# CHICANAS AND THE ISSUE OF INVOLUNTARY STERILIZATION: REFORMS NEEDED TO PROTECT INFORMED CONSENT

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The purpose of this article is to inform the public and its government representatives about practices which have caused the involuntary sterilization of Chicanas. These unauthorized medical practices have occurred within the area presently governed by laws which sanction voluntary sterilization. The right to procure a voluntary sterilization is not challenged, but the duty to provide an opportunity to render informed consent is in need of more stringent guarantees. In too many instances women have been coerced into undergoing sterilization surgery without their informed consent.

Most of the areas to be reviewed involve women who are poor, usually on welfare, and of a racial minority. With respect to Chicanas an additional element, lack of English fluency, deserves considerable attention. Furthermore, any concrete form of analysis cannot ignore the fact that women eligible for welfare not only must contend with the doctor-patient relationship, but also with government participation. At present, the federal and state governments provide substantial assistance to hospitals and women unable to afford medical care on their own. Consequently, doctors and hospitals which receive government subsidies to perform sterilization surgery, but violate a patient's right to informed consent, not only violate existing government regulations but raise the issue of inadequate government enforcement.

A thorough examination of this topic would not be complete without some understanding of the attitudes which cause unwanted sterilizations. Special focus will be directed toward the ethical beliefs held by many medical practitioners, and the transference of these beliefs into nationwide practice. The interrelationship between government and the medical profession also requires some mention of the Supreme Court decision in *Buck v. Bell.*[1] A state

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1. 274 U.S. 200 (1926). A Virginia statute which authorized the involuntary sterilization of an institutionally committed woman was upheld, because both the woman's mother and illegitimate child were mentally incompetent.

policy which required that a woman institutionalized in a mental facility be sterilized prior to her release was upheld. So long as the state's procedures satisfied due process standards, the inability of the woman to render an informed consent did not bar the involuntary condition.

Chief Justice Holmes sanctioned the government's right to exact this condition as the price for freedom in the following terms:

> 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. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.[2]

Such an unequivocal endorsement of the government's right to forcefully deprive an individual of the decision to procreate lessens personal freedom. The *Buck* decision's broad language provided a license for public officials to subject individuals considered "manifestly unfit from continuing their kind." By 1966, for example, twenty-six states had eugenic sterilization laws: twenty-three of these were compulsory.[3] These statutes applied to mentally retarded persons but a dozen extended to certain criminals as well.[4] When compared with similar attitudes held by many doctors, the social implications posed by the tangible existence of the Holmesian philosophy raises the real threat of a professional and governmental denial of a protected right.

To emphasize the gravity of coerced sterilization, the problems which confront Chicana hospital patients will be considered first.

## I. PROBLEMS CONFRONTING CHICANA PATIENTS

A condensed clinical explanation of the tragic circumstances forced upon Chicanas must yield to a graphic narrative of personal harm. The personal experiences attested to by twelve Chicanas in a recent suit, *Madrigal v. Quilligan*,[5] brought against the U.S.C.-Los

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2. *Id.* at 207.

3. Ferster, *Eliminating the Unfit: Is Sterilization the Answer?*, 27 OHIO ST. L.J. 591 (1966).

4. *Id.* California, for example, once authorized the sterilization of those adjudged guilty of carnal abuse of a female person under the age of ten years (1923). But by 1976, this could only be accomplished with the informed consent of the prisoner, and could not be made a term or condition of probation or parole. CAL. PENAL CODE § 645. As of 1974, CAL. PENAL CODE § 2670 was amended to prohibit the punitive sterilization of recidivist prisoners for the crimes of rape, assault with intent to commit rape, or seduction, or who exhibit evidence of moral or sexual depravity.

5. Brief for Plaintiffs, Madrigal v. Quilligan, No. 75-2057 (C.D. Cal., filed June 18, 1975) (hereinafter referred to as *Madrigal*). Joined as defendants were the Director of Obstetrics, U.S.C.-Los Angeles County Medical Center (hereinaf-

Angeles County Medical Center (hereinafter referred to as the Medical Center), relate the abuses perpetrated against them. All of them alleged that they were unduly pressured into accepting an operation to be sterilized.

Dolores Madrigal,[6] on or about October 12, 1973, was admitted to the Medical Center for the delivery of her second child. Even though she had dismissed the suggestions of a staff doctor and nurse that she submit to a sterilization, she was presented with sterilization consent forms while in labor and told to sign them. Under the severe pain of labor, and after being assured that the operation could be easily reversed, she signed these forms and was sterilized. The forms signed by Mrs. Madrigal were printed in English. Her primary language was Spanish, which made it impossible for her to determine the content of the forms. Only after the sterilization operation was completed was she informed that it was effectively irreversible.

Maria Hurtado[7] appeared at the Medical Center for a routine medical checkup on or about December 6, 1972. The doctors who examined her determined that her baby should be delivered by caesarean section. She was anesthesized with a spinal injection for the delivery of her child. After the delivery of the child, she was given general anesthesia. While under this unconscious state, she was surgically sterilized by a staff doctor without her consent. She was not informed about the sterilization until six weeks later when she appeared for a routine checkup. She spoke only Spanish and did not recall signing a form authorizing the operation.

On or about September 13, 1973, Jovita Rivera[8] went to the Medical Center for the delivery of her baby. She was given general anesthesia in preparation for a delivery by caesarean section. While groggy and incoherent she was approached by a staff doctor who told her that she should have her "tubes tied," because her children were a burden on the government. She was never made aware of the definition for "tying tubes," but signed the consent forms. She received no counseling or advice from her doctor or other staff members to inform her of the operation's consequences. She did not learn until some time later that the operation was effectively irreversible. Mrs. Rivera spoke and read

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ter referred to as the Medical Center); Dr. John Doe, physician on the staff of the Medical Center; Jerry Bosworth, Executive Director of the Medical Center; Mario Obledo, Secretary of the Health and Welfare Agency of California; Jerome Lackner, Director of the Department of Health of California; and Caspar Weinberger, Secretary of the United States Department of Health, Education and Welfare.

6. *Id.* Affidavit by Dolores Madrigal, June 18, 1975.
7. *Id.* Affidavit by Maria Hurtado, June 18, 1975.
8. *Id.* Affidavit by Jovita Rivera, April 29, 1975.

only Spanish, and could not read or understand the consent form given to her to sign even if she had been lucid.

As an expectant mother at the Medical Center, and while in labor, Maria Figueroa[9] was approached by a staff doctor who prompted her to undergo a sterilization operation by tubal ligation.[10] He falsely told her that the operation involved "tying," not cutting, her "tubes." She refused the operation, but was solicited again by the same doctor during her stay in the delivery room, and after general anesthesia had been administered to her. As the moment of birth neared, she reluctantly agreed to a tubal ligation, but only if the baby to be delivered was a boy. A baby girl was born to her in June, 1971; nevertheless, she was sterilized. At no time did she consent to the surgery or sign any forms indicating consent.

During the month preceding the delivery of her son, Helena Orozco[11] was repeatedly solicited by Medical Center doctors and staff members to undergo sterilization surgery. She refused these invitations, and stated her preference for birth control pills as the means to achieve family planning. At no time during these solicitations was she ever counseled regarding the irreversibility of tubal ligation. On or about July 11, 1972, she was admitted to the Medical Center for the delivery of her baby. As she experienced regular contractions, which substantially weakened her, Mrs. Orozco was informed by a Medical Center staff member that her "tubes" were to be "tied," and that she sign a consent form. Under these circumstances, she signed the consent form and was sterilized.

In August, 1973, Guadalupe Acosta[12] was admitted to the Medical Center after having suffered labor pains throughout the day. The attending physician in the delivery room pushed violently upon her abdomen in order to induce delivery. Delirious with pain, she flailed at the doctor who responded by punching her in the stomach. Her child was later born dead. It was during the performance of the delivery that the attending physician unilaterally decided to sterilize Mrs. Acosta. She did not learn of her

9. *Id.* Affidavit by Maria Figueroa, June 18, 1975.

10. Tubal ligation is defined by three procedures: (1) *Postpartum* (within 24 hours after delivery). The Fallopian tubes are severed. (2) *Elective* (not with delivery). The Fallopian tubes are cut and tied by entering the abdominal cavity through the vaginal wall. (3) *Transabdominal Laparoscopy or Laparoscopic Tubal Ligation.* The surgeon makes a small hole into the abdomen and through this fills it with about three to four liters (about a gallon) of a gas (carbon dioxide). He then puts in a metal cylinder through which he can visualize the Fallopian tubes and the other abdominal organs. Through this metal cylinder he can first cauterize (burn) and then cut the tubes, one at a time. *Id.* Affadavit by Dr. Bernard Rosenfeld, June 18, 1975.

11. *Id.*

12. *Id.* Affidavit by Guadalupe Acosta, June 18, 1975.

sterilization until more than two months later when she returned to the Medical Center to request birth control pills. The sterilization surgery was never formally requested. She was later hospitalized in October, 1973, for a hemorrhage attributable to the tubal ligation.

Spanish was the primary language of Georgina Hernandez[13] when she was admitted to the Medical Center on April 6, 1972. She was prepared for childbirth and taken to the area of the maternity ward commonly referred to as the labor room. A doctor informed her that her child would be delivered by caesarean section because it would be too dangerous to deliver naturally. She signed a consent form which was written in English for what she believed to be her permission for the caesarean surgery. At 1:00 a.m., on April 7, as she painfully tried to rest in the labor room, two doctors asked her if she wanted to have her tubes tied. After being informed that the operation would result in permanent sterilization, she refused to consent. The doctors persisted in attempting to obtain her consent by emphasizing that her Mexican birth and poverty would make the proper care and education of any additional children unlikely. Four hours later she was anesthetized and taken to the delivery room where she gave birth to a son. When she returned to the Medical Center on April 26, she was informed for the first time that a tubal ligation had been performed on her.

