

**CASE AND COMMENTARY**

**What Should Physicians Consider About American Indian/Alaska Native Women's Reproductive Freedom?**

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**Abstract**

Historically, American Indians and Alaska Natives (AI/AN) have been subjected to a lack of control over various aspects of their lives, including their reproductive health. In discussions of family planning with AI/AN patients, clinicians must consider past violations of reproductive rights and the need for transparent consent. This article explores the following questions: What were historical violations of AI/AN women's reproductive rights? How should physicians express respect for this history and for the autonomy of AI/AN female patients regarding surgical sterilization procedures today?

**Case**

Greg's ob-gyn rotation during medical school was at an Urban Indian Health Program (UIHP) clinic that served American Indian and Alaska Native (AI/AN) patients who lived on a nearby reservation. He had learned little about Indigenous populations throughout his undergraduate and medical education, and he was looking forward to learning more about how to care for different populations. On his first day, he accompanied Dr Smith to meet Ms Davis, an AI patient with bipolar disorder in the 34th week of her sixth pregnancy. Ms Davis had had no prenatal care until she presented to the emergency department with suicidal thoughts the week before. At that time, her drug screen was positive for amphetamines. Prior to entering the exam room, Dr Smith turned to Greg and said, "We need to make sure she has a reliable form of birth control after delivery."

Ms Davis came to her appointment alone. When asked what she wanted to talk about at this visit, she said that she wanted to make sure that her baby was healthy, and she wanted to be a good mother. She revealed that she did not have custody of her other children. Dr Smith stated, "Thank you for coming to clinic today. Along with making sure you and your baby are healthy, I want to ensure you have good birth control after your upcoming delivery. You've had vaginal deliveries and one C-section in the past. If you get a C-section this time, we can tie your tubes then. Or, if you have a vaginal delivery, we can do it shortly after the birth. I think this would be a good option for you." Ms Davis looked surprised but did not respond. She cast her eyes to the floor. Dr Smith continued

to measure her belly and listen to the fetal heartbeat without discussing the topic further.

Greg never saw the patient again, but he ran into Dr Smith in the labor and delivery unit at the local hospital near the UIHP clinic. Dr Smith mentioned to Greg that Ms Davis presented to the hospital 4 weeks later with no prenatal care in the interim and had a precipitous vaginal delivery. She had a bilateral tubal ligation by Dr Smith the next day. Greg wondered how the conversation about consent for the bilateral tubal ligation proceeded and whether it was what the patient wanted, as she seemed so unsure about it during her first prenatal visit.

### Commentary

Coercion or the lack of true informed consent for reproductive surgical procedures, such as tubal ligation and hysterectomy, can lead to forced sterilization. In the case of Ms Davis, the historical forced sterilization of AI/AN women needs to be taken into consideration, as it informs AI/AN women's perceptions of modern health care (including potentially Ms Davis'). To decrease the occurrence of forced sterilization, we not only discuss the history of forced sterilization of AI/AN women but also offer guidance for physicians on appropriate interactions with AI/AN patients when discussing reproductive health.

### A History of Forced Sterilization and Coercion

American Indians/Alaska Natives have been subjected to paternalism since the arrival of European settlers. Colonial contact separated American Indians/Alaska Natives from their land, culture, and children and eroded their self-determination to manage their own affairs as sovereign nations. Forced removal of AI/AN children from their families to boarding schools or foster homes—a practice that began in the 1860s and expanded in the mid-20th century under the US Boarding School Policy and the Latter Day Saints' Indian Student Placement Program—continued until 1978, when the Indian Child Welfare Act was passed—and all of this history remains in the minds of American Indians/Alaska Natives to this day.<sup>1,2,3,4</sup> Historically, AI/AN women have been threatened with removal of their children by social services when seeking and receiving medical services.<sup>4,5</sup> The forced removal of children has continued into contemporary times by physicians taking away AI/AN women's reproductive rights to make decisions over their own family planning.

