UNC SCHOOL OF LAW

NORTH CAROLINA LAW REVIEW

Volume 60 | Number 5 Article 2

6-1-1982

Sterilizing the Retarded: Constitutional, Statutory and Policy Alternatives

Richard K. Sherlock

Robert D. Sherlock

STERILIZING THE RETARDED: CONSTITUTIONAL, STATUTORY AND POLICY ALTERNATIVES

RICHARD K. SHERLOCK†
ROBERT D. SHERLOCK‡

Although the eugenic justification for sterilization of the retarded has long been discredited, sterilization itself has not. Court-ordered sterilizations are still performed, although they are now justified by the perceived harm caused to society by the presumed inability of a retarded person to serve as a parent. The authors suggest that this position needs rethinking, and they examine the justifications offered in support of sterilization in light of the recognition of procreation as a fundamental right. Messrs. Sherlock conclude that some existing state sterilization laws are inadequate to protect the rights of the retarded and present a new procedural and substantive approach to the issue, which should serve to protect both the retarded person and society's interests.

I. INTRODUCTION

On March 24, 1973, Georgia Mae Downs was sterilized permanently without her consent four days after the birth of her second child. Her sterilization was not performed in the austere surroundings of a state institution, nor was she operated on by a government functionary. Her sterilization came at the hands of a respected physician in a small hospital in a quiet, New England town.

Georgia Downs had been a deaf mute since early childhood and never developed strong mental abilities. Her intelligence quotient (I.Q.) registered in the "borderline" range.[1] Fifteen months after the birth of her first child she again became pregnant, prompting concern on the part of state welfare workers. They were troubled by her lack of child care abilities and her seeming inability to control her reproductive activity. They encouraged Mrs. Downs' sister to seek appointment as her guardian, and the sister, acting as guardian, gave consent for the sterilization. Today Georgia Downs works at a steady

† Assistant Professor of Human Values and Ethics, Center for the Health Sciences, University of Tennessee, Memphis; B.A., University of Utah, 1970, Ph.D., Harvard University, 1978.

‡ Attorney, Salt Lake City, Utah; Adjunct Professor, University of Utah College of Law; B.A., University of Utah, 1973; J.D., University of Utah, 1976.

1. Borderline I.Q.'s generally fall in the 68-84 range on the Stanford-Binet and Cattell tests or in the 70-85 range on the Wechsler test, in which 100 is considered average. Persons with borderline intelligence are not significantly impaired in adaptive behavior, meaning they can communicate, hold jobs, assume responsibility, engage in some social activity and write simple missives. See Manual on Terminology and Classification in Mental Retardation 18-20, 32-33 (H. Grossman rev. ed. 1977).

job, is married, cares for one of her children and is suing her sister, the physician, the hospital and the welfare workers for damages resulting from their actions in having her sterilized.[2]

Four years earlier in Texas the parents and legal guardians of a thirty-four-year-old retarded woman also had sought to have their daughter sterilized.[3] The daughter, Daisy Levi, had an I.Q. of approximately 40. She could not count past three, did not know the days of the week, could not tell time and knew nothing of the consequences of sexual intercourse. She had already borne one son, then age eleven, with an I.Q. similar to hers, who had been removed from special education classes on the recommendation of the school psychologist because the child was unable to benefit from them. Alternative contraceptive measures had been tried for Daisy, but those that promised success proved medically unacceptable. Her parents, wanting to care for their daughter at home but unable to care for an unlimited number of grandchildren, sought sterilization as the most effective means of dealing with a difficult situation.[4] The Texas Court of Civil Appeals eventually turned down their request, holding that it lacked the power to authorize sterilization.[5]

These two cases illustrate the confused, often contradictory positions of law and public policy regarding the sterilization of the retarded. Several states have antiquated, little-used laws allowing sterilization without the consent of relatives or guardians upon the initiative of institutions.[6] In the absence of specific statutory guidance, several state and federal courts have followed the lead of Texas and have disclaimed jurisdiction to authorize sterilization.[7] In addition, some courts have denied that the parent has the power to consent on behalf of the child to be sterilized.[8]

This Article will attempt to provide comprehensive answers to the delicate moral, constitutional and policy questions raised by the sterilization issue. We will review the factual background, then analyze the constitutional questions involved, and finally develop the policy options available for implementing a considered approach to the sterilization of the retarded. At each stage

2. Downs v. Sawtelle, 574 F.2d 1 (1st Cir. 1978), cert. denied, 439 U.S. 910 (1978) (court held defendants not entitled to complete immunity from suit under 42 U.S.C. § 1983 (1976); court reversed directed verdict in defendants' favor entered by district court and remanded cause for full determination on the merits; no final disposition had been published as of this printing); Boston Sunday Globe, Feb. 27, 1977, at A1.