Consuelo Hermosillo[14] was taken to the Medical Center's labor room during the evening of September 1, 1973. Her doctor determined that the baby would have to be delivered by caesarean section. He falsely advised her that a sterilization operation would be necessary, because her third caesarean section delivery made the eventuality of a fourth pregnancy hazardous to her life. Groggy and weak from medication, Mrs. Hermosillo signed the consent forms handed to her without comprehending their content. As a result, she was sterilized.

The fear of death from pregnancy, falsely instilled in Estela Benavides[15] by her attending physician, compelled her to consent to a sterilization by tubal ligation. She had gone to the Medical Center on March 7, 1974, for the scheduled birth of her baby by caesarean section.

Rebecca Figueroa[16] had carefully planned for the birth of her child. A devout Roman Catholic, she had already paid for pre-

13. *Id.* Affidavit by Georgina Hernandez, June 15, 1975.
14. *Id.* Affidavit by Consuelo Hermosillo, June 18, 1975.
15. *Id.* Affidavit by Estela Benavides, June 18, 1975.
16. *Id.* Affidavit by Rebecca Figueroa, June 18, 1975.

natal care and the delivery of her baby at Santa Marta Hospital. But on October 18, 1971, at about 2:00 a.m., she woke up and discovered that she was bleeding profusely. Her husband immediately took her to the Catholic hospital. Upon her arrival and examination, the Santa Marta staff decided that they did not have the necessary equipment to care for Mrs. Figueroa. She was taken by ambulance to the Medical Center, where she was again examined and injected with medication. A member of the staff had her call her husband, to inform him that she could not have any more babies and that her "tubes were going to be tied." A nurse intervened throughout the entire telephone conversation. When she finally asked her husband about what the nurse had said, he told her that the nurse had communicated the wife's decision to be sterilized. Mrs. Figueroa informed her husband that she did not want the surgery, but if the child was born healthy, then she would consent. The nurse again intervened in the conversation, informing Mr. Figueroa of his wife's agreement, and then told the patient to sign a form. The form was written in English, a language foreign to the patient. She signed the form at a time when she was under sedation. After the operation was completed her husband also signed the form. As a result, Mrs. Figueroa not only lost the opportunity to procreate, but suffers from severe nervous seizures.

On August 18, 1973, Laura Dominguez[17] was admitted to the Medical Center for the delivery of her third child. As she began her labor several nurses attempted to convince her to accept sterilization surgery. The nurses accused the patient of "burdening the taxpayers" with her children. She consented to the surgery under the physical pain induced by labor, and the psychological promptings of the nurses. A uterine infection spared Laura Dominguez from the irreversible damage. As she recuperated from the infection and pregnancy, the opportunity to resist the coerced sterilization was seized. The attending physician supported her decision, but he no longer practices at the Medical Center. Mrs. Dominguez has since remarried and has had one child by her new husband.

During her pre-natal care at the Medical Center in April, 1974, Blanca Duran,[18] a Medi-Cal recipient, was solicited by a nurse at the Family Planning Clinic for sterilization surgery. Not being able to read or speak English, she made a "good faith" verbal agreement with the nurse. She agreed to sign the sterilization consent form, but accept an actual sterilization only upon the condition that she give birth to a boy. On May 16, 1974, her

17. *Id.* Affidavit by Laura Dominguez, June 18, 1975.
18. *Id.* Affidavit by Blanca Duran, June 30, 1975.

attending physician made sure that she understood the consent form. At that point she informed the doctor about the verbal agreement with the nurse. When she gave birth to her fifth daughter no attempt was made to subject her to a tubal ligation.

In all of the cases just reviewed there existed a number of common conditions. All of the victims and near victims belonged to a racial minority, were poor, and could not readily understand the English language. Most were approached for sterilization surgery while under the duress of labor, drugged, and confined. All of them entered the Medical Center without any intent of becoming sterilized, and all were persistently solicited for the operation. Many of the women encountered doctors and nurses who were openly hostile to them because of their ethnicity or poverty status. The solicitors did not satisfactorily inform the patients of the consequences attendant to such surgery. Because of their low-income status all of the Chicanas were eligible for public medical assistance, but none were on welfare.

What these allegations point out is the existence, at one of our major hospitals, of an unbridled discretion which permits medical personnel to coerce expectant Chicana mothers to accept sterilization. Furthermore, the Medical Center is the recipient of state and federal funds for use in providing sterilization surgery to low-income persons pursuant to federal statute.[19] It was under this professional-governmental relationship, therefore, that these unwanted operations took place.

Of special importance, then, is an analysis of the existing regulations which govern procedures for sterilization.

## II. Regulations Governing Sterilization Procedures

### A. *Controlling Federal Regulations*

On May 18, 1971, the United States Department of Health, Education and Welfare (hereinafter referred to as HEW) began to include sterilization as part of its health program. HEW's family planning projects are funded by its Public Health Service[20] and its Social and Rehabilitation Service.[21] The Public Health Service manages the allocation of federal funds to state health agencies and to public and private programs for the provision of family planning services to the poor.[22] The Medicaid and Aid to Families with Dependent Children programs are funded through the Social and

19. §§ 703(a)(3), 602(a)(19), 139(d)(a)(4)(c), 42 U.S.C. §§ 300 *et seq.*
20. Public Health Service Act, §§ 310, 314(d,e), 42 U.S.C.A. §§ 242(h), 246 (d,e).
21. 39 Fed. Reg. 4730-34 (1974).
22. § 708(a), 42 U.S.C. §§ 300 *et seq.*

Rehabilitation Service.[23] To support the "full range of family planning services," except abortion, was the intent of Congress,[24] and regulations were to be issued by the Secretary of HEW.[25]

Prior to February 6, 1974, federal funds were directed to family planning facilities without the benefit of comprehensive regulations. Interim regulations were then issued to guide the recipient agencies of federal family planning funds.[26] The purpose of these interim guidelines was to safeguard the right of legally competent adults to "informed consent" in obtaining sterilization surgery.[27] This would be accomplished, according to the intent of HEW, by requiring a written and signed document indicating, *inter alia*, that any applicant for sterilization surgery be aware of the benefits and costs involved, and the guaranteed option to withdraw from the surgery without suffering any loss of federal benefits.[28]

The interim regulations included a provision to protect legally competent persons under the age of 18. To ensure the most careful review of these cases, a special *Review Committee of independent persons from the community* must certify that the requested operation is in the best interests of the minor.[29] The Committee must consider two general concerns: (1) the expected mental and physical effects of pregnancy and motherhood on the female applicant, or the anticipated psychological impact of fatherhood on the male applicant; and (2) the expected immediate and protracted mental and physical consequences of sterilization on the person.[30]

More specifically, the Committee was charged with (1) reviewing the minor's medical, social and psychological background, alternative family planning methods, and the adequacy of consent; and (2) interviewing the applicant, both parents of the minor (if available), and all other individuals which could shed light on the appropriateness of the surgery.[31] Parents were required to be consulted, *but parental consent was not required.*[32]

The exclusion of the parental consent requirement, however, was offset in respect to legally incompetent minors. Not only

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23. §§ 1396 *et seq.*, 42 U.S.C. §§ 601 *et seq.* Aid to Families with Dependent Children, 42 U.S.C. §§ 601-610; Medicare and Medicaid, 42 U.S.C. § 602(a)(14).
24. H.R. Rep. No. 91-1472, 91st Cong., 2d Sess. 10 (1970), U.S. Code Cong. & Admin. News 1970, at 5068. 42 U.S.C. § 300(a)(6).
25. 42 U.S.C. § 216.
26. 38 Fed. Reg. 4730-34 (1974).
27. 42 C.F.R. § 50.202(f). 45 C.F.R. § 205.35(a)(2)(ii).
28. 42 C.F.R. § 50.202(f). 45 C.F.R. § 205.35(a)(e)(ii).
29. 42 C.F.R. § 50.206(a). 45 C.FR. § 205.35(a)(4)(i).
30. 42 C.F.R. § 50.206(a). 45 C.F.R. § 205.35(a)(4)(i).
31. 42 C.F.R. § 50.206(b)(1,2). 45 C.F.R. § 205.35(a)(4)(i)(A,B).
32. 42 C.F.R. § 50.203(c). 45 C.F.R. § 205.35(a)(5)(ii).

would they be provided with the aforementioned safeguards, but a state court of competent jurisdiction would have to rule on the propriety of sterilization in each case.[33] However, *personal consent was not made mandatory*.[34] A request for sterilization by the minor's "representative" was deemed as sufficient evidence of consent.[35] HEW's interpretation of the term "representative," as including any person empowered under state law to consent to an incompetent minor's sterilization, finds no explicit support in the regulations.[36] It is within the Committee's delegated authority, therefore, to arrange for the required court determination.[37]

Each Committee was also charged to maintain records[38] of its determinations, including a summary of the reasons therefor, and all relevant documentation. This information would become part of the patient's permanent record. All such files were made subject to inspection by the Secretary or his designated representative, to measure compliance with the regulations.

