians who had resisted departmental regulations from the outset. Indeed, the medical profession, although defeated at the sterilization hearings, would rally to oppose the newly adopted safeguards in the months that followed.

Concern over opposition from within the medical community would lead to yet another delay in the regulations process. While signed by the Secretary of State in May, with an intended effective date of August 1, the CDH ultimately decided to postpone the

112 “Testimony of Molly Berigan,” *Sterilization Hearings, February 12*, 40.

113 “Jerome A. Lackner Memo to Physicians,” Box 908, Folder 4, MALDEF, SUA.

114 Ibid.

implementation of the regulations until December. Lackner's deputy, Ray Procunier, claimed that neither the CDH nor the hospitals were prepared to implement the new rules, and the procedures for handling the required documents still needed clarifying. Implementing the regulations at this time, Procunier argued, would have led to a "virtual moratorium on sterilizations" across the state.¹¹⁵ While it is possible, given the administrative shambles that characterized the CDH, that the department was unprepared to implement the regulations, it is likely that a preliminary injunction, filed by the CMA on the same day as the government's decision to halt the onset of the regulations constituted the true cause. The injunction sought to block the regulations, arguing that, by deterring women from choosing sterilization, they posed an "increased risk of serious injury and death to a large number of patients," and represented a "massive governmentally-direct invasion of privacy."¹¹⁶ The stalling, the CMA argued, was an attempt by the CDH to avoid instituting regulations that they did not have the authority to issue in the first place.

Although the CMA's motion was subsequently denied, their actions clearly troubled the department, which, over the next four months, made numerous attempts to renege on the outcome of the hearings. Each time, the CMRW was forced to intervene and reiterate the need to issue the safeguards without alteration.¹¹⁷ In the meantime, the CMA took their challenge to the courtroom, naming Lackner and the CDH in a suit that challenged the state's right to regulate the doctor-patient relationship. This action, conceivably, represented the embodiment of the fears that had paralyzed the CDH through the drafting process; embroiling them at a time of already considerable pressure in a potentially lengthy legal battle. Thus, despite the already protracted battle to pass regulations, when they finally went into effect on December 1 1977, they sat precarious ground in the face of determined pressure from the medical profession.¹¹⁸

Aware of the government's tenuous commitment to the regulations, members of the coalition made a final attempt to win CANOW's support. In early January, Esther Talavera, representing the CMRW, canvassed the CANOW membership, reiterating that due to their status most prominent women's organization, it was critical that the group "reconsider its position on the state regulations and that it take a stand against the CMA suit." Talavera suggested that NOW members, friendly the CMRW's cause, write to the NOW state coordinator, Mary Smith, in support of action.¹¹⁹

115 "New Sterilization Rules Delayed," *The San Mateo Times*, July 28, 1977, 4.

116 "Complaint for Preliminary Injunction, Permanent Injunction, Writ of Mandate and Declaratory Relief." *CMA v. Lackner Pleadings*, Box 908, Folder 3, MALDEF, SUA.

117 "Declaration of Mary Foran," 3-5.

118 "CMA Sues State Over New Sterilization Rules," *The Los Angeles Journal*, November 2, 1977, 1.

119 "Esther Talavera to 'Friends,'" January 15, 1978. Letter. Box 54, Folder 4, MALDEF, SUA.

Talavera certainly had reason to believe that her request would be effective. First, the San Francisco and San Jose chapters of Now had passed resolutions voicing their official support for the regulations, and their intention to “work closely and coalesce” with other organizations. As Fernandez had stressed at the hearings, the San Francisco and San Jose resolutions were born of the desire to promote unity in the women's movement, even if that meant compromising NOW's stance on government regulations. “An unclear stand on this issue by NOW,” the chapters' recognized, “could divide the women's movement in that poor and/or third world women could feel that the membership is not in support of their concerns on this vital issue.”¹²⁰ Second, discussion at CANOW's state conference in November, where attendees left the organization's position on sterilization abuse unresolved, proved that disagreement existed within even the state organization. Attempting to seize on the incertitude, Talavera presented a resolution at the CANOW board meeting in January, 1978, stressing that the groups set aside their differences to meet the medical profession's challenge. The resolution requested that NOW form a sterilization abuse committee, composed of NOW women from all chapters, and other groups working on sterilization abuse, including the CMRW and the *Comisión Femenil*, which would facilitate debate within the organization and convince it to take a stand on the issue.¹²¹

CANOW, however, never did change their stance on the issue, leading, as Fernandez feared, to lasting animosity between NOW and minority women's groups.¹²² This was true of the organization on a national level, too, where the leadership's resolute stance against further sterilization regulations released by DHEW in 1978 left NOW not only increasingly alienated from the majority of the women's movement, but also torn apart by bitter internal struggles over the issue.¹²³ The resistance of NOW, both in California and nationally, to sterilization safeguards, despite their exposure to considerable evidence of abuses, and repeated supplication by minority women, points to a deep ideological commitment among influential members of the organization to a narrow and decidedly racially- and class-based definition of reproductive choice. Furthermore, the bitter chafing of this position against that held not only by minority women, but also segments of NOW's own splintered membership, highlights the divisions that characterized debates over sterilization and reproductive freedom, and the innate difficulty

120 “Resolution Passed by the San Francisco and San Jose Chapters of the National Organization for Women Concerning Forced Sterilization,” January 26, 1978. Box 98, Folder 5, MALDEF, SUA.

121 “Copy of Resolution Presented to California National Organization for Women Board Meeting, January 21, 1978,” Box 54, Folder 4, MALDEF, SUA.

122 Gutierrez, *Fertile Matters*, 105.

123 Shapiro, *Population Control Politics*, 154-155.

of regulating it, in a period of significant change.

Fighting for a “Protective Umbrella”: The Medical Profession, Federal Regulations, and the Two-Track System.

Just days after the new regulations took effect, the CMA's legal challenge began in Sacramento's superior court.¹²⁴ In *CMA vs. Lackner*, the CMA argued that as informed consent was a form of medical practice, the Department of Health, by issuing regulations, had exceeded its expressed authority to protect the public health, and was attempting, instead, to regulate the conduct of physicians.¹²⁵ This, the physicians argued, represented an “obvious infringement” on both the informed consent process and practice of medicine.¹²⁶ The CMA declared that only the *Board of Medical Quality Assurance* (BMQA)—a physician-dominated “watchdog” committee created in 1975—held the authority to regulate and police the medical profession.¹²⁷ If they had to be regulated at all, the medical profession wanted other physicians to be the ones to do so. Indeed, it is clear that the CMA questioned both the need for sterilization regulations and the evidence of abuse upon which they rested. CMA attorney, David Willett, implying an air of conspiracy, argued that the coalition and other activists had “convinced” the CDH as to the existence of sterilization abuse, despite the absence of clear “evidentiary support” in the administrative record.¹²⁸ John Miller, one of the co-plaintiffs in *Lackner*, went further, arguing that the evidence presented at the hearings was insubstantial and based on “apocryphal tales.”¹²⁹ The thrust of Willett's argument was that the health department had used these unsubstantiated claims as a smokescreen to justify exerting greater control over the medical profession.

The message from the CMA testimony was clear: the medical profession did not wish to be regulated. They feared that the sterilization regulations would be open the door to a deluge of state interference in the practice of medicine. As CMA lawyers later argued: “If these regulations are not struck down, what is to prevent the Department from prescribing 'informed consent' or other procedures for all kinds of medical treatment?”¹³⁰ In this way, the medical profession's resistance to regulations mirrored that of white feminists, who viewed acquiescing to sterilization regulations as a precursor to further

124 “CMA Challenges Sterilization Rule,” *San Bernardino County Sun*, July 14, 1977, 8.

125 “Complaint for Preliminary Injunction,” 2.

126 “CMA Sues State Over New Sterilization Rules,” 1.

127 Linda A. McCready and Billie Harris, *From Quackery to Quality Assurance: The First Twelve Decades of the Medical Board of California* (Sacramento: Medical Board of California, 1995), 27.

128 “Reporter's Transcript of Proceedings, Friday, December 9, 1977,” *CMA v. Lackner*, 14. Sacramento Superior Court Records, Microfiche, case 268099. (Hereafter “RTP”).

129 “CMA Sues State Over New Sterilization Rules,” 1.

130 “Appellant's Opening Brief,” 22.

state intervention in women's reproduction. So afraid were the medical profession of the knock-on effect of accepting regulations that, when in 1974, the Board of Medical Examiners—the predecessor to the BMQA—drafted informed consent standards for all medical procedures that delegated a greater role to the patient in choosing treatment, the proposal had to be abandoned following fierce resistance from the CMA and CHA.¹³¹ Likewise, a CMA committee formed in 1973 to investigate the feasibility of standardizing informed consent procedures, disbanded in 1976 after declaring that such an effort was “impossible.” “Compassionate medicine,” the physicians' maintained, “could not be accomplished by rote procedure.”¹³² The problem was not with informed consent per se, but the inflexible regulation of what doctors were required to say by the state. Informed consent was a matter firmly and solely to be decided by physicians.

Indeed, one the CMA's major contentions against the regulations was patients were already protected under a 1972 statute. In *Cobbs vs. Grant* - a malpractice suit arising from a botched surgical operation - the California Supreme Court established state's first standard for informed consent, which held that “part of the physician's overall obligation to the patient[...]is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each.”¹³³ Under *Cobbs*, physicians were rendered liable to a negligence suit if they failed to inform the patient of all risks and alternatives of a proposed treatment. Yet, aside from mandating that a physician provides “enough information to the patient to allow a reasoned, informed decision,” the court ordered no fixed rule on the content of this information, and instead delegated this task to the physician.¹³⁴ *Cobbs*, then, granted significant leeway to the physician in what knowledge they deemed important for a patient to know. At the preliminary hearings on December 9, Willett argued that *Cobbs* provided sufficient protection for patients undergoing sterilization. “There is a standard set to protect a public interest, and there's penalties if you violate that standard,” Willett affirmed.¹³⁵ Beyond this, the state had no legitimate interest, argued Willett, and the regulations, greatly exceeding the requirements set forth in *Cobbs*, not only overreached the department's authority, but also impaired physicians' ability to treat their patients effectively and compassionately.¹³⁶

The administrative record—a foot and a half high document compiled over two

131 Skane, “Health's Embattled Lackner,” 55.

132 Ibid; “Appellant's Opening Brief,” 18.

133 *Cobbs v. Grant*, 8 Cal.3d 229 (1972).

134 Sandra A. Salazar, “Absence of Informed Consent in Female Sterilization Procedures: California and *Cobbs v. Grant*,” 11. Box 54, Folder 1, MALDEF, SUA.

135 RTP, *Lackner*, 48.

136 Ibid, 18.

years which detailed the “background of abuse” in the sterilization field—proved otherwise, argued Deputy Attorney General and CDH representative, Byron Chell.¹³⁷ Evidence that “citizens and patients[...]were being subjected to sterilization operations when they either did not know what was occurring to them or did not fully understand the nature of consequences of sterilization,” proved that *Cobbs* had not provided the protective value identified by the CMA.¹³⁸ The CDH had thus been left with two choices: simply ignore the comprehensive record of sterilization abuse, or fulfill its mandate to protect and preserve the public health.¹³⁹ This context, combined with the special nature of sterilization operations, underpinned the department's case in favor of regulations.

Intervening in the case, the CMRW agreed with the CDH that sterilization required stronger informed consent standards than other operations. The testimony of hundreds of health consumers and providers at the hearings had surely demonstrated this need, argued CMRW coordinator, Mary Foran. Highlighting the gulf between the standards laid out in *Cobbs* and the CDH regulations, Foran stressed that the latter was intended to “create a method for *preventing* the violation of a patient's right to informed consent before it happens” (emphasis mine).¹⁴⁰ In the face of the considerable record of abuse, Foran believed that physician “penalties” pinpointed by Willett, held little value for the remedying abuse more broadly. “At best,” she argued, “a malpractice suit might change the practices of one doctor or one hospital, but it does not change the practices overall.”¹⁴¹ But more importantly, any damages awarded under *Cobbs* for unwanted sterilization simply could “never adequately compensate for the loss of the fundamental and valuable right to have children.”¹⁴² While the CMRW, joined by MALDEF, the *Comisión Femenil*, and the SFNLAF, threw their support behind the department's right to issue regulations, they nevertheless admonished the CDH before the court for the “chronic delays” and lack of cooperation throughout the regulations process, which, they maintained, signaled a “serious difference of interest and intent” over the importance of regulations.¹⁴³

Nevertheless, *Lackner* saw their interests align in attacking the CMA's preference for malpractice action over preventative safeguards. Judge Lawrence Karlton agreed on this point, stressing that *Cobbs* was not a protective measure, but merely established the

137 Ibid, 34.

138 “Supplemental Points and Authorities in Support of Defendants' Motion for Summary Judgement,” *CMA v. Lackner*, 8. Box 908, Folder 4, MALDEF, SUA.

139 Ibid, 9.

140 “Declaration of Mary Foran,” 11

141 Ibid.

142 Ibid.

143 Ibid.

“standards below which no physician may fall without exposing his assets.”¹⁴⁴ The regulations, the judge declared, were not concerned with policing the physicians' standard of care, but with the protection of citizens, and thus served an entirely different purpose than *Cobbs*. Karlton was also stumped as to why the potential receipt of damages trumped preventative regulations, and queried why the state had “to be bound by that tort standard and can't create a higher standard for state interests.”¹⁴⁵ Ultimately, the judge affirmed, the state desired a “preventative” regulation which would preempt “the very malpractice which would otherwise arise.”¹⁴⁶ For Karlton, regulations were a tool for the state and physicians to avoid becoming embroiled in needless and costly litigation.

As to their legitimacy, Karlton examined the definition of “public health” - which the health department was mandated to protect - and whether sterilization abuse constituted a threat to it. If, in fact, it was, then regulations would be a legitimate exercise of departmental authority. The case law involved in settling this question was copious and relatively straightforward, argued Karlton. The Judge drew upon two cases in particular which specifically defined protection from “unnecessary operations” as a legitimate public health concern.¹⁴⁷ As such, on April 24, 1978, Karlton ruled in favor of the health department's petition for summary judgment, adjudging that the regulations, against a background of evidence detailing significant abuse in state health facilities, represented a “valid exercise of the quasi-legislative authority of the department.”¹⁴⁸

The exception to Karlton's comprehensive ruling in favor of the department was over the regulation's minimum age requirements. The CMA had argued that the regulations violated the rights of minors, as California law allowed minors who were married, serving in the armed forces, or above fifteen and emancipated, to consent to medical or surgical care on their own authority. Thus, Karlton declared, the regulation's stipulated minimum age limit of eighteen stood in contravention of state law and exceeded the department's regulatory power.¹⁴⁹ Aside from this caveat, however, the judge had, for all intents and purposes, removed the last remaining opposition to the regulations. Yet, if the coalition thought their campaign was over, events set in motion by the federal government were soon to provide perhaps the greatest challenge to the protections.

The CMA's defense of its professional autonomy was offered an inadvertent

144 RTP, *Lackner*, 18.

145 Ibid, 47.

146 Ibid.

147 “Opinion and Order,” *CMA v. Lackner*, 14. Sacramento Superior Court Records, Microfiche, case 268099; *Barkin v. Board of Optometry*, 269 Cal. App.2d 714; *People v. Rehman*, 62 Cal.2d 138.

148 “Findings of Fact and Conclusions of Law,” *CMA v. Lackner*, 3. Sacramento Superior Court Records, Microfiche, case 268099.

149 “Opinion and Order,” 23.

lifeline by the announcement of DHEW's long-awaited successor to its "interim" regulations published four years prior. On the very same day that California's regulations finally went into effect, DHEW's secretary, Joseph Califano, publicly proposed new regulations for sterilizations funded by his agency, which were "designed to eliminate federal support for coerced or uninformed sterilizations."¹⁵⁰ The sudden urgency shown by Califano on the issue of sterilization abuse sprang from the publication a year prior of a report on the involuntary sterilization of over 3,000 Native American women in Indian Health Service hospitals, and the complete failure of federal informed consent standards.¹⁵¹ Published in their final form in November 1978, following nationwide hearings, the new federal regulations far exceeded their provisional forerunners. These standards mandated a thirty-day wait between signature and operation, waivable to the former requirement of seventy-two hours only in specific medical circumstances. Only those over twenty-one years old, legally capable of providing consent, and not institutionalized, were eligible for reimbursement. In a significant addition, the new regulations also banned the funding of hysterectomies performed for sterilization purposes only. Along with these specific stipulations, the regulations set the limits of what information constituted informed consent, and when it could be legally obtained.¹⁵² The reaction from within California to DHEW's new stringent funding policy was generally favorable. However, women activists, including the CMRW, still maintained that state regulations were more effective at preventing abuse.¹⁵³ While the new regulations promised increased protection for vulnerable patients across the nation, their promulgation was to put California and New York, the only states with their own set of regulations, in a difficult position, as failure to follow the federal standards would threaten an important source of funding for already over-subscribed state Medicaid programs.

The awkward bureaucratic dissonance triggered by the release of the federal regulations troubled California's new health chief, Beverlee Myers. Myers was both the first woman, and non-physician, to head the CDH, which she had taken over in April, 1978, after Lackner's removal by Governor Brown.¹⁵⁴ Lackner's firing had come swifter

150 "Statement by Joseph A. Califano, JR. Secretary of Health, Education and Welfare," December 1, 1977. Box 54, Folder 8, MALDEF, SUA.

151 Elmer B. Staats, *Investigation of Allegations Concerning Indian Health Service: B-164031(5) HRD-77-3* (Washington, D.C., General Accountability Office, 1976); David E. Rosenbaum, "H.E.W. To Issue New Regulations to Prevent Forced Sterilizations," *The New York Times*, December 22, 1977, 20.

152 "Sterilizations and Abortions: HEW/PHS, HCFA, and HDSO Issue Rules on Federal Financial Participation, Effective 2-6-79," *Federal Register* 43, no. 217 (November 8, 1977), 52146-52173.

153 Ralph Craib, "Feminists Fight for Sterilization Surgery Regulations," *San Francisco Chronicle*, February 9, 1978, 22.

154 "Brown Fires Health Chief: Lackner Long Criticized on Handling Job," *The Los Angeles Times*, March 28, 1978, A1; Jerry Gillam, "Brown 'Replaces' Lackner, Insists He Was Not Fired," *The Los Angeles Times*, March 25, 1978, A1; See also Camilla Stivers, "Beverlee A. Myers: Power, Virtue, and

than expected, in an attempt, according to Brown, to “accelerate the reorganization” of the chronically troubled CDH. This reorganization entailed disassembling the health giant created by Brown's republican predecessor back into its five constituent departments.¹⁵⁵ Sterilization services and the administration of Medi-Cal would now fall under the *Department of Health Services* (DHS), headed by Myers. Along with the administrative mess left by this reorganization, the departure of Lackner, and a public scandal over the over-prescription of painkillers to Medi-Cal Patients, Myers was tasked with solving the sterilization regulation problem. Thus, in February 1979, the new director announced her intention to bring the department's regulations in compliance with DHEW's, yet only after two unsuccessful petitions were sent by Myers to the federal agency requesting that California be allowed to keep its own, internally-devised regulations in place.¹⁵⁶ Myer's acquiescence was born of necessity, as failure to comply would have resulted in the state forfeiting approximately four million dollars annually, the majority stemming from Title X, in federal subsidies for sterilizations services.¹⁵⁷ “While I firmly believe California's current sterilization regulations are superior to the new federal regulations,” noted Myers, a former DHEW staffer herself, “HEW's waiver denial makes it fiscally impractical to continue our regulations in effect.”¹⁵⁸ Reluctantly, Myers intended to amend the state regulations as they applied to *both* Medi-Cal recipients and private pay patients—regulations the coalition had fought for over four years—to conform with the new federal requirements. Yet, while outwardly definitive in her decision, privately Myers remained concerned with the practicality of it, and on March 9, 1979, one day after the new federal regulations took effect, the director sought counsel with her department on the issue.

The answer from advisors within her department appeared unanimous. While keeping the state regulations, which, they argued, “reflect the views of its constituency[...]as expressed through the public hearing process,” was preferable, the financial impact of losing federal financial participation made the position untenable. On the other hand, amending both Medi-Cal *and* private regulations to conform with the federal standards presented a legal quandary. In particular, the advisors questioned the legality of requiring patients, paying for sterilization with their own money, to adhere to the increased age limit, and ban of contraceptive hysterectomies, set forth in the federal

Womanhood in Public Administration,” in *Exemplary Public Administrators*, eds Terry L. Cooper and N. D. Wright (San Francisco: Jossey-Bass, 1992), 166-192.

155 “California's Health Chief Not Fired, Brown Insists,” *San Bernadino County Sun*, March 25, 1978, 1.

156 “State Elects to Comply with Sterilization Law,” *Santa Cruz Sentinel*, February 14, 1979, 7.

157 Medical Care Standards Division and Community Health Services Division to Beverlee A. Myers, Director, March 9, 1979, 3. Memo. Box 908, Folder 2, MALDEF, SUA.

158 “State Elects to Comply with Sterilization Law,” 7.

requirements, when state law dictated otherwise. The solution, it was argued, was a “two-track” health system which met the federal mandate while continuing to protect private patients. In their recommendation, the advisors stressed that “two-track” did not mean two distinct regulations.¹⁵⁹ Indeed, the CMA had already attacked such a solution, arguing that concurrent regulations would “unnecessarily confuse the public and profession in an area where greater clarity is needed.”¹⁶⁰ Instead, the DHS advisors recommended the adoption of a single regulation, set in accordance with DHEW's standards, though with some restrictions, i.e. the prohibition on hysterectomies, excluded for private patients. Given the relative similitude between the state and federal regulations, it was stressed that instituting such a system would be relatively simple. It would also permit the state to receive federal monies without unnecessarily burdening private patients. “While the system we are proposing may cause some confusion in the beginning,” the advisors admitted, “we feel this will be alleviated once the providers become familiar with the regulations.”¹⁶¹ On the face of it, the “two-track” proposal seemed advantageous on all fronts, and won endorsement from a number of DHS subdivisions including the Office of Family Planning. Furthermore, given the outcome of *Lackner*, the department's authority to implement such a system was no longer in doubt.

Seeking public comment, as was required before taking any action on the regulations, Myers called public hearings in the summer of 1979. Yet, any hope that she may have held that the hearings would reveal a solution to the DHS's quandary was swiftly crushed as the testimony provided proved equally, if not more divisive than that heard in the 1977 hearings. Apparently ignoring department advice, the DHS, represented by Deputy Director of Community Health Services, Thelma Frazier, voiced the department's preference for applying the DHEW regulations universally to both Medi-Cal and private-pay patients. Frazier claimed that, over the preceding five years, the state had lost seven million dollars in federal funding for sterilization by maintaining its different standards.¹⁶² As they had since 1975, the CMRW once again came to the defense of the state regulations. Represented by Laura Rodriguez, the CMRW urged that “the more stringent aspects of the federal regulations[...]be incorporated with the state's protective provisions.”¹⁶³ However, as the state's proposal of a single, federally-derived standard did

159 Medical Care Standards Division to Beverlee A. Myers, 1-5.

160 Nicholas P. Krikes to Robert Barnhouse, Health Program Advisor, Office of Family Planning, December 20, 1978, 2. Letter. Box 908, Folder 2, MALDEF, SUA.

161 Medical Care Standards Division to Beverlee A. Myers, 3.

162 Harry Nelson, “Doctors Disagree on Sterilization Rules: Hearing Held on U.S. Regulation of Private Surgeries,” *Los Angeles Times*, August 2, 1979, B26.

163 “State Must Follow Sterilization Regulations, Or...” *Santa Cruz Sentinel*, August 1, 1979, 4.

not “adversely affect the protective policies” of the state, pro-regulation women activists were willing to accept this action.¹⁶⁴ Predictably, not all agreed with this point.

Assemblywoman Leona Egeland, a legislator deeply embedded in the women's movement, argued that the state regulations should be kept unchanged, believing them “adequate to keep women from being coerced into unwanted sterilizations.” Adopting the regulations would have the effect of changing the age of majority in California, Egeland argued, and requested that Myers once again seek an exemption from adopting DHEW's standards.¹⁶⁵

The CMA, on the other hand, argued that the federal regulations should be applied solely to Medi-Cal patients, and that sterilizations for private-pay patients should be deregulated as “there is no present abuse of sterilization on them.”¹⁶⁶ While the CMA's support of the strict DHEW regulations at first appears surprising, the group had advanced this opinion since DHEW promulgated them. This support stemmed from their belief that if California adopted the federal regulations, which they viewed as unavoidable anyway, the DHS could be persuaded to deregulate private operations. A further reason for support came from the fact that the federal regulations, in contrast to the state's, exempted secondary sterilizations—sterilization that occurs as secondary result of other operations, i.e. radiation therapy or prostatectomy—from the stringent informed consent standards for elective sterilizations. “Most physicians,” the CMA argued, “would be very grateful to have the burden of these regulations lifted” from the performance of these procedures.¹⁶⁷ At the hearing, the CMA and other members of the medical profession attempted to advance their Medi-Cal-only argument by emphasizing the discriminatory nature of any regulatory double standard. John Bridgeman of the CMA declared that such a standard was “sexist and patronizing to the poor,” while another physician from LACMC argued that the poor were being “shafted” with additional burdens not shared by private patients.¹⁶⁸ Given this divergence of opinions voiced at the hearings, it is likely that the testimony, perhaps as the CMA had hoped, contributed to, rather than abated the CDH's dissonance over the issue. Indeed, the 1979 hearings illustrate once more the complex nexus of arguments that the DHS and the government had to grapple with in transforming state policy from one of compulsion to protection.