3. Frazier v. Levi, 440 S.W.2d 393 (Tex. Civ. App. 1969).

4. Id. at 393-94.

5. Id. at 394-95.

6. See Conn. Gen. Stat. Ann. § 45-78r (West 1981); Del. Code Ann. tit. 16, §§ 5701-5703 (1974); Miss. Code Ann. § 41-45-1 (1972); N.C. Gen. Stat. § 35-36 (1976); Okla. Stat. Ann. tit. 43A, § 341 (1979); S.C. Code Ann. § 44-47-10 to -50 (Law. Co-op. 1977); Utah Code Ann. § 64-10-1 (1978); Vt. Stat. Ann. tit. 18, § 8704 (1968); W. Va. Code § 27-16-1 (1980).

7. Wade v. Bethesda Hosp., 337 F. Supp. 671 (S.D. Ohio 1971); Guardianship of Kemp, 43 Cal. App. 3d 758, 118 Cal. Rptr. 64 (1974); Holmes v. Powers, 439 S.W.2d 579 (Ky. 1968); In re R., 515 S.W.2d 467 (Mo. 1974). Contra Stump v. Sparkman, 435 U.S. 349 (1978) (Indiana); Wyatt v. Aderholt, 368 F. Supp. 1383 (M.D. Ala. 1974); In re Grady, 85 N.J. 235, 426 A.2d 467 (1981).

8. L. v. H., 163 Ind. App. 636, 325 N.E.2d 501 (1975), cert. denied, 425 U.S. 936 (1976) (minor child); Holmes v. Powers, 439 S.W.2d 579 (Ky. 1968) (adult child). Contra In re Grady, 85 N.J. 235, 426 A.2d 467 (1981) (minor child); In re Sallmaier, 85 Misc. 2d 295, 378 N.Y.S.2d 989 (Sup. Ct. 1976) (adult child).

we will work toward a comprehensive policy that meets standards of factual soundness, legal and constitutional scrutiny, and the most exacting concern for the rights of retarded persons. Clearly, the finality of sterilization[9] must be given considerable weight, but, just as clearly, any policy that does not allow parental or guardian consent for sterilization in the most compelling cases is inhumane and ultimately shortsighted. It is the goal of this Article to develop a policy proposal in light of these two concerns.

A. Historical Background

Interest in sterilizing the retarded first emerged in America early in this century. The development of surgical techniques permitting sterilization combined readily with reigning beliefs concerning the genetic transmission of retardation itself. The rediscovery of Mendelian genetics led to medical theories postulating that many of the most perplexing forms of mental illness, including mental retardation and even "habitual criminality," were inherited through the simple Mendelian schema of dominant and recessive traits.[10]

The legislative response to these medical theories was straightforward and predictable: if retardation was inherited, a sterilization program limited to the relevant target groups would, over time, eliminate the problem of retardation.[11] Beginning in Indiana in 1907, this simple logic spread until thirty states eventually enacted such a sterilization program into law.[12]

Many of these early laws were grossly deficient from a constitutional standpoint. Most applied only to institutionalized persons.[13] Many failed to provide for notice of a hearing and for the right to be represented at such a hearing.[14] Some failed to provide for any hearing at all, relying instead on the discretionary judgment of the officers at a state institution.[15] Most of these deficiencies were eventually recognized by courts, and after modification many revised statutes have been upheld by a succession of courts.[16] The prin-

9. Although reversibility of sterilization occasionally is a possibility, the success rates vary widely from study to study and between methods of sterilization. For decision-making purposes, it is best to consider the sterilization to be nonreversible; in other words, one should make a decision to sterilize only if such action is appropriate if nonreversible. Sherlock & Sherlock, Voluntary Contraceptive Sterilization: The Case for Regulation, 1976 Utah L. Rev. 115, 116 & n.7.

