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HISTORY OF MEDICINE

Federal Sterilization Policy: Unintended Consequences

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On July 19, 1989, a commercial airliner crashed in Sioux City, Iowa. Four "lap" children were on that flight, the youngest of whom was 26 months old. As the plane crashed, two mothers were unable to hold onto their children due to the forces generated by the impact. Both children, including the 26-month-old, perished [1]. Subsequently, the National Transportation Safety Board (NTSB) accident report recommended that the Federal Aviation Administration (FAA) mandate child restraint systems for all children during airline travel. In fact, just two months before the Sioux City crash, the NTSB added mandatory child safety seats to its list of "most wanted" improvements from the FAA.

Despite these recommendations and requests, the debate over the use of mandatory child restraint systems for children during air travel continued, largely due to concern over the possible unintended consequences of such a policy. It has been estimated that universal use of child restraint systems could prevent 0.4 child air crash deaths per year in the United States; however, if due to increased costs, even as few as 5-10 percent of parents were to switch their mode of travel to the roadways, the number of deaths that might result from highway travel would outweigh the benefit gained from mandatory child restraint systems in the air [2]. While there is no question that "lap" children continue to be placed in jeopardy when they fly unrestrained, policy makers should be commended for their unwillingness to institute a policy with such serious possible consequences—in an effort to protect some of the most vulnerable members of society, children would inadvertently be put at increased risk. In November 2006, the NTSB removed mandatory child restraint seats from their wish list.

The discussion of women's reproductive rights and access to care has not seen the same considered debate, and the consequences of sterilization policies are overlooked or ignored, often for decades. In the late 1970s, in an effort to protect women's reproductive rights, federal legislation preventing sterilization of women without their consent was passed. One of the most important features of this legislation is that it applies only to women who receive government assistance for their medical care. The history of the Federal Sterilization Policy is one of unintended consequences, best understood in the historical context of the eugenics movement.

The term eugenics derives from the Greek word *eugenes*, which means "well born" and refers to the promotion of breeding among the most fit of citizens in an attempt to produce the most desirable offspring [3]. There are two types of eugenic

programs: positive and negative. Positive eugenics programs are designed to maximize the spread of desirable genetic traits, while negative eugenics programs work to prevent transmission of undesirable traits.

The eugenics movement in the United States gained ground in the late nineteenth and early twentieth centuries as a result of four independent factors: rediscovery of Gregor Mendel's laws of inheritance, increasing crime rates and other social problems, the rise of unemployment, and increased immigration. In 1907, Indiana became the first state to implement a sterilization policy based on eugenic principles, requiring sterilization of inmates at state institutions who were deemed to be "insane, idiots, imbeciles, feeble-minded, convicted rapists, or habitual criminals" [4].

Virginia's law, passed on March 20, 1924, provided for the "sterilization of mental defectives" to promote the "health of the patient and the welfare of society" [5]. The statute applied to both males and females; men were to be sterilized by vasectomy and women by salpingectomy [6]. The rationale for the statute was twofold: (1) that "defective persons" if sterilized prior to discharge "might become self-supporting with benefit to themselves and to society" and (2) that "heredity plays an important part in the transmission of insanity, imbecility, etc." [7]. Provisions were made for the protection of these individuals, including a formal appeals process.

In 1924, 18-year-old Carrie Buck was committed to the Virginia State Colony for Epileptics and Feeble Minded. Due to her status as a "feeble-minded" woman, daughter of a "feeble-minded mother in the same institution, and the mother of an illegitimate feeble-minded child," the superintendent of the State Colony petitioned for her sterilization by salpingectomy [8]. She appealed the decision, and the case reached the United States Supreme Court. In an opinion penned by one of the most learned legal scholars of the twentieth century, Oliver Wendell Holmes Jr., the Court found,

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind [9].

In sum, the Court concluded, "three generations of imbeciles are enough" [9]. Carrie Buck was subsequently sterilized on October 19, 1927 [10]. Of course, many interesting facts were omitted from Carrie Buck's appeal. Her foster parents committed Carrie to the Colony after she gave birth to an illegitimate daughter. Furthermore, Carrie's daughter, Vivian, was not the product of her mother's promiscuity nor was she feeble-minded [11]. Rather, Vivian was born following the rape of her mother by the nephew of her foster parents. Unfortunately, Vivian died at

a young age, but prior to her death, she was a solid "B" student in the first grade. Even more disturbing is the fact that the Supreme Court's decision in *Buck v. Bell* is still on the books; the decision has never been challenged or overturned.