Myers continued to grapple with the problem for the next five months, until, in January 1980, she announced her intention to completely repeal the protections for private

164 “Testimony of Lois Salisbury, Attorney, PAI, On Behalf of the CMRW, June 10 1980,” Box 909, Folder 8, MALDEF, SUA.

165 Nelson, “Doctors Disagree on Sterilization Rules,” B26.

166 Ibid.

167 Nicholas P. Krikes to Robert Barnhouse.

168 Nelson, “Doctors Disagree on Sterilization Rules,” B26.

patients. A defensive tone permeated the press release on January 15, 1980, in which Myers attempted to justify her decision. Myers, in a complete turnabout from the department's stance at the hearings, argued that the DHEW standards were “more restrictive than necessary,” and that she considered it “undesirable” to burden Medi-Cal and private-pay patients alike with the federal regulations' rigid criteria. “Conversely,” she contended, using language strikingly similar to that used earlier by the CMA, “to go forward with DHEW requirements for MediCal patients and at the same time maintain state regulations for private pay patients would result in a great deal of confusion in both the patient and provider communities.”¹⁶⁹ Here Myers apparently ignored the advice from within her department over the ease with which a “two-track” system could be implemented across the state. The hearings, although intended only to discuss the modification, not removal, of the private regulations, apparently led Myers to this decision. As she wrote several months after announcing her decision: “If the testimony given at the public hearings[...]were heavily weighted in favor of retaining some regulations for private pay patients, then the effort would be justified to proceed with separate regulations, however, this was not the case.” Myers described how even many of those who supported protections for private patients, refused to accept the extra sixteen day wait included in the federal rules.¹⁷⁰ Yet, while noting the lack of consensus, Myers, at the same time, cited the testimony of groups opposed to the regulation of private sterilizations, namely the CMA, CHA, and Planned Parenthood, as being central to her decision to rescind the state protections. In a tremendous victory for the medical profession, their testimony had apparently convinced Myers that it would be “in the best interests of all parties concerned” to solely regulate Medi-Cal sterilizations.¹⁷¹

Yet, while the medical community had convinced Myers of their position, it appears that their contributions at the hearings, as cited in her memo, did not prompt her sudden resolve to remove private-pay protections. More likely, Myers change of heart appeared to be the result of a surreptitious bargaining process in the interim period. Shortly following Myers announcement that private-pay regulations were to be rescinded, one of the director's deputies admitted that Myers had secretly met alone with the CMA Executive Council, where the Association's president, John Tupper, presented the DHS chief with a seductively simple resolution to the regulations dilemma. The CMA proposed that they, in exchange for Myers de-regulating private-pay sterilizations, would develop an

169 “Department of Health Services Press Release #4-80,” January 15, 1980. Box 909, Folder 6, MALDEF, SUA.

170 Beverlee A. Myers to F. Burns Vick, JR., April 25, 1980. Letter. Box 909, Folder 6, MALDEF, SUA.

171 “Department of Health Services Press Release #4-80,” 2.

education program for patients designed to provide information about informed consent prior to surgery. Furthermore, in lieu of regulations, the CMA were to develop guidelines for physicians outlining what information was to be imparted to patients before sterilization. The major difference between the state regulations and the proposed CMA-devised guidelines was that the latter would be internally policed through a “peer review process,” and not subject to any external review.¹⁷²

The guideline proposal, then, was an expert piece of maneuvering by the physician-activists—one that held the potential to put control of the informed consent process, for private patients at least, squarely back into the medical profession's hands. Likewise, for Myers, the offer provided not only a simple and cost-free solution to the regulatory millstone hanging around the department's neck, but also, in light of the CMA's decision in November, 1979 to file an appeal in the *Lackner* case, to the protracted legal battle between the CMA and the DHS. There was further suggestion that Myers' decision represented a “tradeoff” with the doctors who had stubbornly resisted the implementation of the state's new Medi-Cal billing system.¹⁷³ In 1978, Myers had awarded the Los Angeles-based *Computer Services Corporation* (CSC) a \$130 million contract over the physician-run Blue Cross/Blue Shield group to modernize Medi-Cal's inefficient billing administration, which the latter had supervised since 1966. While hospitals, pharmacies, and nursing homes across the state had promptly complied with Myers' wishes and switched to the new billing system, physicians continued to resist the change.¹⁷⁴ Yet, mere months after Myers' meeting with the CMA Executive Council, new CMA president Joseph F. Boyle announced that the state's physicians, after almost two years of resistance, would comply with Myers' request. “We now believe,” Boyle announced in the *Los Angeles Times*, “that it is our obligation to try to make the CSC system work, so that Medi-Cal patients can continue to receive needed medical care.”¹⁷⁵ It is possible, then, that Myers' sudden reversal on the issue of private-pay regulations represented a concession to physicians, who, in return, would assist the department chief by complying with the new billing system.

Despite the anger that the repeal was sure to prompt, the offer was too

172 “Declaration by Sioban Harlow, Committee to Defend Reproductive Rights, 2/28/1980,” 1. Box 909, Folder 13, MALDEF, SUA; “Coalition for the Medical Rights of Women: Rebuttal,” 4. Box 909, Folder 6, MALDEF, SUA.

173 Paul Jacobs, “Debate on Sterilization Rules Set: Waiting Period for Private Patients Would Be Ended,” *Los Angeles Times*, June 10, 1980, B3.

174 “Bill on Delay in Medi-Cal Change Gains: Medi-Cal Action,” *Los Angeles Times*, February 26, 1980, 13.

175 Claudia Luther, “Senate Subcommittee Cuts Funding for Medi-Cal Computer Billing Program,” *Los Angeles Times*, May 30, 1980, 22.

attractive for Myers to refuse. Indeed, shortly following her decision, Myers wrote to the CMA president, expressing her gratitude for his organization's cooperation with the department, and noting how the guideline proposal had been “instrumental” in the outcome of the decision. Myers concluded the letter by announcing her intention to form a task-force designed to coordinate efforts in developing the proposed guideline and educational program.¹⁷⁶

At the task-force's first meeting, in late-February 1980, the extent of the secrecy surrounding the Myers-CMA treaty became clear as representatives from both the CMA and DHS expressed when and where the idea of guidelines had originated. It became clear that the highest echelons of the CMA had negotiated an agreement that was highly favorable to their organization. One only has to look at the composition of Myers' task-force, composed of representatives of the CMA, CHA, ACOG, and Health Department, to recognize that the medical profession was to be firmly in control of the drafting process. Out of all the consumer and activist groups who had fought for regulations, only the CMRW was invited to participate in the task-force. However, clearly outnumbered by the medical profession, their voices were marginalized.¹⁷⁷ Yet, attempts by the CMRW to strengthen the guidelines in their favor would have been futile regardless, as the CMA retained ultimate discretion over the form that the guidelines were to take. The CMA, in effect, could veto any proposal they considered to impinge on their professional authority.¹⁷⁸ With Myers already announcing her intention to repeal the private regulations, any disagreement from the CMA would have left patients paying for their own operations completely unprotected from coercion. The *sub rosa* stratagem of the CMA, culminating, as they had hoped for all along, in the repeal of the private regulations, highlights once more the influence of non-state actors in shaping sterilization policy, and the intense resistance of the medical profession to regulation by the state.

Understandably vexed by Myer's duplicity, CMRW Staff Coordinator, Roberta Young, wrote to Myers to protest the action. As a result of her decision, Young warned the director, “many thousands of women” currently offered protection by the state regulations would be left “without any safeguards whatsoever from unscrupulous providers.” Guidelines, Young stressed, attacking the department's kowtowing to CMA pressure, were “NO substitute for material restrictions on abusive providers.” While the CMRW had indeed agreed to participate on the task-force, they urged that guidelines be an adjunct to regulations, not an alternative. Regulations empowered consumers, they contended, while

176 Beverlee A. Myers to John Tupper, January 17, 1980. Letter. Box 909, Folder 13, MALDEF, SUA.

177 “Declaration by Sioban Harlow,” 1-2.

178 “Coalition for the Medical Rights of Women: Rebuttal,” 4.

guidelines, especially those policed by the medical profession themselves, were ineffectual at best. Young attempted to convey this important point to Myers, noting that: “all the education in the world is of little help to the woman who is pressured to agree to sterilization in labor or who must consent as the price of an abortion, etc.” Myers decision to rescind the protection, Young declared, was not supported by testimony at the public hearings. On the contrary, consumers had largely requested that private regulations be kept, and even strengthened. Likewise, *Lackner* provided judicial support for the motion to continue private regulations. Instead, Myers decision was rooted in complicity with the CMA and similar groups who shared a “historic bias against government activity in fertility matters.” The exception to this position, Young pointed out, was in their support and funding of eugenic sterilization programs—the revelations of which were being brought into sharp focus by the media during this period. The CMRW, through Young's letter, had thrown down the proverbial gauntlet to Myers. It would not stand for collusion between the DHS and CMA, nor any attempt to weaken or outright reverse the protections that they and other activists had struggled bitterly to secure.¹⁷⁹

In the face of criticism, Myers continued to emphatically deny any double-dealing with the CMA, and argued that her decision to repeal private-pay regulations was in no way connected to the billing issue.¹⁸⁰ Yet, Myers response to Young smacked of CMA influence. While Myers expressed her agreement with the CMRW that no person should undergo sterilization without first being fully informed of the consequences, she admitted that, despite the department's cooperation with the CMRW over several years, her organization now differed in their approach to this issue. Indeed, alongside her original justification for repealing private protections—that administering a “two-track” system was confusing and administratively cumbersome—Myers now appeared to question the efficacy of regulations all together. “There is no guarantee,” wrote Myers, “that the public is at all times adequately protected against unnecessary or ill-advised surgery of any description.” Instead, clearly towing the CMA line, Myers expressed her hope that “matters of this kind can be resolved without necessarily resorting to laws and regulations.”¹⁸¹ Myers statement was curious, in that it stood in contrast not only to the admittedly enthusiastic cooperation between the DHS and the CMRW over the preceding five years to pass regulations, but also the legal battle that the CDH had engaged in in 1977 to establish exactly this right to resort to regulation. Evidently, whatever deal had

179 Roberta Young and Alice Wolfson to Beverlee A. Myers, January 21, 1980. Letter. Box 909, Folder 5, MALDEF, SUA.

180 Jacobs, “Debate on Sterilization Rules Set,” B3.

181 Beverlee A. Myers to Roberta Young and Alice Wolfson, February 7, 1980. Letter. Box 909, Folder 13, MALDEF, SUA.

been struck between Myers and the CMA, it was a powerful one, as the department head remained committed, against the advice of those within her department, to undo the work of her predecessor. The last remaining hope for the CMRW members to save the regulations came in late March, when the DHS announced that it would, once again, hold public hearings before final action was taken on the protections.¹⁸² Women activists would again converge at the hearing, held this time in Berkeley, to fight for regulatory guarantees of their reproductive autonomy in sterilization decisions.

Although the battle lines at the Berkeley hearings mirrored those drawn at earlier functions - with the CMA on one side, and women's minority and health groups on the other - the DHS, in this instance, sided squarely with the medical profession. Undeterred by this relationship, pro-regulation activists attempted to dispel the myth that private patients were somehow less susceptible to sterilization abuse than Medi-Cal recipients. Representatives from MALDEF, for instance, highlighted the "working poor" - impoverished and largely undereducated women who could not qualify for Medi-Cal—as likely victims of abuse under the proposed regulatory void.¹⁸³ Likewise, the CMRW's *Committee to Defend Reproductive Rights* used the example of five female employees of the American Cyanamid chemical company, who were coerced in sterilization surgeries after a supervisor implied that refusal to do so would result their dismissal. No specific protections existed to protect women at American Cyanamid, and other companies alleged to support sterilization as a condition for employment. Thus, they argued, private-pay regulations were necessary to fill this gap.¹⁸⁴ Similarly, the *Madrigal* women, all but two of whom were private-pay patients, were used as glaring examples of the coercion that could befall women were regulations to be repealed. "It is too late for these women," *National Health Law Program* attorneys argued, "but the state should not be permitted now to sacrifice the regulatory protections for which they fought so hard."¹⁸⁵

However, by far the most compelling testimony as that given by PAI attorney, Lois Salisbury, on behalf of the CMRW. Attacking the seemingly contradictory nature of the CMA's guideline proposal, Salisbury inquired how guidelines, if followed truthfully, would prove any less "confusing" to physicians than regulations. In effect, guidelines still

182 "Notice of Proposed Changes in Regulations by the State Department of Health Services, March 31, 1980," Box 909, Folder 8, MALDEF, SUA.

183 "Testimony of MALDEF in Opposition to the Proposed repeal of Sterilization Regulations for Private Pay Patients, June 10, 1980," 3. Box 909, Folder 8, MALDEF, SUA.

184 "Testimony at Public Hearings Re Repeal of State Informed Consent Regulations Governing Sterilization, June 10, 1980," 1-2. Box 909, Folder 8, MALDEF, SUA; Bill Richards, "Women Say They Had to Be Sterilized to Hold Jobs," *Washington Post*, January 1, 1979, A1.

185 "Testimony of the National Health Law Program in Opposition to the Proposed Repeal of Title 22, Division 5," 10-11. Box 909, Folder 8, MALDEF, SUA.

represented a double standard of care. The only way such physician-imposed standards would be less confusing, Salisbury argued, is if their designers chose to ignore them. Therefore, the CMA's willingness to accept unenforceable guidelines over regulations proved to Salisbury that it was not the confusion of the two-track system that underpinned the physicians resistance, but rather regulation itself. The CMA, Salisbury concluded, "do not like to be regulated," but, as the testimony from other witnesses at the hearing proved, nor had they ever "demonstrated the ability or the will to regulate themselves."¹⁸⁶ The appearance of a cesarean section "epidemic" in the lead-up to the 1980s, which one later observer described as an "onslaught of unnecessary and dangerous surgery," proved that this situation showed no signs of improving.¹⁸⁷ It was unacceptable to the CMRW, especially in light of this "hauntingly familiar pattern of coercion," that control of sterilization decisions be placed, without oversight, back in the hands of doctors.¹⁸⁸

While the CMA influence had clearly influenced Myers decision, Salisbury also took notice of the director's professed rationale, that two sets of regulations would be administratively inconvenient, for abandoning private safeguards. Like her attack on the CMA, Salisbury reiterated that guidelines still represented a "two-track" system, and that for Myers to follow this clearly fatuous excuse in repealing regulations was "irresponsible" of the DHS.¹⁸⁹ The CMRW had explicitly urged the department *not* to establish two separate regulations in the past to prevent not only the expressed confusion from arising, but also the loss of protections specific to the state regulations for Medi-Cal patients, i.e. restrictions on procedures resulting in secondary sterilization. The CMRW's recommendation to Myers differed slightly from the earlier suggestions from within her department, though the protective effect remained identical. Instead of adopting a uniform code following DHEW's standard that would contain exceptions for private patients in line with California law, the CMRW suggested that the unified regulation follow the state regulations, with additional conditions required of Medi-Cal patients to meet federal standards. This unified standard, anchored in the 1977 state regulations, Salisbury argued, presented little confusion to providers, and provided consumers, private or otherwise, with a "complete protective umbrella" over their rights. The state regulations, proven effective by the "very little sterilization abuse" reported since they were adopted, were too valuable

186 "Testimony of Lois Salisbury," 3.

187 Gena Corea, "The Cesarean Epidemic," *Mother Jones Magazine*, July, 1980, 28-35; Lynn Silver and Sydney M. Wolfe, *Unnecessary Cesarean Sections: How to Cure a National Epidemic* (Washington D.C., Public Citizen Health Research Group, 1989), 7.

188 "Testimony of Lois Salisbury," 8.

189 *Ibid*, 6.

to dispense with entirely.¹⁹⁰ Ultimately, concluded Salisbury, emphasizing the department's mandate to protect its citizens, “there can be no justification for returning to the regulatory void which permitted so much irrevocable abuse and forced so much heartfelt regret by those who[...]would have chosen to retain their reproductive capacities.”¹⁹¹

The regulation rollercoaster was to continue when, in the interim between the Berkeley hearings and the proposed repeal date of October 15, Myers, in an unexpected move, reversed her position once more and announced that she now intended to keep regulations for private patients.¹⁹² The CMRW were elated, and announced in a newsletter to supporters that: “we have won a great victory!” The women had reason to celebrate, as Myers attributed her decision to keep private protections directly to the testimony presented by them and other sterilization activists at the June hearings. “The California Medical Association,” Sioban Harlow of the CMRW claimed, “could not refute the overwhelming testimony presented by consumers and providers stating that regulations were necessary to prevent women and men from suffering sterilization abuse.” This testimony had apparently finally convinced Myers that maintaining a “two-track” system of regulations would not prove to be administratively arduous, despite DHS advisors recommending this course of action over a year prior.¹⁹³ Given the intrigue leading up to the hearings, it is likely that this testimony alone did not prompt Myers sudden reversal, though this remains unclear. Whatever the case, activists, on the whole, would be pleased with the final form of regulations, within which the most important provisions of the California regulations were kept, including the bilingual informed consent booklet, and the requirement that a translator be provided for non-English speaking patients. The unified regulations stipulated that private patients must be at least eighteen, and wait a period of thirty-days, waivable upon request to seventy-two hours, prior to sterilization. Private patients would still be able to receive hysterectomies for contraceptive purposes, as long as physicians followed the informed consent process required for tubal ligations. A section entitled “additional requirements for informed consent process when specified federal funds are used,” detailed the extra requirements for Medi-Cal patients. Arguably the most significant amendment to the regulations was Myers' decision to deregulate secondary sterilizations entirely.¹⁹⁴

While the latter amendment did not please the CMRW, they nevertheless had

190 Ibid, 6-7.

191 Ibid, 9.

192 “Private Patients Subject to State Sterilization Rules,” *San Bernardino County Sun*, September 11, 1980, 7.

193 Sioban Harlow, “Dear Friends,” September 22, 1980. Box 909, Folder 2, MALDEF, SUA.

194 See Cal. Code Regs. Title 22, §§ 70707.1-70707.6.

succeeded in establishing the “complete protective umbrella” for all potential sterilization patients in the California.¹⁹⁵ How secure the umbrella was, given Myers erratic stance on the issue, was unclear. However, it probably came as no surprise to the CMRW that days before the regulations were to take effect in mid-October, Myers announced, without reason, that they were to be delayed until December 1.¹⁹⁶

Despite the declaration of victory, on October 24, Harlow wrote to CMRW members noting that the issue of regulations had “not yet been resolved,” as the DHS had been forced to permit another round of written comment until mid-December before the issue was finalized.¹⁹⁷ This delay was the result of lingering resistance from the medical profession. On the same day that Myers announced her intention to keep private protections, CHA spokesman, Tony Browne, reiterating the group's position that “the state doesn't have any business between private patients and their doctors,” indicated the CHA's intention to have the regulations invalidated by the *Office of Administrative Law* (OAL).¹⁹⁸ The CHA proceeded by pointing out inconsistencies in the department's notification procedure; arguing that the DHS's notification of public hearings, issued in March, concerned only repeal, not revision, of the private regulations. Likewise, since over a year had elapsed since the department's June, 1979 notification to revise the regulations, after which Myers announced her intention to repeal the protections, the CHA argued that its findings were no longer admissible. The OAL agreed with the lobbyists for the CHA, and argued that the department's notice of repeal effectively indicated that the DHS was no longer considering any further revision to the regulations. Cognizant of this latest, in an extensive series of challenges to the regulations, the CMRW once more enlisted the help of its members. While the leadership appreciated that some women were not entirely satisfied with the substance of the new regulations, despite them being “generally” stronger than state regulations alone, they urged their members and supporters to write to Myers in force, expressing their gratitude for choosing to keep the regulations, and requesting that they be implemented “without further delay.”¹⁹⁹

Ultimately, the CHA's attempt to block the regulations was unsuccessful, and served only to delay the protections for private patients from taking effect until May 17, 1981. Yet, the final *coup de grâce* for the medical profession's challenge came months later when the court of appeals affirmed the lower court's judgment in the *Lackner* case,

195 “Testimony of Lois Salisbury,” 7.

196 “New Rules on Sterilization are Delayed,” *San Bernardino County Sun*, October 11, 1980, 8.

197 Sioban Harlow, “Dear Friends.”

198 “Health Director Won't Repeal Restrictions on Sterilizations,” *Santa Cruz Sentinel*, September 11, 1980, 5.

199 Sioban Harlow, “Dear Friends.”

bringing to an end the protected legal battle between the DHS and the CMA. As judge Karlton had, the appellate court attacked the physicians' "extraordinary thesis" that government regulations were superfluous as patients could recover damages for unnecessary surgery under *Cobbs vs Grant*. "The merit of the principle," the court ruled, "by which recovery for an injury is exalted over the prevention of an injury wholly escapes us." In doing so, the justices affirmed that there was nothing "arbitrary or capricious," in the department's preference for an approach calculated to prevent consented-to sterilizations over a tort remedy."²⁰⁰ The evaporation of the medical profession's challenge to the regulations after this point brought an anchoring effect to the protections, as no further doubt or anxiety over them emanated from the Myers or the DHS. Indeed, the unified "protective umbrella" remains virtually unchanged in the California Code of Regulations to this day. This fact stands testament to the work of the CMRW and its allied activists who stepped in repeatedly to defend the regulations against unremitting criticism and legal attacks from powerful actors, in an attempt to safeguard the right to reproductive choice of all women in California.

Conclusion

Thus, while the established historiography holds that California "bore the distinction of being the only state to have to weaken its guidelines" in the face of federal changes, this chapter has shown, on the contrary, that the state emerged from the regulatory morass of the late-1970s with a unified and stronger set of protections for patients undergoing sterilization.²⁰¹ With the exception of the deregulation of secondary sterilizations, California's new protective policy merged the best facets of the state and federal protections in an effort to guarantee the reproductive rights of health consumers. This chapter emphasized the complex and tortuous negotiations leading up to the final success for regulation activists in 1981 in order to underline the state's struggle to reshape sterilization policy from one centered on institutional force to one concerned with reproductive freedom. It was precisely the competing definitions of the latter term between white and minority women which informed much of the early resistance to policy changes, and accentuated bitter and irreparable divides within the women's movement. For the medical profession, it was freedom too—freedom to sterilize patients unencumbered by government regulation—that informed the persistent resistance of their political representatives to policy changes. This resistance came despite the fact that it was the actions of individuals within the profession's ranks that necessitated regulations to begin

²⁰⁰ *CMA v. Lackner*, 229.

²⁰¹ Kluchin, *Fit to be Tied*, 203.

with, as attested to in the sizable administrative record. Undoubtedly it was the tenacity of the activist coalition, spurred to action by the events at LACMC, in both the courtroom and the administrative arena to which the eventual success of regulations can be attributed. Indeed, the coalition's actions, highlighting the need for community action in ensuring government accountability, provide perhaps one of the most important lessons of this period in Californian history. Without their efforts, it is conceivable that more tragedies mirroring the events at LACMC could have occurred before the state was forced to take action.

Many individuals believed that the passage of the regulations marked the “culmination” of the state's transition away from its eugenic past, based on compulsion, to a present centered on patient choice.²⁰² For poor, minority women, the overwhelming targets of sterilization abuse in the 1970s, the regulations certainly acted as a significant guarantee on their reproductive autonomy. Yet, while the women activists had achieved their aims, the passage of the regulations and the plethora of abuses that necessitated them, threw light on another, as yet unfinished, aspect of the sterilization debate. Indeed, in light of the increased attention on sterilization, the American public at the turn of the 1980s were confronted with revelations of the nation's eugenic past. The “horror” over such revelations prompted revisions of largely long-defunct state sterilization statutes, which, when combined with DHEW's 1978 regulations prohibiting the sterilization of individuals with intellectual disabilities, effectively closed off sterilization as an option for the developmentally disabled community.²⁰³ This action would spark yet another period of heated debate and bureaucratic dissonance in California over the issue of sterilization and the limits of informed consent. Activists on one side argued that developmentally disabled individuals had a right to be sterilized, and that doing so provided them with greater freedom to live normal lives. Opponents argued that sanctioning the sterilization of low IQ individuals, especially via substitute consent, represented a palatable window-dressing to what was, in effect, the resurgence of an earlier era of eugenics. The regulations, then, while adding significant protections for a portion of the population, far from completed the state's transition to a more enlightened sterilization policy. In the 1980s, judges, legislators, and activists of all persuasions continued to grapple with important questions over legacy of California's eugenic sterilization program, and its lingering impact on the class of individuals who were once its primary targets.

202 “Opinion and Order,” *CMA vs. Lackner*, 2.

203 See Clark McKinley, “Sterilizations of Retarded Confirmed,” *The Los Angeles Times*, March 28, 1980, B3; Paul Nussbaum, “Brothers Suit Reveals Horrors Suffered During Confinement in Mental Institutions,” *The Los Angeles Times*, July 17, 1980, 6; “Virginia Lawmakers Appalled to Find Law for Sterilization ‘Misfits’ Still on the Books,” *The Los Angeles Times*, February 24, 1980, 4.