10. M. Haller, Eugenics 40-75 (1963). This book is the best general history of the subject.

11. The most comprehensive review of the early legislative history is J. Landman, Human Sterilization 54-93 (1932); also useful are S. Davies, The Social Control of the Mentally Deficient (1930), and H. Laughlin, Eugenical Sterilization in the United States (1922). An excellent survey of the legal issues is O'Hara & Sanks, Eugenic Sterilization, 45 Geo. L.J. 20 (1956).

12. See J. Landman, supra note 11, at 54-93, for a presentation of the 30 states.

13. An equal protection argument was used to invalidate several state laws until the argument was rejected by the Supreme Court in Buck v. Bell, 274 U.S. 200 (1927). See Haynes v. Lapeer Circuit Judge, 201 Mich. 138, 166 N.W. 938 (1918); Smith v. Board of Examiners, 85 N.J.L. 46, 88 A. 963 (1913); In re Thompson, 103 Misc. 23, 169 N.Y.S. 638 (Sup. Ct. 1918).

14. See, e.g., Davis v. Berry, 216 F. 413 (S.D. Iowa 1914), rev'd as moot, 242 U.S. 468 (1917); Wyatt v. Aderholt, 368 F. Supp. 1382 (M.D. Ala. 1973); Brewer v. Valk, 204 N.C. 186, 167 S.E. 638 (1933). Vermont's apparently little-used statute (Vt. Stat. Ann. tit. 18, § 8702 (1968)) seems to be still deficient in this respect.

15. E.g., Conn. Gen. Stat. Ann. § 19-569g (West 1977) (originally enacted as § 17-19) (repealed 1979); Wisc. Stat. Ann. § 46.12 (West 1957) (repealed 1977).

16. See Buck v. Bell, 274 U.S. 200, 206-07 (1927); State v. Troutman, 50 Idaho 673, 299 P. 668

ciple that the police power of the state includes the power to sterilize some retarded or mentally ill persons received the sanction of the Supreme Court in 1927[17] and has not been rejected since, although some state laws have been struck down for procedural reasons.[18]

In thirteen states laws remain on the statute books.[19] They are often confusing and poorly drafted, and several have not been revised in decades;[20] most have been little used.[21] These laws provide for varying degrees of protection of both procedural and substantive rights of the retarded.[22] Procedurally, some of these statutes establish state boards to hear sterilization petitions.[23] Others provide recourse to the courts either directly[24] or on appeal from the orders of such a board.[25] Substantively, the rationale for the laws and the concomitant finding that must be made by either the court or the board may be poorly stated or missing.[26] Even in those instances where the rationale is clearly stated, the statutes differ substantially. Some require a finding that it would be "best for society" if a given person did not bear or beget children.[27] A finding that the sterilization would be best for the candi-

---

(1931); State ex rel. Smith v. Schaffer, 126 Kan. 607, 270 P. 604 (1928); In re Cavitt, 182 Neb. 712, 157 N.W.2d 171 (1968) (four-to-three vote to declare statute unconstitutional, but Nebraska Constitution requires five votes to invalidate statute), appeal dismissed, 396 U.S. 996 (1970); In re Clayton, 120 Neb. 680, 234 N.W. 630 (1931); Cook v. State, 9 Or. App. 224, 495 P.2d 768 (1972). Many of these cases applied to persons found guilty of sex offenses. E.g., People v. Blakeship, 16 Cal. App. 2d 606, 61 P.2d 352 (1936).

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

18. E.g., Wyatt v. Aderholt, 368 F. Supp. 1383 (M.D. Ala. 1974); In re Opinion of the Justices, 230 Ala. 543, 162 So. 123 (1935); Brewer v. Valk, 203 N.C. 186, 167 S.E. 638 (1933); In re Hendrickson, 12 Wash. 2d 600, 123 P.2d 322 (1942).

19. Ark. Stat. Ann. § 59-501 (1971); Conn. Gen. Stat. Ann. § 45-78q (West 1981); Del. Code Ann. tit. 16, §§ 5701-5703 (1974); Ga. Code Ann. § 84-933 (1979); Miss. Code Ann. § 41-45-1 (1972); N.C. Gen. Stat. §§ 35-36 to -37 (1976 & Supp. 1981); Okla. Stat. Ann. tit. 43A, § 341 (1979); Or. Rev. Stat. § 436.041 (1979); S.C. Code Ann. § 44-47-10 (Law. Co-op. 1977); Utah Code Ann. § 64-10-1 (1978); Vt. Stat. Ann. tit. 18, § 8701 (1968); Va. Code § 54-325.11 (Supp. 1981); W. Va. Code § 27-16-1 (1980).