An inadequate consent process, due to either lack of procedural explanation or absence of consent, leads to coerced or **forced surgical sterilization** (hysterectomy or tubal ligation) and loss of reproductive freedom. All of these violations have been experienced by AI/AN women.<sup>4</sup> Coercion can occur when women feel they do not have a choice when it comes to being surgically sterilized. There have been cases of sterilizations being performed on vulnerable AI/AN women not capable of providing consent. Between 1973 and 1976, 36 AI/AN women who were judged mentally incompetent or who were less than 20 years of age were sterilized.<sup>4</sup> In addition to experiencing coercion, AI/AN women have undergone surgeries for which the physician has not provided surgical explanations or disclosed surgical consequences<sup>4</sup>—as modeled by Dr Smith not discussing the procedure or outcomes in the scenario. In some cases, surgeons have given AI/AN women no information on the medical procedure that they were to undergo and false information on its consequences when they learned of it. It has been reported that in the mid-20th century and within multiple AI/AN communities, it was not infrequent for physicians to perform a discussed procedure, such as appendectomy,

that would include a sterilization procedure that had not been clearly discussed or properly consented.<sup>6,7</sup> When AI/AN women awoke to learn of the incidental tubal ligation or hysterectomy that had been performed, they were often told that it was reversible.<sup>6</sup> Ms Davis undergoing a tubal ligation the day after giving birth evokes remembrance of how other AI/AN women have been coerced into giving consent for sterilization during labor and delivery.<sup>7</sup> Understandably, the physical and mental stress associated with childbirth can compromise a person's decisional capacity, and, in the early 1970s, this vulnerability was often taken advantage of by physicians who would gain consent for sterilization immediately after childbirth, if consent was obtained at all.<sup>8</sup>

In this way, a moratorium on performing sterilizations on those under 21 and **guidelines on informed consent** put in place by the US Department of Health, Education, and Welfare (HEW) in 1973 and 1974 were violated,<sup>4,9</sup> as were court orders, such as a key protective order passed by a US district judge in 1974 that required oral notification to patients that they could refuse surgical sterilization without loss of federal benefits.<sup>6</sup> It is estimated that 25% of AI/AN women of reproductive age were sterilized between 1970 and 1976, with cases going back to 1962.<sup>5,6,10</sup> The number of sterilizations is greatly underestimated, however, as other AI/AN women who had been surgically sterilized might not have reported it due to feelings of shame and fear of losing government benefits, health and nonhealth related.<sup>7</sup> Although the Hippocratic Oath includes doing no harm, many physicians have greatly harmed AI/AN female patients within recent medical history. Reasons cited for medical professionals performing these sterilizations have included accelerated certification for subspecialty practice, disengagement due to placement at Indian Health Service (IHS) hospitals via drafts or owed service, and discrimination.<sup>4,5</sup>

### **Honoring AI/AN Female Reproductive Freedom**

In 2016, the American College of Obstetricians and Gynecologists (ACOG) stated that “Obstetrician-gynecologists are discouraged in the strongest possible terms from the use of duress, manipulation, coercion, physical force, or threats, including threats to involve the courts or child protective services, to motivate women toward a specific clinical decision.<sup>11</sup>” This guidance should be adhered to when consulting with AI/AN patients on their reproductive surgical options. ACOG has stated that, in addition to its being a legal requirement, consenting patients is an ethical process and requirement.<sup>12</sup> Portions of the ACOG consent process include respecting patient autonomy, including patients in their health care decisions, communicating in an effective manner, and identifying a surrogate as needed.<sup>12</sup>

These pieces of the ACOG consent process, seen through an AI/AN lens, would include respecting reproductive freedom by doing the following:

1. Fully informing AI/AN women, such as Ms Davis, of the procedure they are to undergo.
  - a. Offering an interpreter to patients who primarily speaks their Indigenous language since communication is the cornerstone of consent.<sup>10</sup>
  - b. Allowing the patient time to discuss their choice with their family when requested and providing information and materials to the family members the patient identifies.
2. Explaining to patients that they will not be penalized or lose any government benefits if they choose not to have the surgical procedure and assuring them that their reproductive autonomy is safeguarded as part of including patients as

partners in their own decision making and discussing each individual patient's desires for their own family planning.