Chapter IV

The Knife's Edge: Sterilization, Mentally Retarded Individuals, and Informed Consent in the 1980s

We feel that we are more in danger than any other single group of having our rights violated even in this country, because it is so hard for so many of us to speak for ourselves, and so many people simply don't understand that we can ever grow and be useful and responsible citizens, and even good parents.¹

In hearings in April and May, 1982, Alexandra Hurlbut's parents petitioned the Superior Court of Butte County to authorize a hysterectomy for their daughter. Due to an unnamed “mental instability,” Alexandra was deemed unable to consent and placed under the conservatorship of her parents. The action arose when doctors found a large malignant tumor on Alexandra's cervix, which the “eminent gynecologist,” as the court saw him, Dr. Leland Fillerup estimated to have an eighty percent chance of turning cancerous. If it did, Fillerup testified, the cancer would spread rapidly, and quickly become life threatening to the girl.² Due to Alexandra's uncooperative behavior—shouting that she was already sterile; too old to care for a child; and that she had already “had it sewn up”—Fillerup viewed less invasive treatment options like cryosurgery to be unworkable and consequently recommended hysterectomy surgery. His recommendations were supported by two colleagues and Alexandra's parents.³ However, while the court, too, agreed that the operation “would be the most appropriate treatment and would be in the best interests of the health, welfare and protection of Alexandra,” the judge refused to permit the surgery.⁴ The judge's hands were tied by changes to the California probate code passed a year prior that placed a blanket ban on sterilizations for those deemed incompetent to consent. The ban was the outgrowth of the recognition and subsequent purging of the state's eugenic legislation which permitted the mass sterilizations witnessed in the first half of the century. Even though sterility would be a secondary effect of Alexandra's surgery, the judge nonetheless felt compelled to follow the legislature's authoritative embargo on sterilization. Although an appeals court would ultimately order Alexandra's sterilization under a different statute, used for medically-necessary surgeries, the initial refusal of the judge to authorize her sterilization illustrated the complex situation faced by judges, parents, politicians, and indeed, DD people themselves, surrounding sterilization in 1980s California.⁵

1 CPF to John A. Flaherty, May 15, 1986. Letter. SJ, MF 6:1(76), CSA.

2 *Maxon v. Superior Court.*, 135 Cal. App.3d 628 (1982).

3 Ibid, 630-631.

4 Ibid, 631.

5 A note on language: In the 1970s and 1980s, developmentally disabled increasingly replaced the term

This situation sprang directly from major government action in the late 1970s and 1980s that sought to recognize the constitutional rights of persons with DD, providing them with new freedoms, a wider choice of community care programs, and initiating a wave of deinstitutionalization. The new rights afforded to persons with DD, coupled with the shuttering of institutions, unsurprisingly raised questions about parenthood, childbearing, and their right to procreative choice. Correspondingly, the 1970s saw an increasing number of petitions filed at local courts by parents seeking to have children with DD sterilized, and an intense debate in society about the legitimacy of these actions. Parents and other supporters argued that access to sterilization was a right for those with DD; that it could be elected to by another person on their behalf; that it represented a key tool in enhancing their freedom and integration in society; and that it permitted them to engage in fulfilling sexual relationships, and its social corollaries, like marriage.

Opponents of such petitions, on the other hand, disputed their putatively voluntary nature. For such an operation to be truly voluntary, the clear and understood informed consent of the individual undergoing the procedure must be obtained; opponents of the substitute consent argument contended individuals with DD were unable to meet this standard. Given the widespread sterilization scandals in the 1970s discussed in the preceding chapter, and more importantly, the lingering shadow cast by the eugenically-justified mass sterilization program of the first of the twentieth century, opponents viewed the new wave of petitions as an updated, palatable version of an older impulse. Indeed, it was seen, as legal scholars Monroe Price and Robert Burt wrote, as “an attempt to humanize and render more informal and more individual a system that seemed rigid and unyielding.”⁶ Courts nationwide, too, at the time failed to reach a consensus on such petitions, though, prior to 1980, the majority would rule that they lacked sufficient powers to authorize such procedures in the absence of statutory imprimatur. However, with the repeal of eugenic sterilization laws, and the growing calls for sterilization from parents in the community, courts and legislators were forced to revisit these questions in the 1980s. The result was a period of legal battles and the overhaul of sterilization policies in a number of states nationwide.

Despite being a case *par excellence* of the tumultuous revision of sterilization

“retarded” to describe those with intellectual disabilities. This shift, however, was from from universal, and the terms “mentally retarded” and developmentally disabled were used concurrently. Accordingly, and to aid historical accuracy, the terms mentally retarded and retardation are used when discussing events in the early-1970s, or when directly quoted from texts. As the chapter proceeds, the term developmentally disability is used to reflect this shift in language.

6 Monroe E. Price and Robert A. Burt, “Nonconsensual Medical Procedures and the Right to Privacy,” in *The Mentally Retarded Citizen and the Law*, ed. Michael Kindred (New York: Free Press, 1976), 109.

policy in the 1980s, surprisingly little attention has been paid to California's struggle with the issue of sterilization and people with DD. It is somehow ironic that during the 1970s, while involuntary institutional sterilizations of DD people could still occur in California, those outside the institution were denied the ability to choose the same. This strange system persisted until events both within the state, and nationwide, led to the purging of the antiquated Asexualization Act discussed in chapter one. While this event was celebrated, it set in motion what would become a seven-year judicial and legislative struggle to shape an adequate response to the questions that it raised. Yet, if the cleansing of a eugenic law laid the groundwork for change, one family from San Jose were the prime movers. The resolve of Millie and Doug Gedney, who wished to have their twenty-three-year-old severely disabled daughter, Valerie, sterilized formed the benchmark around which policy changes were formed. Through interviews, court documents, newspaper accounts, and personal correspondence, this chapter presents Valerie's story as a personal pathway into the reshaping of sterilization policy in California in the 1980s. Aside from her impact on judicial and legislative changes, Valerie's story, which was marked by numerous failures of protection, is also used to highlight the dangers faced by DD individuals in California during this process, and how enduring attitudes towards the capacity of the individuals with DD to make their own decisions shaped the proceedings in cases like Valerie's.

Finally, the case also provides compelling insights into the questions of disability, informed consent, reproductive freedom, and state intervention, that sit at the heart of sterilization policy, especially as it relates to DD people. Further case studies are used throughout to provide a lived experience of this period of dramatic change.

Just as lurid reports of racially-motivated sterilizations took precedence over the less sensational battle for protective regulations in the 1970s, a similar obfuscation of the "right to choose" argument has occurred in the historiography. Despite its inexorable connections to histories of eugenics and forced sterilizations, examinations of sterilization in the "post-eugenic era" by historians of these fields have overwhelmingly focused on the threat of resurgent eugenic science summoned by advances in genetic knowledge and reproductive technologies, or the induced sterilizations of groups like drug addicts, sex offenders or those on public assistance.⁷ While the historical literature review highlighted

7 See Largent, *Breeding Contempt*, 138-149; Stern, *Eugenic Nation*, 211-215; Paul, *Controlling Human Heredity*, 129-135; Kevles, *In the Name of Eugenics*, 291-301; Troy Duster, *Backdoor to Eugenics*, (New York: Routledge, 2003); Linda L. McCabe and Edward R. B. McCabe, "Are We Entering a 'Perfect Storm' for a Resurgence of Eugenics? Science, Medicine, and their Social Context," in *A Century of Eugenics in America: From the Indiana Experiment to the Human Genome Era*, ed. Paul A. Lombardo (Bloomington: Indiana University Press, 2011), 193-218; Kluchin, *Fit to be Tied*, 215-224.

the efforts of some scholars attempting to correct this oversight, the impact of sterilization on DD people in post-1950s California has not received adequate attention. This chapter, then, presents a novel contribution to the historiography by examining how “right to choose” arguments manifested in California's courtrooms and legislature, and their subsequent impact on individuals. In doing so, it will provide the most in-depth account of any state's action on the issue of sterilization by substitute consent heretofore seen in the literature.

The analysis will proceed chronologically, beginning with an examination of the changing attitudes towards, and provision of services for, individuals with DD both nationally and in California in the 1960s and 1970s that preceded the wave of sterilization petitions. Using case studies, this chapter will then highlight the nebulous and hesitant legal environment that surrounded non-institutional sterilizations in the 1970s. The work will then move to a comprehensive analysis of how the repeal of eugenic legislation affected both the California legislature, and DD individuals in the state by following Valerie Nieto's case leading up to the Supreme Court appearance that prompted a reshaping of sterilization policy. Finally, it will examine the important contributions of self-advocates in the debate over and crafting of sterilization legislation designed to protect the procreative rights of DD individuals in such petitions, and provide insights into the long-term impact of this legislation.

Changing Conceptions of Retardation and Sterilization in the 1960s and 1970s

In July 1973, prior to the emergence in the press of the explosive allegations of abuse at LACMC, an article in the *San Francisco Examiner-Chronicle* reported that sterilizations were being carried out on mentally retarded women in the state's psychiatric hospitals. Doctor William Keating, former surgeon at the Sonoma State Home, and then chief of the DMH's Retarded Care Division, revealed that eleven women had been sterilized under the quiescent eugenic sterilization statute. Despite the substantial slowdown in operations, which Keating attributed to an evolving preference for less drastic interventions such as oral contraceptives, California's state-run sterilization program, contrary to the belief of many historians, continued to function quietly in the background into the 1970s. The vigilance displayed by Keating in his discussion of the program, in which he went to great lengths to distance practice of sterilization within the state hospitals from its eugenic origins, illustrate both the distaste towards eugenic sterilization by this point, and doubt over the strictly genetic explanation of mental retardation. Instead, the former surgeon, who later admitted to personally sterilizing over one thousand patients, stressed that, in

practice, sterilizations were ordered only for “health reasons” or to aid habilitation, and that they held particular value for mentally retarded women who although not requiring institutional care, were nevertheless unable to cope with the “responsibility of motherhood.” Highlighting both its benevolent basis and judicious application, Keating assured readers that the program was not being “administered promiscuously,” and that “elaborate” procedural standards had to be met before the operation was carried out. Keating's tentative treatment of the subject was mirrored by Lotte E. Moise (1918-2010), a disability advocate, who had her retarded daughter, Barbara, privately sterilized when she was eleven out of fear that the “affectionate” girl would fall pregnant. While Moise acknowledged that she would, at the time of writing, have approached the subject differently, giving Barbara more choice in her sterilization, she noted the difficulty parents faced in dealing with their retarded children's sexuality.⁸ The loosening of restrictions on the lives of retarded citizens in the 1970s, and the reluctance of physicians to perform sterilizations in the absence of statutory authority posed a problem for parents. However, as racially-motivated sterilization abuse, and subsequent battle for informed consent protections, took center stage from the mid-decade, questions surrounding both state-run and private sterilizations of retarded people in California largely receded from the public's mind.

That was until the first months of 1980, when Keating's tentative defense of the Asexualization Act was replaced with widespread outrage as revelations of the state's “dark chapter” of eugenic sterilizations surfaced in the press once more. The revelations arose following a discovery by officials in Virginia, themselves newly confronted by their state's practice of eugenics, of a 1945 report authored by Sonoma's sterilizer-in-chief, Fred Butler, detailing the sterilization of 4,000 California state hospital patients between 1919 and 1943.⁹ For Virginia's assistant attorney general, Mary Yancy Spencer, who argued that to focus only on her state's involvement in eugenic sterilization was “unfair,” the finding was a blessing and was used to divert attention towards the west coast.¹⁰ Californian officials too went into damage control mode. The newly appointed Executive Director of the Sonoma State Hospital, where both Butler and Keating had sterilized thousands, denounced the sterilizations as a “philosophy of the times” and, as continues to be done,

8 Dennis J. Opatrny, “Sterilization – What about California?” *Sunday Examiner-Chronicle*, July 29, 1973, 9; “11 Sterilized in California,” *Independent-Press Telegram*, July 29, 1973, 4; For more on Lotte Moise and Barbara, see Lotte E. Moise, *As Up We Grew With Barbara* (Minneapolis: Dillon Press, 1980).

9 “Sterilization Report Unveils Dark Chapter in State,” *San Bernardino County Sun*, March 28, 1980, 7; Nussbaum, “Brothers' Suit Reveals Horrors,” A1.

10 “Virginia Sterilized Over 7500 in State Institutions,” *Mental Disability Law Reporter* 4 (1980): 123-124.

conflated them with antiquated Nazi ideals of race purification.¹¹ Likewise, Bertha Gorman, spokeswoman for the Department of Mental Health, the successor to the DMH, erroneously assured readers of the *Los Angeles Times* that the state had “literally stopped” performing involuntary sterilizations after 1960.¹² Gorman's comments came despite both Keating's disclosure in 1973, and evidence presented in the legislature that the statute had been invoked as recently as 1978.¹³

In contrast to lawmakers in Virginia, hurriedly working to repeal the state's eugenic sterilization statute, extant since 1924, California had already discreetly expunged the Asexualization Act from the statute books on January 1, before the news broke.¹⁴ In late-1979, Assemblyman Art Torres wrote to Governor Brown asking that the “outdated” law be deleted. In doing so, Torres asserted that the terms used in the law used to select a patient for sterilization had “no meaning in modern medical terminology.”¹⁵ The bill passed through both houses of the legislature unanimously, and was signed by Governor Jerry Brown on September 10, 1979, officially marking the end of the state's relationship with eugenic sterilization that had begun seventy years prior. While this action definitely settled the question of eugenic sterilization in the state, the action brought the intense and dissonant debate over the sterilization of mentally retarded individuals outside state hospitals to the foreground.

As the Examiner-Chronicle article made clear, this debate was exacerbated by substantial changes towards the treatment of retarded individuals that emerged in the 1960s. At this time, the nation was experiencing an ideological shift away from “warehousing” patients in large custodial institutions, to community-centered and non-residential treatment.¹⁶ This process of deinstitutionalization was largely propelled by president Kennedy, who in a 1963 address, attacked the “outmoded,” isolated, and ineffective institutions, and called for a “bold new approach” towards treatment for the mental retardation, based around the development of community-based services. This undertaking, Kennedy estimated, would make it possible to reduce the nation's institutionalized population by fifty per cent within two decades.¹⁷ Along with grass-roots support, particularly from parents of mentally retarded individuals, deinstitutionalization

11 “Sterilization Report Unveils Dark Chapter in State,” 7.

12 McKinley, “Sterilizations of Retarded Confirmed,” B3.

13 “Enrolled Bill Report: AB 1204,” GCBF, MF 3:3(57), CSA.

14 “Virginia Lawmakers Appalled,” 4.

15 Art Torres to Edmund G. Brown Jr, September 7, 1979. Letter. GCBF, MF 3:3(57), CSA.

16 Kevin L. DeWever, “Deinstitutionalization of the Developmentally Disabled,” *Social Work* 28 (1983): 436.

17 John F. Kennedy, “Special Message to Congress on Mental Illness and Mental Retardation,” February 5, 1963.

won support from both liberals, who supported it on humanitarian grounds, and conservatives, who valued the cost-saving benefits of community care.¹⁸ This eased the passage of legislation, most notably the landmark Mental Retardation and Facilities and Community Mental Health Centers Construction Act, which provided federal funds to stimulate and maintain the development of community-based treatment, training, education, rehabilitation and residential services for people with mentally retardation.¹⁹ The push for deinstitutionalization was continued after Kennedy's demise, most notably by Ronald Reagan, who, in a 1971 address, stated his goal of returning 200,000 retarded individuals to "useful lives in the community."²⁰ By 1990, it was estimated that only 85,000 mentally retarded individuals remained in mental institutions.²¹ Providing care in a manner that gave the most freedom, and permitted people with mentally retardation to lead as normal and independent lives as possible became the guiding principle for the delivery of community mental health services in most states.

California's decision to reshape its provision for mentally retarded people in the 1960s and 1970s was born as much from practicality as it was from humanitarian intentions. By 1965, California had two to three year waiting lists for admission to its perennially oversubscribed state hospital system. The state had to decide between developing community-based alternatives to relieve the burden on the hospital system, or approve a \$47 million request from the DMH to add three-thousand more hospital beds.²² A report issued by the Study Commission on Mental Retardation one year later indicated overwhelming support for the former option, and recommended that the legislature establish a network of "regional diagnostic and counseling centers, located no more than two hours' drive time from any California family."²³ The following year witnessed the birth of the regional center, which was to form the backbone of California's community care system for mentally retarded people, when the legislature approved the establishment of two pilot centers—one in Los Angeles and one in San Francisco. The regional centers were designed to provide for all the needs—diagnostic, counseling, referral, and guardianship—of the mentally retarded citizen in the community, as well as screening

18 "Sounding Board; Deinstitutionalization of the Chronically Mentally Ill," *New England Journal of Medicine* 305 (1981): 339.

19 Carey, *On the Margins of Citizenship*, 130.

20 Richard Nixon, "Statement about Mental Retardation," November 16, 1971, in *Public Papers*, 1111-1113.

21 *Strengthening the Commitment, Reinvesting in the System: A Journey of Community Partnership – A History of the Regional Centers in California* (Los Angeles: Frank D. Lanterman Regional Center, 2015), 19.

22 Ibid, 4.

23 California Study Commission on Mental Retardation, *The Undeveloped Resource: A Plan for the Mentally Retarded in California* (Sacramento: GPO, 1965), 3.

patients to assess their suitability for admission to a state hospital, and providing aftercare for those released from the same.²⁴ A report two years later provided a glowing appraisal of the regional centers, and stated that they had “solved many of the problems they were designed to solve.”²⁵ Therefore, the report proposed, the legislature should “fully implement the establishment of a statewide network of regional centers for the retarded.”²⁶ This mission was taken up by Frank Lanterman (1901-1981), the veteran mental health legislator, whom governor Brown heralded as a “voice for those who too often go underrepresented in the halls of power.”²⁷ The Lanterman Mental Retardation Services Act, passed in late-1969, established a “single, coordinated system for the provision of services to the mentally retarded,” which it based around an expanded regional center system.²⁸ Lanterman's pivotal legislation had a tremendous impact on deinstitutionalization in California, and by the end of the 1970s, a network of twenty-one regional centers had been established across the state, which, by 1985, were providing services to almost 80,000 mentally retarded Californians. By this point, only approximately 7,000 retarded individuals remained in the state hospitals—many of which closed as deinstitutionalization accelerated in the seventies.²⁹

A central impulse towards deinstitutionalization was the principle of “normalization.” Introduced to American audiences by Bengt Nirje at the President's Committee on Mental Retardation, the principle was described as: “making available to the mentally retarded, patterns and conditions of everyday life which are as close to the norms and patterns of the mainstream society.”³⁰ The principle posited that the differential treatment given to people with mental retardation, cloistered in isolated institutional settings, fostered many of the aberrant behaviors that underscored their “otherness” from the community as a whole. On the other hand, allowing retarded people to live in a “culturally normative” environment, without excessive constraints, aided their ability to integrate into society, and provided positive growth factors for development.³¹ A troubling corollary of this principle, especially for parents, was its impact on the sexuality of

24 California Bureau of Mental Retardation Services, *Regional Centers for the Mentally Retarded: The First Two Years* (Berkeley: Bureau of Mental Retardation Services, 1969), 4.

25 California Assembly Office of Research, *A Proposal to Reorganize Fragmented System of Services for the Mentally Retarded: A Staff Report* (Sacramento: California Legislature, 1969), I.

26 Ibid, iii-iv.

27 “Ex-Legislator Frank Lanterman Dies at Age 79,” *Santa Cruz Sentinel*, 28 April, 1981, 26.

28 “Summary of AB 225,” LP414:31, Frank Lanterman Papers, CSA.

29 *Strengthening the Commitment*, 17.

30 Bengt Nirje, “The Normalization and its Human Management Implications,” in *Changing Patterns in Residential Services for the Mentally Retarded*, eds Robert B. Kugel and Wolf Wolfensberger (Washington D.C: President's Committee on Mental Retardation, 1969), 181.

31 Ruth Macklin and Willard Gaylin, *Mental Retardation and Sterilization: A Problem of Competency and Paternalism* (New York: Plenum, 1981), xxi.

retarded people. Proponents argued that negative assumptions about the sexuality of mentally retarded individuals—for instance, that they were promiscuous, and incapable of responsible parenthood—and corresponding attempts to limit it, placed a restrictive ceiling on their development.³² Normalization attacked these assumptions, and encouraged retarded people's sexuality as part of their full participation in mainstream society. This can be seen in a CDH publication from 1975, which described retarded individuals as “sexual human beings who, although impaired, have a right to reach their highest level of development sexually.”³³ This view was mirrored by Deborah Kelly, a counselor at a San Francisco-based developmental center, who argued that with appropriate education, people with retardation should be encouraged to engage in sexual relationships if they so wished.³⁴ Yet, as Ladd-Taylor notes, while the principle of normalization enhanced the freedoms of retarded citizens tremendously, prompting the push for community care, and allowing them to pursue comparatively independent lives, including the potential for sexual relationships, its impact was Janus-faced. As admittance to institutions became more difficult, and freedoms for individuals with mental retardation grew, an appreciable rise in private sterilization petitions by parents, fearful of the consequences brought by these new freedoms, occurred in the 1970s.³⁵

Such parents stressed the operation's advantageous impact for the lives of their children. They argued, in line with the normalization principle, that sterilization aided their children's integration in the social community, and permitted them to lead fulfilling sex lives without the “disorienting and even terrifying traumata” of childbirth, and the accompanying responsibilities for which they were ill-equipped to handle.³⁶ This belief was underlined by Keating, who argued that by the 1970s, California's Asexualization Act had evolved into a habilitative rather than eugenic sterilization statute, and aided retarded patients to effectively re-enter the community.³⁷ This understanding was shared by the Study Commission on Mental Retardation, from whom the impetus to reshape California's mental health provision around community originated, who suggested that sterilization could be beneficial for the “protection of retarded individuals who are able to live fairly normal lives in the community but who are unable to handle family responsibilities.”³⁸

32 Bill Stein et al., *Sex Education for the Mentally Retarded: A Resource Curriculum for Program Development* (Sacramento: Department of Health, 1975), 3; Betty Liddick, “‘We Want to Live a Normal Life!’ Sexuality and the Mentally Disabled,” *Los Angeles Times*, June 15, 1975, D1.

33 Stein et al., “Sex Education,” 2.

34 Opatrny, “Sterilization – What about California?” 4.

35 Ladd-Taylor, “Contraception or Eugenics?,” 200.

36 Macklin and Gaylin, *Mental Retardation and Sterilization*, 183.

37 Opatrny, “Sterilization – What about California?” 4.

38 Study Commission, *The Undeveloped Resource*, 103.

Opponents of such action, however, remained troubled by the porous border between putatively voluntary, contraceptive sterilization, and the involuntary control of undesirable reproduction, especially in light of the wave of racially-motivated sterilization abuse that unfolded in the 1970s, and the state's eugenic history. In particular, the inability of retarded individuals to legally provide consent, thus necessitating the involvement of a third-party to act on their behalf, was especially troubling. The process by which this was achieved was described by one critic as a “miraculous creation of the law, adroit and flexible, capable of covering unseemly realities with a patina of cooperation.”³⁹ This pseudo-voluntary action, critics argued, was more troubling than the history of state-directed compulsory sterilization. While bemoaning the “unsound” and “unscientific” rationales under which such actions were previously carried out, such programs, the critics admitted, were at least required to follow a circumscribed statutory procedure to achieve their “interventionist goal,” and offered a modicum of protection to those who fell under their purview.⁴⁰

By contrast, extra-institutional sterilization in the 1970s proceeded without the benefit of statutory authority, nor the procedural protections contained therein. Many of the suits brought by parents seeking sterilization for retarded dependents, usually necessitated by the reluctance of surgeons to operate without a guarantee of immunity from malpractice actions, focused on the question of whether judges, in lieu of specific statutory authorization, held the power to order sterilization, and determine the circumstances that constitute legitimate grounds to proceed. This legal debate displayed a polarity akin to the moral arguments over the issue. For instance, if a judge authorized a sterilization without the retarded patient fully comprehending the outcome, the court would violate the patient's individual choice. However, if the court opted to deny the procedure, this too represented a breach of individual choice, by not allowing the individual and avenue to exercise his or her right to control their own body. The courts, then, and the retarded citizens upon whose reproductive autonomy these questions rested, were locked in a problematic catch-22. In the early 1970s, courts across the nation struggled with this issue, reaching divergent conclusions on the competing commands of individual choice. Most, however, proceeded with caution on the issue and ruled that, in the absence of an authorizing statute, they lacked the power to grant the sterilization of a retarded individual by substitute consent; that is, the power conferred to a parent or guardian to provide consent on behalf of a DD or otherwise incapacitated person, adjudged

39 Price and Burt, “Nonconsensual Medical Procedures,” 95.

40 Ibid, 100.

incapable of providing informed consent themselves.⁴¹

Two cases overlooked by historians in California—that of Holly Kemp and Dianne Tulley—established the state's orientation towards the problematic issue of the sterilization of mentally retarded people in the 1970s, and perfectly illustrated both the impassioned moral arguments of parents seeking sterilization and those concerned over its eugenic implications, and the difficulties faced by the court in deciding on the limits of individual choice.