20. E.g., Miss. Code Ann. § 41-45-1 (1972); Okla Stat. Ann. tit. 43A, § 341 (1979).

21. See M. Haller, supra note 10, at 143.

22. Compare Vt. Stat. Ann. tit. 18, §§ 8701-8704 (1968) (no hearing or consent required for inmate of state institution) with Conn. Gen. Stat. Ann. § 45-78p to -78y (West 1981) (mandating hearing, guardian ad litem, cross-examination of witnesses; statutory definition of "best interests").

23. Del. Code Ann. tit. 16, §§ 5701-5703 (1974); Miss. Code Ann. § 41-45-7 (1972); Okla. Stat. Ann. tit. 43A, § 342 (1979); Or. Rev. Stat. § 436.050 (1979); S.C. Code Ann. § 44-47-30 (Law. Co-op. 1976).

24. Ark. Stat. Ann. § 59-501 (1971); Conn. Gen. Stat. Ann. § 45-78q (West 1981); Ga. Code Ann. § 84-933 (1979); N.C. Gen. Stat. § 35-36 (Supp. 1981); Utah Code Ann. § 64-10-1 (1978); Va. Code § 54-325.11 (Supp. 1981); W. Va. Code § 27-16-6 (1980).

25. Miss. Code Ann. § 41-45-11 (1972); Okla. Stat. Ann. tit. 43A, § 343 (1979); Or. Rev. Stat. § 436.110 (1979); S.C. Code Ann. § 44-47-60 (Law Co-op. 1977).

26. See Ark. Stat. Ann. § 59-501 (1971); Del. Code Ann. tit. 16, §§ 5701-5703 (1974).

27. Laws containing this standard often give no guidance regarding how the "best interests of society" are to be determined. See, e.g., Miss. Code Ann. § 41-45-1 (1972); Utah Code Ann. § 64-10-1 (1968); Va. Code § 32-424.1 (Supp. 1978); id. § 37.1-171.1 (Supp. 1975); W. Va. Code § 27-16-1 (Supp. 1976). In some statutes there are explicit or vague references to eugenic purposes. See Me. Rev. Stat. Ann. tit. 34, § 2461 (1964); N.C. Gen. Stat. § 35-39 (Supp. 1981); Okla. Stat. Ann. tit. 43A, §§ 341-342 (1971); Vt. Stat. Ann. tit. 18, § 8701 (Supp. 1968). Other laws expressly include provisions allowing sterilization to those who cannot provide adequate parental care, indepen-

date as well also may be required,[28] or may even be sufficient in itself.[29]

The role of parents or guardians likewise differs substantially among the various statutes. Many of the laws make no mention of the parent or guardian. Several, however, do provide for the obtaining of consent from parents or guardians as an integral part of the sterilization process.[30] Nonetheless, this consent comes only after the institutional staff has located an individual whom they believe is an appropriate candidate for sterilization. Finally, in a few states parents and the institutional staff are given parallel authority to present candidates directly before a board or court.[31]

The general tenor and ethos of these laws no longer reflect contemporary procedural rights nor do they reflect any current medical justification for sterilization. The eugenic justifications originally articulated are now repudiated by most medical experts and hardly would provide a compelling state interest.[32] The laws themselves provide little or no guidance concerning the factors that must be taken into account in passing on a sterilization petition. Should the welfare of the family involved be considered? Must the individual be sexually active already or only "likely to be active"? From a medical justification standpoint, it must be noted that institutional personnel do not now seek sterilization as often as do parents, nor do parents or physicians seek sterilization as a solution to problems of public welfare and racial decline. Instead, parents and guardians seek sterilization as a solution to particularly trying and very personal circumstances. These personal dilemmas confront not only parents but also physicians, policy makers and courts.[33]

The need for a clear and comprehensive policy for dealing with these parental requests is demonstrated further by recent judicial history. In the last

---

dently of any finding that the child would be genetically defective. See Ga. Code Ann. § 84-933 (1975); N.C. Gen. Stat. § 35-39 (Supp. 1981); Or. Rev. Stat. § 436.070 (1971).

28. See, e.g., Miss. Code Ann. § 41-45-1 (1972); Vt. Stat. Ann. tit. 18, § 8701 (Supp. 1968); Va. Code § 32-424.1 (Supp. 1978); id. § 37.1-171.1 (Supp. 1975); W. Va. Code § 27-16-1 (Supp. 1976).