The crucial language focused on the "voluntariness" of each applicant:

> The acceptance by any individual of family planning services . . . provided, through financial assistance under this title (whether by grant or contract) *shall be voluntary* and shall not be a prerequisite to eligibility for a receipt of any other services or assistance from, or to participation in, any other program of the entity or individual that provided such service or information.[39]

In compliance with this requirement, and in response to various court suits, Frank Carlucci, Acting Secretary of HEW, announced that the Department's preexisting moratorium,[40] enjoining the allocation of federal money for any sterilization to be "performed on an individual who is under the age of 21, or who is himself legally incapable of consenting to the sterilization," would continue.[41] This federal moratorium was again extended on April 16, 1974.[42]

As of April 18, 1974, HEW required that all family planning programs under its revised Sterilization Restriction regulations had to document informed consent. This would be effected by having each applicant sign a consent document, or acknowledge that oral

33. 42 C.F.R. § 50.203(c). 45 C.F.R. § 205.35(a)(1)(iv)(A,B).
34. 42 C.F.R. § 50.203(a). 45 C.F.R. § 205.235(a)(1).
35. 45 C.F.R. § 50.203(a). 45 C.F.R. § 205.235(a)(1).
36. 45 C.F.R. § 50 *et seq.*
37. 45 C.F.R. § 50.203(c). 45 C.F.R. § 205.35(a)(1)(iv)(A,B).
38. 45 C.F.R. § 50 *et seq.*
39. 42 U.S.C. § 300a-5. 42 U.S.C. §§ 602(a)(15), 708(a).
40. 38 Fed. Reg. 20930-20931 (Aug. 3, 1973).
41. 39 Fed. Reg. 10431-10432 (Mar. 20, 1974).
42. 39 Fed. Reg. 13873 (Apr. 18, 1974).

counseling was provided. Furthermore, each written consent document had to prominently display the following legend:

> Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects.[43]

Every applicant electing to be sterilized, therefore, was given the right to a fair explanation of the medical procedures, a description of the attendant discomforts, risks, and benefits to be expected, information covering the available alternative family planning methods, *and the affirmation that such surgery is irreversible.*[44] All applicants were also entitled to have any inquiry about the medical procedures answered, and withhold or withdraw voluntary consent at any time prior to the surgery without incurring any loss of future care or program benefits.[45]

The revised regulations mandated each federally assisted family planning program "not to perform nor arrange for the performance of a *nontherapeutic sterilization*[46] sooner than 72 hours following the giving of informed consent."[47] To assure compliance with the revisions, HEW ordered each family planning program to supplement the existing reporting procedure:

> In addition to such other reports specifically required by the Secretary, the State agency shall report to the Secretary at least annually, the number and nature of the sterilizations subject to the procedures set forth in this section, and such other relevant information regarding such procedures as the Secretary may request.[48]

### B. *Applicable California Regulations*

California's applicable regulations are examined here in light of the harm suffered by Chicanas at the Medical Center, and also because its population of Chicanas is the highest in the nation. The jurisdictional basis for standing provided in the statutory scheme follows.

The Administrative Procedure Act provides that "any interested person may petition a state agency requesting the adoption

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43. 39 Fed. Reg. 13873.
44. *Id.*
45. *Id.*
46. 22 Cal. Adm. Code § 1266.1(e) defines *Nontherapeutic sterilization* as any treatment, procedure, or operation, the primary purpose of which is to render an individual permanently incapable of producing offspring, and which is neither: (a) a necessary part of the treatment for an existing illness or injury, or (b) medically and surgically indicated as an accompaniment of a surgical procedure on the genito-urinary or reproducing organs. (Mental or emotional incapacity is not considered an illness or injury).
47. 39 Fed. Reg. 13873, 13887.
48. 39 Fed. Reg. 13873, 13888.

. . . of a regulation as provided" in the Government Code.[49] Jurisdiction may also be invoked under the Health and Safety Code[50] and the Welfare and Institutions Code.[51] Under these code sections, the Department of Health is obligated to carefully license and regulate all health care facilities in the state. Specifically, Health and Safety Code, section 1276, provides that "regulations shall prescribe standards of . . . services based on the type of health facility and the needs of the persons served thereby."

On March 13, 1975, the Administrative Code was revised in respect to the regulations governing sterilization.[52] The purpose of these revisions was to conform state procedures with those enacted by the federal government. As a result, the requirements for nonemergency therapeutic[53] and nontherapeutic sterilizations were augmented. The new regulations substantially emulated the federal regulations. Each applicant must voluntarily request the surgery,[54] no person can be penalized for a refusal of the operation,[55] legally informed consent must be obtained from each applicant,[56] and no such surgery can be performed sooner than 72 hours after informed consent is given.[57] California makes two exceptions to this 72 hour limit. This occurs when the sterilization surgery is in response to an emergency medical condition,[58] or, to a life threatening disease.[59]

The regulations further provide that the attending physician

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49. CAL. GOV'T CODE §§ 11426 *et seq.*

50. §§ 1250-1276, 429.50, 429.64, 429.66, 1100-1111, 1177, 1178, CAL. HEALTH AND SAFETY CODE §§ 1100 *et seq.* Sections 1250 *et seq.*, require that the Department of Health approve an application and issue a license to those who wish to operate health care facilities. Under the authority of section 1276, the Department must establish by regulation the requirements to be fulfilled by any licensed health facilities.

Sections 1100 *et. seq.*, authorizes the Department of Health to provide financial aid to assist local public health agencies in providing "effective public health services to all the people of the state." Section 1111 charges the Department of Health to adopt rules and regulations necessary to ensure that the aforementioned directive be complied with.

The Director of the Department of Health, under section 1177, is empowered to make loans and provide technical assistance to Health Maintenance Organizations. The services provided by such organizations must be delivered, according to standards set by the Department of Health, pursuant to section 1178.

51. CAL. WELFARE AND INSTITUTIONS CODE §§ 14132, 14124. Section 14132 provides for Medi-Cal coverage of family planning services. Reasonable rules and regulations must be established by the Department, under section 14124.5, to protect any recipient of family planning services under the Medi-Cal program.

52. 22 Cal. Adm. § 1266.1(e).

53. *Therapeutic sterilization*, as defined under 22 Cal. Adm. § 1266.1(e), is any treatment, procedure, or operation, the primary purpose of which is to correct or treat a medically recognized abnormal condition, or disease, but which also secondarily results in a permanent inability to reproduce offspring.

54. 22 Cal. Adm. § 1266.1(e)(1)(A).

55. 22 Cal. Adm. § 1266.1(e)(1)(B).

56. 22 Cal. Adm. § 1266.1(e)(1)(C).

57. 22 Cal. Adm. § 1266.1(e)(1)(D).

58. 22 Cal. Adm. § 1266.1(e)(1)(D)(1).

59. 22 Cal. Adm. § 1266.1(e)(1)(D)(2).

sign a form[60] attached to the surgical request document[61] for nonemergency therapeutic and nontherapeutic sterilization procedures. In addition, telephone authorization shall not be accepted.[62] It is with reference to "legally effective informed consent," however, where the state regulations differ most from the federal scheme.

One major difference applies to the age level of legal competence to give informed consent. Whereas federal law sets this limit at age 21, California permits 18 year olds to make a unilateral decision.[63] Federal law did provide the same opportunity for persons under the age of 18 prior to the moratorium, but only after a rigorous review procedure was applied.[64] Since April, 1974, the federal government has discontinued its funding of any sterilization performed on individuals under age 21.[65]

The state expands the required description of the medical procedure by requiring the following: (1) an explanation of the surgical techniques, (2) a description of the anesthesia to be used, (3) the approximate duration of hospitalization and expected recuperation, and (4) the consequences of the operation.[66] The latter description includes the disclosure of the anticipated and potential side effects, complications, and any important psychological or emotional effects.[67] A patient must also be informed about the surgical procedure's novelty or experimental nature when applicable.[68]

The regulations not only provide for a disclosure of alternative birth control methods, but also for an explanation of *alternative sterilization procedures* available in nontherapeutic situations.[69] The same requirement applies in the case of therapeutic surgery, including the disclosure of whether such alternative treatments result in sterility.[70] An explanation of the procedure must also include specific information relative to the applicant's medical history when material to the issue of consent.[71]

Moreover, all of this information must be contained in a Medical Information Statement, attached to the Consent Docu-

60. 22 Cal. Adm. § 1266.1(e)(1)(E). *See* Form MC 128: *Certification of Compliance with Requirements for Sterilization.*
61. 22 Cal. Adm. § 1266.1(e)(1)(E). *See* Form entitled: *Treatment Authorization Requests.*
62. 22 Cal. Adm. § 1266.1(e)(1)(F).
63. 22 Cal. Adm. § 1266.1(e)(2).
64. 42 C.F.R. § 50.206(a). 42 C.F.R. § 205.35(a)(4)(i).
65. 38 Fed. Reg. 20930-20931 (Aug. 3, 1973). 39 Fed. Reg. 10431-10432 (Mar. 20, 1974). 39 Fed. Reg. 13873 (Apr. 18, 1974).
66. 22 Cal. Adm. § 1266.1(e)(2)(A)(4).
67. *Id.*
68. 22 Cal. Adm. § 1266.1(e)(2)(A)(5).
69. 22 Cal. Adm. § 1266.1(e)(2)(C).
70. 22 Cal. Adm. § 1266.1(e)(2)(E).
71. 22 Cal. Adm. § 1266.1(e)(2)(F).

ment.[72] Applicants for the surgery are required to be presented with these two documents.[73] However, any distribution of the documents to the applicants must be supplemented. Every applicant must be informed of the presiding physician's name.[74] It is required that this physician discuss with the applicant the nature of the operation relative to the patient's medical history and preoperative examination.[75] Any proposal of a surgical procedure not contained in the Medical Information Statement requires full notification to the applicant.[76]

A fundamental departure from the federal regulations in securing "legally informed consent" is the requirement that any Consent Document be co-signed by the applicant and an auditor-witness.[77] This auditor-witness cannot be affiliated with the physician or the medical facility, but must be independently selected by the person contemplating the surgery. It follows from this emphasis on an independent decision that any signature indicating consent, obtained during labor or delivery, or while the patient is under the influence of drugs, shall be invalid.[78] As a further precaution, the revised regulations provide that the entire process established to provide legally informed consent be presented "in easily understandable lay language."[79] Included in the language requirement is the provision that all instructions, both written and oral, be provided in English, Spanish, Cantonese or in the language of the applicant.[80]

California now authorizes its Department of Health to demand from any health agency a report disclosing the number of therapeutic and nontherapeutic sterilization operations conducted by the agency, evidence of compliance with the documented consent process, and demographic data of the sterilized individuals.[81]

As a result of these modifications to solidify the consent process, the broad discretion exercised by medical personnel to the detriment of Chicanas has been technically, but not effectively, narrowed. Regardless of these revisions, there remain areas which the federal and state regulations fail to properly supervise. The subsequent survey of ethical and empirical evidence which follows

72. 22 Cal. Adm. § 1266.1(e)(3)(A,B,C). The Medical Information Statement shall be framed by the State Department of Health, after the submission of recommendations by consumer and health organizations, and be updated by the Department not less than once every 12 months.
73. 22 Cal. Adm. § 1266.1(e)(4).
74. 22 Cal. Adm. § 1266.1(e)(4)(A).
75. 22 Cal. Adm. § 1266.1(e)(4)(B).
76. 22 Cal. Adm. § 1266.1(e)(4)(C).
77. 22 Cal. Adm. § 1266.1(e)(4)(D).
78. 22 Cal. Adm. § 1266.1(e)(4)(D)(1).
79. 22 Cal. Adm. § 1266.1(e)(5).
80. *Id.*
81. 22 Cal. Adm. § 1266.1(e)(6).

should illuminate the issue, and give impetus to a more comprehensive reform of the existing regulations.