Disability and Sterilization On Trial

The first action arose in May 1974 when Joseph Kemp, a retired African-American railroad worker, petitioned the Contra Costa probate court to have his daughter, Holly, age 32, sterilized. Holly had been diagnosed as “mildly retarded,” which doctors attributed either to the degenerative impact of epilepsy, or the sequela of a “birth injury.”⁴² Holly had previously been committed to the Sonoma State Home, where she had been adjudged to have an IQ of 59, but had, at the time of the petition, been discharged and was living in a female-only boarding house in Lafayette, California. It was here, according to Holly's social workers, that she had expressed an interest in engaging in sexual relations. The social workers, in fact, suggested that Holly may have already been sexually active, though presented no evidence in support of this claim.⁴³ Given his daughter's apparently limited capacity to care for herself or another, Joseph requested the authority to have her sterilized, in order to protect Holly from “the dangers which pregnancy will present to her health and well-being, and to the health and well-being of any child she may bear.”⁴⁴ The hearing, set on September 8, was a brief affair, as the public defender appointed to represent Holly's interests, as required by the state in any guardianship matter, submitted no evidence, nor called any witnesses.⁴⁵ As Joseph Remcho, an attorney who would later represent Holly, scornfully remarked of the public defender: “he might as well have not appeared.”⁴⁶ Weighing up the evidence, or lack thereof, in September, judge S. C. Masterson, in bold decision, opted to authorize Holly's sterilization on the potential that her health might be harmed by her conceiving. In doing so, Masterson made the first decision in the state over the right to sterilize a mentally retarded individual outside the state hospital system, and

41 For example: *In the Interest of MKR*, 515 S.W.2d 467 (1974); *A.I. v. G.R.H.* 325 N.E.2d 501 (1975); *In the Matter of re Flanary*. 6 Fam. L. Rep. 2345 (1980); *Hudson v. Hudson*, 373 So.2D 310 (1979).

42 Mark Wisen, M.D. to Kirby West, M.D. June 7, 1971. Letter. in “Appendix C. Respondent's Reply Brief”, *In the Guardianship of Kemp* (1974). UCHLL, MF, 27:3.

43 “Respondent's Reply Brief,” *Kemp*, 17-18.

44 *Ibid*, 5.

45 Gene Marine, “Sterilization: Who Decides?” *Ramparts Magazine*, September 1974, 15.

46 “Appellant's Opening Brief,” 40. *In the Guardianship of Kemp* (1974). UCHLL, MF, 27:3.

asserted his court's authority to do so.⁴⁷

Looking over the court record, Joseph Remcho labelled the probate court trial a “farce and a sham” that “reeked of casual paternalism and token, indifferent contest,” and appealed the ruling.⁴⁸ At the appellate hearings, the attorney, now acting as Holly's counsel, contended that the tenuous medical evidence used to justify his client's sterilization obfuscated both the eugenic motives of her father, and the racist beliefs of the physician who supported them. Of the twelve medical reports entered into evidence, none recommended that Holly be sterilized, and either made no statement on the subject, or actively opposed it. The sole psychiatrist to issue a report, Richard Komisaruk, argued against the procedure. “The fact of her retardation does not, in my opinion,” wrote Komisaruk in a 1972 letter to Holly's social worker, “justify the use of the most drastic procedure when more conservative and less psychologically traumatic methods are available and should be attempted at first.”⁴⁹ Further, no conclusive evidence was presented that less restrictive means of contraception had been employed, or that Holly was even in danger of falling pregnant.

Remcho did not hesitate to cast Holly's father's concerns on potential hereditary transmission of mental deficiency to “any child born to the incompetent” as a eugenic motive underlying his petition.⁵⁰ Joseph's eugenic concerns were furthered, believed Remcho, in concert with Dr Kirby West, who in a medical evaluation of Holly, described her as a “colored female.” The use of this racial slur, argued Remcho, was “indicative of the attitude of many towards eugenic manipulation. It is no different in form than that practiced by the Nazis.” The attorney considered Joseph's belief that Holly would bear defective offspring as “rank speculation,” and privately held doubts over Holly's reported deficiency. In fact, in a humorous rebuke, Remcho declared that, given both Holly and her brother's reported mental deficiency, Joseph's interest in the public good might “more logically be advanced by his undergoing a voluntary sterilization himself.”⁵¹ Humor aside, Remcho was concerned by the cursory defense provided to Holly at the probate court, and the stated hereditary concerns of her father, which he viewed as a eugenic plot to deprive Holly of her reproductive capacity as a matter of convenience. The points drawn out by Remcho highlighted the fears voiced by critics of sterilization of people with mental retardation, who viewed substitute consent in such proceedings as palatable window dressing for what were involuntary and unwanted interventions on the “incontestably

47 Ibid, 3.

48 Ibid, 44.

49 Marine, “Sterilization: Who Decides?” 15.

50 “Appellant's Opening Brief,” *Kemp*, 17-18.

51 Ibid, 18.

fundamental rights” of retarded people like Holly and other “helpless litigants.”⁵²

In rebuttal, William Hoffman, Joseph's attorney, refuted Remcho's allegations of eugenic motives, and claimed that “any sterilization is 'eugenic' in the sense that it precludes reproduction by the sterilized party, but that is not the theory or the approach in this case.”⁵³ Hoffman asserted that sterilization was the humane option in this case. It would allow Holly to live in relative independence, and participate in a sexual relationship, which the attorney described as “one of the few experiences that the ward can participate in in relative equality with her sisters who are equipped with the mental ability to exercise choice.”⁵⁴ By contrast, not authorizing the procedure would necessitate greater constraints on Holly's life, and possibly her re-institutionalization, which, in turn, would restrict her participation in a “needed program that is enjoyable to her.”⁵⁵

Throughout his argument, Hoffman made repeated reference to Joseph Heller's *Catch-22* in order to highlight the circular logic of asserting “abstract” rights for those who lacked the legal capacity to exercise the same. By asserting Holly's right to privacy, for instance, Hoffman argued that Remcho was, in effect, leaving his client without any choice at all, as she could not independently opt to undergo a sterilization nor abortion. Strictly following the “great edifice” of the right to privacy, Hoffman urged, was shortsighted and based on emotional reactions against eugenics. In fact, he argued, “it precludes her[...]from exercising any choice whatsoever, except the choice of doing nothing, a sentence of the damned, which at the least, involves a life that is assured to be “short, brutish, and mean” for her and her progeny.”⁵⁶ Defending his action, Hoffman claimed that it was not his, nor Holly's father's, intention to deprive the woman of her right to privacy, nor any of the rights asserted by her counsel, but rather, that these rights had to be considered in light of Holly's disability and its effect on her ability to exercise these rights. The appropriate means for Holly, and others similarly affected to exercise these rights, claimed Hoffman, was, as in this case, through the impartial judicial direction of the courts, who served as the legitimate protector of these individuals' interests in society.⁵⁷

Justice J. Emerson, however, writing the majority decision in the case in December 1974, disagreed with Hoffman, and declared that Masterson, by authorizing Holly's sterilization, had acted far in excess of the powers afforded to the probate court. While acknowledging the novelty of the case, Emerson was confident in his decision that the

52 Ibid, 45.

53 “Respondent's Reply Brief,” *Kemp*, 37.

54 Ibid, 17.

55 Ibid, 41.

56 Ibid, 50.

57 Ibid, 51.

power to order such a procedure had to derive from statutory authority.⁵⁸ As this was the first time that the question had been raised in California, Emerson based his decision on an Ohio case, where a judge, having ordered the sterilization of a “feebleminded” girl at the request of child welfare authorities, was determined by the local federal court to have acted without jurisdiction, and was accordingly stripped of his judicial immunity.⁵⁹ Emerson and his fellow justices did not want to see a similar situation arise in California. Given his belief that authority for sterilization had to derive from statutory authority, Emerson pointed to the Asexualization Act as the sole manner in which this end could be accomplished. Noting the administrative framework provided by the Dillinger bill, Emerson wrote:

In view of the fact that the legislature has prescribed a comprehensive scheme requiring examination, notice, administrative review, and judicial review, it may be concluded that the legislature did not intend that sterilization of the mentally retarded was to be carried out without meeting the requirements imposed by this statute.⁶⁰

Believing that this answered the fundamental question on trial—that of judicial authority—Emerson and two other judges reversed the sterilization order, and declared that the other issues raised by both counsels “need not be considered.”⁶¹ In doing so, the judges turned a blind eye to the important constitutional arguments made over the “right” of retarded people to choose sterilization. The Kemp case, then, presented an interesting feature of California law in the mid-1970s, as the Asexualization Act, under which so many involuntary sterilizations had occurred, and which, in the years following the case, would be attacked as a relic of the state's illiberal past, became the sole avenue through which a retarded individual could exercise what some considered their constitutional right to procreative choice.

The impact of the Kemp decision was felt beyond that courtroom when a similar petition was heard by a San Mateo court following Emerson's embargo. The petition was brought by Edwin Tulley, who sought the authority to have his daughter, Dianne, who suffered from brain damage and had cerebral palsy, sterilized. Edwin claimed that, as a result of Dianne's “profound mental retardation,” she lacked the ability to understand her bodily functions, i.e. her menstrual cycle, and to attend to her sanitary needs, and thus requested that permission for a hysterectomy be granted by the court.⁶² In contrast to the Kemp case, the testimony of medical experts was unanimously sympathetic to Edwin's

58 *Guardianship of Kemp*, 43 Cal. App.3d 760 (1974).

59 *Wade v. Bethesda Hospital*, 337 F. Supp. 671 (1971).

60 *Guardianship of Kemp*, 763.

61 *Ibid*, 765.

62 “Appendix B. Appellant's Opening Brief,” 2. *Guardianship of Tulley* (1978), UCHLL, MF 27:6.

case, agreeing that a hysterectomy would be in Dianne's best interests, and would solve not only the problems brought on by her menstrual cycle, but also protect the girl against the potential for pregnancy—which psychiatrists averred would be harmful—without unsexing her.⁶³ Edwin's petition was also met with sympathy by the court, and Gerald Ragan, in his June 1977 decision, declared his belief that a hysterectomy was “without question” in Dianne's best interest.⁶⁴ Yet, despite his belief that Dianne's sterilization was both medically and socially desirable, Ragan, following the black-letter law established by Kemp, declared that he lacked the authority to authorize the operation, and rejected Edwin's petition. Furthermore, Ragan claimed that were the court to order the sterilization, it would be “tantamount to involuntary sterilization of the incompetent.” “The court truly empathizes with the parents and the doctors in this case,” the judge concluded, “and has a strong desire to particularize and allow the operation, but there remains a necessity to generalize for the protection of the commonwealth.”⁶⁵ With both Ragan and Masterson's rulings against court-ordered sterilizations for retarded individuals, the state's stance towards such actions appeared fixed. Yet, despite this rising barrier, Dianne's father chose to appeal Ragan's decision in an attempt, as he saw it, to exercise his daughter's decision-making power.

At the appellate trial, constitutional arguments were invoked once again, with Edwin's counsel claiming that Dianne's “right to be sterilized” had been invaded by the lower court's prohibition. Who else, they argued, would make a “more loving and concerned decision” in the best interests of Dianne than her father.⁶⁶ The opposing counsel emphasized the reverse, and declared that an equal, if not stronger right to *not* be sterilized existed. However, in his ruling on the matter in August 1978, Judge Kane, argued that, even though Dianne's sterilization had been denied, such matters were inconsequential given that no “absolute bar on sterilization” of individuals with mental retardation existed, pointing, once again, to the quiescent yet viable alternative of the Asexualization Act.⁶⁷ If Dianne could be admitted to the state hospital system, and if her father met all procedural requirements of the act, there was nothing stopping her sterilization. As the sole piece of legislation in California dealing with the sterilization of the mentally retarded people, Kane agreed with the Kemp court that the strict procedural safeguards contained therein

63 John Fogarty, “High Court Rejects Father's Plea to Sterilize Daughter,” *San Francisco Chronicle*, March 20, 1979, 12.

64 “Appellant's Opening Brief,” *Tulley*, 3.

65 *Ibid*, 10.

66 *Ibid*, 13.

67 *Guardianship of Kemp*, 705.

were “sine qua non” to any court-ordered sterilization such individuals.⁶⁸ In doing so, Kane forcefully tied access to sterilization with institutionalization, and as Dianne lived in the community, and her father had not followed any of the procedural requirements contained in the eugenic legislation, the judge, “for this reason alone,” denied Edwin's petition. Although he did sympathize, as the lower courts had, with Edwin's dilemma, and noted the increasing difficulty involved, given the movement in the opposite direction, of getting a dependent institutionalized, Kane nevertheless maintained that the “awesome power to deprive a human being of his or her fundamental right to bear offspring” must be derived from clear-cut state law, not the independent reasoning of judges.⁶⁹ Kane's decision highlights, once more, how the Asexualization Act, in the twilight of its existence, served not only as the only recourse for retarded individuals in California to access sterilization in the 1970s, but also as an “escape hatch” for judges to avoid addressing the more complex constitutional questions of the fundamental right of the same individuals to have these decisions made for them.⁷⁰

With this, and the preceding decision, the direction of California's policy towards the sterilization of the mentally retarded people in the 1970s was firmly established, rendering institutionalization a necessary prerequisite to the operation at a time when deinstitutionalization became a dominant paradigm in treatment delivery. The refusal of the California Supreme Court in October 1978 to hear Edwin Tulley's appeal from Kane's ruling indicated the extent to which the issue appeared settled to the state's legal authorities. While, as Ragan's desire to “particularize” in Dianne's trial indicated, individual judges may have been sympathetic to the plight of those petitioning, sterilization's sordid history led them to err on the side of caution, as was the trend of courts nationwide, and refuse requests for court-sanctioned action.⁷¹ Yet, the courts' prohibition of these operations rested on unsteady foundations. The reliance of judges in both the Kemp and Tulley trials on the Asexualization Act as a remedy to the petitioners represented a band-aid solution, to which the viability of their rulings, and their ability to avoid critical constitutional issues were tied. Within a year of the Tulley decision, however, legislative changes in California would rip off this convenient band-aid and expose the raw and inflammatory issue of the right of retarded people to choose sterilization to the eyes of the courts, the legislature, and the parents.

68 Ibid, 703.

69 Ibid, 704.

70 The term “escape hatch” was used to describe the Kemp and Tulley in a 1984 *Valerie N* opinion. See “Appendix A. Dissenting Opinion, Sims, J.,” 18. *Conservatorship of Valerie N.*, (1983). UCHLL, MF 25:3.

71 “Appellant's Opening Brief,” *Tulley*, 10.

Balancing the Interests of the State and the Rights of Persons with Disabilities

In 1979, a major legislative overhaul was initiated in California. It began in 1972 when the *California Law Review Commission* (CLRC), a small but influential team of legal experts and active legislators based at Stanford University, had been charged with overhauling and modernizing the state's probate code, originally adopted in 1931.⁷² As part of the CLRC's endeavor to streamline California's inconsistent and overlapping guardianship and conservatorship law, within their broader probate code revision, the problematic issue of the sterilization of retarded people would fall under their purview. In their November 1978 report to the legislature, the body's legal experts proposed that the legislature adopt section 2356(d), stipulating the conditions under which a conservator may consent to sterilization on behalf of an incompetent dependent. Citing Kemp and Tulley, the section read: "A ward or conservatee may be sterilized only as provided in section 7254 of the Welfare and Institutions Code [Asexualization Act]."⁷³ This proposal was formally submitted to the legislature in early 1979 by Alistair McAlister, as part of a comprehensive bill containing the recommendations of the CLRC, and would enshrine the position taken by the *Kemp* and *Tulley* courts in legislation that steer all future decisions concerning the sterilization of incompetents⁷⁴. A companion bill submitted by McAlister around the same time proposed to update the language of the Asexualization Act, adding the terms "guardian" and "conservator" to its procedural scheme, in an attempt to modernize the antiquated eugenic legislation to reflect its new role.⁷⁵ These CLRC's submissions to the legislature indicate the body's intention to keep the "narrow legal door" of the Asexualization Act, and the strict procedural process to access sterilization for retarded individuals contained therein, open for families in "extraordinary hardship conditions."⁷⁶ Whether out of concern over the plight faced by families with retarded children, or the constitutional quandary posed by a complete prohibition, the CLRC chose not to erect "an absolute bar" to sterilization.⁷⁷ Yet, it would soon become apparent that the CLRC, and the legislature that oversaw their work, sat at odds on the sterilization question.

Just two months after McAlister submitted the recommendations of the CLRC to

72 California Law Review Commission, *Recommendation Relating to Guardianship Conservatorship Law* (Palo Alto: California Law Revision Commission, 1978), 505; Alistair McAlister Interviewed by Carole Hicke (Sacramento: CSA Oral History Program, 1988), 153-154.

73 California Law Review Commission, *Recommendation*, 725.

74 "Assembly Judiciary Gives Tentative Nod to Probate Code Revision." McAlister Papers, MF 6:2(77), CSA.

75 A.B. 167, Introduced by Assemblyman McAlister, California Legislature, 1979-90 Regular Session.

76 George Newman, "Bill Would Allow Sterilization of Some Mentally Retarded," AB 603, MF 6:2(25), CSA.

77 *Guardianship of Tulley* 83 Cal. App. 3d 705 (1978).

the legislature, Art Torres, at the behest of the *California Association for the Retarded*, submitted his bill to repeal the Asexualization Act, and “remedy the inequities caused by the existence of the antiquated and unconstitutional” eugenic statute.⁷⁸ Yet the bill, designed to benefit, and supported by, retarded citizens and their representatives, was to amount more than the purging of an antiquated law. For when a senate committee recognized the conflict between the CLRC bill, which relied on the Asexualization Act for its sterilization clause, and the Torres bill, which dismantled the same, McAlister simply deleted all reference to the eugenic statute. Instead, a new section, 2356(d), was added that read: “No ward or conservatee may be sterilized under the provisions of this division.”⁷⁹ This new clause, in effect, denied retarded citizens and their families any forum through which sterilization could be accessed. The decision to engineer this prohibition must be viewed as the state's intention to end its involvement in the involuntary sterilization of individuals with mental retardation, as part of the ongoing transition of sterilization policy away from compulsion and towards protection. In doing so, the legislature had made it clear that the state's interest in preventing the potential for abuse outweighed the potential hardship that may be brought on retarded people or their families through the blanket ban. The “narrow legal door” through which petitions for the sterilization of incompetent dependents was intended to have been achieved had been abruptly slammed shut.⁸⁰ Commenting shortly after these changes took effect, Lawrence Swenson, an attorney from Sonoma County who represented a family seeking sterilization for their retarded child, noted that by prohibiting sterilization, the law had “gone so far in protecting the rights of the mentally retarded that we've denied them another right.”⁸¹

The dilemma posed by the state's protective pivot away from the sterilization of retarded people was illustrated almost immediately by one San Jose family. In September 1980, Millie Gedney, a board member of Hope Rehabilitation Services, which provided educational services for retarded adults, and her husband, Doug, petitioned the Santa Clara probate court to authorize the sterilization of their twenty-five-year-old daughter, Valerie. Valerie had been born with Downs Syndrome, and had an estimated IQ of thirty.⁸² She could perform only basic household tasks, and spent much of her day at a group center for people with disabilities, before returning home for the evening. Worried about Valerie's future, and their capacity to care for her, it was Millie and Doug's long-range plan that

78 Benton A. Sifford to Edmund G. Brown, Jr., September 4, 1979. Letter. AB 3900, MF 9:3(57), CSA.

79 “Amendments to Assembly Bill No. 261,” August 21, 1979, 1. McAlister Papers, MF 6:2(77), CSA; “Dissenting Opinion, Sims, J.,” 24.

80 Newman, “Bill Would Allow Sterilization.”

81 McKinley, “Sterilizations of Retarded Confirmed,” B3.

82 “Daughter Can't Be Sterilized, Court Rules,” *Santa Cruz Sentinel*, February 4, 1981, 47.

Valerie transition to living at the group home full-time. In preparation, they hoped that she would be able to broaden her social activities, including attending summer camps, where she could begin to form normal social relationships with her peers. Valerie had, however, proven to be very affectionate towards men, even to the point of being “very aggressive,” and would hug, kiss, and climb on them.⁸³ Her parents were troubled by this behavior, and feared that she could be taken advantage of and fall pregnant. Given these fears, they had reluctantly found it necessary to limit her social freedoms, and kept her either confined at home, or closely supervised. “Retarded people should be able to live as normal lives as possible,” declared Millie, “[...]but Valerie can't do it, the way things are now. There are always unscrupulous people who would take advantage of her.”⁸⁴ Millie believed that sterilization represented the most appropriate solution to this dilemma. Little did she know, however, that the legal action brought by her, and attorney Allen Fleishman, to have Valerie sterilized in the hope of permitting her to live a “normal” life, would become a defining case in the state's transition away from its eugenic past, and in doing so, would stir a fierce debate among California's foremost legal minds.

The Gedneys' hopes of a quick resolution fell at the first hurdle when Santa Clara superior court judge, Bruce Allen, denied the couple's petition on December 10, 1980. Millie had attempted to impress on the court that sterilization represented the only feasible solution to Valerie's situation. Valerie had previously been administered two different forms of oral birth control, but became ill and rejected both. Doctors then attempted to fit Valerie with an IUD, but this too was deemed undesirable after Valerie violently refused to allow a pelvic examination to be performed on her. After attempts to use contraception Valerie failed, her parents employed a behavioral management specialist who attempted to modify Valerie's aggressively affectionate behavior without success. As a result, both physicians and the behavioral specialist agreed that sterilization was advisable and medically appropriate.⁸⁵ As with the *Tulley* case, where the courts expressed sympathy for the petitioner's predicament, Judge Allen believed that sterilization in Valerie's case was appropriate and would serve her best interests. “I think she would be much happier if she had it [the operation],” declared Allen, “and I think sterilization, from what I’ve heard, is desirable and should be ordered.”⁸⁶ Along with his sympathy for Gedneys, Allen also expressed doubt over the constitutionality of the blanket ban on such operations imposed the legislature's passage of probate code 2356(d).⁸⁷ Yet, even though the new probate code

83 Herbert A. Michelson, “IQ of 30, She Gets Law Killed,” *Sacramento Bee*, September 28, 1986, A1.

84 “Daughter Can't Be Sterilized,” 47.

85 “Petition for Hearing,” 4-5. *Conservatorship of Valerie N.*, (1983). UCHLL, MF 25:3.

86 “Daughter Can't Be Sterilized,” 47.

87 “Petition for Hearing,” *Valerie N.*, 6.

would only become effective twenty-two days after the court's decision, on January 1, 1981, Allen felt compelled to follow the nascent legislation. As a result of the decision, the Gedneys were left with the options of limiting Valerie's freedom by confining her at home, or risk her falling pregnant, with only abortion—which, ironically, guardians could consent to—as an alternative “protection.”⁸⁸ Millie and Doug would be offered a shred of hope, however, as the interest that the decision sparked, both in the plight of the Gedney family, and the new legal framework that prohibited Valerie's sterilization, prompted an attempt in the legislature to reopen the legal door to sterilization for incompetent citizens.

This attempt to correct the blanket ban on sterilizations for retarded individuals was initiated by assemblyman Gordon Duffy, who viewed the foreclosure of such operations not as a deliberate move by the state to prevent abuse, but rather as an “inadvertent, but yet inexcusable” legislative mistake.⁸⁹ In February 1981, Duffy, who had previously served as the Chairman of California's assembly health committee, introduced a bill that would reverse the sterilization embargo established by code 2356(d) for those unable to consent, and establish the procedures through which a parent or conservator could provide substitute consent for sterilization on behalf of those unable to do so.⁹⁰ Given the polarizing and impassioned nature of the subject, introducing legislation to reopen the door to sterilization represented a politically risky maneuver, as evidenced by the unwillingness of other legislators to approach the issue. For instance, earlier, California's *Association for Retarded Citizens* (ARC), had implored assemblyman William Filante, who had expressed misgivings of the legislative ban erected in 1980, to introduce a proposal similar to Duffy's that would reestablish a forum for the incompetent individual to access sterilization. However, despite Filante's apparent concern, the legislator reversed his intention to submit legislation in early 1981.⁹¹ “Every due process loophole,” noted Filante's administrative assistant, John Valencia, explaining the assemblyman's hesitance to act, “will have to be closed before anyone will introduce it.”⁹² Clearly, the controversial nature of reopening access to sterilization, and the potential for abuse it entailed, dissuaded other legislators from submitting a fix to the wholesale denial of contraceptive sterilization for retarded people. The potential for controversy did not deter Duffy, who, when asked whether he feared repercussions over his sterilization bill, replied: “This bill has nothing to do with

88 “High Court Hears Testimony on Sterilization for Retarded,” *Torrance Daily Breeze*, September 8, 1984, A4.

89 Newman, “Bill Would Allow Sterilization.”

90 “Subcommittee on Mental Health and Developmental Disabilities, Analysis of AB 603, April 22, 1981,” AB 603, MF 6:2(25), CSA.

91 McKinley, “Sterilizations of Retarded Confirmed,” B3.

92 Daughter Can't Be Sterilized,” 47.

political expediency or lack thereof. I am a strong enough person to take any kind of heat from anyone for a cause I believe in. And I believe in this.”⁹³ However, while the thick-skinned legislator stood resolute in the face of brewing controversy, whether his bill would survive the scrutiny of both the legislature and the multitude of interest groups whose attention it courted remained to be seen.