3. Fully disclosing what female family planning procedures are not reversible and stating in clear and commonly understood terms that, after irreversible procedures (eg, hysterectomy), the patient will not be able to have any children postprocedure. Tubal ligations may be reversible, although various factors affect postreversal pregnancy success.<sup>13,14</sup> It should further be disclosed that access to reversal procedures might not be widely covered even if the individual has access to insurance. (IHS does not cover tubal ligation reversal.)
4. Finally, as the American Medical Association advises on consent for all patient groups, there must be a discussion of the alternatives, including nonsurgical methods, as well as risks, benefits, steps of the procedure, and rationale for the type of surgery to be performed.<sup>12</sup> In addition to proper consenting processes, we advocate for implementing cultural competency training that includes local tribal input on how to successfully interact with AI/AN patients.

AI/AN people live with historical trauma that they have experienced personally or that has been experienced by family and community members. Some of these violations have occurred within the health care system charged with the task of protecting their health and well-being, and it must be remembered that this history is more recent than many physicians realize and that it has a pervasive influence over what AI/AN patients bring to their medical encounters. The topic of reproductive rights is particularly sensitive because of recent forced sterilization practices and should be remembered and respected by physicians when discussing family planning with AI/AN women. Transparency in the consent process is a universal requirement, but there are additional considerations in consenting AI/AN patients, as outlined above, that are critical not only for preventing their being coerced into any surgical procedure but also for promoting informed, shared decision making.

### References

1. Keel J. Call for the United States to acknowledge its role in the US Boarding School Policy and to account for the American Indian and Alaska Native children who did not survive as a result. Presented at: National Congress of American Indians; October 1, 2016; Phoenix, AZ.  
<http://www.ncai.org/resources/resolutions/call-for-the-united-states-to-acknowledge-its-role-in-the-u-s-boarding-school-policy-and-to-account-for-the-american-indian-and-alaska-native-children-who-did-not-survive-as-a-result>. Accessed June 17, 2020.
2. Cordova-Marks FM, Solomon TGA, Garba I, Garcia J, Peaches E. Spotlight on American Indians in Arizona. In: Quintana E, ed. *Arizona Town Hall: Strong Families, Thriving Children: Background Report*. Phoenix, AZ: Morrison Institute for Public Policy, Arizona State University; 2019:151-159.
3. Church of Jesus Christ of Latter-Day Saints. Indian placement: the three most common questions.  
<https://www.churchofjesuschrist.org/study/ensign/1976/07/keeping-pace/indian-placement-the-three-most-common-questions?lang=eng>. Accessed June 17, 2020.
4. Torpy SJ. Native American women and coerced sterilization: on the Trail of Tears in the 1970s. *Am Indian Cult Res J*. 2000;24(2):1-22.
5. Killing our future: sterilization and experiments. *Akwesasne Notes*. 1977;9(1):4-6.

6. Miller M, Miller J, Szechenyi C. Native American peoples on the Trail of Tears once more. *Akwesasne Notes*. 1979;11(2):18.
7. Hart S. *Urban Community Leaders: Ojibwe and Dakota Women, Urbanization, and Community Renewal in the Twin Cities From 1940 to 1969* [master's thesis]. Kearne, NE: University of Nebraska at Kearney; 2016.
8. Witt SH. The brave-hearted women: the struggle at Wounded Knee. *Civ Rights Dig*. 1976;8(4):38-45.
9. Brueggemann CS. *Permanent Solution: Contraceptive Sterilization Policies and Practices in the US From 1960-1979* [master's thesis]. Kansas City, MI: University of Missouri; 2015.
10. Theobald B. A 1970 law led to mass sterilization of Native American women. That history still matters. *Time Magazine*. November 27, 2019. <https://time.com/5737080/native-american-sterilization-history>. Accessed April 29, 2020.
11. Committee on Ethics, American College of Obstetricians and Gynecologists. Committee opinion no. 664: refusal of medically recommended treatment during pregnancy. *Obstet Gynecol*. 2016;127(6):e175-e182.
12. Ogburn T. Shared decision making and informed consent for hysterectomy. *Clin Obstet Gynecol*. 2014;57(1):3-13.
13. Mayo Clinic. Tubal ligation reversal. <https://www.mayoclinic.org/tests-procedures/tubal-ligation-reversal/about/pac-20395158>. Accessed July 2, 2020.
14. Godin PA, Syrios K, Rege G, Demir S, Charitidou E, Wery O. Laparoscopic reversal of tubal sterilization: a retrospective study of over 135 cases. *Front Surg*. 2018;5:79.

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