## III. The Conflict Between Regulatory Intent and Medical Practice

The intent of the regulations was to ensure that every applicant for sterilization surgery be afforded the protection of an explicit consent process. Several cases indicate that this has not transpired. Both raise doctrinal arguments considered basic to an understanding of the rights of patients and the duties of medical personnel.

### A. *The Relf Case*

The Relf family resided in east-central Alabama where both parents worked as farmhands. Illiterate and unskilled, they lost their jobs when machines made manual labor expendable. They were compelled to move the family, which included three daughters, to Montgomery in search of employment. Unprepared to compete in an urban economy, Mr. and Mrs. Relf resigned themselves to a shack in the city garbage dump. Welfare authorities eventually provided the family with money for food and child support, an apartment in a housing project, free medical care, and family planning services.

The Montgomery Community Action Agency, a federally funded organization,[82] supervised the issuance of Depro-provera, an experimental birth control drug,[83] to Minnie, Mary Alice, and Katie Relf. Katie, the oldest daughter was also told to accept an intra-uterine device (I.U.D.). In June, 1973, nurses from the agency took the younger daughters to be sterilized. Mrs. Relf was informed that Minnie and Mary Alice were to receive additional birth control drugs, and based on this information she signed a consent form with her "X." The signed form provided the technical consent of the parent necessary for the resultant sterilization of the children. Katie, however, successfully dodged the attempts by

82. 42 U.S.C. §§ 2781-2837 (1964).

83. Investigational drugs, as defined by the Federal Drug Administration (hereinafter referred to as F.D.A.), are those which have not been approved for distribution. A drug may be approved for a certain use where its safety is verified, but unapproved for other uses.

Such drugs may be legally administered in two situations. (1) Local physicians may prescribe an approved drug for an unapproved purpose, because the F.D.A.'s jurisdiction does not extend to the local level. *See Hearings on S. 974 before the Subcomm. on Health of the Comm. on Labor and Public Welfare*, 93d Cong., 1st Sess., pt. 1, at 41 (testimony of F.D.A. Commissioner), 74 (testimony of Marcia Greenberger) (1973). (2) A license may be obtained from the F.D.A. to investigate the drug's effects, authorizing the interstate shipment and use of the drug, provided that strict recording and consent procedures are followed.

the nurses to sterilize her by locking herself in a bedroom. All of Mrs. Relf's daughters were under the age of 21.

The precise reason for the Agency's decision to sterilize the minors remains unascertainable. Mary Alice suffered from some form of educational disability and might have been partially mentally retarded.[84] Minnie, however, was a normal seventh grade student attending the public school system. Without evidence to the contrary, it can be fairly implied that the sole reason for the compelled operation was to prevent the girls from bearing children.

Joining the Relf sisters in their suit against HEW were Dorothy Waters and Mrs. Virgil Walker. Each received assistance under the federal categorical grant program known as Aid to Families with Dependent Children (hereinafter referred to as AFDC).[85] Their eligibility for AFDC also entitled them to services available under Medicare and Medicaid.[86] HEW program funds paid for the prenatal care of Ms. Waters when she became pregnant with her fifth child. Her physician was Dr. Clovis H. Pierce, who regularly cared for welfare mothers in Aiken County, South Carolina. He conditioned the rendering of his professional services upon Ms. Waters' submission to sterilization surgery. Threatened by possible lack of medical care, she agreed to be sterilized following the uncomplicated delivery of her child. Mrs. Walker also relented in her refusal to be sterilized when Dr. Pierce threatened to have her removed from the relief roles. She was then pregnant with her fourth child.

All of the plaintiffs were Black.

### B. *The Brown Case*

Dr. Pierce was also involved in another suit brought by Mrs. Shirley Brown, and the aforementioned Mrs. Walker, for damages.[87] In September, 1973, Mrs. Brown was approached by Dr. Pierce, one day following the delivery of her child. He demanded that she be sterilized. Her refusal resulted in her dismissal as a patient at the Aiken County Hospital. This retaliation, alleged Mrs. Brown, placed the life of her infant in jeopardy. Both women were legally separated from their husbands and had long relied on public assistance.

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84. Tests conducted by a separate public agency prior to the sterilization operation showed that Mary Alice was at least trainable and she had been selected to begin a special training center for handicapped children. Brief in Support for Motion for Preliminary Injunction, Relf v. Weinberger, 372 F. Supp. 1196 (D.D.C. 1974) (hereinafter referred to as *Relf Brief*). Joseph J. Levin, Jr., Southern Poverty Law Center, Inc., P.O. Box 548, Montgomery, Alabama 36106.

85. 42 U.S.C. §§ 601-610.

86. 42 U.S.C. § 602(a)(14).

87. Brown v. Pierce, (D.C. S.C., 1975), in the Los Angeles Times, July 27, 1975, at 7.

The federal court held that Mrs. Brown's civil rights had been violated, but assessed only nominal damages of five dollars because the jury concluded that she had not suffered serious harm.[88] Recovery was also denied to Mrs. Walker. This discouraging finding resulted, even though Dr. Pierce testified that his personal policy was to prevent welfare mothers from bearing children after their third or fourth pregnancy.[89]

As a matter of litigation strategy, the result in *Brown* should not discourage the use of damage claims as a way of countering medical malpractice in sterilization cases. Unlike the Chicanas in *Madrigal*, the women in *Brown* were welfare recipients and were unmarried or without the father's presence in the home. The human element probably played an important role in the jury's determination. Even though one half of the jury was composed of Blacks, the moral prejudice against women on welfare who bear children out of wedlock was very likely a crucial factor. The only note of guidance advanced by U.S. District Judge Solomon Blatt, Jr., was the muffled conclusion that the trial presented "novel legal questions." However, as a way to protect the right to procreate from an abuse of professional authority, the award of large damages for a denial of that right would seem to be one of the most effective methods.

### C. *Constitutional Guidelines*

Federal law has a pervasive influence in determining the exercise of the sterilization option for family planning. The leading example is *King v. Smith*,[90] which stands for the proposition that in programs using both federal and state funds, the federal law prevails over nonconforming state rules. In relation with this decision, HEW is delegated with the duty of compelling the states to comply with federal law.[91] Should a state fail to comply, the Secretary is required to discontinue federal assistance to the delinquent program.[92] Under the AFDC statute, regulations issued by the Secretary are binding on the states.[93] When compliance is not enforced by the controlling federal agency, suit can be brought in a federal court for an order to compel enforcement.[94] Such orders are "to be obeyed until they expire . . . or [are] . . . set aside by

88. *Id.*
89. *Id.*
90. 392 U.S. 309, 316 (1968). *See also* Townsend v. Swank, 404 U.S. 282 (1971); Rosado v. Wyman, 397 U.S. 397 (1970).
91. *Id.*
92. 42 U.S.C. § 304. *See* LEVY & LEWIS, CASES AND MATERIALS ON SOCIAL WELFARE AND THE INDIVIDUAL 81-82 (1971).
93. Lewis v. Martin, 397 U.S. 552 (1970).
94. *See Relf Brief*, note 84, *supra.*

appropriate proceedings, appellate or otherwise."[95] As a result of the availability of this equitable relief, the *Relf* sisters case succeeded in causing HEW to revise its regulations.[96]

*Relf v. Weinberger*, therefore, resulted in a court declaration of HEW's then existing regulations as unreasonable and arbitrary in application.[97] Only the voluntary, knowing and uncoerced consent of individuals competent to give consent would satisfy the reasonableness test. The case of *Madrigal v. Quilligan* raises the issue of individual competence to render consent, since the federal and state regulations defining consensual age are inconsistent.[98] This inconsistency necessarily exposes state licensed health facilities to a loss of federal funds for certain medical procedures. The less strict California regulations are consequently vulnerable to attack based on *Smith*[99] under the supremacy clause, and subject to revision through the *Relf*[100] approach. Such a relationship is highly significant since most states are heavily dependent upon federal funds to continue family planning services.

### D. *Constitutional Protections*

The issues raised by *Madrigal* focus on the right to procreate and to due process of law.

In *Hathaway v. Worcester City Hospital*,[101] a city hospital's prohibition of the use of its facilities for consensual sterilization violated the equal protection clause, since no other surgical procedures of equal risk, including nontherapeutic procedures, were barred. A compelling state interest was required to justify a denial of the fundamental right to procreate or not to procreate. Furthermore, a parity formula, based on a woman's age and number of children, would probably not withstand a *Stanley v. Illinois*[102] test. An irrebuttable presumption cannot be erected to deny an individual's qualification for sterilization.