Contrary to expectations, Duffy's bill, which endeavored to equalize access to sterilization, providing retarded people with a forum to choose sterilization while also protecting them against the injudicious application of the law, was comprehensively passed by the assembly sixty-one votes to nine. The assemblymen appeared convinced that the procedural protections contained in the bill were appropriate. The bill provided for multiple safety checks to be met before a sterilization could be authorized, which included the submission of three reports, two from physicians and one from either a psychologist or psychiatrist, stating whether sterilization was appropriate, an interview of the retarded person by a court investigator to assess the former's understanding of proceedings, the appointment of a public defender for the retarded person, and finally, a unanimous jury decision that sterilization was necessary for the mentally and physical well-being of such person. Additionally, the petitioners would have to prove that (a.) the retarded individual had not refused sterilization, (b.) that the retarded person lacked the capacity to give informed consent, and (c.) that sterilization represented the least invasive alternative available.⁹⁴ The Gedneys' attorney, Allen Fleishman, fully endorsed the provisions of the bill, and at a legislative committee meeting in April, explained the “dilemma” faced by his clients in an attempt to secure its passage. At the meeting, Fleishman strongly praised Duffy's “excellent bill” for both recognizing the need to access sterilization in cases like Valerie's, while also “zealously” protecting the rights of the retarded individual.⁹⁵ Fleishman, who was referred to by judges as the “king of the developmentally disabled community” for his work with families of retarded people, stated his confidence that if the Duffy bill were to be enacted, it will “ensure that every application for sterilization be carefully scrutinized before permission is granted.”⁹⁶ The bill also received support from several advocacy groups for retarded people, and the *Association of Regional Center Agencies*, who expressed their belief that, while they remained concerned about the protection of the human rights of their clients, the proposed safeguards contained in the Duffy bill would “adequately protect those individuals who might be inappropriately

93 Newman, “Bill Would Allow Sterilization .”

94 “Subcommittee on Mental Health and Developmental Disabilities, Analysis of AB 603, April 22, 1981,” AB 603, MF 6:2(25), CSA.

95 Allen Fleishman to Assemblyman Duffy, April 20, 1981. Letter. MF 6:2(25), CSA.

96 Ibid; Interview with Allen Fleishman, February 25, 2016, San Jose.

sterilized” while permitting “the remaining individuals to receive a desired operation.”⁹⁷

Despite these positive comments and a strong showing in the assembly, the bill came under considerable criticism in the senate. Critics argued that the Duffy bill was not just opening a “narrow legal door” to contraceptive sterilization for retarded people, but also a potential floodgate through which the abusive practices of the past might reemerge.⁹⁸ Mary S. Burdick of the *California Women Lawyers*, for instance, petitioned members of the senate to reject Duffy's bill, citing its “vague and subjective” standard that sterilization improve the dependent's “mental or physical health and wellbeing” as a criteria for authorization. Burdick argued that this “imprecise nature” of the bill underscored its potential for abuse:

Even court procedures which appear elaborate on paper can become rote; if that happens with court-ordered sterilizations, we are seriously concerned that disadvantaged men and women, who are least able to resist a routinized, formal system, could be disproportionately subjected to sterilization by well-meaning judges anxious to protect the undefined “well-being” of those people.⁹⁹

A similar argument was made by members of the ACLU in their condemnation of the Duffy bill. ACLU legislative advocates told senate members that the proposed reopening of sterilization would “establish a dangerous precedent” in the state, and that by permitting courts to make decisions on sterilizations for those unable to consent, the bill “might open the door to the sanctioning of sterilization to control all sorts of supposed ills and incompetencies.”¹⁰⁰ Likewise, PAI, who had assisted the CMRW in the guidelines battle, and were designated by the governor to protect the rights of California's retarded citizens, argued that more research into the due process and public policy implications was required before a bill as far-reaching and controversial as Duffy's was adopted.¹⁰¹ Under the weight of this considerable scrutiny, which was largely based on the ghost of past practices of involuntary sterilization, the Duffy bill died in the senate. In a considerable hit to the hopes of the Gedneys, the legislature reaffirmed their belief that the potential for abuse outweighed any hardship caused by denying retarded people and their parents a forum to exercise any true reproductive choice.

While Duffy's attempt to reopen the door to sterilization ultimately failed, his bill's strong showing in the assembly highlighted both a degree of sympathy over the issue, and its recognition as a problem that demanded legislative attention. Although it would take several years, the Gedneys' case would receive this attention in mid-1984 when the justices

97 Robert J. Baldo to Omer Rains, August 3, 1981. Letter. MF 6:2(25), CSA.

98 Newman, “Bill Would Allow Sterilization.”

99 Mary S. Burdick to Members of the Senate Committee on Judiciary, September 9, 1981. Letter. MF 6:2(25), CSA.

100 Beth J. Meador and Brent A. Barnhart to Assemblyman Duffy, August 4, 1981. Letter. MF 6:2(25), CSA.

101 Carolyn Schneider to Honourable Gordon W. Duffy, July 27, 1981. Letter. MF 6:2(25), CSA.

of California's highest court agreed to hear their petition. In the interim, Judge Bruce Allen's original ruling had been upheld by the Santa Clara appellate court, which reasoned, in denying Valerie's sterilization, that the wholesale ban on sterilization "protects the fundamental right of an incompetent person to bear children."¹⁰² As in earlier cases, competing meanings of reproductive choice were brought to the fore. Undeterred, however, Allen Fleishman, in his petition to the Supreme Court, reasserted that Valerie had a constitutional right to have sterilization decisions made on her behalf, and that to uphold the sweeping prohibition, would see Valerie and others like her lose "the right to live their fullest lives as retarded persons."¹⁰³ "It is a sad irony," Fleishman told the justices, "that the best intentions of the state to prevent the abuses of the past with respect to the sterilizations of retarded person should, in effect, deny those persons who cannot consent to sterilizations procedures the right to experience their full range of physical and sexual emotions and needs."¹⁰⁴ The need to provide retarded individuals with a forum to exercise their reproductive choice through sterilization, and thereby allow them to live with greater freedom, outweighed the threat of an "occasional abuse" occurring through the same forum, the attorney argued.¹⁰⁵ As had been attempted by the Duffy bill, Fleishman argued that the state interest in preventing the abuses of the past could be adequately served through a scheme of "rigorous procedural safeguards," without resorting to an absolute prohibition by the arbitrary fiat of the legislature.¹⁰⁶ By contrast, Valerie's state-appointed public defender, Ezra Hendon, argued that it was precisely this potential for abuse, evidenced by the "thousands and thousands of involuntary sterilizations" carried out in the name of eugenics, that justified the outright ban established by the legislature.¹⁰⁷ Like the opponents of the Duffy bill, Hendon contended empowering the courts to authorize sterilizations for those who cannot consent was "very dangerous business," and that doing so would "open the door to sterilizations of other citizens whom society considers incapable of rearing children."¹⁰⁸

The distinctly opposed arguments over the probate code and its prohibition on sterilizations for individuals with mental retardation can be seen in the divided opinion of the seven Supreme Court of California justices. In a case that stirred the "judicial viscera"

102 "Appendix A. Opinion of Rattigan, P.J. And Poche, J." 19. *Conservatorship of Valerie N.*, (1983). UCHLL, MF 25:3.

103 "High Court Hears Testimony on Sterilization on for Retarded," *Torrance Daily Breeze*, September 8, 1984.

104 "Petition for Hearing," *Valerie N.*, 27.

105 "Sterilization Now Before High Court," *Sacramento Bee*, September 9, 1984, AA8.

106 "Petition for Hearing," *Valerie N.*, 25.

107 "High Court Hears Testimony on Sterilization for Retarded," *Sacramento Bee*, September 8, 1984, A4.

108 "Sterilization Now Before High Court," AA8.

of the court, the majority, in a four to three split, ruled that probate code 2356(d) swept “too broadly” in its blanket ban on sterilization, and in doing so, “impermissibly” denied retarded people their constitutional right to procreative choice.¹⁰⁹ “True protection,” wrote the ultra-liberal Justice Joseph Grodin, “of procreative choice can be accomplished only if the state permits the court-supervised substituted judgment of the conservator to be exercised on behalf of a conservatee who is unable to personally exercise this right.”¹¹⁰ The concurring justices accepted Fleishman's reasoning that to deny retarded people the ability to choose sterilization would severely impair their ability to lead fulfilling and independent lives. As Grodin noted: “if the state withholds from her [the incompetent woman] the only safe and reliable method of contraception suitable to her condition, it necessarily limits her opportunity for habilitation, and thereby her freedom to pursue a fulfilling life.”¹¹¹ In making their landmark ruling, the justice's acknowledged the danger, implicitly looming over the case, that were they to reopen sterilization to the retarded individuals, so too would they reopen a potential floodgate to abuse, by declaring that the decision would not “open the way to unrestricted guardian-conservator sterilization practices.”¹¹² This ruling, which once again dramatically reshaped sterilization policy in California following the protective turn prompted by the disclosures of the state's eugenic past, was heralded by the San Jose Mercury, which had been following Valerie's case, as a “victory for the humane treatment of the developmentally disabled.”¹¹³

Yet, for Millie and Doug, the ruling represented only a partial victory. For while their legal battle resulted in the removal of probate code 2356(d), which both they and the justices saw as a barrier to meaningful choice for families in their predicament, the court refused to order Valerie's sterilization.¹¹⁴ The majority believed that the Gedneys had not presented sufficient evidence that sterilization in Valerie's case was required, pointing specifically to doubts over whether Valerie was in fact capable of conceiving a child, and whether the parents had attempted all possible less restrictive alternatives before deciding on the irreversible procedure. However, not wishing to foreclose the operation for Valerie, Grodin referred the case back to the Santa Clara superior court, where a judge would now be free to order the sterilization after receiving the requested evidence.¹¹⁵

Despite the restraint shown by the majority in refusing to order Valerie's

109 Michelson, “IQ of 30, She Gets Law Killed,” A1.

110 *Conservatorship of Valerie N.*, 40 Cal.3d 168 (1985).

111 *Ibid.*, 163.

112 *Ibid.*, 168.

113 “Protections for the Retarded,” *San Jose Mercury*, November 6, 1985, 10B.

114 *Conservatorship of Valerie N.*, 169.

115 *Ibid.*

sterilization, the dissenting justices remained disturbed by the decision to overturn probate code 2356(d). The legislation, the dissenting justices believed, did not result from an inadvertent legislative overlap, as Duffy stated, but represented a calculated move by the legislature to foreclose sterilization for retarded individuals following a “study of the sad historical reality” of the state's practice of eugenics.¹¹⁶ The ban, then, represented the legislature's view that it represented an “unacceptable hazard” to leave sterilization decisions solely in the hands of judges.¹¹⁷ Given the centrality of the eugenic past in the legislature's decision to ban sterilization, Chief Justice Rose Bird argued that this history of eugenics had to serve as a “frame of reference” for evaluating the constitutionality of the legislation.¹¹⁸ Yet, in their opinion, the majority “cavalierly ignored” this history when striking down the legislation.¹¹⁹ When they did comment on this “shameful history,” the Chief Justice noted, it was to explain “sympathetically the legal justifications advanced during that period were merely expressions of 'the prevalent attitude.'”¹²⁰ The majority's uncritical approach towards the rationale underpinning the defunct ban troubled Bird and her dissenting colleagues, who argued that these attitudes that once supported compulsory sterilization were not temporally-specific, and held the potential to remerge in the present. Justice Malcolm Lucas was particularly alive to this threat, and worried that by removing the ban, the majority opened the way to the possible misuse of sterilization once more.¹²¹

Despite being “poles apart philosophically,” Lucas agreed with Bird's objection to the ruling, which he believed favored the “rights” of parents to have their retarded children sterilized, more than the children themselves.¹²² The record of Valerie's case, now stretching back more than four years, only heightened Lucas's fears. The Justice decried the original willingness of Bruce Allen to order Valerie's operation, “but for clear restraints” in the form of the new probate code, based on the “briefest of written declarations” from Valerie's pediatrician and counselor that doing so would have been desirable.¹²³ Alongside this “skimpy” medical and psychological evidence, Lucas was concerned by the mention of the “family's desire” as a rationale in favor of the ordering the operation.¹²⁴ With the legislative veto on sterilization which had blocked Valerie's sterilization, and ultimately led her family to the Supreme Court, now removed, Lucas

116 Ibid, 170.

117 Ibid, 174.

118 Ibid, 177.

119 Ibid, 176.

120 Ibid.

121 Ibid, 170.

122 “Lucas Seems Likely for Top Post,” *Santa Cruz Sentinel*, October 26, 1986, 34.

123 *Conservatorship of Valerie N.*, 173.

124 Ibid, 172.

feared that operations ordered out of a family's desire for the same would become “pro forma commonplace occurrences.”¹²⁵ Likewise, Bird too feared that the majority's decision would give rise to sterilization practices which would “serve the convenience of conservators, parents, and service providers rather than incompetent conservatees.”¹²⁶ Clearly, the dissenting justices viewed the majority's decision as an ill-conceived and perilous backwards evolution in the state's transition away from coercive sterilization practices, and the ghost of the eugenic past.

While the dissenting justices clearly felt that the majority's decision to remove the sterilization embargo for those incapable of consenting was foolhardy and ill-conceived move, Grodin and his allies did recognize the need for new protections. By reopening the legal door to sterilization, the majority had corrected a constraint on retarded individuals' reproductive choice, but they had done so without providing a firm protective framework to safeguard those undergoing the procedure. While the *Valerie N.* decision dismantled what the legislature had considered an appropriate safeguard against abuse—a wholesale interdiction on sterilization—the justices re-entrusted the legislature with developing an appropriate protective framework to ensure, as Daniel Kevles framed it, that the newly established “civil liberty” afforded to California's retarded citizens did not come to represent a “civil danger.”¹²⁷ In the interim, the justices, aware that sterilization petitions could now proceed without legislative safeguards, established temporary protections modeled primarily on those established in the state of Washington.

The judges in *In Re Hayes*, while denying a mother's request to have her daughter sterilized, nevertheless acknowledged that in “rare and unusual cases,” sterilization could serve the best interests of retarded individuals.¹²⁸ The decision was among the first that made a positive ruling on retarded individuals' right to access sterilization, and established a protective standard that was adopted in a number of states under which sterilizations for incompetent individuals could proceed.¹²⁹ This standard held that the petitioner had to prove by “clear, cogent and convincing evidence” that the incompetent individuals would never be able to exercise independent choice, and that sterilization represented the only viable option, and served the individual's best interest. Further, these claims all had to be based on “substantial medical evidence.”¹³⁰ These guidelines, however, as instituted by the justices in California following *Valerie N.*, were no substitute for clear statutory protections

125 Ibid, 175.

126 Ibid.

127 Daniel J. Kevles, “Sterilization Imperils Rights of Retarded,” *Los Angeles Times*, October 30, 1985, B5.

128 *In Re Hayes*, 93 Wn.2d 230 (1980).

129 See Ladd-Taylor, “Contraception or Eugenics?” 202-203.

130 *In Re Hayes*, 237.

established by the legislature, and many individuals and advocacy groups doubted their value. Even Valerie's mother, who fought to reopen access to sterilization for her daughter, expressed her discomfort with the "openness" of the procedure following the ruling. "If it is left completely in a judge's hands," Millie noted, "it could be abused. I have always said it shouldn't be up to one person." This sentiment was echoed by Valerie's public defender Ezra Hendon, who noted that the temporary standards adopted by the court were "no obstacle to allowing a judge to do what he wants to do."¹³¹ This, however, until the legislature acted to erect a procedural framework to safeguard the reproductive autonomy of those individuals at the centers of these petitions, was exactly the position that retarded individuals now found themselves in in the wake of the *Valerie N* ruling.

Nevertheless, *Valerie N* was a defining moment for both disability rights and sterilization policy in California. It recognized that retarded individuals shared the constitutionally protected procreative rights afforded to those not similarly affected, and provide a forum for them to assert the same. Furthermore, while the legislature's ban on sterilization had aimed to condemn the state's practice of eugenics to the dustbin of history, the action brought by the Gedneys, with the help of Allen Fleishman, forced the state to confront this unpalatable truth, and formulate a response sensitive to the reproductive rights of the state's retarded citizens. Yet, it also highlighted the complex and incendiary issues inherent in such an undertaking. As the legislature's original ban on sterilization demonstrated, any solution would be Janus-faced: either denying retarded people procreative choice by limiting their access to sterilization, or permitting it and potentially reopening the way to mass non-consenting sterilizations. In its attempt to strike a safe and delicate balance between these two outcomes, the Supreme Court, in the absence of legislative protections, had not so much cracked as flung the door to sterilization back open in the wake of the "corrective" action taken by the legislature in 1980. However, despite the momentous ruling, *Valerie N* left both the state and Valerie's parents with unanswered questions and impending challenges. How to guarantee that sterilization proceedings for retarded people were equitable and protective, and whether a sensitive legislature could write such guarantees into law without, as many feared, allowing the specter of the eugenic past to find expression in the present through it, preoccupied the former. While the Gedneys, beginning their petition anew in San Jose, continued the fight in the lower courts, Valerie, meanwhile, who had been silent throughout the proceedings—a "leading lady without lines" as the *Sacramento Bee's* Herbert Michelson dubbed her—

131 Dan Morain, "Sterilization Ban Overturned: State High Court Upsets Law Covering Retarded," *Los Angeles Times*, October 22, 1985, 18.

would remain the poignant focal point around which both challenges revolved following the trial.¹³²

Protection or Peril? Individuals with Mental Retardation and the Right to Access Sterilization

Now with the backing of the Supreme Court, and the constitutional questions settled, Millie brought the case back to the Santa Clara County Superior Court—dubbed Valerie 2—in February, 1986 to win the authorization for Valerie's sterilization. In what proved to be an open-and-shut case, Judge John Flaherty declared that “there was no reasonable alternative to sterilization, and that Valerie was permanently incapable of rearing a child—even with assistance.”¹³³ Accordingly, Valerie's long-awaited sterilization was ordered to proceed any time after May 19.¹³⁴ Were the operation to proceed as expected, it would be a pivotal moment in the state's long history of sterilization, marking the first sterilization of a retarded individual since eugenic sterilization was discontinued, and the complete negation of the now-defunct 1980 sterilization ban in reaction to the same. Yet, while Flaherty's order may have come as no surprise following the Supreme Court's decision, the details of the case troubled many. For instance, despite the Supreme Court's ruling that there was insufficient evidence to sterilize Valerie, Flaherty had ordered the operation to proceed without any further proof.¹³⁵ Troubling, too, were the actions of Valerie's attorney, John Horning. Prior to the trial, Horning has spent only thirty minutes with his client, accompanied by her mother. While, at the trial, the attorney conducted only a perfunctory cross examination of Millie, and called just one witness for the defense, Valerie, who had no understanding of the proceedings. Finally, once handed down, Horning controversially opted not to appeal Flaherty's order. Later justifying his actions, Horning noted: “I don't see why it's best to automatically resist. You look at what's best for the client, and my investigation persuaded me that I should agree with the judge's decision.”¹³⁶ It was exactly the worrying ease with which Flaherty seemingly rubber-stamped Valerie's sterilization through his court, and the patriarchal attitude shown by her “advocate,” that concerned the dissenting Supreme Court justices and opponents of the doctrine of substitute consent over the clear threat it posed to vulnerable individuals.

While a number of groups were perturbed by the events of Valerie 2, none were

132 Michelson, “IQ of 30, She Gets Law Killed,” A1.

133 Ibid.

134 Morain, “Sterilization of Retarded Woman, 30, Faces a Test,” *Los Angeles Times*, June 3, A3.

135 CPF to John A. Flaherty.

136 Alicia C. Shepard, “Court of Appeal Bars Woman's Sterilization,” *San Jose Mercury News*, June 5, 1986, 2B.

more so than *Capitol People First* (CPF), a self-advocacy group from Sacramento. Holding signs that labelled the Gedneys' attorney, Fleishman, as “the butcher of San Jose,” the advocates picketed the Santa Clara courthouse to protest the injustices they saw.¹³⁷ The premise of self-advocacy—the so-called “third wave” of disability advocacy—was that the individuals with disabilities themselves, not their parents nor professionals, were best placed to recognize and campaign for their own wants and needs in society.¹³⁸ Beginning in America in the early-1970s, after a group of disabled people in Oregon returned from a self-advocacy conference in Canada, subsequently forming People First, the movement began to spread across the nation. By 1985, there were fifty-five People First chapters nationwide, and fifteen in California alone. In 1987, this figure had mushroomed to over 200 People First chapters across the United States.¹³⁹ The agenda of these individual chapters varied widely; some closely resembling social clubs—from which many had originated—while others, more in line with the goals of self-advocacy, pursued a more politically active focus. It was often the interest of the groups' facilitator, a non-disabled aide to the advocates with complex matters, who influenced the activities of the particular chapter.¹⁴⁰ CPF was highly active in the political sphere with its members recognizing the importance of influencing policy to achieve their goals. Accordingly, members of CPF sat on the boards of PAI and the *State Council on Developmental Disabilities* (SCDD)—a federally-funded body created to include disabled consumers in the formulation and administration of community services designed for them. In a major achievement for the group, in 1983 the SCDD contracted CPF to produce a detailed report on the unmet needs of disabled individuals in the state, and to provide a blueprint for other communities to establish their own self-advocacy groups.¹⁴¹ Underpinning the report, and self-advocacy more broadly, was the conviction that individuals with disabilities, with time, understanding, and education, could grow to make informed choices about their own lives.

It was this tenet alike that informed the group's stance towards sterilization. CPF were not opposed to sterilization per se, which they viewed as a matter of individual choice. The group did, however, oppose sterilization via substitute consent which took that choice away from the disabled conservatee, and replaced it with the discretion of parents

137 Interview with Allen Fleishman.

138 Joseph P. Shapiro, *No Pity: People with Disabilities Forging a New Civil Rights Movement* (New York: Times Books, 1994), 186.

139 Ibid, 185.

140 Ibid, 187.

141 California State Council on Developmental Disabilities, *Surviving the System: Mental Retardation and the Retarding Environment* (Sacramento: CSCD, 1984); see also, Robert R. Rosenberg, “Capitol People First: Self-Advocacy and Quality of Life Issues,” in *Quality of Life for Persons with Disabilities International Perspectives and Issues*, ed. David Goode (Cambridge: Brookline Books, 1994), 176-182.

and judges. Accordingly, they viewed the probate code amendments that supported this doctrine as a dangerous “backwards step” in the state's troubled shift away from its eugenic history, and a major hazard for the rights of individuals with mental retardation statewide. As Flaherty's willingness to flout the protections mandated by the Supreme Court had demonstrated, CPF believed that the sweeping lack of understanding over the nature of retardation, and the ability of those affected by it to learn and grow, rendered it unlikely that disabled people could have due process under such laws. Thus, “while judges and parents are learning what retarded people already know,” declared CPF's position paper on sterilization reprinted in *WAYS Magazine*, “they shouldn't allow Valerie or anyone else to get sterilized without their consent.”¹⁴² Instead, members of CPF viewed education of the DD person, to the point that they could make their own decisions on matters such as a sterilization, as a more equitable and effective alternative to dragging individuals through the court system for years. Indeed, as retarded people themselves, CPF felt uniquely placed to educate their peers. For instance, the group maintained that had they been given an opportunity to teach Valerie to make her own decision over her sterilization, they could have resolved the issue much “faster and better” than the years-long legal logjam, and the anguish involved therein, caused by the route taken by her parents.¹⁴³ Overall, CPF aimed to reassert the right and ability of retarded people to exercise autonomy in such decisions, as well as the danger posed by those individuals professing to acting in their “best interests,” a belief summed up in the groups byword: “we need teachers, not keepers.”¹⁴⁴

In a letter to Flaherty in early May, the board of directors of CPF summarized their concerns to the judge: “we feel we are more in danger than any other single group of having our rights violated, even in this country, because it is so hard for so many of us to speak for ourselves.”¹⁴⁵ It was for this reason that CPF, and self-advocacy more broadly, existed, and one day after their letter, three CPF delegates, including Chairman Thomas Hopkins, visited Flaherty's chambers in Santa Clara to protest the simulacrum of a trial that had transpired, to halt Valerie's sterilization, and to signal to courts and guardians statewide that any quiet or routine sterilization of the developmentally disabled under the state's latest policy would not go unchallenged.¹⁴⁶ The group pointed to a number of

142 “CPF Position Paper: Substitute Consent for Sterilization of the Retarded,” 1-2. Undated reprint from *WAYS Magazine*. SJC, MF 6:1(76), CSA.