29. See, e.g., N.C. Gen. Stat. §§ 35-37, -39 (Supp. 1981); Utah Code Ann. § 64-10-1 (1968).

30. See Me. Rev. Stat. Ann. tit. 34, § 2461 (1964); N.D. Cent. Code § 25-04.1-01 (1970); Or. Rev. Stat. § 436.100 (1971).

31. See Ga. Code Ann. § 84-933 (1975); Va. Code § 32-424.1 (Supp. 1978); W. Va. Code § 27-16-1 (Supp. 1976). In North Carolina Ass'n for Retarded Children v. North Carolina, 420 F. Supp. 451, 456 (M.D.N.C. 1976), the court found unconstitutional a provision giving a public official the duty to institute sterilization proceedings when requested to by the next of kin or a legal guardian, because under the provision "for any reason, or for no reason at all, he [the next of kin or legal guardian] may require an otherwise responsible public servant to initiate the procedure. This he may do without reference to any standard and without regard to the public interest or the interest of the retarded person." In light of this decision, the constitutionality of the Virginia statute is suspect. The Georgia and West Virginia laws may be distinguished because they require the parent or guardian to set forth the basis for his opinion that the candidate should be sterilized, by referring to the standards set forth in the statutes.

32. American Ass'n on Mental Deficiency (AAMD), Sterilization of Persons Who Are Mentally Retarded: Proposed Official Policy Statement of the American Association on Mental Deficiency, Mental Retardation, April 1974, at 59 (approved at Mental Retardation, August 1974, at C-17); Ferster, Eliminating the Unfit—Is Sterilization the Answer?, 27 Ohio St. L.J. 591 (1966); Murdock, Sterilization of the Retarded: A Problem or a Solution?, 62 Calif. L. Rev. 917 (1974).

33. See Perrin, Sands, Tinker, Dominquez, Dingle & Thomas, A Considered Approach to the Sterilization of Mentally Retarded Youth, 130 Am. J. Diseases of Children 288, 289-90 (1976) [hereinafter cited as Perrin]. See also Ruby v. Massey, 452 F. Supp. 361 (D. Conn. 1978).

decade courts in six states have considered directly the question of parental or guardian consent to sterilization. Five have reached the same general conclusion: absent specific statutory authority, neither parents, guardians nor courts have the power to authorize sterilization.[34]

The general reasoning behind these decisions reflects growing judicial awareness of the right of individuals to control their own reproductive behavior. In the wake of *Griswold v. Connecticut*,[35] *Eisenstadt v. Baird*[36] and *Roe v. Wade*,[37] no longer can it be maintained that a general grant of authority to parents and guardians to act for the "best interest" of the retardate includes the power to sterilize.[38] If procreative powers are constitutionally protected, then actions that would destroy the capacity to exercise such powers must receive strict scrutiny on both procedural and substantive grounds:

> The courts are not faced in this case with a prayer for a judgment authorizing ordinary medical treatment, or radical surgery necessary to preserve the life of a child; we are faced with a request for sanction by the state of what no doubt is a routine operation which would irreversibly deny to a human being a fundamental right, the right to bear or beget a child. Jurisdiction of the juvenile court to exercise the awesome power of denying that right may not be inferred from the general language of the sections of the code to which

34. Kemp v. Kemp, 43 Cal. App. 3d 758, 118 Cal. Rptr. 64 (1974); A.L. v. G.R.H., 163 Ind. App. 636, 325 N.E.2d 501 (1975), cert. denied, 425 U.S. 936 (1976); Holmes v. Powers, 439 S.W.2d 579 (Ky. 1968); In re M.K.R., 515 S.W.2d 467 (Mo. 1974); Frazier v. Levi, 440 S.W.2d 393 (Tex. Civ. App. 1969). But see In re Sallmaier, 85 Misc. 2d 295, 378 N.Y.S.2d 989 (Sup. Ct. 1976). In the last case the court approved a sterilization petition from the mother of an adult daughter. The basis for approval was the general *parens patriae* power of the court with respect to incompetent persons, as New York had no statute authorizing sterilization of individuals. A similar rationale was used in In re Simpson, 180 N.E.2d 206 (Ohio P. Ct. 1962), in which the judge relied on the broad statutory authority given to probate courts over the feeble-minded to order the sterilization of an adult retarded woman on the petition of her mother/guardian.