Ever since *Meyer v. Nebraska*,[103] there has developed a substantial body of law tending to make certain family associated functions protected from government intrusion. It is now considered a fundamental right to create a family unit through mar-

95. U.S. v. United Mine Workers of America, 330 U.S. 258, 294 (1947).
96. 38 Fed. Reg. 4730-34 (1974). 39 Fed. Reg. 13873.
97. Public Health Service Act, § 1007, 42 U.S.C.A. § 300a-5; Social Security Act, §§ 402(a)(15), 508(a), 1905(a)(4), 42 U.S.C.A. §§ 602(a)(15), 708(a), 1396(d)(a)(4).
98. 22 Cal. Adm. § 1266.1(e)(2).
99. 392 U.S. 309, 316 (1968).
100. *See Relf Brief*, note 84, *supra*.
101. 475 F.2d 701 (1st Cir. 1973).
102. 405 U.S. 645 (1972).
103. 262 U.S. 390 (1923) (dictum).

riage,[104] to decide privately and personally when and whether to have children, [105] and to raise and educate the offspring of the union.[106] The right to procreate, therefore, is so intertwined with marriage, child bearing, and the quality of child rearing that it must also be considered fundamental.

A key element in this discussion focuses on the meaning of privacy. In *Eisenstadt v. Baird*, Justice Brennan made the distinction between private rights and public interests more definite:

> If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted government intrusion into matters so fundamentally affecting a person as the decision whether or not to beget a child.[107]

The right at issue, said the Supreme Court in *Roe v. Wade*,[108] encompassed the "[w]oman's decision whether or not to terminate her pregnancy." Reference was not only made to the doctrine of government exclusion from the decision not to bear children, but in *Griswold v. Connecticut*,[109] Justice Goldberg directly addressed the issue of the parental right to procreate.

> Surely the government . . . could not decree that all husbands and wives must be sterilized after two children have been born to them . . . [if] a law outlawing voluntary birth control by married persons is valid, then, by the same reasoning, a law requiring compulsory birth control also would seem to be valid. In my view, however, both types of law would unjustifiably intrude upon rights of marital privacy which are constitutionally protected.[110]

Privacy emanates from the concept of personal liberty embodied in the first, fifth, ninth, and fourteenth amendments. Each individual is guaranteed the autonomy necessary to make decisions of a personal nature. The decision to procreate or not centers on the people's basic freedom from the government's interference. When this freedom involves a fundamental right, such as the private decision to procreate, only a compelling state interest can justify its denial.

The Chicanas victimized in *Madrigal* suffered from a direct government relationship with the medical profession. Coupled with the unauthorized practices of medical personnel, the government's permeation of the entire sterilization process has served to deprive Chicanas of the right to procreate. If government author-

104. *See* Loving v. Virginia, 388 U.S. 1 (1967).
105. *See* Eisenstadt v. Baird, 405 U.S. 438 (1972).
106. *See* Pierce v. Society of Sisters, 268 U.S. 510 (1922).
107. 405 U.S. at 453. *See* note 103.
108. 410 U.S. 113 (1973).
109. 381 U.S. 479 (1965) (Goldberg, J., concurring).
110. *Id.* at 496-497.

izes certain practices which touch upon fundamental rights, its failure to properly supervise those practices negatively intrudes upon personal liberty. Even though the intent behind the intrusion be benign, the actual application has resulted in damaging effects. This same finding was alluded to in *Relf* when the court explained that "it is for Congress and not individual social workers and physicians to determine the manner in which federal funds should be used to support such a program."[111]

## IV. Ethical Attitudes Effecting the Question of Regulatory Reform

An examination of current ethical premises among medical personnel is necessary, to fully appreciate the need to promulgate regulations which will satisfactorily protect Chicana patients.

After surveying the available medical literature, V. B. Marrow arrived at the conclusion that most physicians consider their own "vast experience and common sense" determinative in ethical decisions.[112] According to Dr. Samuel Vaisrub, doctors should be their own philosophers: "[the] ethical dilemmas of medicine often defy rational solutions [and are] more in need of the intuitive perceptions of Aeschylus rather than of the logical analysis of an Aristotle."[113] Writing in 1936, Dr. H. J. Stander indicated that medical practitioners exercised one standard of consultation with solvent patients, and another with poorer patients, when sterilization was considered attendant to a caesarean section.[114] The availability of proper medical care in the poorer communities was considered crucial in arriving at a decision to sterilize.[115] But poor women were generally categorized for sterilization without consultation, as the following quotation indicates:

> [I]f she is weak-minded or diseased and is liable to become a public charge, the operation is justifiable. In general, with pauper patients, it is our practice to effect sterilization at the third [caesarean] section.[116]

Modern medical practice assigns a high priority to surgical experience. This preoccupation with "cutting" encourages hospital personnel to solicit consent for sterilization operations for the purpose of training interns. Generally, the patients selected for this training are poor women. A good record of surgical participa-

111. 372 F. Supp. at 1204.
112. Marrow, *Medical Ethics: Should Healers Think?*, Medical Dimensions, at 31-32 (March, 1975).
113. *Id.*
114. Dr. H.J. Stander, Williams Obstetrics (7th ed. C.D. Appleton-Century, 1936).
115. *Id.*
116. *Id.*

tion usually results in residency certification and specialty board qualification. This experience is ultimately converted into higher financial rewards.

Based upon a report by the acting director of obstetrics and gynecology at a New York City municipal hospital, an unwritten policy exists within most of the City's teaching hospitals to perform elective hysterectomies on poor Black and Puerto Rican women, with only minimal medical indications, in order to train residents.[117] Dr. A. Shapiro asserts that such an attitude does not protect the interests of the patient: "We have got to stop people who are doing [sterilization] for their own profiteering motives or referring for that reason."[118] Supporting this view is Dr. J. Knowles, former head of the Massachusetts General Hospital who stated:

> Human beings rationalize what they do without any conscious effort to be dishonest or greedy . . . . Doctors are human. A significant number of them, 20 to 30 percent, are *de facto* fleecing the public while 'knowing they are doing good'.[119]

It would be unfair to condemn the entire medical profession for the unethical motives of a few, but the minority of doctors performing unjustified sterilizations warrants regulatory attention. Perhaps, as has been generally argued, society expects too much from the presently inadequate supply of doctors. Dr. C. E. Lewis focused on the impact felt by overworked doctors when he said:

> "Because her husband is absent so much, the surgeon's wife may seek tangible compensations such as a better house or a fur coat. And medicine is one of the few fields . . . where if a wife wants a new coat, all you have to do is a couple more hysterectomies, and she can buy it."[120]

Yet even the most coercive violations of individual rights are often ignored, sometimes even applauded, by medical associations. This raises a question pertinent to the efficacy of self-regulation in such cases. For example, the South Carolina Medical Association responded to the *Brown* decision by unequivocally supporting the practices of Dr. Clovis Pierce. The Association's resolution declared that "it is entirely ethical for a physician to inform a woman who desires to become his patient that he will require her to agree to sterilization as a condition to accepting her as a patient."[121]

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117. Newsday, Jan. 2, 1974, at 4A.
118. Medical World News, Nov. 1972, at 19-20.
119. Hospital Physician, Feb. 1973, at 35-40.
120. *Id.*
121. *S.C. Society Calls Sterilization Precondition in Taking Patient Ethical,* Obstetrician and Gynecology News, Aug. 1, 1974.

Entirely ignored was the unconscionable position of the patient which would compel her to yield under pressure.

Some doctors have relied on a pragmatic stance to justify the increased spread of sterilization surgery. Leaders of the Association for Voluntary Sterilization support this trend as the most effective means of avoiding the harm engendered by the radical growth of population. They particularly dismiss the studies purporting to cite the psychological ill effects associated with sterilization. A past president of the Association, Dr. Curtis Wood, summed up this philosophical position:

> People pollute, and too many people crowded too close together cause many of our social and economic problems. These, in turn, are aggravated by involuntary and irresponsible parenthood. As physicians we have obligations to our individual patients, but we also 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 which is fertility control.[122]

There is also evidence indicating that this attitude is not limited to medical practitioners. Proposals have been introduced in the legislatures of eight states, to punish by sterilization those welfare recipients who have given birth to a number of children in excess of a set limit.[123] This attitude could help to explain why, in an alarming number of recent cases, women have awakened from minor surgery to be informed of their sterilization.

The conclusion recently framed by several prominent members of the medical profession condemns the stated justifications for involuntary sterilization. Specifically criticized is the proliferation of abuse suffered by minority women. They characterize such tragic results in ironic terms:

> [W]hereas middle class women have had to go to court to obtain voluntary sterilization, poor women are in danger of the procedure being performed without their consent.[124]

It has also been recommended that the value of sterilization as a method of contraception may be lessened unless careful attention is paid to any potentially harmful psychological effects. Another major argument is that "a contraceptive method with harmful side

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122. 1 CONTEMPORARY OBSTETRICS & GYNECOLOGY 31-40 (1973).

123. *Panel Recommends Caution in Federal Family Planning.* Obstetrician and Gynecology News, Dec. 15, 1974, at 2. Address by Dr. James E. Allen of the School of Public Health at the University of North Carolina, at the annual meeting of the American Public Health Association.

124. GYNECOLOGY AND OBSTETRICS: THE HEALTH CARE OF WOMEN (S. Romney ed. 1975), at 12, 48, 49, 577. The textbook was edited by Seymour L. Romney, M.D., Professor in the Department of Gynecology and Obstetrics at the Albert Einstein College of Medicine and by five other professors of obstetrics and gynecology from different universities.

effects released on large sections of the population will ultimately do more to retard than advance the cause of family planning."[125]

It is not enough, therefore, if the motives of medical practitioners are lofty when the techniques of duress they employ violate a patient's privacy and due process rights, and result in irreversible sterilization. No less an authority than Dr. Julius Paul has warned about this danger:

> Where the persons who are affected by these laws or administrative decisions are mentally incompetent (by some standard), poor, or in any fashion or form vulnerable to blandishments of various kinds, the problem of protecting personal rights is even more difficult, and the obligation of the administrator to protect personal rights should be even higher.[126]

The obligation to protect personal rights is even more significant when one considers the magnitude of current sterilization programs, the lack of compliance with existing regulations, and empirical data indicating a disturbing frequency of postoperative complications.