143 Ibid, 2.

144 Ibid.

145 CPF to John A. Flaherty.

146 Alicia C. Shepard, “Sterilization Order Sparks Rights Protest,” *San Jose Mercury News*, May 17, 1986, 1B.

concerns they had over *Valerie 2*, including continuing doubt over whether Valerie was even capable of conception. She had previously resisted when doctors attempted a pelvic exam, and not wishing to subject her to two general anesthetics (assuming she could get pregnant), Flaherty ordered her sterilization anyway upon the condition that a pelvic exam was performed concurrently. The Supreme Court, CPF pointed out, mandated that the ability to conceive must be established *prior* to a sterilization order, and that Flaherty's reasoning was "like giving anesthesia to her [Valerie's] rights." The group further attacked the lack of education provided by Valerie's regional center, whose staff reported that "intensive education would improve her understanding but it would be unlikely that her knowledge would increase enough to give informed consent." Upon the regional center's "guess," as CPF viewed it, all educative efforts had ceased. However, again, the Supreme Court had mandated that education had to be proven unworkable before sterilization could be ordered.¹⁴⁷

Given these criticisms, the members of CPF respectfully demanded that a new trial be set to address these concerns, and that Horning, who had proven himself a woefully inadequate defender of Valerie's rights, be replaced as her counsel. It was clear that the group would not allow the new permissive sterilization policy to be abused. CPF's calls, however, fell on deaf ears as Flaherty refused to reverse his order. The decision, he maintained, pertained only to Valerie, and in no way threatened the rights of the developmentally disabled more broadly, and that sterilization was wholly appropriate in her "unique case."¹⁴⁸ While CPF had failed to obstruct the order themselves, their efforts did attract the attention two state Deputy Public Defenders, Ezra Hendon and Michael Pescetta, who interceded after learning of the "sham of a hearing" in Flaherty's court.¹⁴⁹ Hendon had previously served as Valerie's counsel at the Supreme Court, where he had urged the justices to leave the sterilization embargo in place out of concern of the abuses that may arise.¹⁵⁰ The record of *Valerie 2* vindicated Hendon's concerns, and those of many others, who argued that stronger safeguards, if not outright prohibition, was the only way to keep the developmentally disabled safe from forced sterilization. The attorney heaped particular scorn on the passive Horning, noting that his client "got no representation there was nobody to put before the trial court the position that Valerie should not be sterilized."¹⁵¹ "This is the equivalent," Hendon told the *San Francisco Chronicle*, "of a

147 CPF to John A. Flaherty.

148 Shepard, "Sterilization Order Sparks Rights Protest," 1B.

149 Morain, "Sterilization of Retarded Woman," 18.

150 Ibid; *Conservatorship of Valerie N.*, 144.

151 Shepard, "Court of Appeal Bars Woman's Sterilization," 2B.

public defender deciding that the client is guilty and refusing to put on a defense.”¹⁵²

Steadfast in his decision, however, Flaherty refused Hendon and Pescetta's request for a retrial, leading the attorneys to petition the local appellate court. In a private hearing, the court granted an emergency order blocking Valerie's sterilization once again, two days before Millie was due to put her daughter under the knife.¹⁵³ Speaking on the decision, Hendon reiterated his belief that “all the T's should be crossed and all the I's should be dotted” before a decision as “irrevocable, permanent, and final” as sterilization is ordered.¹⁵⁴ This would now, once again, be the responsibility of the court of appeals. This most recent delay in the now eight year legal struggle over Valerie's reproductive integrity, coupled with the strong opposition from Hendon, who wished to see the sterilization ban reinstated, highlights both the complexity involved in individual sterilization cases, and how the issue served as a major source of legislative dispute since the dismantling of eugenic legislation 1979.

The Legislature Attempts to Provide Clarity

“It isn't clear what Valerie's case portends for future cases,” wrote ARC representative Rand Martin in the *LA Times*, “what it does suggest is that there is a need for additional safeguards.”¹⁵⁵ In fact, attempts to correct the legislative void, which had allowed the missteps seen in *Valerie 2* to occur in the wake of the California Supreme Court ruling, were underway already. In February 1986, as *Valerie 2* was going to trial, Johan Klehs, a first-term assemblyman from San Leandro, introduced AB 3900, a bill designed to establish a legislative framework of strict protections that courts would be required to follow before approving the sterilization of a developmentally disabled individual.¹⁵⁶ The public knew little of Klehs's bill, as his staff, cautious that misunderstandings could arise over an issue as emotionally charged as sterilization, purposefully shied from media attention. Klehs had not been aware of the legislative friction following the repeal of the eugenic statute, nor Valerie's case, and it was not until the issue was put to him by representatives of ARC California that the assemblyman intervened.¹⁵⁷ Despite a failed attempt in 1981, protective sterilization legislation remained a critical priority for ARC's governmental affairs platform which, having had their belief in the necessity of such legislation validated by the Supreme Court, wasted no time in acting.¹⁵⁸ In a December

152 Thomas G. Keane, “Court Halts a Sterilization,” *San Francisco Chronicle*, June 6, 1986, 37.

153 “The State,” *Los Angeles Times*, June 5, 1986, 2.

154 Shepard, “Court of Appeal Bars Woman's Sterilization,” 2B.

155 Morain, “Sterilization of Retarded Woman,” 18.

156 Johan Klehs to George Deukmejian, August 29, 1986. Letter. SJC, MF 6:1(76), CSA.

157 Interview with Johan Klehs, January 11, 2016, Sacramento.

158 “California Supreme Court Overturns Sterilization Ban,” *ARC California News*, Fall 1985. AJC, MF

1985 letter, ARC formally requested that Klehs sponsor their legislation, promising to provide “considerable material” on the present problem to his aides, and to work closely with PAI in order to translate their proposal into the appropriate legal language for submission to the legislature.¹⁵⁹ Klehs agreed, and in his only public comments on the bill's purpose assured the *LA Times* that “before a step like sterilization, we want to be sure that every remedy has been exhausted and that it is the correct decision.” He further noted that, although the legislation would be strict, it would remain “very workable,” and allow up to thirty operations per year.¹⁶⁰ Were it to be successful, the legislation would be a groundbreaking moment for sterilization policy in California, and enshrine in law the right of the developmentally disabled to access sterilization on their own terms.

Events immediately following the introduction of AB 3900 pressed home the need for such legislation. In May, a thirty-one year old Milpitas woman with Down's Syndrome, Anne-June Espiritu, was sterilized by court order. As the first court-ordered sterilization of a developmentally disabled individual since the cessation of the state's eugenic sterilization program, Espiritu's sterilization represented a truly “historic” moment in California's troubled history of sterilization.¹⁶¹ People with DD had once had sterilization forced on them, then were outlawed from choosing the same, now, after Valerie's challenge, Espiritu ostensibly represented the first beneficiary of a law that allowed DD individuals to elect sterilization.

Yet, while the Espiritus believed they had acted in their daughter's best interest, the case highlighted disturbing actions which bore striking similarities to those seen in Valerie's emerged. In a virtual “mirror image” case, both girls were the same age, and both afflicted with Down's Syndrome, though Espiritu was estimated to have a slightly higher IQ.¹⁶² Both cases were presided over by Flaherty, and Horning was entrusted to protect Anne-June's reproductive rights and, again, failed to do so out of belief that he was acting in her best interests. When Flaherty ordered the sterilization, no appeal, as was required, was filed. The only significant difference between the two affairs was that while the attention brought by the Supreme Court case and subsequent press inquiry shed light on Horning's actions and launched the intervention of CPF to protect Valerie's rights, a concomitant shadow was cast that allowed Espiritu's sterilization to slip through the back

9:3(57), CSA.

159 Rand Martin to Johan Klehs, December 2, 1985. Letter. AJC, MF 9:3(57), CSA.

160 Dan Morain, “Woman With Down's Syndrome is Sterilized After Court Approves,” *Los Angeles Times*, August 23, 1986, V28.

161 “Retarded Woman Sterilized: Court, Parents OK'd Surgery,” *San Jose Mercury*, August 23, 1986, B1.

162 Herbert A. Michelson, “One Sterilization Case Resolved in May, Milpitas Woman Had 1st Ordered Surgery Since 1969,” *Sacramento Bee*, September 28, 1986, A21.

door. Indeed, so focused on Valerie's case, Pescetta and Hendon were completely unaware of the Espiritu trial until after the sterilization had been performed. "I never thought," Pescetta told the *Sacramento Bee*, "with the Nieto case on appeal, that other cases would be coming through this quickly." Indeed, it was only by chance, after a journalist contacted district attorney for comment, that Pescetta finally learned of the outcome. While there was nothing "unethical" in Horning's failure to inform the DA's office of the case, said Pescetta, the covert proceedings had prevented them from intervening. "I suppose Mr. Horning did what was right according to his likes," concluded Pescetta.¹⁶³

It was precisely Horning's license to represent Espiritu according to his likes that represented a major threat to California's developmentally disabled community in the regulation-free, post-Supreme Court milieu. If the events in Valerie's case had not yet done so, the complete failure to protect Anne-June Espiritu's reproductive rights, and the recognition of this fact only months after she was operated on, highlighted a glaring and perilous dearth of oversight over sterilization operations on people with DD, and forcefully emphasized the need for firm protective regulations to ensure that such failings were not repeated.

Although doubtful whether any legislation could guarantee the rights of developmentally disabled people undergoing sterilization, CPF agreed to work with a group of interested parties asked by Klehs to give their input on his bill. As DD people themselves, CPF felt uniquely placed to suggest content that would make the proposed sterilization law both safer and "more fair and acceptable" to primary consumers.¹⁶⁴ Talking through her facilitator, Bob Rosenberg, Connie Martinez, a founding member of the self-advocacy group, would present their suggestions at an April 18 forum on the Klehs bill hosted by SCDD. Following the group's emphasis on the ability of individuals with DD to grow and learn, Martinez's central concern was the bill's failure to "make very, very sure that sterilization isn't done to a person who will someday grow into the ability to make his or her own decisions." "We want the judge," Martinez continued, "to have to spend much more time and effort on making his or her own informed and sensitive judgement about whether or not the incapacity of a person to give informed consent 'is in all likelihood permanent'" (emphasis in original).¹⁶⁵ This could be achieved, Martinez proffered, by instituting a test of permanent incapacity as the final item to address before a sterilization petition was granted. CPF, too, worked with experts who could design such a test, and Martinez offered their involvement at future hearings. Alongside this test of

163 Ibid.

164 Connie Martinez to Fellow Members of the SCDD. April 18, 1986. Letter. SJC, MF 6:1(76), CSA.

165 Ibid.

incapacity, CPF requested a clause be added that mandated the court to “supervise a very serious educational effort aimed at one last try to get the person to give informed consent.”¹⁶⁶ Given that many members of CPF, including Connie, had been told by experts and carers that they would never be able to make their own choices, especially in matters as significant as reproduction, the group's insistence on protecting DD people, who might one day exercise their own choice on an irreversible proposal like sterilization, from the premature involvement of others purportedly acting in their best interests was understandable. With these amendments, designed to maximize the rights of people with DD, CPF would throw their support behind Klehs.

Yet, by August, with the bill, having convincingly passed through the lower house, now in the senate, CPF delegates appeared more hesitant than ever. An apparent lack of progress over their suggestions, the furor around Valerie's trial, and positive international developments which questioned the utility of the entire conservatorship scheme had all caused the self-advocates to distance itself from the Klehs bill. CPF facilitator, Robert Rosenberg, reported in testimony before the Senate Judiciary Committee that his group's growing concerns were shared by members of ARC—the original sponsors of the bill—who, unsettled by the “embarrassment” of *Valerie 2*, had “backed away” from their position.¹⁶⁷ No evidence of ARC's change of heart appears in the bill's records. Yet, this alleged hesitancy of the advocate groups was not reflected by the legislators in the Senate, who, impressed by the protections contained in the Klehs bill, passed the legislation 21-6 on the Senate floor.¹⁶⁸ Indeed, Chairman of the Senate Judiciary Committee, Bill Lockyer, reportedly commended Klehs on one of the finest pieces of work of his career.¹⁶⁹ Subsequently signed into law by Governor Deukmejian, the new law, taking effect on January 1, 1987, would form sections 1950-1969 of the California probate code dealing with conservatorships, where it still sits to this day.¹⁷⁰

As the enrolled bill report pointed out, the protections contained therein were “extensive.” For a petition to be filed, the petitioner had to prove beyond a reasonable doubt—the highest evidentiary standard and in excess of the California Supreme Court's “clear and convincing evidence” requirement—eight criteria.¹⁷¹ The included that the

166 Ibid. For full-text of proposed amendments, see Connie Martinez to Connie Riley, April 28, 1986. Letter. SJC, MF 6:1(76), CSA.

167 “Testimony of CPF to SJC Regarding AB3900 (Klehs),” August 12, 1986. SJC, MF 6:1(76), CSA. CPF highlighted the Australian “tribunal” system as a viable alternative to the practice of conservatorship, and suggested an interim study of the issues involved with implementing it in California.

168 Johan Klehs to George Deukmejian, August 29, 1986. Letter. SJC, MF 6:1(76), CSA; Enrolled Bill Report, AB3900. SJC, MF 6:1(76), CSA.

169 Interview with Johan Klehs.

170 Cal. Prob. Code. § 1950-1969.

171 Enrolled Bill Report, AB3900, 3. SJC, MF 6:1(76), CSA.

individual named was capable of conception; capable and likely to engage in sexual activity; that all less intrusive methods of birth control had been proven unworkable; and that, in the near future, no advancements were likely to be made either in sterilization procedures or treating the individuals condition.¹⁷² Alongside these criteria were rigid procedural safeguards that required a facilitator be appointed to help the individual communicate in proceedings; that the appointed attorney presume the individual's opposition to the sterilization procedure; and that an automatic appeal be launched whenever a sterilization operation is approved by the court. Importantly, the law also mandated that a sterilization be denied if the DD individual made a knowing objection, independent of their ability to provide informed consent, to the procedure.¹⁷³ Yet, perhaps the greatest contribution of the legislation appeared in the opening section, in which the legislature recognized both the right of DD people to “exercise choice over matters of procreation” without prejudice, and that sterilization, “historically” had been used abusively.¹⁷⁴ In this light, the legislation marked a significant moment in the state's difficult transformation to a sterilization policy centered on choice and autonomy. For Klehs, too, the bill marked a major success in the legislator's career. The impact that the legislation was to have on the DD community however, was less clear.

Notably absent from the bill were CPF's suggestions to make the legislation more acceptable to the DD community. Though records of the Senate Judiciary committee indicate an amendment that would have necessitated additional education for an individual, if it was believed he or she could “become capable of informed consent,” this did not appear in the final bill.¹⁷⁵ Nor would the expert-designed test of incapacity, which was replaced by the criteria that an incapacity was “in all likelihood permanent.”¹⁷⁶ Additionally, despite Klehs's earlier contention that his legislation would be “very workable,” doubts emerged over the efficacy of the scheme.¹⁷⁷ The new law, for instance, insulated courts from the costs of such procedures, but in doing so, placed a tremendous financial burden on the petitioners. Courts would assign all costs, including those involved in hiring expert witnesses, court-appointed counsels, and conducting any investigations, to the petitioner. Other unassigned costs, were to be split between the petitioner and the county.¹⁷⁸ Further, most insurers, including Media-Cal, would not cover operations

172 ARC-California, Fact Sheet: AB 3900 (Klehs). SJC, MF 6:1(76), CSA.

173 Lore Radisch and Maureen Fitzgerald to Bill Lockyer, July 3, 1986. Letter. SJC, MF 6:1(76), CSA.

174 Cal. Prob. Code. § 1950-1969.

175 Bill Analysis, Senate Committee on Judiciary, 9. AJC, MF 9:3(57).

176 Cal. Prob. Code. § 1950-1969.

177 Morain, “Woman With Down's Syndrome is Sterilized,” V28.

178 Enrolled Bill Report, AB3900, 3. SJC, MF 6:1(76), CSA; Arc-California, Fact Sheet: AB 3900 (Klehs).

ordered under the new probate code.¹⁷⁹ The potential high sums now involved in petitions would necessarily limit the number who could apply for sterilization. Coupled with the law's lengthy and rigid procedural standards, Allen Fleishman believed that the new probate code sections made it virtually impossible to bring a successful sterilization petition to court.¹⁸⁰ The law, then, suffered from two seemingly contradictory drawbacks, though both of which acted to restrict the reproductive autonomy of people with DD. It at once lacked the elements deemed necessary by informed advocates to protect the rights of DD individuals in sterilization petitions, while also restricting access to the same by erecting overwhelming financial and procedural barriers to the process. It was both too strict and too lenient. In this light, the passage of AB3900 again demonstrates the problematic nature of legislating an issue as complex as reproduction, especially involving special populations, such as the DD, who are unable to provide consent. Just as Valerie Nieto and Anne June Espiritu had their voices silenced in courtrooms by those acting in their best interests, the final form of AB3900 similarly conveys a seeming marginalization of the advocates from CPF.

The Gedneys' Final Throw

Shortly after the law came into effect in January, 1987, Valerie, who unbeknownst to her had now left an indelible mark on California law, returned to court, for what her parents hoped would be the final time. The wider threat to the DD voiced by opponents of Valerie's sterilization had by now been rendered "moot" by the new probate code sections, and the action re-centered solely on her. Surprisingly, Fleishman and the Gedneys presented no new evidence in the appeals court, merely reiterating arguments that sterilization was the best option for Valerie's wellbeing, and that to needlessly confine her, or experiment with numerous types of birth control would be "cruel and hazardous to her health." Pescetta, now Valerie's appointed representative, maintained that it was the family's obligation to try other forms of birth control before sterilization could proceed, and, further, that no evidence had yet been presented that Valerie was even capable of conception.¹⁸¹ Presumably out of concern for Valerie's comfort, the Gedneys had not pursued either of these claims, despite being central objections since appearing before the Supreme Court two years prior. This would prove to be a major error in the Gedneys' case as Justice Nat Anglia, siding with Pescetta, noted that the "record does not reveal whether

179 Gary D. Macomber, Director of Department of Developmental Services, to Johan Klehs, May 19, 1986. Letter. SJC, MF 6:1(76).

180 Lorenzo P. Romero, "Involuntary Sterilization Case Argued," *San Jose Mercury*, January 22, 1987, 3B.

181 Ibid.

more than one formulation of birth control pill was tried[...]or whether alternative methods of administering these contraceptive drugs are available or were considered.”¹⁸² On February 3rd, Anglia denied Valerie's sterilization, leaving the Gedneys with few further options. Furthermore, in light of the adoption of the new probate code sections, future efforts to sterilize Valerie would now only prove more difficult.

Fleishman was understandably dissatisfied with the decision handed down by Anglia. Speaking outside the courtroom, Fleishman reminded reporters that “Judge Flaherty had adequate information to determine that it wasn't in Valerie's best interest to experiment with over 40 different kinds of birth control pills.” Similarly, while Flaherty could not prove that she was capable of conception, the judge settled that she was not capable of raising a child.¹⁸³ To Fleishman, these points were enough to warrant renewed action. Seemingly undeterred, he noted that it was the intention of the Gedneys to launch a renewed application under the new statute, and if denied, to take their challenge once more to the California Supreme Court.¹⁸⁴

A more surprising source of dissatisfaction with the judgement came from Valerie's attorney. Although clearly pleased that his client had not been subjected to sterilization, Pescetta felt that the decision had not gone far enough, and wished to see the 1985 Supreme Court decision overturned, and, by proxy, the new probate code sections, and to revert California back to a flat prohibition against the sterilization of the DD in practice at the turn of the 1980s. In papers filed with the Supreme Court, Pescetta attacked the handling of the *Nieto* case prior to his involvement, and the decision that had allowed it. “This case,” Pescetta's statement noted, “demonstrates that whatever theoretical protections are afforded will not be capable of affording actual protection to (the) constitutional right to avoid non-consensual sterilization.”¹⁸⁵ Given the power dynamics at play in a sterilization petition, Pescetta felt that it was impossible for a DD individual to get a fair hearing. The judge hearing a petition, Pescetta maintained, would always be more likely to side with the “generally sympathetic figure” of the petitioner in such hearings, while the DD individual will be unable to express or defend themselves.¹⁸⁶ And, as the *Nieto* and *Espiritu* cases had demonstrated, there was be no guarantee that even an attorney appointed for this purpose would carry out their task appropriately. Despite the

182 Lorenzo P. Romero, “Retarded Woman May Not Be Sterilized, Appeals Court Rules,” *San Jose Mercury*, February 4, 1987, 8B.

183 Romero, “Involuntary Sterilization Case Argued,” 3B.

184 Philip Hager, “Sterilization for Retarded Woman Denied,” *Los Angeles Times*, February 5, 1987, B25.

185 “State Court Denies New Hearing on Sterilizing Retarded,” *San Francisco Chronicle*, April 23, 1987, 17.

186 “Court Backs Previous Decision to Allow Sterilization,” *San Jose Mercury*, April 23, 1987, 2B.

record of abuses in both cases, as well as Pescetta's impassioned argument, the Supreme Court ultimately refused to reconsider its landmark decision from three years prior, and in doing so, marked a frustrating and anticlimactic conclusion to Valerie Nieto's story. Neither Valerie, nor her parents, would appear again in a California court. After a seven year legal battle in which the legal landscape surrounding the DD and their right to reproductive choice had been completely reshaped, Valerie had retained her reproductive integrity—but at what cost?

With the paper trail ceasing after this point, it is difficult to ascertain what eventually happened to Valerie. Fleishman, who maintained contact with the Gedneys for a short time after the trial, suggests that her mother and step-father may have taken Valerie outside of California to have the sterilization performed in a state with less restrictive standards, though we cannot be sure.¹⁸⁷ Ultimately, the somber story of Valerie's lengthy journey through the court system provides insights into the turbulent development of California's sterilization policy aimed at the DD at the turn of the 1980s, and poignantly highlights the impact of these developments on a personal level. This ranged from the stress of numerous examinations, and having to appear in courtrooms for the better part of a decade, to the agony of the decision itself. Although, on the face of it, Valerie appears to have “escaped” an unwanted sterilization, in contrast to Espiritu, had the court in fact robbed her of a more an independent and fulfilling life? Was she now destined to a future of isolation and supervision as her mother mournfully testified? Similarly challenging and emotionally charged questions were faced by the state over this period: when is sterilization appropriate? How far should safeguards go? What constitutes reproductive freedom? How do you balance the right for the DD to exercise reproductive choice with the dangers that doing so entails? It must also be remembered that these questions were permeated and muddled by the looming shadow of the state's significant and, at the time, not too distant eugenic past. Sections 1950-1969 of the probate code, however, represent the state's reckoning on these questions, and their attempt to strike a balance between the right to reproductive choice and the need to protect the vulnerable. How successful were they in this effort? Were Pescetta's criticisms of impotent and ornamental “theoretical protections” to the Supreme Court accurate?¹⁸⁸

Akin to the circumstances surrounding Valerie's life following the final Supreme Court decision, details about sterilization petitions made under the probate code are difficult to come by. Indeed, in contrast to the diligent record keeping of the DMH and its

187 Interview with Allen Fleishman.

188 “Court Backs Previous Decision,” 2B.

predecessor agencies throughout the eugenic sterilization years, there remains a glaring absence of data regarding these modern sterilization petitions. Originally, AB 3900 contained a comprehensive reporting clause that required the *Department of Developmental Services* (DDS) to collect information annually from the clerk of each county court on the total number of petitions filed; the number filed in which a regional center client was named; the number of petitions which resulted in a sterilization order; and the relationship of the petitioner to the named individual. These findings were then to be submitted in a report to appropriate committees in the legislature.¹⁸⁹ However, during the drafting phase of AB 3900, the DDS resisted this clause, citing both the expense and difficulty faced by the department in fulfilling similar requirements for the *Mentally Retarded Defendant Diversion Program*. Collecting data on the sterilization program, they maintained, was likely to be “even more problematic.” “Further,” wrote Gary Macomber in a letter to Klehs explaining his department's position, “we seriously question the need for an annual report which simply counts the number and disposition of certain civil actions.”¹⁹⁰ Macomber noted that the DDS would be willing to vote in favor of the legislation if this and several other concerns were addressed. In what was presumably a compromise between the DDS and the bill's author, Klehs kept the reporting clause, but added a sunset provision that would see the requirement automatically expunged from the law after three years. The sole report published by the DDS' Office of Human Rights, charged with producing the data, reported zero sterilization petitions registered in 1991, the final year of the reporting requirement.¹⁹¹ In a telephone conversation on September 21, 2017 with the Legal Services Manager at Alta California Regional Center, Robin Black, Black reported that since the DDS's commitment to tracking sterilization petitions ended, it is unknown how many petitions have been filed or operations carried out under the these sections, and that no system exists for tracking these figures. This lack of oversight should be viewed as a major failing in the state's mandate to protect the vulnerable from inappropriate sterilization. Indeed, and worryingly, the lone documented case of a sterilization petition filed under the probate code indicates gross failings which bear striking similarities to those seen in both the Valerie Nieto and Anne-June Espiritu cases.

In September 1997, Robert and Donna D. filed a petition under the probate code to have their daughter, Angela, sterilized. Then 19, Angela suffered from a severe developmental disability, along with severe seizures and diabetes. Their court brief would

189 Department of Developmental Services, *Implementation of AB 3900, Chapter 1012, Statutes of 1986 Regarding Petitions for Sterilization of Developmentally Disabled Adults; Annual Report to the Legislature* (Sacramento: DDS, 1991), 3; ARC-California, Fact Sheet AB 3900.