Several federal courts, including the Supreme Court, have had to address the line of reasoning advanced in *Sallmaier* and *Simpson*. In Wade v. Bethesda Hosp., 337 F. Supp. 671 (S.D. Ohio 1971), motion for reconsideration denied, 356 F. Supp. 380 (S.D. Ohio 1973), an action was brought against a probate judge for ordering the plaintiff to submit to sterilization. The district court refused the judge the shield of judicial immunity, because he had acted in absense of all jurisdiction: "Nor has this Court been able to discover any judicial precedent for such an order in the absence of a specific statute." Id. at 674. However, in Sparkman v. McFarlin, 552 F.2d 172 (7th Cir. 1977), rev'd sub nom. Stump v. Sparkman, 435 U.S. 349 (1978), the issue was again whether a judge had acted in clear absence of all jurisdiction when he ordered sterilization of a child simply upon the petition of a parent. The Seventh Circuit Court of Appeals found that there was no statutory or common-law basis for the sterilization order, even though an Indiana statute conferred broad and general jurisdiction in the state's circuit courts. Id. at 174-75. The Supreme Court reversed, deciding that Indiana law vested in the judge "the power to entertain and act upon the petition for sterilization." 435 U.S. at 364.

35. 381 U.S. 479 (1965) (statute forbidding use of contraceptives by married persons declared unconstitutional).

36. 405 U.S. 438 (1972) (statute forbidding distribution of contraceptives to unmarried persons found to be unconstitutional).

37. 410 U.S. 113 (1973) (declared unconstitutional a statute making abortion criminal without regard to the stage of pregnancy).

38. On the development of the general idea of reproductive freedom, see Doss & Doss, On Morals, Privacy, and the Constitution, 25 U. Miami L. Rev. 395 (1971); Note, On Privacy: Constitutional Protection for Personal Liberty, 48 N.Y.U. L. Rev. 670 (1973).

> we have referred. Such jurisdiction may be conferred only by specific statute.
>
> Whatever might be the merits of permanently depriving this child of this right, the juvenile court may not do so without statutory authority—authority which provides guidelines and adequate legal safeguards determined by the people's elected representatives to be necessary after full consideration of the constitutional rights of the individual and the general welfare of the people.[39]

Despite the absence of specific statutory guidelines, there is continuing evidence of physicians' accession to parental requests for sterilization. The American Medical Association's handbook on retardation for primary-care physicians specifically notes that parents of retarded children often will seek advice on sterilization from pediatricians and family physicians.[40] A recent example of professional concern about this issue is the new, official policy statement of the American Association on Mental Deficiency (AAMD), the largest professional organization in the field. Its guidelines reflect a serious attempt to balance the right of the retarded person to reproductive freedom against the demonstrated need, in some cases, for sterilization.[41]

The absence of specific legal guidelines fosters abuse of the rights of the retarded on the one hand and unwarranted hesitancy in cases of demonstrated need on the other. Neither of these situations should be tolerated; both lead to human suffering and to a diminished concern for the welfare of retarded persons.

B. Justifications

Early legislative efforts to provide for the sterilization of institutionalized persons were based on eugenic theories that are now repudiated by most experts.[42] Knowledge gained from the study of genetics and epidemiology has

---

39. In re M.K.R., 515 S.W.2d 467, 470-71 (Mo. 1974). The issue on appeal was whether the juvenile court had jurisdiction to order sterilization on petition from the mother. The court concluded that it did not. Id. at 470. This same argument also was advanced by the Dep't of Health & Human Services (DHHS) in suggesting regulations governing DHHS financing of sterilization in family planning clinics or with federal funds. Originally, DHHS had permitted sterilization with federal funds under certain guidelines, but DHHS has revised its regulations in light of Relf v. Weinberger, 372 F. Supp. 1196 (D.D.C. 1974), modifications rejected, 403 F. Supp. 1235 (D.D.C. 1975), dismissed as moot, 565 F.2d 722 (D.C. Cir. 1977) (court found that Secretary of DHHS lacked authority to fund the sterilization of any person incompetent under state law to consent to such an operation). Federal financial participation in the sterilization of incompetent or institutionalized persons now is prohibited. 42 C.F.R. § 441.254 (1980). The rationale follows that noted in the state court decisions discussed in the text: sterilization is such a serious and irreversible measure that it cannot be presumed to be included in a general grant of authority from Congress. Absent a clear legislative mandate to the contrary, sterilization must be assumed to be excluded in the case of incompetent persons who cannot give legal consent for themselves.