## V. THE EMPIRICAL CASE FOR REGULATORY REFORM

### A. *The Expanded Use of Sterilization for Contraception*

Federal support for family planning services has rapidly increased since 1967. By 1973, the amount of annual federal expenditures had grown from $11 million to $149 million.[127] Dr. Louis Hellman, Assistant Secretary of HEW for Population Services, estimated that $1 billion would be spent on the program by 1975. The federal government now pays 90 percent of the total contribution for birth control services offered to Medicaid recipients, and obliges every state to provide such services to every woman on welfare.[128] With the expansion of federal expenditures has come a comparable increase in sterilization surgery.

During the period 1970 to 1974, the number of yearly female sterilizations increased from 192,000 to 548,000.[129] At the Medical Center there was a 450 percent rise in the number of steriliza-

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125. 4 BRIT. MED. J. 297-300 (Oct. 1970).

126. Paul, *Population "Quality" and "Fitness for Parenthood" in the light of State Eugenic and Sterilization Experience: 1907-1966*, 11 POPULATION STUDIES 3, at 295 (Nov. 1967). *See also* AMERICAN PHILOSOPHICAL SOCIETY, YEARBOOK, at 379, 380-381 (1967).

127. *D.H.E.W. 5-Year Plan Report: Program Served 3.2 Million in FY 1973*, 3 FAMILY PLANNING DIGEST (May 1974).

128. *Birth Curb Leaders Cite Future Needs*, AMERICAN MEDICAL NEWS, May 16, 1974, at 16.

129. 39 Fed. Reg. 237 (1974). *See also* E. KRAUSS, *Hospital Survey on Sterilization Policies*, March, 1975 (American Civil Liberties Union, 22 E. 40th St., New York, N.Y. 10016) (hereinafter referred to as KRAUSS).

tions performed just between 1968 and 1970.[130] This included elective hysterectomy,[131] elective tubal ligation, and tubal ligation after delivery. The largest expansion occurred in the performance of hysterectomies, almost 750 percent.[132] This is not surprising since hysterectomies rank as the fourth common operation performed in the country.[133] Such an augmentation reflects a relaxation of prior restrictions based on a patient's age, parity (number of children) and marital status. Similar expansion has taken place in other parts of the country.[134] For example, the number of sterilizations performed at the Mount Sinai Hospital in New York City increased 200 percent from 1970 to 1974,[135] and a large hospital in St. Paul, Minnesota, reported that the ratio of tubal ligations to births had increased from 1:9.2 in 1968-1969 to 1:4.3 in 1973.[136]

Women who are poor and of a racial minority experience a higher incidence of sterilization than do other women. Among those women who undergo the surgery with less than a high school education, 14.5 percent were Caucasian but 31.6 percent were Black.[137] Thirty-five percent of Puerto Rican women, aged 15 to 44, have been sterilized and two-thirds of these women are under age 30.[138] The Minnesota report indicated that over half of the hospital's patients were Caucasian, but only 40 percent of those sterilized were Caucasian; one third of the patients were Black, but they constituted 43 percent of those sterilized.[139] This information becomes even more relevant when postoperative complications are considered.

### B. *Postoperative Complications*

According to Dr. Curtis Wood, as women become better informed about contraception, they will increasingly realize that "over all, sterilization is the safest of all methods."[140] The evi-

130. *Sterilization: Women Fit to be Tied*, HEALTH POLICY ADVISORY CENTER BULLETIN, Jan. Feb., 1975, at 2.

131. DR. G. ROSENFELD & DR. S. WOLFE, *A Health Research Group Study On Surgical Sterilization: Present Abuses and Proposed Regulations*, October, 1973. (Health Research Group, funded by Public Citizens, Inc., 2000 P. Street, N.W., Washington, D.C. 20036) (hereinafter referred to as ROSENFELD).

132. The surgical removal of all or part of the uterus.

133. *See* ROSENFELD, note 129, *supra* at 1.

134. Brief for Plaintiff at 5, California Coalition for the Medical Rights of Women v. California Dept. of Health, (unfiled). Prepared by B. Grubb, S. Wolinsky, Public Advocates, Inc., 433 Turk St., San Francisco, CA 94102. Tonsillectomy, hernia repair and gall bladder removal rank ahead of hysterectomy in frequency of performance.

135. Newsday, Jan. 2, 1974, at 4A.

136. L. Edwards & E. Hakanson, *Changing Status of Tubal Sterilization: An Evaluation of Fourteen Years' Experience*, 115 AMER. J. OB. & GYN. 347 (1973).

137. *See* note 128, *supra* at 3.

138. 1 FAMILY PLANNING DIGEST 6 (May, 1972).

139. *See* note 134, *supra* at 347.

140. 1 CONTEMPORARY OBSTETRICS & GYNECOLOGY 31-40 (1973).

dence seems to contradict this view. In terms of psychological impact, the existence of sterility in a marital relationship has been found significant. Extensive research suggests that the inability to procreate has a profound emotional effect on married couples, and hastens marital dissolution.[141] Dr. M. H. Johnson has described the serious psychological repercussions derived from sterilization as long "a matter of common medical knowledge."[142] One study found that 12 percent of the women sterilized suffered postoperative harm.[143] More recent data suggests that this incidence of mental regret may be as high as 25 percent.[144]

The risk of physical harm is also very significant. A surgery for tubal ligation "sounds attractive to the uninformed, but a serious complication rate exists."[145] A survey of obstetricians and gynecologists who had participated in 7000 tubal ligation operations found that a major complication rate .6 percent or 6000 per million women, resulted.[146] Data applying to the mortality rate differ somewhat, but still tends to affirm the gravity of risk involved. For example, one study determined that the mortality rate was .15%, or 1500 per million women, with the failure rate at .3 percent, per million women.[147] Another study indicated that the mortality rate was as low as 25 per 100,000 women;[148] but associated with a post-operative morbidity rate of from 2 to 4 percent, usually from bleeding or infection.[149] In comparison with hysterectomy, tubal ligation produces less certain results but is also less expensive, requires a shorter period of convalescence, and causes less complications.[150]

Information gathered by Dr. Lester Hubbard, Professor of Obstetrics and Gynecology at the Medical Center, points out that the complication rate resulting from hysterectomy is 10 to 20 times greater than for tubal ligation.[151] It costs 4 to 5 times more for the surgery, and the convalescent period is six weeks compared to the few days required after a tubal ligation.[152] The high rate of complications, manifested as bladder trauma, excessive blood loss and pelvic hematomas, persuade many physicians to forego hysterectomy unless there are additional indications for the operation.[153]

141. *See* ROSENFELD, note 129, *supra* at 16, 20.
142. 121 AM. J. PSYCH. 482-486 (July 1964-1965).
143. 4 AM. MED. J. 297-300 (Oct., 1970).
144. Whitehouse, *Sterilization of Young Wives,* BRIT. MED. J. (June 19, 1973), at 707.
145. *See* ROSENFELD, note 129, *supra* at 14.
146. 10 J. REPR. MED. 301 (1973).
147. *See* ROSENFELD, note 129, *supra* at 13-14.
148. Presser, *Voluntary Sterilization: A World View,* REPORTS ON POPULATION & FAMILY PLANNING 1970), at 1.
149. *Id.*
150. *See* ROSENFELD, note 129, *supra* at 14.
151. 112 AM. J. OB. & GYN. 1076 (1972).
152. *Id.*
153. 114 AM. J. OB. & GYN. 670 (1972).

Not included as a valid interest is a history of previous caesarean sections, unless the object is to remove a cancerous growth or an intractable uterine hemorrhage.[154] Death from this operation occurs 300 to 500 times for every 100,000 operations.[155] The mortality rate is, in fact, greater than that for uterine cervical cancer.[156]

### C. *Impact on Minors and Incompetents*

Considered within this context the term "voluntary" requires "that the individual have at [her] disposal the information necessary to make a decision and the mental competence to appreciate the significance of that information."[157] The case of *Relf v. Weinberger* presented uncontroverted evidence that minors and incompetents had been sterilized with federal funds, and had been improperly coerced into accepting the surgery.[158] Dr. Louis Hellman, reported that only between 2,000 and 3,000 individuals under the age of 21, and fewer than 300 under age 18, had been sterilized.[159] At the Baltimore City Hospital twelve women, most of whom were between the ages of 18 and 21, were coerced under duress to give consent to sterilization surgery just minutes before undergoing caesarean section.[160] No authority for the federal funding of such procedures relative to minors and mental incompetents is discernable from the Social Security,[161] or Public Health Service Acts.[162] The court's reaction in *Relf* was to enjoin the further allocation of federal funds for the sterilization of incompetent minors and adults.[163] So even though the number of minors and incompetents sterilized may be comparatively small, the need to protect their personal rights is no less mandatory.