190 Gary D. Macomber to Johan Klehs.

191 Department of Developmental Services, *Implementation of AB 3900*, 3.

further attest that Angela “cannot read or write; she cannot talk, except for speaking simple words like Hello, Goodbye etc. she cannot mentally determine right from wrong.” The petition arose from the parents’ fear that the passive and compliant Angela would soon, when her special education program at Chino high school, where she was supervised and protected, ended at age 22, have to attend a day program at their local regional center where she would come into contact with male consumers. Doctors warned the parents that due to Angela's condition, pregnancy could prove life threatening to both her and the child.¹⁹²

In shades of Horning, these facts apparent proved so compelling that Angela's court-appointed counsel elected not to prepare a defense for his client. Despite acknowledging his statutory obligation to oppose the sterilization, the attorney told the court that his “thought was that if the evidence is overwhelming that it’s in her best interest to do it [sterilization], then I have the authority to say it’s in her best interest.”¹⁹³ The attorney's erroneous reasoning clearly breached the standards established by Klehs, yet instead of simply refusing to mount a defense, the attorney argued in *favor* of his client's sterilization. Despite scant evidence that Angela was likely to be sexually active, the major point on which the case hinged, Angela's counsel argued that “in the absence of continual parental supervision or upon placement in a residential facility[Angela] could easily engage in sexual activity,” and therefore “every element required [to order Angela's sterilization] can be proved.”¹⁹⁴ The attorney's actions were, as Ezra Hendon noted earlier in the *Nieto* case, the “equivalent of a public defender deciding that the client is guilty and refusing to put on a defense.”¹⁹⁵ The gross mishandling of the trial did not stop there, however. Suffering from the flu, Angela was unable to attend the scheduled hearing in early March, 1998. Given that the illness was only temporary, the hearing should have been postponed, but Angela's pro-sterilization facilitator, appointed by the statute to “assist [Angela] to understand the proceedings and to communicate his or her views as fully as possible,” recommended that the court proceed in her absence as, she told the court, Angela would be unlikely to contribute to proceedings if present.¹⁹⁶ Unsurprisingly, Angela's attorney agreed. Far from enhancing Angela's understanding and involvement in the case then, both her facilitator and counsel's actions limited further what little ability to participate Angela may have had. Despite these clear failures to follow the probate code's protections, the judge found in favor of the parents and, in Angela's absence, ordered her

192 *In re Conservatorship of Angela D.*, 70 Cal. App. 4th 1413 (1999).

193 *Ibid*, 1415.

194 *Ibid*, 1414.

195 Keane, “Court Halts a Sterilization,” 37.

196 Lore Radisch and Maureen Fitzgerald to Bill Lockyer CSA. *In re Conservatorship of Angela D.*, 1415.

sterilization to “be accomplished as soon as possible.”¹⁹⁷

As prescribed by the new law, an automatic appeal was triggered, and Angela's counsel was replaced by Peggy O'Neill, who the presiding judge described as a “vigorous advocate.” O'Neill attacked the major failure of due process in the probate court, and the lack of evidence presented that Angela was likely to engage in sexual activity.¹⁹⁸ O'Neill also pointed out at that, as with Valerie's trial, there was no evidence presented that Angela was capable of conception. The only “evidence” came from Angela's doctor, W. Donald Shields, who, when asked whether Angela was capable of conception, replied: “I don't have any evidence that says she is [fertile], but nothing that suggests she is not.”¹⁹⁹ But whereas the failure to provide evidence of fertility derailed the Gedneys' attempts to sterilize Valerie, the judge in Angela's case seemed untroubled by the paucity of proof. So too was the judge happy to proceed given what he remarked was the lack of evidence that Angela was likely to be sexually active. Considering the “context of the facts that appear in this case,” the judge merely accepted the admittedly “slim” evidence, as he saw it, that Angela would engage in sexual activity.²⁰⁰ Finally, on the failure of due process, the judge agreed with O'Neill that her predecessor had failed in his responsibility to Angela, and praised O'Neill for her diligence. However, while recognizing this fact, the court declared that, as O'Neill had been unsuccessful in persuading the judges that sterilization was not appropriate, then the probate attorney's failures were ultimately inconsequential to the trial. With this, the judge affirmed that Angela's sterilization should proceed.

Angela's case marks a troubling blot on the legacy of California's efforts to balance reproductive freedom with the need to protect the vulnerable. While, given Angela's significant health problems, and movement into a less restrictive environment, sterilization may well have been an appropriate choice, the willingness and ability of her counsel and facilitator to argue in favor of the operation, as well as numerous other failures, highlighted deficiencies in the supposed “extreme” protections of the new probate code sections. With seemingly no mechanism of enforcement, Angela's case demonstrated that the authority over such decisions still largely rested upon the discretion of individual judges. While the judge in the *Nieto* case ultimately found the lack of evidence presented by the parents as grounds to deny the petition, similar evidence presented in Angela's trial was deemed compelling enough to order the operation. The case also highlighted, as CPF identified in the drafting of AB 3900, how enduring

197 Ibid, 1416.

198 Ibid.

199 Ibid, 1419.

200 Ibid, 1425.

assumptions about over the capacity of DD individuals to make their own decisions continued to shape such petitions. Before the passage of the law, CPF continued to wonder, as Bob Rosenberg told the Senate, if “it is possible to get genuine and widespread due process with the present level of comprehension of retardation held by most members of society, including the judiciary.”²⁰¹ Even under a law designed to empower the DD, as far as was possible, to exercise reproductive choice, Angela's case highlights the ability of these attitudes to direct proceedings. Indeed, that Angela's counsel was so quick to declare sterilization to be in her best interests, and that both they and her facilitator directed the court to proceed with the hearings in her absence, suggests that CPF's fears were not unfounded thirteen years on from Rosenberg's statements in the senate. While Angela's case makes a compelling case for the veracity of these fears, assessing the extent and character of sterilization petitions under probate 1950-1969 represents an important and valuable area of future research in the success of the state's attempt to reorient sterilization policy from one centered on coercion to one based on procreative freedom and impartiality.

Conclusion

This chapter sheds new light on the debates and practice surrounding the sterilization of the DD in 1970s and 1980s California. Contrary to popular belief that such debates subsided with the primary focus on racially-motivated sterilization in the 1970s, or with the repeal of eugenic legislation at the turn of the 1980s, this chapter had shown that far from receding, this period witnessed an intensification of the debates around the DD and the right to choose sterilization. This chapter has also illuminated a number of interesting features that arose from these debates.

One interesting feature highlighted has been the dual reshaping of society's understanding to both the DD and sterilization during this period. The principles of mainstreaming and normalization, the push for a development of rights legislation, and the development of community-based service networks all developed from a professional and public shift away from a traditionally pessimistic view of developmental disabilities to a more optimistic understanding. While these changes proved beneficial, removing the DD from dehumanizing institutions and integrating them into society to varying degrees, they also led to a new peril. For while the legal and intellectual backlash against eugenic sterilization had, with some exceptions, led to the decline of state-run institutional sterilization programs, this chapter has demonstrated that the entrance of the formerly

201 Testimony of CPF to SJC Regarding AB3900.

institutionalized DD into the community witnessed parents and guardians seeking new avenues to control their dependents' fertility in a far more legally nebulous and systemless environment, and the struggles faced by the state in attempting to bring order to this phenomenon.

An examination of this period in California has also illuminated how the vestigial eugenic legislation, the Asexualization Act, continued to serve as a boon to both parents and the state in the 1970s. While not administered “promiscuously,” nor any longer in the aid of a eugenic goal, the testimony from Keating highlighted that both parents and the institutions were still, towards the mid-1970s, benefiting from the ease with which sterilizations, performed to safely parole women without fear of pregnancy, could be performed on the institutionalized.²⁰² This contradicts the belief that institutional sterilizations ceased in the 1960s. For the state, the “escape hatch” provided by the legislation has been shown to be utilitarian, insulating legislators from the responsibility of clarifying the powers of the courts in ordering extra-institutional sterilizations, and from having to wade into debates on the procreative freedoms afforded to the DD.²⁰³ It has been shown that only with the repeal of the Asexualization Act, and the commencement of negotiations around sterilization by substitute consent did the state's eugenic past act as a hindrance to lawmakers, as newspapers and testimony invoked lurid stories of mass sterilizations.

This chapter has also highlighted the major debate that gripped California legislators, and, indeed, the public more broadly during the 1980s, around the right of the DD to choose sterilization. The case of Valerie Nieto was used to elucidate the polarities of this argument on a compelling and personal level. Those like Valerie's parents and attorney claimed that sterilization represented an important therapeutic option that could better her health and wellbeing, and permit her full enjoyment of a sexual life, and that she should not be denied this right afforded to others on the basis of her disability. The *Nieto* case was also used, however, to highlight the inverse position. The outrage elicited by Horning's refusal to defend Valerie, predicated on his belief that sterilization was in her best interest, and the willingness of judge Flaherty to order the sterilization despite the flouting of procedures, were used to illuminate popular fears at the time that sterilization by substitute consent imperiled the rights of the DD, and opened the way for a covert resurgence of eugenics. The metamorphosis of sterilization policy from the removal of eugenic legislation, to the sterilization embargo, to the protections set out in the probate

202 “Sterilization – What about California?” 4.

203 “Dissenting Opinion, Sims, J.,” 18.

code may be viewed as a manifestation of this debate. Ultimately, while the state, whether inadvertently or not, had sided with those who feared the repercussions of sanctioning extra-institutional sterilizations, the outcome of Valerie's trial set in motion a tremendous reorientation in state sterilization policy which privileged the DD's right to choose the operation, while also erecting some of the strictest safeguards from abuse in the nation. Although Valerie's sterilization was denied, her long and winding case provided the greatest impetus for state involvement in the issue, and acted as a touchstone for discussions of the potential dangers faced by the DD in sterilization decisions.

Finally, and most importantly, this chapter demonstrated how individual interest and assumptions hold the ability to shape the practice of sterilization. While assumptions that people with DD were, to some degree, subhuman, justifying violations of their bodily rights, had faded by the 1970s and 80s, the belief that they lacked total capacity to make their own choices, and to grow and learn, as consistently pointed out by CPF, certainly persisted. Despite the contested definitions of what constituted the “best interests” of the DD, the attorneys in four cases highlighted by this chapter—*Kemp*, *Nieto*, *Espiritu*, and *Angela D*—flouted their obligation to defend their clients, and decided for them that sterilization was the correct choice. These cases bespoke CPF's fears voiced at the start of the legislative battle for protections over the intrusion of “good-hearted people figuring out more ways to interfere with our rights in the name of our 'best interests.'”²⁰⁴ This complete negation of their clients right to due process and reproductive freedom undoubtedly sprang from the assumption that these individuals' views either did not matter, or that they were too irresponsible to have a say in these decisions. That these failures occurred, with the exception of *Kemp*, under the protections established by the California Supreme Court and later legislation considered so strict in its procedural standards that it was criticized as unfairly restricting access to sterilization, highlights the power of individual interests and assumptions—those of judges, attorneys, and parents/guardians—in shaping the practice of sterilization under even the strictest policy. These cases highlight a troubling transition in sterilization policy from coercion to choice in the latter decades of the twentieth-century, and, given the lack of oversight with which, theoretically, similar cases continue to operate today, present important areas for further research.

204 “CPF Position Paper: Substitute Consent for Sterilization of the Retarded, 3.”

Conclusion

Eugenics, Sterilization and Debates on Reproductive Technologies Today

While never far from public discussion, the subject of eugenics is currently at the foreground of policy discussions across the United States, necessitating a more critical reading of the sterilization programs implemented during the twentieth century. Following North Carolina in 2013, and Virginia in 2015, the California legislature is currently deliberating whether it will become the third state to compensate victims of state-run eugenic sterilization programs. Noting the shortcomings of the 2003 apology issued by then-Governor Gray Davis and Attorney General Bill Lockyear in addressing the victimization of those sterilized under the directives of the Asexualization Act, in 2018, Senator Nancy Skinner submitted to the legislature the Forced Sterilization Compensation Act, in the hope of offering “some small solace to the people affected.”¹ At its core, the bill, which is co-sponsored by the California Latinas for Reproductive Justice and the Disability Rights Education and Defense Fund, is designed to identify and adequately compensate surviving victims of the state's eugenically-inspired sterilization program. Since its reintroduction to the legislature in 2019, however, the authors have enlarged its remit. Acknowledging that “further involuntary and systematic sterilization abuse occurred,” the bill calls for legislative recognition of the involuntary sterilizations suffered both by Chicana women at LACMC, and the more recent victims of the prison sterilization scandal. Yet, while recognizing this abuse, these women are not eligible for compensation under the bill's terms.² Instead, the bill calls to memorialize these events alongside the state-run sterilizations, calling for the erection of plaques at facilities where sterilizations took place. Furthermore, in line with the urging of Davis in 2003 that “every citizen of the state[...]become familiar with the history of the eugenics movement,” Skinner has also suggested the creation of an exhibition and educational activities centered on eugenics in California that would tour the state.³

But while the North Carolinian legislature is currently poised to decide on a second round of compensation, the first of which saw 220 victims come forward, the California

1 “California Introduces Eugenic Sterilization Compensation Bill,” March 29, 2018, <https://dredf.org/2018/04/04/california-introduces-eugenics-sterilization-compensation-bill/>

2 “SB 1190 Eugenics Sterilization Compensation Bill,” accessed June 24, 2019, https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180SB1190;

3 Emily Galpern, “A Bill to Compensate Survivors of Eugenic Sterilization in California,” last modified, September 6, 2018, <https://www.geneticsandsociety.org/biopolitical-times/bill-compensate-survivors-eugenic-sterilization-california>; Matoq, *California's Compulsory Sterilization Policies*, 18.

legislature is unable to decide on its first.⁴ Despite unanimously passing the senate, further movement through the legislature has not been forthcoming. With ranges of payments from \$25,000, in line with Virginia, to as high as \$70,000, there has been no decision on the key issue of payment size, nor the total size of the fund, causing the bill to stall indefinitely, as it did in 2018, in an appropriations committee. Haste, however, is critical. With an average age of 88 years, it is estimated that 100 of the originally suggested 800 victims of California's sterilization program die every year. Of these, it is estimated only a quarter will come forward.⁵ With each victim of sterilization who passes away, California loses not only the opportunity to provide redress for past wrongs, but also valuable insights into the lived experience of those who suffered under its sterilization law. In this critical moment, then, it is vitally important that California has clarity about the shape and subtleties of its eugenic past.

More acutely, the shadow of eugenics has been invoked in the ongoing abortion rights battle unfolding across the United States. In early 2018, Planned Parenthood of Indiana challenged a 2016 state law signed by then-governor Mike Pence, that, among other restrictive provisions, prohibited all abortions sought solely on the basis of sex or disability of the fetus. The so-called “Sex Selective and Disability Abortion Ban” is one in a spate of recent draconian laws passed in conservative states that seeks to restrict abortion practices, and thereby give the Supreme Court the chance to reconsider *Roe v. Wade*.⁶ After the Indiana court begrudgingly ruled that the law violated the provisions of *Roe* and a later precedent, the state referred the case to the US Supreme Court.⁷ By late May 2019, the specter of eugenics came to the fore, as Justice Clarence Thomas issued a blistering anti-abortion diatribe that referenced eugenics over a hundred times, and warned that freedom of selection in abortion decisions would serve as a potential “tool of eugenic manipulation.”⁸ In bolstering his argument, the Bush-era appointee embarked on an uncritical tour of eugenic history, mentioning Margaret Sanger's—an opponent of abortion—involvement in the birth control movement, as well as loosely related topics like the

4 Richard Craver, “Another Attempt at Allowing Counties to Pay Eugenics Compensation,” *Winston-Salem Journal*, April 7, 2019, https://www.journalnow.com/news/local/another-attempt-at-allowing-counties-to-pay-eugenics-compensation/article_66de0f63-c6ae-51f9-9d67-1cd085bfb98e.html.

5 “Senate Floor Analyses,” May 29, 2018, https://leginfo.ca.gov/faces/billAnalysisClient.xhtml?bill_id=201720180SB1190; Stern et al., “California's Sterilization Survivors,” 50.

6 Adam Liptak, “Supreme Court Sidesteps Abortion Question in Ruling on Indiana Law,” *New York Times*, March 28, 2019, <https://www.nytimes.com/2019/05/28/us/politics/supreme-court-abortion-indiana.html>.

7 *Planned Parenthood of Indiana and Kentuck v. Commissioner of the Indiana State Department of Health*, 888 F.3d 300 (2018).

8 “Opinion of Thomas, J., concurring,” *Box, et al. v. Planned Parenthood of Indiana and Kentucky*, 587 U.S. 9 (2019).

1924 National Origins Act and *Buck v. Bell*. Connecting this history to current practice, Thomas argues that technological advances have “only heightened the eugenic potential for abortion” as a tool to eliminate undesirable characteristics.⁹ His singular focus on eugenics comes at the expense of an analysis of arguably more relevance in abortion decisions today, including access to healthcare, sex education, poverty, and sexism. This, however, is not wholly surprising. In embedding the reproductive technology within a history of loosely-related, yet unpalatable policies and reviled figures, Thomas advances the association fallacy—the attack on a belief or action due to its association with another belief or action, no matter how distant—common to anti-abortion activists.

Eugenics, as is often the case, serves as a political tool in Thomas's statements rather than as a useful analytical category for assessing the costs and benefits of reproductive technologies. Indeed, Thomas's desire to assert strict state control of women's reproductive decisions comes closer to a central mission of eugenics than anything in the original wording of the law. While the meaning of “eugenics” can and has been stretched in many directions, there is no concerted plan for the so-called racial improvement in an individual choice not to give birth to a child suffering from a disabling and life-altering condition. Yet this uncritical association between reproductive technologies and the history of eugenics continues to both stigmatize and obfuscate policy discussions.

As Koch wrote in 2004: “The witless reference to 'eugenics' with no further specification is empty and more often a pattern of our own projection and interests than a reference to history.”¹⁰ Thomas's statement represents merely the most recent in a long line of public admonishments that fall into this trap. Repeatedly in discussions around reproductive technologies, we are warned against returning to, or otherwise reviving, an era where eugenic principles governed the use of these tools; but exactly what that entails is often left undefined. As a result, such inflammatory yet, ultimately, vacuous condemnations serve only to manipulate and control such discussions. In contemporary discussions over the regulation of these tools, the reliance on unsophisticated and distorted visions of the eugenic past bypasses important assessments of the values and ethics of these technologies, while, perhaps more critically, neglecting awareness of the very real historical patterns of coercion and prejudice that shaped the past use of these tools and practices.

While this is unsurprising from policy-makers, historians, too, have been guilty of drawing empty statements on the eugenic past. As Diane Paul states, weak and lazy

⁹ Ibid, 3.

¹⁰ Lene Koch, “The Meaning of Eugenics: Reflections on the Government of Genetic Knowledge in the Past and Present,” *Science in Context* 17 (2004): 329.

conclusions that “we should avoid the mistakes of the past, proceed cautiously in adopting new technologies, and other platitudes with which virtually no one would disagree” abound in the literature, serving only to further stifle meaningful scholarship.¹¹ Ultimately, it is these simple retellings of the past that end up on the desk of policy-makers. Yet, as the case of Thomas and abortion shows, the unending and fraught debate on reproductive technologies necessitates a movement to transcend easy generalizations about the role of the past in current policy discussions, and for increased attempts by scholars, as far as possible, to disentangle the histories of reproductive technologies, like sterilization and abortion, but also less directly linked, though nonetheless demonized tools, like PGD or mitochondrial transfer therapy, from eugenics. The desire to disentangle these histories is in no way exculpatory of eugenics past wrongs, nor understates the role that a critical and sensitive analysis of the history of eugenics could serve in current policy discussions; rather it aims to address the need for greater conceptual clarity about what practices we may, or may not, view as a “eugenic” practice. The need for greater definitional clarity of what exactly eugenics is, and sensitivity to how the ideology of its proponents differed from its practical application, has been shown most sharply by studies of involuntary sterilization. A growing body of work has highlighted that, even at height of its popularity, the eugenic justification for sterilization proffered by Eugenic Boards and medical superintendents across North America could often serve merely as the legal conduit for social, therapeutic, institutional, or contraceptive objectives. Through its excavation of successive institutional policies and practices of sterilization in the key state of California throughout the twentieth century, this thesis has sought to further the argument that eugenics, as an analytical category, fails to adequately explain the history of voluntary, and involuntary sterilization in the state.

The Policy and Practice of Sterilization in California

Just as it is problematic to draw generalizations about the practice of involuntary sterilization nationally, so too no singular period can define the entirety of California's history of sterilization in the twentieth century. Nor, as this thesis has established, can we view the evolution of sterilization policy or practice in California as a linear progression from compulsion to full and free reproductive choice. Instead, this thesis has highlighted a mosaic of successive policies and practices, shaped and mediated by numerous state and sub-state institutions, and the individuals who controlled them.

While eugenic beliefs were certainly at work in founding California's first

11 Diane B. Paul, “Reflections on the Historiography of American Eugenics: Trends, Fractures, Tensions,” *Journal of the History of Biology* 49 (2016): 652.

sterilization policy, embodied by the Asexualization Act, the ideology has been shown to have been less impactful overall than is generally understood. For while the eugenic bent of the law may have grown in successive policy updates in the 1910s, in response to a safer legal climate around such laws, the practice of sterilization in the state institutions did not match this shift. Instead, this study has highlighted the power of individuals—that is, institutional superintendents—in shaping the state's practice of involuntary sterilization. Whether it be for the purported rejuvenating qualities of the operation; its ability to remove the social and psychological pressures of pregnancy; or simply its practical importance in relieving overcrowding on a hospital system at the point of collapse, it has been demonstrated that these individuals, and indeed their staff, performed sterilizations for a wide range of reasons. To be sure, eugenic justifications sometimes sat alongside these alternative factors, but it would be reductive and ultimately historically inaccurate to paint all operations under the Asexualization Act as “eugenic” sterilizations. This institutional focus has also shed new light on the policy transition process. It has been shown that the restructuring of the Asexualization Act, designed to insulate the DMH from legal challenges, served not entirely as a victory for the opponents of eugenic sterilization, but also as a pragmatic and engineered policy change to keep sterilization functioning in the hospital system.

The focus on institutional policy development has yielded further findings about how ideas other than eugenics shaped the policy, and, ultimately, the practice of sterilization in California. Examining the court as an institution of policy development, this thesis has demonstrated how fears of overpopulation exerted significant influence on the development of California's first “voluntary” sterilization policy. The lobbyist from the AVS, another policy development institution, put the idea forcefully before the courtroom that voluntary sterilization should be legalized based on its capacity to remedy what was viewed at the time as a cataclysmic drift towards overpopulation and its effect on swelling welfare rolls. An examination of the institutional records of both the court and the AVS highlights the powerful force exerted by these ideas on policy development—ideas which cannot be separated from the sterilizations at LACMC that followed soon after. Examining how these ideas were translated into sterilization practice, this thesis has demonstrated how both the institution, and the individuals within them, mediated this transition. Given its location, LACMC overwhelmingly served inner city poor and minority women, bringing their breeding habits into sharp focus. From the testimony and reports of doctors’ conduct, we see the same attitudes, albeit more prominently racialized, that featured in policy discussions. With the encouragement of the institutional head, doctors translated

these ideas into sterilization practice, forcing or deceiving women who were seen as contributing to the crises of overpopulation and welfare explosion through irresponsible childbearing into surgery.

Similarly, this focus on institutions has brought into sharp focus new explanations for how and why sterilization policy unfolded as it did in the 1970s, and brought forth an expanded explanation of the role played by the state in sterilization deliberations. Specifically, it has highlighted the triadic relationship between the CDH, the medical lobby, and women activists in the creation of protective sterilization regulations. With the medical profession demanding professional autonomy, and women activists seeking regulatory protections of involuntary sterilization, this dissertation has exposed, in depth, how the CDH struggled to balance these positions in formulating sterilization policy. This has provided fresh insights into the internal dynamics of a government institution struggling with the complexity and rigors of regulating reproductive technologies, and highlights the influence that personal and professional interests, institutional relationships, collective bargaining, and legal conflict all exerted on the schizophrenic course of sterilization policy in the 1970s. Specifically, this dissertation has painted a more nuanced picture of the policy development process and the debates around reproductive freedom in California. For while mainstream feminists spurned state involvement in matters of reproduction, this thesis has shown how women activists broke ranks with this point of view to safeguard the bodily autonomy of vulnerable women. Highlighting the involvement of all of these groups in the policy development process underlines the complexities of regulating reproductive technologies. While eugenics was invoked in these debates, an institutional examination of this period shows that eugenics was neither the sole, nor most relevant, concern.

Finally, the approach taken by this dissertation has shed fresh light on an under-explored era of change in sterilization policy and practice towards the developmentally disabled in the 1970s and 1980s. It has shown that debate around the reproduction of the DD did not disappear with the changes to the Asexualization Act in the 1950s. Indeed, in a novel finding, this thesis has shown how, as late as the 1970s, the Asexualization Act was being used by parents struggling with the pressures of keeping DD dependents at home, following widespread deinstitutionalization, as a loophole for securing contraceptive sterilization. Contrary to established opinion, the repeal of this legislation in 1979 was far more problematic than has been appreciated. The fierce swings in state policy following this decision, from outright prohibition of sterilization, to the renewed efforts to broaden access to the operation for the DD once more, provides insights into legislative attempts to

strike a balance between ease of access and protective regulation in sterilization debates, and the complex decision making process faced by the courts and the government in legislating the substitute consent sterilizations. The actions of individuals and institutions played a central role in the shaping of sterilization policy during this time, particularly the troubled legal campaign launched by Millie and Doug Gedney to have their daughter, Valerie, sterilized upon the notion that it would provide her with greater freedom in life.