40. American Med. Ass'n, Mental Retardation: A Handbook for the Primary Physician 56-58 (3d ed. 1976); see also Perrin, supra note 33, at 289.

41. See AAMD, note 32 supra. In general the AAMD statement rejects any sterilization done by the state on an involuntary basis and supports only those sterilizations of impaired or incompetent persons performed with the consent of his next of kin or guardian after court approval also has been obtained. Id. at 61.

42. See note 32 supra.

demonstrated that the eugenic theories of racial and social decline that animated concerns half a century ago were invalid. Furthermore, it is now clear that, except for a few specific syndromes, no specific biological factor is known to account for retardation;[43] thus, sterilization as an instrument of social policy designed to eliminate retardation, while effective in some cases, sweeps too broadly, as many retarded individuals would not pass their afflictions on to offspring.

The earlier period of legislative and judicial activity also took place before courts had enunciated clearly a constitutionally protected right to engage in reproductive activity free from governmental intrusion or controls by other parties.[44] Nevertheless, the courts have not held that this right is so absolute as to be placed beyond any reasonable legal regulation when it implicates other, equally fundamental interests.

Procreation is held justifiably to be a fundamental right both in American law[45] and in most international human rights declarations and covenants.[46] Nonetheless, it is clear that no single right can be honored in the abstract, divorced from the whole cluster of individual rights and social responsibilities that protect human freedom, nourish human virtue and sustain the common good of society.[47] One right, such as procreation, cannot be isolated from the matrix of compromise and adjustment that is an essential part of the public policy of any society. Nor can the welfare and rights of the retarded person always take precedence over the welfare and rights of his family. The fundamental right of procreation cannot be honored without considering the effect of that right on the welfare of others who possess equally fundamental rights and equally serious responsibilities.

Rights, therefore, must be understood both as fundamental claims of the individual to be allowed the freedom or provided the resources to pursue certain ends, and as inherently limitable entitlements the exercise of which must be constantly adjusted to avoid impinging on the rights of other persons. For example, it might reasonably be claimed that the most pressing need of severely retarded persons is to have their welfare looked after by competent, caring persons, since the severely retarded cannot be expected to do that for themselves. It seems abundantly clear, however, that fulfilling this need in

43. American Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 5-6, 332 (3d ed. 1980).

44. See Skinner v. Oklahoma, 316 U.S. 535 (1942) (statute providing for sterilization of certain habitual criminals violated the equal protection clause of the fourteenth amendment).

45. "We are dealing here with legislation which involves one of the basic civil rights of man." Id. at 541. See also note 38 supra.

46. "Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family." Universal Declaration of Human Rights, G.A. Res. 217(III), ESCOR Annex 5, at art. 16, ¶ 1 (1948).

47. This point has been amply discussed in the spate of legal commentary dealing with the possible need to control rapid population growth through legal means. See Clark, Law as an Instrument of Population Control, 40 U. Colo. L. Rev. 179 (1968); Dileo, Directions and Dimensions of Population Policy in the United States: Alternatives for Legal Reform, 46 Tul. L. Rev. 184 (1971); Gray, Compulsory Sterilization in a Free Society: Choices and Dilemmas, 41 U. Cin. L. Rev. 529 (1972); Montgomery, The Population Explosion and United States Law, 22 Hastings L. Rev. 629 (1971).

instances such as that of Daisy Levi will be inconsistent with the exercise of the individual's fundamental procreative right. The recognition that procreation is a fundamental right renders suspect all but the most compelling justifications for the exercise of the awesome power of sterilization. Nevertheless, there are compelling societal and individual interests that can be furthered by sterilization in some cases. It is to these that this analysis now must turn.

Although the eugenic justification for sterilization no longer is plausible, new rationales for sterilization have been proposed by a number of professionals and policy makers. One of the most popular of these new rationales focuses on the harms suffered by society from the presumed inabilities of a retarded person to function adequately as a parent. A few states even have revised their statutes specifically to include this new "justification." The most direct of these revisions is Oregon's "Sterilization for Social Protection" law, which provides:

> The investigation, findings and orders of the board . . . shall be made with the purpose in view of avoiding the procreation of children:
>
> (a) Who would have an inherited tendency to mental retardation or mental illness; or
>
> (b) Who would become neglected or dependent children as a result of the parent's inability by reason of mental illness or mental retardation to provide adequate care.[48]

This general policy must rest upon two fundamental assumptions: (1) that some persons or groups will be harmed as a result of procreation by a retarded person, and (2) that retardation can render a person substantially inadequate as a parent. Both assumptions need to be examined in light of the constitutional status of procreation as a fundamental right and the corresponding need for a compelling justification for irreparably terminating the capacity to exercise this right.