### D. *Summary of Compliance with the Requirement of Informed Consent*

After the federal court order of March, 1974, which required HEW's revision of its sterilization regulations to ensure informed consent, it was reported that 76 percent of 51 hospitals surveyed

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154. *See* ROSENFELD, note 129, *supra* at 10.
155. C. Porter, Jr. & J. Hulka, *Female Sterilization in Current Clinical Practice*, 4 FAMILY PLANNING PERSPECTIVES 35 (Winter 1974).
156. *See* note 132, *supra*.
157. *See, e.g.*, Dusky v. United States, 362 U.S. 402 (1960); Elder v. Crawley Book Machinery Co., 441 F.2d 771, 773 (3d Cir. 1971), Pearson v. United States, 117 U.S. App. D.C. 52, 325 F.2d 625, 626-667 (1963).
158. 372 F. Supp. at 1199.
159. *Id.* at 1198.
160. *See* ROSENFELD, note 129, *supra* at 4.
161. 42 U.S.C. §§ 330 *et seq.*
162. Public Health Service Act, §§ 310, 314(d,e), 42 U.S.C.A. §§ 242(h), 246(d,e).
163. 372 F. Supp. at 1201.

continued in complete noncompliance as of January, 1975.[164] Another 12 hospitals failed to comply with part of the revised regulations.[165] For example, only 15 of the hospitals had a policy prohibiting staff members from discussing sterilization with patients in labor.[166] Twenty-one hospitals completely failed to provide for an oral and written description of medical indications to patients requiring therapeutic sterilization.[167] Only 15 hospitals gave the required protective notice to welfare recipients.[168] Moreover, there was extensive noncompliance with the required 72 hour waiting period, the content of the consent form, the requirement that all pertinent information be communicated to each applicant in clearly understandable terms, and mention that the surgery is irreversible.[169] Not surprisingly, though, each consent form found out of compliance due to an ambiguous explanation of surgical procedures contained a very concise statement absolving the medical personnel from liability.[170]

A recent study[171] of 17 hospitals in San Francisco yielded similar results. Four out of the ten East Bay hospitals studied, including the hospital with the largest volume of obstetric and gynecology patients in the area, were completely uninformed about the regulation changes.[172] Ten of the 17 total hospitals surveyed could not recall having received printed regulations from HEW, and 9 hospitals had no knowledge of the specific revisions.[173] Furthermore, some of the hospitals did not even provide consent forms to patients prior to performing sterilization operations.[174]

The extent of noncompliance may be the result of both a relaxation of precautionary measures once considered mandatory, and the widespread belief that sterilization is particularly effective in controlling population growth among the poor. For example, in 1970, the American College of Obstetricians and Gynecologists withdrew its guideline recommending the signature of two or more doctors plus a psychiatric consultation as necessary prior to effecting a sterilization.[175] Commensurate with this adoption of a less stringent standard was an attitudinal shift favoring the expanded

164. *See* KRAUSS, note 127, *supra* at 20.
165. *Id.*
166. *Id.* at 16.
167. *Id.* at 13. *Therapeutic sterilization* refers to any treatment, procedure, or operation, the primary purpose of which is to correct or treat a medically recognized abnormal condition, or disease, but which also secondarily results in a permanent inability to reproduce offspring.
168. *Id.* at 14.
169. *Id.* at 8, 10, 15.
170. *Id.* at 11.
171. *See* note 132, *supra.*
172. *Id.*
173. *Id.*
174. *Id.*
175. *See* note 128, *supra* at 3.

use of sterilization surgery. One study indicated that between 45 percent and 94 percent of the doctors surveyed "encourage" the compulsory sterilization of welfare mothers and "any woman who has more than two illegitimate children."[176] A different poll showed that only 6 percent of the doctors surveyed would recommend sterilization as a contraception method for *private* patients, but 14 percent considered sterilization as the primary contraceptive method for *public* patients.[177] This same poll also revealed the following attitudinal prevalence:

> The obstetrician-gynecologists were the most punitive of the doctors surveyed, 94 percent favoring compulsory sterilization or withholding of welfare support for unwed mothers with three children.[178]

The motive behind such a menacing posture may be the belief that poor women are less likely to use less drastic contraceptive methods. On the contrary, a number of studies have supported the opposite conclusion.[179]

## VI. SPECIAL CONCERNS OF CHICANAS

The circumstances in *Madrigal* present additional shortcomings in the existing regulations. It was discovered that consent documents, informational materials and oral presentations were not given in the primary language of the patients.[180] No provision was made that consent forms be legible.[181] Guidelines were not established to protect patients with limited reading ability, or those unable to read.[182] Medical terms, such as therapeutic and nontherapeutic, were not defined in terms which could be readily understood by each patient.[183] When federal regulations were considered separately, the failure to specify against the practice of considering caesarean delivery as a valid medical indication for sterilization was found to be a harmful omission.[184] In addition, the federal regulations did not prohibit the practice of approaching patients to consider sterilization and to sign consent forms while

176. H. Werley, J. Ager, R. Rosen, F. Shea, *Medicine, Nursing, Social Work, Professionals and Birth Control: Student and Faculty Attitudes.* 5 FAMILY PLANNING PERSPECTIVES 42-49 (1973).
177. *Physician Attitudes: MDs Assume Poor Can't Remember to Take Pill,* 1 FAMILY PLANNING DIGEST 3 (Jan., 1972).
178. *Id.*
179. *Poor Women Good Pill Users, Study Finds,* 1 FAMILY PLANNING DIGEST 1-2 (1973); H. Davis, The I.U.D. (The Williams & Wilkens Co., Baltimore, 1971); M. Vessey & P. Wiggins, *Use-Effectiveness of the Diaphragm in a Selected Family Planning Clinic Population in the United Kingdom,* 9 CONTRACEPTION 15 (1974).
180. *Madrigal,* note 5, *supra.*
181. *Id.*
182. *Id.*
183. *Id.*
184. *Id.*

they were in labor and under anesthesia.[185] Regulatory concerns alone, however, cannot explain the depth of hurt felt by the victims.

Cultural values vary from individual to individual, but among Chicanas a pervasive set of beliefs are still given great weight. These beliefs are as important in weighing the extent of damage suffered as the physical impact itself. Sterility not only strikes at traditional religious values but also at the viability of the marital relationship

Catholicism, though not universally accepted among Chicanos and Chicanas, continues to be a powerful influence within the community. For centuries it has been established among the Mexican people as the source of moral authority. The faith has given definition to the spiritual essence of the human experience. This spiritual commitment varies and is subject to flux, but the longevity of the Church gives testimony to a continuous acceptance.

The Church operates one-fourth of the hospitals in the United States. A staunch position on sterilization and birth control reflects cherished principles of human conduct. The following directive was issued by the National Conference of Catholic Bishops:

> Sterilization, whether permanent or temporary, for men or for women, may not be used as a means of contraception. Similarly excluded is every action which, either in anticipation of the conjugal act, or in its accomplishment, or in the development of its natural consequences, proposes, whether as an end or as a means, to render procreation impossible.[186]

*Allen v. Sisters of Saint Joseph*,[187] provided an opportunity to test the Church's right to implement its anti-sterilization policy. A Catholic hospital which received federal and state funds was held not to be operating under the color of law when it refused to use its facilities to perform a requested sterilization operation. The court could not find a "compelling reason appearing to issue an injunction in order to prevent irreparable harm and injury to the life and health" of a patient.[188]

Even though the woman who requested the surgery would have been required to undergo separate operations for a caesarean section and sterilization, instead of combining both procedures, this was held not to be sufficient grounds for ordering the hospital to

185. *Id.*
186. CATHOLIC HOSPITAL ASS'N OF THE U.S. AND CANADA, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HOSPITALS (3d ed. 1972).
187. 361 F. Supp. 1212 (N.D. Texas 1973).
188. *Id.* at 1214.

reverse its policy. The court explained its decision on First Amendment grounds:

> The interest that the public has in the establishment and operation of hospitals by religious organizations is paramount to any inconvenience that would result to the plaintiff in requiring her to either be moved or await a later date for her sterilization.[189]

This religious philosophy underlines related attitudes about the spousal relationship. Two examples from the *Madrigal* case suggest the importance of the family as an institution to Chicanas. Guadalupe Acosta was led to believe that her husband had authorized her sterilization, but he believed that his consent was limited to her caesarean section. The wife angrily blamed the husband for the tragic result, and the husband came to feel that his wife's inability to procreate made their eight year common law marriage severable.[190]

Maria Diaz was informed some weeks after the operation about being sterilized. She cried when she heard the news. The doctor responded by saying, "Don't cry. It's best for you that you not have any more children. In Mexico, the people are very, very poor and it's best that you not have more children."[191] Mrs. Diaz has revealed that her involuntary sterilization has caused great friction in her relationship with her husband. He has already warned her that they would part.[192]

Among Chicanos and Chicanas the purpose of marriage continues to be, for the most part, the bearing and rearing of children. Without children the prized continuation of the family, and all of the cultural values embodied therein, is lost. The reality of the situation burdens the sterile woman with decreased prospects for marriage, and the increased possibility of marital discord and dissolution. So when a Chicana is made sterile she not only loses the opportunity to procreate, but also the chance to live a precious cultural role.

Thus, the impact of a coerced sterilization strikes at the heart of the woman's existence within the culture. Guadalupe Acosta gave expression to this loss of identity when she related the following sentiment:

> Ever since the operation, I am very inattentive. Not forgetful, inattentive. People sometimes have to tell me things twice. It's not that I don't understand them, it's that I'm not there.[193]

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189. *Id.*
190. C. Dreifus, *Sterilizing the Poor*, THE PROGRESSIVE (Dec., 1975), at 14.
191. *Id.*
192. *Id.*
193. *Id.*

When the evidence is considered, including the cultural reality of Chicanas, the necessity to make sure that low-income consumers receive complete and understandable information pertinent to sterilization is underscored. Only a reform of the existing regulations can ensure voluntary and informed consent. To accomplish this fundamental goal, the following solutions are recommended.

## VII. SOLUTIONS RECOMMENDED TO SECURE INFORMED CONSENT

The following provisions should become a mandatory part of the existing federal regulations and all state regulations where applicable.

A. The right to be free from a physical intrusion into the body is as fundamental a part of the right to privacy as the decision whether or not to beget children.[194] For this reason *any nonemergency sterilization must be initially requested by the patient or potential patient, and the medical record must indicate that the request for surgery originated with the patient.* The necessity for this measure is substantiated by Drs. Barner and Zuspan: "Where the procedure is proposed by the attending physician, approximately 32 percent of the patients become unhappy, compared with only 9 percent if initiation of the idea is with the couple."[195] As a prerequisite of this request provision, *only those persons who are 21 years of age or older shall* be eligible for the surgery. Such a policy was recently supported through injunctive relief by federal Judge E. Avery Crary in the *Madrigal* case.[196]

B. The following statement must be printed directly above the patient's signature line on the consent form in bold face type:

> "I UNDERSTAND THAT THE PURPOSE OF THIS OPERATION OR SURGERY IS TO MAKE ME STERILE, AND THAT I WILL NEVER BE ABLE TO HAVE A CHILD IN THE FUTURE."