This dissertation has helped bring the efforts of the self-advocacy group CPF into focus. Their perspective, as disabled people, on sterilization laws, while critical, has been widely ignored by historians. CPF argued that the disabled had the right and, through education, the capacity to make their own choice in sterilization decisions. Their testimony on questions of competency, educability, and reproductive choice which sat at the heart of this debate, cut through a commentary overly focused on the history of eugenics and the state's past wrongs. Ultimately, the sidelining of their testimony in the formation of sterilization regulations in the 1980s was detrimental to the reproductive autonomy of disabled people in California and cast doubt on whether California's developmentally disabled truly achieved reproductive freedom with the policy changes. The study of numerous cases, both during and after the creation of protective regulations guiding substitute consent sterilization petitions, has demonstrated the willingness of judges to order the sterilization of disabled people without following the standards mandated by the state.

Avenues for Future Study

Nonetheless, much more work remains to be done. It has been established, for instance, that the historians of involuntary sterilization have, through a preoccupation with race and class, neglected the study of disability as an explanatory category for surgeries after the nationwide decline of eugenic sterilization programs around the mid-point of the twentieth century. This has certainly been true in the case of California, where studies of sterilization of the state's disabled population have been linked solely with the operations of the Asexualization Act. Indeed, while this thesis approached the story of sterilization policy development during the 1980s primarily through the story of Valerie Nieto and her parents, as the prime-movers in this process, the other numerous cases cited, like that of Anne-June Espiritu, warrant further investigation in order to excavate the nuances of the practice of sterilization during this period.

But perhaps of greater importance, and also greater complexity, would be a study of sterilization petitions after the “protective” additions to the California probate code

submitted by Johan Klehs. As the inclusion of the case of Angela D. highlighted, the strict standards set by the probate code, agonized over for years before their eventual passage in 1986, failed to ensure proper procedural protections were followed, resulting in Angela's sterilization. Given the expiration of the reporting requirement only three years after the legislation's passage, the California DDS has not tracked sterilization proceedings since the early 1990s. Combined with major shortcomings in the conservatorship process generally to protect the rights of individuals with developmental disabilities in California, there has existed for decades now sufficient conditions for many more rote sterilization petitions like Angela's to pass discreetly through the legal system.

Understanding the failings in the *Angela* case, and potentially others like it, as well as the historical development of the laws under which her sterilization was accomplished, require further investigation to truly assess California's movement away from coercive sterilization policies. Indeed, as the state currently works to decide on a compensation program for those sterilized under the Asexualization Act, a closer eye needs to be cast on the functioning of more recent policies in the state's dealing with this vulnerable population. But the importance of understanding these more modern changes extends beyond California's borders. The Nevada and Washington legislatures, for instance, have recently reopened the question of how the states should handle the sterilization of disabled people.¹² This, too, is a neglected area in sterilization studies that needs attention.

More broadly, closer attention must be paid to the limits of the conceptual framework of eugenics in discussions on involuntary sterilization. As this thesis has shown, an institutional examination of involuntary sterilization draws out a host of different policies and practices that cannot be adequately explained solely by reference to eugenics. While this has been growing in recognition in the historical literature for some time now, further work should be accomplished to disentangle the histories of involuntary sterilization and eugenics. Accordingly, this thesis calls for the wider use of the institutional approach in sterilization studies in order to uncover, where records allow, the idiosyncratic policies and practices in sterilizing states that remain under-explored by historians. This should include novel studies of states like Utah or Delaware that have received scant historical attention, as well as re-examinations of otherwise well-trampled states whose sterilization programs have not, as yet, been studied at an institutional level,

12 April Corbin, "Advocates Seek to Strengthen Laws Regarding Sterilization of Disabled People," *Nevada Current*, last modified August 1, 2018, <https://www.nevadacurrent.com/2018/08/01/advocates-seek-to-strengthen-laws-regarding-sterilization-of-disabled-people/>; Ari Ne'eman, "Washington State May Make It Easier to Sterilize People with Disabilities," *ACLU*, last accessed January 29, 2018, <https://www.aclu.org/blog/disability-rights/integration-and-autonomy-people-disabilities/washington-state-may-make-it>.

and with any eye to policy development, as well as its implementation.

As discussions around the legality of certain reproductive technologies continue to proliferate in the United States, it is increasingly important that historians provide empirical studies that delineate the boundaries of which practices can be painted with the brush of eugenics. It is hoped, just as this thesis has, that further studies can evaluate more critically the intersections of involuntary sterilization with the history of eugenics. For while, as Diane Paul states, the history of eugenics is a “policy-oriented history,” the term “eugenic” currently risks losing all meaning, and being wielded solely as a political tool in policy debates.¹³ Indeed, while the uncritical use of the term “eugenics” has been shown to stifle legitimate discussions on reproductive technologies, this position also dangerously suggests a false illusion of security: that if we can only guard against the past flagrant abuses of eugenics, we can insulate future reproductive practices from similar misuse. Such a position necessitates the presence of “eugenics” as a precondition for abuse. This myopic view of the past, however, allows the less observed factors that historically pushed involuntary sterilization—sexism, racism, fiscal and institutional concerns, etc.—to re-emerge unchecked. Despite having already grappled with its eugenic past, California, as recently as 2013, has already fallen victim to this pitfall, as seen in the sterilizations carried out in women's prisons. As the potential for further abuse remains ever present, the findings in this dissertation, and other empirical studies of sterilization, will play an ever more important role in explaining how, despite our best warnings about eugenics, such events could occur in the future.

13 Paul, “Reflections,” 651.

Appendix I

Key judicial decisions in, and related to, Californian sterilization policy

1927 – *Buck v. Bell*

Buck v. Bell originally arose as a test case in order to subject the 1924 *Virginia Eugenic Sterilization Act* to judicial review. Albert Priddy, superintendent of the Virginia State Colony, selected Carrie Buck to be the defendant. Both Carrie and Carrie's mother were adjudged to be "feeble-minded." Likewise, the seventeen year old Carrie had recently given birth outside of wedlock to a baby also adjudged to "not quite normal."¹ After a Virginia court ruled in favor of her sterilization, the case, as planned, moved up through the legal system, eventually reaching the U.S. Supreme court. Justice Oliver Wendell Holmes Jr ruled that the sterilization was appropriate, famously averring that "three generations of imbeciles is enough."² The affirmative ruling of the nation's highest court effectively legalized compulsory state-run sterilization, and both the number of states enacting sterilization laws, and the number of individuals sterilized in states with existing laws, grew markedly following the ruling.

1939 – *State Dept. of Institutions v. Garcia*

Sole case to challenge the operations of the Asexualization Act. Sara Rosas Garcia attempted to block the sterilization of her daughter, Andrea, at the Pacific Colony. Although the decision to sterilization Andrea was upheld, a blistering dissent was issued by judge J. White which openly attacked the procedural failures of the Asexualization Act.

1942 – *Skinner v. Oklahoma*

U.S. Supreme Court case challenging the sterilization of Jack T. Skinner as ordered under Oklahoma's Habitual Criminal Sterilization Act of 1935. As white-collar crimes were excluded from this act, the justices declared that the statute violated the fourteenth-amendment's Equal Protection Clause, and ruled that Skinner may not be sterilized. The majority decision excoriated the practice of compulsory sterilization. While not overturning *Buck v. Bell*, the decision did all but end the practice of punitive sterilization, and also highlighted legal weaknesses in compulsory sterilization laws more broadly.

1969 – *Jessin v. Shasta*

Worried about the economic hardship the potential conception of a seventh child could bring, Marion Jessin requested that Shasta county hospital physicians perform a tubal ligation on her. Believing that the operation was not medically necessary, and that performing the operation could open them up to legal liability. Judge Richard Abbe authorized Marion's request, arguing that voluntary sterilization operations for the sole purpose of contraception were legal in California, and that they were a legitimate and reimbursable method of family planning.

1974 – *Relf v. Weinberger*

When sisters Minnie Lee, 12, and Mary Alice, 14, were coerced into sterilizations by officials from the Montgomery Community Action Committee, who provided aid to Montgomery's poorest families. The officials tricked the girls' mother, Minnie Relf, who was illiterate, into signing a form that gave physicians permission to sterilize the girls. The

1 Paul A. Lombardo, *Three Generations, No Imbeciles*: Eugenics, the Supreme Court, and Buck v. Bell (Baltimore: John Hopkins University Press, 2010), 117.

2 Ibid, 169.

next day, the girls were sterilized. The case heard in the Washington D.C. District Court was significant in that, for the first time, it highlighted abusive sterilization practices unfolding across the country, when judge Gerhard Gesell acknowledged that between 100,000 to 150,000 women vulnerable women had been sterilized under federal family planning programs without providing informed consent. Gesell prohibited federal funds being used in the sterilizations of mentally or legally incompetent persons, and ordered DHEW to formulate stronger informed consent regulations for sterilization operations funded by federal monies.

1974 – In the Guardianship of Kemp

In the Guardianship of Kemp, Joseph Kemp sought the sterilization of his developmentally disabled daughter Holly. Joseph alleged that pregnancy posed a severe risk to Holly's wellbeing, and that other forms of contraception were contraindicated. The case is important for two reasons. Firstly, the lack of evidence brought by Holly's father in pursuance of Holly's sterilization, and the willingness of the probate court to accept this as sufficient in ordering the procedure highlighted the potential for abuse of such petitions. Secondly, the refusal by the appellate court to allow Holly's sterilization, citing insufficient statutory authority, highlights the legal uncertainty around substitute consent petitions for sterilization in the mid to late 1970s.

1977 – In the Guardianship of Tulley

Similar to Kemp, Tulley saw the father of a developmentally disabled girl, Dianne, petition the court to have his daughter sterilized via hysterectomy. Edwin Tulley, Dianne's father, alleged that Dianne was unable to meet the sanitary needs that arose as a result of her menstrual cycle, and that were Dianne to fall pregnant, immense psychiatric harm could result. The court, again, ruled that they lacked statutory authority to order Dianne's sterilization, but, crucially, noted that the quiescent Asexualization Act provided an avenue to achieve the procedure in lieu of a court order. This case highlighted, again, that until the legislature passed a law allowing sterilization by substitute consent, such petitions were prohibited outside the walls of the state's psychiatric hospital system.

1978 – Madrigal v. Quilligan

Madrigal v. Quilligan was a case brought by ten women who had been coercively sterilized by medical staff at the Los Angeles County Medical Center. The suit charged that between 1971-1974, physicians at the facility, through deceptive tactics like misrepresenting the operation, approaching patients while under the influence of drugs, and providing consent forms in English to patients who only spoke Spanish, tricked the ten plaintiffs into unnecessary and unwanted surgeries. Despite significant evidence of abusive conduct, the judge found no wrongdoing on the part of the physicians, and attributed the grievances of the women to a “clash of cultures” between the Latinx women who prized large families, and the physicians' belief in the value of smaller families.³

1980 – In Re Guardianship of Hayes

Hayes saw a mother, Sharon Hayes, petition the Washington supreme court to have her sixteen year old severely disabled daughter, Edith, sterilized. Both Sharon Hayes and doctors that had examined Edith believed that she was sexually active, and then pregnancy would be immensely damaging to her. The court refused to order Edith's sterilization, as the evidence that the sterilization was in Edith's best interest was unconvincing. The case is important for, while taking strong stand against the sterilization of individuals incapable of providing informed consent, the court stated that there were “rare and unusual circumstances” in which sterilization served in such an individual's best interest. The

3 *Madrigal v. Quilligan*, RTP, June 7-8, 823-825. Box 7, Folder 7, VISP, UCLA-CSRC.

justices then laid out the standards by which these circumstances could be proven.⁴ Importantly, when the Valerie N. case overturned California's statutory ban on the sterilization of individuals incapable of providing informed consent themselves, the court defaulted the standards laid out in *Hayes*, while the legislature formulated new statutory protections.

1981 – *California Medical Association v. Lackner*

Begun in 1978, this case saw the California Medical Association challenge the 1977 sterilization regulations issued by the California Department of Health in response to evidence of involuntary sterilizations occurring in hospitals across California and nationally. The suit was the greatest challenge brought by the medical profession, who viewed informed consent as a form of medical practice, and thus the domain of physicians. The CMA lawyers argued that the CDH had exceeded their regulatory authority to protect the public health, and had instead crossed into regulation medical practice. The judges ultimately found in favor of the CDH, arguing that the regulations were reasonably necessary in light of the evidence of sterilization abuse. However, this did not stop the medical profession's attempts to exert influence on the deliberations surrounding sterilization regulations in the late-1970s.

1985 – *Conservatorship of Valerie N.*

In 1979, Millie and Doug Gedney appeared before the Santa Clara Superior Court, seeking to have their daughter, Valerie, who suffered from a developmental disability, sterilized. Millie and Doug wished for Valerie to lead a more independent life, but were troubled by her very affectionate behavior towards strangers, and feared that, were she to fall pregnant, it could pose significant physical and psychologically health risks. But what started out as a case centered solely on Valerie, transformed into a wider argument on the constitutional right of people with developmental disabilities choose sterilization, when, in 1980, a new law flatly prohibiting all such sterilizations went into effect in California. Reaching the California supreme court in 1985, the majority opinion ruled that the blanket ban on sterilization for those unable to provide consent denied the individuals suffering from developmental disabilities their constitutional right to procreative choice. As a result, legislators set to work to establish strict protections that courts would be required to follow to ensure people suffering from developmental disabilities were not subject to unwanted and necessary sterilization procedures. Importantly, the supreme court did not find enough evidence to order Valerie's sterilization, and after several further appeals, in 1987 Valerie's parents ultimately abandoned their campaign to have Valerie sterilized.

1999 – *In Re Conservatorship of Angela D.*

The case of Angela D. was the first, and only recorded case, heard regarding the sterilization of an individual with developmental disabilities after the California legislature enacted the protective safeguards required as part of the state supreme court's Valerie N. ruling. While these safeguards were supposed to ensure the reproductive rights of the conservatee, in this case Angela, were protected, the *Conservatorship of Angela D.* showed that even the strongest protections can be ignored. The petition for Angela's sterilization originated with her parents, he grew concerned that as Angela would soon be living, she would end up spending more unsupervised time with other males with development disabilities at the local regional center. At the trial, Angela's defense attorney, who was apparently in favor of her sterilization, made no attempt to argue her case. Indeed, due to illness, Angela was not even present at the hearing, which should have been postponed. Despite the glaring failures of due process, Angela's sterilization was affirmed. This case

4 *In Re Hayes*, 93 Wn.2d 230 (1980).

serves as a troubling beacon of the potential for further failures of the enforcement of statutory protections in such cases.

Appendix II

A Timeline of the Development of Informed Consent Standards

1905 – *Mohr v. Williams*

In *Mohr v. Williams*, Mrs. Mohr sued Dr. Williams for battery as a result of him performing an operation on her without her express consent. The *Mohr* case represents the first significant consent case in U.S. History. The judge found Dr. Williams guilty of battery, and in doing so, foregrounded the right of the patient to decide about treatment. It also emphasized the decisional process in providing consent, noting that patients held the right to weigh the potential risks and benefits of an operation, and have sufficient time to evaluate them prior to deciding.

1907 – *Pratt v. Davis*

Similar to the *Mohr* case, *Davis* involved a surgeon performing an unwanted surgery on a patient. Mrs. Parmelia Davis had agreed that Dr Pratt would perform a surgery on her to which she consent. However, while the patient was sedated, Dr Pratt also performed an unwanted hysterectomy her. Dr Pratt admitted that he deliberately misled the patient in performing the procedure, and was found guilty of battery. In refuting Dr Pratt's defense, the court laid out the foundational elements of consent: “Under a free government, at least, the free citizen’s first and greatest right, which underlies all others—the right to the inviolability of his person; in other words, the right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon[...]who has been asked to examine, diagnose, advise, and prescribe[...]to violate, without permission, the bodily integrity of his patient by a major or capital operation, placing him under an anesthetic for that purpose, and operating upon him without his consent or knowledge.”¹

1914 – *Schloendorff v. Society Hospital of New York*

In *Schloendorff*, a patient had agreed to have a fibroid tumor examined while sedated, but informed the physician that she did not want an operation. However, while the plaintiff was sedated, the physician opted to remove the tumor anyway, resulting in the spread of gangrene and, ultimately, requiring the amputation of the patients fingers. Although the patient sued the hospital, rather than the physician, the case remains important to the timeline of informed consent. In it, Justice Cardozo explicitly laid out the patient's right to bodily autonomy: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages. This is true, except in cases of emergency where the patient is unconscious, and where it is necessary to operate before consent can be obtained.”²

1947 – The Nuremberg Code

The Nuremberg Code was a set of ten codified principles that were created in response to revelations at the Nuremberg Doctors' Trial of unethical human experimentation carried out under the National Socialist regime. These principles were designed to act as ethical guidelines for experiments involving human participants. Among the ten points was the

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- 1 William M. McKinney et al., *The American and English Annotated Cases: Containing the Important Cases Selected From the Current American, Canadian and English Reports, Thoroughly Annotated*, Vol. 5 (Northport, NY: Edward Thompson Company, 1907), 305.
 - 2 Ruth R. Faden et al., *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986), 123.

mandate that human participation be voluntary and informed. The code stated that “the voluntary consent of the human subject is absolutely essential”, that participants “have sufficient knowledge and comprehension of the elements of subject matter,” and, finally, “be so situated as to be able to exercise free power of choice.”³ According to the code, consent required four notable features: that it be informed, voluntary, competent, and fully comprehending. These were the first significant standards imposed on the wider medical community by a court system.

1964 – The Declaration of Helsinki

Similar to the Nuremberg Code, the Helsinki Declaration was the formal outlining of ethical principles regarding research involving human participants. Unlike the Nuremberg Code, the Declaration was created by the medical profession themselves rather than by an outside entity.

In matters of consent, the 1964 code separated “clinical research combined with professional care” from non-therapeutic clinical research. In the former, the code stated that “consistent with patient psychology” the doctor should “obtain the patient’s freely given consent after the patient has been given a full explanation.” In contrast, non-therapeutic research could, under no circumstances, “be undertaken without [the patient’s] free consent after he has been informed” of the “nature, the purpose, and risk” of the proposed research.

Importantly, the Helsinki Declaration contained an mechanism for substitute consent, whereby if a participant was “legally incompetent,” the consent of a guardian could be obtained.⁴

1972 – Cobbs v. Grant

Cobbs v. Grant was a malpractice suit brought by Ralph Cobbs against Dr Dudley Grant, who, Cobbs' maintained, failed to adequately inform him of the risks involved in multiple abdominal surgeries he had undergone. Cobbs is key, especially in respect to medical practice in California, as it saw the California Supreme Court declare it “a necessity, and resultant requirement,” that a physician divulge “to his patient of all information relevant to a meaningful decisional process.” The court also recognized that “a person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment.” At a minimum, the *Cobbs* ruling declared that it was a physician's duty to inform the patient of “the potential of death or serious harm, and to explain in lay terms the complications that might possibly occur.” However, above this minimum disclosure, Cobbs also required a physicians to “reveal to his patient such additional information as a skilled practitioner of good standing would provide under similar circumstances.”⁵

1974 – DHEW Interim Sterilization Guidelines

In response to evidence of abuse of informed consent violations in sterilization operations occurring publicly funded hospitals. The guidelines, that arose as a result of judge Gesell's decision in the Relf case, set standards to ensure that patients were supplied with enough information to supply informed consent and were not subject to coercion. Included in the guidelines was an eight point plan to ensure that consent was informed and voluntary. Included in these points was a mandated three day wait period from the signing of a consent form to the surgery, a clear notice that refusal to undergo sterilization would not

3 “The Nuremberg Code,” *British Medical Journal* 313 (1966): 1448.

4 “Declaration of Helsinki, recommendations guiding doctors in clinical research, adopted by the 18th World Medical Assembly, Helsinki, Finland, June 1964,” <https://www.wma.net/wp-content/uploads/2018/07/DoH-Jun1964.pdf>.

5 *Cobbs v. Grant*, 8 Cal.3d 229 (1972).

result in federal benefits being withdrawn, an explanation of the procedure involved, a full explanation of the risks and benefits, mandated counseling on alternative birth control options and a full explanation that sterilization was irreversible.

1974 – National Research Act

Established the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research: a committee tasked with identifying and selecting the fundamental ethical principles that should guide research projects involving human participants, and creating a unified code to guide researchers. These findings were published five years later in the Belmont Report.

1975 – First Revision to the Declaration of Helsinki

The first revision to the Helsinki Declaration expanded the basic principles of the code from five points to twelve. This expansion more explicitly foregrounded the role of informed consent in the provisions: “In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The doctor should then obtain the subject's freely-given informed consent, preferably in writing.” Between 1975 to 2000, only relatively minor changes would be made to the code.⁶

1975 – California Emergency Sterilization Regulations

The California emergency regulations were released after it was discovered that in late-1974, California hospitals were still not in compliance with DHEW sterilization guidelines. The California regulations were virtually identical to DHEW's 1974 guidelines bar the lowering of the age requirement from twenty-one to eighteen per California's state regulations. It was hoped that initiating state oversight of the informed consent process would ensure greater compliance. However, the state regulations, like DHEW's, contained little in the way of effective enforcement mechanisms.

1977 – California Full Sterilization Regulations

After significant debate in public hearings across California, the CDH enacted permanent sterilization regulations that strengthened informed consent requirements for those electing to sterilization using federal or state funds. Building upon the guidelines already established by DHEW, the 1977 regulations promulgated by the CDH extended the waiting period between providing consent and the operation from seventy-two hours to fourteen days. This was a uniform standard established across all CDH licensed facilities in California, and included private patients, as well as those whose sterilizations were funded by federal family planning programs.

1978 – DHEW Final Sterilization Guidelines

In 1978, the long awaited successor to the 1974 interim DHEW guidelines were released. Significantly, the new regulations stipulated that a consent form had to be issued in the patient's primary language, and that the seventy-two hour wait period was replaced with a thirty day mandatory delay between the signing of a consent form and an operation. Likewise, anyone adjudged “mentally incompetent” was not eligible to receive sterilization using DHEW funds. These guidelines, however, still lacked any significant enforcement mechanism beyond the loss of financial participation.

6 “Declaration of Helsinki, recommendations guiding doctors in clinical research, as revised by the 29th World Medical Assembly, Tokyo, Japan, October 1975,” <https://www.wma.net/wp-content/uploads/2018/07/DoH-Oct1975.pdf>.

1979 – The Belmont Report

In 1979, the findings of the National Commission for the Protection of Human Subjections of Biomedical and Behavioral Research were published in the form of the Belmont Report. The report indicated that “while the importance of informed consent is unquestioned, controversy prevails over the nature and possibility of an informed consent.” This shows that despite decades elapsing since the Nuremberg Code first established a framework for informed consent, there was still debate about what it constituted. The report identified three key elements that needed to be present for consent to be informed: information, comprehension and voluntariness. The report expands in great detail on each of these criteria, analyzing understood notions of each in existing informed consent protocols, and where they might be improved.⁷

1981 – California Sterilization Regulations Revised

The publishing of DHEW's sterilization regulations in 1978 led to problems with California's own state guidelines. In order to maintain federal financial participation, California had to meet the standards in DHEW's new guidelines. DHEW's new guidelines prohibited sterilizations of those under twenty-one years old, and also prohibited contraceptive hysterectomies—neither of which were illegal under California law. As California's regulations also covered private patients, this put the state in a difficult legal position. Instead of forgoing significant federal money by staying out of compliance with DHEW, the state developed a two-track system whereby patient's receiving DHEW funds met the 1978 standards, private pay patients continued to follow California's informed consent regulations that emerged in 1977.

1987 – Sections 1950-1969 Added to the California Probate Code

Following the Valerie N. trial and the overturning of probate code section 2356(d) which banned sterilization via substitute consent in California, Johan Klehs submitted a legislative bill designed to provide safeguards for people with developmental disabilities involved in sterilization decisions. Becoming law in 1987, Klehs's legislation required petitioners to prove beyond a reasonable doubt eight clear points. These included evidence that the individual was capable and likely to engage in sexual activity; that all less intrusive methods of birth control had been proven unworkable; and that, in the near future, no advancements were likely to be made either in sterilization procedures or treating the individuals condition. Sections 1950-1969 also required a facilitator be appointed to help the individual communicate in proceedings; that the appointed attorney presume the individual's opposition to the sterilization procedure; and that an automatic appeal be launched whenever a sterilization operation is approved by the court. Perhaps the most important element of Klehs's legislation, however, was the recognition by the legislature that individuals with developmental disabilities have the fundamental right to exercise choice over matters of reproduction.

2000 – Fifth Revision to the Declaration of Helsinki

In the fifth revision to the Declaration of Helsinki, the distinction between therapeutic and non-therapeutic research programs was dropped to emphasize a more general approach to the principles being discussed. Previously, physicians engaging in therapeutic research had leeway in the informed consent process if it affected the patient's “psychology.” The changes in the fifth revision removed this language.

7 National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Washington D.C.: U.S. Government Printing Office, 1978), 10.

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