Once the Virginia law was upheld by the Supreme Court, involuntary sterilization movements in the United States continued to grow. By 1931, 30 states had eugenic laws, laws that would target and systematically discriminate against some of the most vulnerable members of society. It was not until the 1940s that eugenics came under close scrutiny for its lack of scientific basis and its disproportionate effects on the poorest and most disenfranchised citizens. By the 1950s, most states had abandoned involuntary sterilization programs. Despite this, it would be another 2 decades before the federal government issued its own protections in an attempt to prevent sterilization of incompetent persons.

Regulations governing sterilization under federally funded programs went into effect on March 8, 1979, eliciting a great deal of controversy; proponents favored protection of vulnerable persons otherwise destined to undergo involuntary sterilization, while detractors believed that the policy interfered with use of sterilization for population control. Sterilization was a popular method of birth control in the United States in the 1970s, second only to oral contraceptive pills [12]. By 1976, 30 percent of all women in the United States between the ages of 15 and 44 were surgically sterilized [13]; estimates by the Association for Voluntary Sterilization state that approximately 10 million men and women had undergone sterilization procedures in the United States by 1977 [13].

The 1979 federal sterilization regulations provide a number of protections for individuals covered by federally funded programs who desire sterilization, including a standardized consent form with an attestation that the individual appeared mentally competent and knowingly and voluntarily consented to the procedure [14]. Furthermore, official documentation must be signed at least 30 days but not more than 180 days before the procedure [15]. If an individual who desires sterilization undergoes premature delivery or an emergency abdominal surgery within 30 days, at least 72 hours must have elapsed between the time the consent was signed and the time the procedure is performed [15]. In addition, an emergency abdominal surgery must be described or, in the case of a premature delivery, the expected estimated date of delivery must be noted.

The desired result of the federal sterilization policy was to prevent sterilization of mentally incompetent individuals or of women who do not voluntarily consent to sterilization; the policy would protect an individual's autonomy by ensuring (1) that the individual was competent and (2) that informed consent for the procedure was obtained. However, there have been other consequences of that policy for women who receive federal financial assistance for their health care. For example, such a woman cannot have a tubal sterilization performed if she fails to sign the consent form at least 30 days prior to her procedure or if she inadvertently leaves her papers at home.

A woman covered by private insurance or one who pays out of pocket can present to the hospital, deliver her child, and have a sterilization procedure performed without any prior preparation or any negative financial repercussions to the physician or hospital. Whether the delivering physician would choose to perform a sterilization procedure for a woman without previous discussion is a separate question, particularly considering the risk of regret among those undergoing permanent sterilization.

Conversely, if a woman of limited resources, whose care is supported in whole or part by federal financial assistance, presents to labor and delivery and requests a sterilization procedure, she will be, in effect, denied access to that procedure if she has not signed federal sterilization papers at least 30 days prior to delivery. In fact, even women who have had consistent prenatal care and discussed the desire for sterilization with their clinicians will be unable to undergo a sterilization procedure without the appropriate documentation, even if the clinician failed to alert them to the regulations. While not physically prevented from performing the procedure for the woman, physicians face a significant financial disincentive—lack of reimbursement—for performing the sterilization without proper documentation.

A 2008 study published in *Contraception* reported that 4 of the 34 women who did not receive desired postpartum sterilization were denied the procedure because they lacked a valid Medicaid consent form [16]. The study was performed on the west side of Chicago in a university-based hospital serving a low-income population. In one case, a woman left her signed Medicaid papers at home because she mistakenly believed they would be on file at the hospital. Another woman, who attempted use of a reversible contraceptive after she was unable to have her tubal ligation due to lack of a valid standardized consent form, became pregnant and summed up her experience with the following statement: "Actually, I think I should have had it done because um it just that since then I have gotten pregnant again and I think that if I had had the tubal ligation done, I would never have gotten pregnant again…I had an abortion" [17]. In fact, all four women who were unable to have their sterilization procedure due to lack of signed Medicaid papers expressed anxiety regarding prevention of future pregnancy.

Thus, the unintended consequence of the federal sterilization policy is to treat women who are the most financially vulnerable quite differently from women of means. The irony here is that the women who may most need a sterilization procedure, due to the financial inability to provide for more children and the lack of access to routine medical care, are the least able to obtain it. As a result, rather than protecting women's autonomy, the federal sterilization policy may in fact prevent a physician from carrying out a woman's value-based decision to undergo permanent sterilization. Not only is a woman's autonomy not respected in this scenario, but if she goes on to have an unintended pregnancy, there is an additional violation of the principle of nonmaleficence insofar as the physician could have prevented harm to the patient. Unquestionably, the federal policy was intended to protect women from

the abuses of the past. Regrettably, the very attempt to protect this vulnerable group has resulted in a frequently insurmountable obstacle and a reduction in reproductive freedom for these women. An unfortunate consequence, indeed.

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