Furthermore, *a written consent form must be properly signed, witnessed, and made a part of the hospital record 30 days before the actual performance of the surgery, or, in expectation of a postpartum sterilization, 60 days before the expected date of con-*

194. *See* Roe v. Wade, 410 U.S. 113 (1973) (Douglas, J., concurring); Mackey v. Procumier, No. 71-3062 (9th Cir., Apr. 16, 1973); Kaimowitz v. Dept. of Mental Health, No. 73-19434 (Mich. Cir. Ct. of Wayne County, Jul. 10, 1973) (three judges).

195. 89 AM. J. OBST. 395-400 (1964).

196. *Madrigal*, note 5, *supra*. The court enjoined state health officials from using federal funds for voluntary sterilizations of women between 18 and 21 years of age. California presently allows the voluntary sterilization of anyone over 18 years of age, but federal law limits this procedure to persons 21 years of age or older. *See also* Calderon, *Sterilization Suit by Chicanas*, 2 La Raza 21 (1975).

*finement.* Dr. T. W. Adams' study, conducted at a hospital where this rule was applied, showed that of those patients dissatisfied with the results of the operation, 36 percent had undergone a sterilization in disregard of the rule compared to a 16 percent dissatisfaction rate among those in compliance.[197] Such an extended waiting period is necessary because studies have consistently indicated that women below age 30 are more likely to regret sterilization than women over 30.[198] In addition, sterilization is not any safer physically than continued use of oral contraceptives, and is more dangerous than the I.U.D. or diaphragm.[199]

C. *For persons who speak and understand only Spanish, or a language other than English, the prescribed "informed consent" can be obtained only after all pertinent information is provided in the patient's own language.* This must include verbal counselling and all written forms; particularly in regards to the *alternative methods available to effect contraception and sterilization. All consent forms must be written at a sixth grade education level of comprehension.*

There can be no informed consent to sterilization as mandated by the federal regulations when counseling is provided in a language which the patient does not understand, nor where the consent form is written in a language which the patient cannot read. Even though this provision may entail additional administrative costs, increased costs cannot justify the abrogation of the fundamental right to procreate. This policy was clearly stated in *Castro v. California.*[200]

> Avoidance or recoupment of administrative costs, while a valid state concern, cannot justify the imposition of an otherwise improper classification, especially when, as here, it touches on 'matters close to the core of our constitutional system'.[201]

While there exists a strong societal interest in the uniformity of language, as the Court said in *Meyer v. Nebraska,*[202] basic consti-

197. 89 AM. J. OBST. & GYN. 395-401 (1964).
198. *See* ROSENFELD, note 129, *supra.* The mathematical likelihood of such things as divorce and remarriage or a child dying during a woman's reproductive years is much greater for younger women than older women.
199. *See* ROSENFELD, note 129, *id.* at 18.
200. 2 C. 3d 223 (1970).
201. *Id.* at 242. In *Castro,* the California Supreme Court invalidated the state's constitutional provision conditioning the right to vote upon the ability to read the English language as applied to persons who are literate in Spanish but not in English. The Court balanced the state's concern in avoiding the cost and administrative burden of providing a bilingual electoral system against the fundamental right to vote and found that the importance of the individual's right to vote outweighed the state's interest.
202. 262 U.S. 390 (1923).

tutional rights cannot be violated for the sake of linguistic homogeneity:

> The protection of the Constitution extends to all, . . . to those who speak other languages as well as to those born with English on the tongue. Perhaps it would be highly advantageous if all had ready understanding of our ordinary speech, but this cannot be coerced by methods which conflict with the Constitution, . . . a desirable end cannot be promoted by prohibited means.[203]

In addition, *every person who voices a desire to undergo nontherapeutic sterilization surgery must be provided with an illustrated booklet, written in the language of the applicant, which clearly describes the surgical procedures and effects of the operation.*

D. *Every hospital providing sterilization surgery must also present to every applicant a detailed audio-visual explanation, in the language of the applicant, which accurately describes the surgical procedures and effects of the operation.*

E. *The results of an preoperation examination must be made available to the applicant.*

F. *An auditor-witness, independent of the medical facility, and chosen by the applicant, must be present for the entire counseling and consent process. This provision may be waived by the applicant by a written statement on the consent form. Spousal consent is not necessary, but a spouse's participation in the process of securing informed consent should be encouraged. A spouse may act as an auditor-witness.*

G. *No person under the influence of any anesthetic, hypnotic, narcotic, tranquilizing or mood altering substance (unless the person is a chronic user of such substance, the withdrawal of which would be seriously detrimental to his or her health) shall be solicited for a nontherapeutic sterilization.*

H. *Consent for a nontherapeutic sterilization shall not be solicited from any person undergoing the labor of pregnancy. Nor shall consent be solicited for a period less than 30 days following delivery, an abortion, or any other postpartum surgery.*

I. *A copy of the consent document shall be provided to the patient who signs it.*

J. *To qualify for federal assistance, each state department of health must disseminate copies of the regulations, and prototype copies of the illustrated booklet and audio-visual material, to all licensed physicians within its jurisdiction.*

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203. 262 U.S. at 401. *See also* Note, *El Derecho de Aviso: Due Process and Bilingual Notice*, 83 YALE L.J. 385 (1973). F. Terry v. Alabama, 21 Ala. App. 100, 105 So. 386 (1925) (deaf mute).

K. *Copies of the regulations shall be posted in all health agencies performing sterilizations and shall be made available to all patients or potential patients upon request. All of the facility's personnel, including medical and support staff, shall be made aware of the contents of the regulations.*

L. *California's Department of Health shall commence and maintain all necessary actions and proceedings to enforce the regulations in accordance with Section 205 of the Health and Safety Code. Penalties for violations shall include, but not be limited to, those provided for in Sections 1290*[204] *and 1293,*[205] *and 1294*[206] *of the Health and Safety Code. Similar sanctions must be established by all of the states.*

## VIII. CONCLUSION

For Chicanas, the crucial issue is the assurance that their right to procreate is respected and safeguarded. The current extent of governmental funding and direction over family planning agencies, absent adequate safeguards, has enabled medical personnel to violate this basic right in too many cases. Even in cases currently covered by regulations abuses have taken place because the doctor-patient relationship has not been closely monitored. Enforcement of the regulations must be more strictly compelled. Under the existing structural relationship between the medical profession and government, which permits doctors to enjoy a large amount of autonomy, the most prominent instrument to compel the enforcement of the existing regulations is legal action by patients aggrieved by practitioner abuses. Respect for the right to procreate on the part of doctors and medical staffs is more adequately

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204. Section 1290 of the HEALTH AND SAFETY CODE reads as follows: Any person who violates any of the provisions of this chapter or who willfully or repeatedly violates any rule or regulation promulgated under this chapter is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not to exceed five hundred dollars($500) or by imprisonment in the county jail for a period not to exceed 180 days or by both such fine and imprisonment.

205. Section 1293 of the HEALTH AND SAFETY CODE reads as follows: The district attorney of every county shall, upon application by the state department or its authorized representative, institute and conduct the prosecution of any action for violation within his county of any provisions of this chapter.

206. Section 1294 of the HEALTH AND SAFETY CODE reads as follows: The state department may suspend or revoke any license or special permit issued under the provisions of this chapter upon any of the following grounds and in the manner provided in this chapter:

(a) Violation by the licensee or holder of a special permit of any of the provisions of this chapter or of the rules and regulations promulgated under this chapter.

(b) Aiding, abetting, or permitting the violation of any provision of this chapter or of the rules and regulations promulgated under this chapter.

(c) Conduct inimical to the public health, morals, welfare, or safety of the people of the State of California in the maintenance and operation of the premises or services for which a license or special permit is issued.

ensured when they must pay substantial monetary damages for the harm they perpetrate.

The emphasis on enforcement, however, does not understate the necessity of regulatory reform. In order to correct the existing deficiencies, the regulations must be reformed to effectively provide stricter adherence to the standards of procedural due process. One major way to satisfy this constitutional requirement is to mandate that oral counseling and written consent forms be provided in Spanish. This would make it possible for medical personnel to meet the standards of *Canterbury v. Spence*.[207] In *Canterbury*, the right of the patient to expect, and the duty of the physician to impart, information concerning the details of the therapy was established.[208] The existing regulations were intended to accomplish this end, but they have not been efficiently enforced, and, in many instances, have proved inadequate. In response to similar situations, courts have long held that a right can be infringed not only by unconstitutional laws but also by the unconstitutional actions of public officials.[209] Such is the case under the current regulations governing sterilization surgery.

There is a difference between an inconvenience and a constructive denial of the right to undergo sterilization surgery. The harm experienced by Chicanas and other poor women require greater controls on the doctor-patient relationship within this context. The amount of time needed to make an informed decision is already available to the better educated middle class woman. Sterilization in her situation is usually the result of extensive consultation with a private physician, and an even longer period of discussion with the male spouse. It may inconvenience some women to read a consent form written at a sixth grade comprehension level, or view an audio-visual presentation, but when compared to the threat of involuntary sterilization, inconvenience must give way to considerations of health, safety, and the fundamental right to procreate. Middle class women who have striven to acquire greater control over their own bodies should not view the inconvenience of stricter regulations as an obstacle to this end, especially when such an inconvenience is necessary to safeguard the physical and psychological well being of their less fortunate sisters. Judge Gesell expressed the necessity for this position quite precisely in *Relf*: "Under these circumstances it is well established that one does not have to forfeit fundamental rights before he or she may com-

207. 464 F.2d 772 (D. Col. 1972).
208. *Id.* at 782. This included the goals to be expected and the risks involved.
209. *See* Goldberg v. Kelly, 397 U.S. 254 (1970) (due process), Yick Wo v. Hopkins, 188 U.S. 356 (1886) (equal protection).

plain, so long as the threat is real and immediate, as it is here."[210] To undermine this threat, and to protect the rights of Chicanas, the recommendations submitted herein need to be adopted and enforced.

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210. 372 F. Supp. at 1201.