There are several separate "foci of harm" that may justify a policy of sterilizing retarded persons. The first and most obvious is potential harm to society through procreation by individuals who are incapable of caring for their offspring. This is the probable rationale of the Oregon statute noted above. Careful analysis of the epidemiological data, however, strongly suggests that this is an overly broad justification. First, the percentage of retarded individuals in the population is extremely low. Dr. Tarjan and his associates recently have argued that the prevalence is in the neighborhood of one percent; even those who place the figure higher do not claim that it exceeds three percent.[49] The total retarded population is, therefore, not large enough to warrant fears that society will be harmed significantly if retarded persons bear children. Second, the known reproductive rate of retarded persons is signifi-

48. Or. Rev. Stat. § 436.070 (1979).

49. Tarjan, Wright, Eyman & Keeran, Natural History of Mental Retardation: Some Aspects of Epidemiology, 77 Am. J. Mental Deficiency 369, 370 (1977). On the higher percentage figure, see N. Robinson & H. Robinson, The Mentally Retarded Child 35-36 (2d ed. 1976); R. Heber, Epidemiology of Mental Retardation 6-23 (1970).

cantly below that of a control group of nonretarded individuals. Elizabeth Reed notes:

> Our data from 1016 families with I.Q. scores for both parents and children showed a negative correlation of family size with both the mean I.Q. of the children and of the parents. However, when the tested non-reproducing siblings were included in the calculations the order changed and the larger family sizes were found at higher I.Q. levels . . . . It is not likely that the I.Q. of the general population is declining because of the negative relation of family size and the mean I.Q. of the children.[50]

This same result is consistent with other studies conducted in the United States, England and Sweden.[51]

A second focus of harm is that which might befall the retarded person herself. There are cases in which the burdens of child care and anxieties associated with having a reproductive capacity would have a serious adverse effect on the retarded person.[52] Consider for example the case of a mentally retarded girl unable to maintain adequate menstrual hygiene habits. In such a case, hysterectomy may alleviate the hygienic problem and provide permanent reproductive control.[53] It must be noted, however, that data on the child care capacities of retarded persons make it questionable that concern about harm to the retarded person is justified with respect to most retarded persons.[54]

---

50. Reed, Mental Retardation and Fertility, 18 Soc. Biology 542, 549 (1971).

51. See B. Farber, Mental Retardation: Its Social Context and Social Consequences 91-92 (1968); L. Penrose, The Biology of Mental Defect 57-58 (3d ed. 1962); E. Reed & S. Reed, Mental Retardation: A Family Study 50-51, 64-68 (1965); Bajema, Estimation of the Direction and Intensity of Natural Selection in Relation to Human Intelligence by Means of the Intrinsic Rate of Natural Increase, 10 Eugenics Q. 175, 178, 184-85 (1963); Böök, Fertility Trends in Some Types of Mental Defects, 6 Eugenics Q. 113, 113-15 (1959).

52. This argument has been incorporated into state sterilization statutes that require a finding of benefit to the candidate in addition to a eugenic basis for ordering sterilization before sterilization is permissible. See Vt. Stat. Ann. tit. 18, § 8701 (1968). In Davis v. Walton, 74 Utah 80, 276 P. 921 (1929), the Utah Supreme Court upheld the constitutionality of the state's compulsory sterilization law but rejected the pending petition for sterilization because the requirement of benefit to the candidate had not been met. A newer Utah statute (Utah Code Ann. § 64-10-1 (1978)), however, requires benefit to the candidate *or* a eugenic reason for sterilization. See also In re Cavitt, 182 Neb. 712, 720, 157 N.W.2d 171, 176 (1968), appeal dismissed, 396 U.S. 996 (1970).

53. Consider the following case recently reported in the medical literature:

> A "14 year old" girl, the youngest of 10 children, was a premature baby with trisomy 21 Downs Syndrome complicated by pneumococcal meningitis when she was 5 months old, and severe myopia. She was known to the Comprehensive Care Program from birth, and serial psychological testing showed an IQ of 30 with minimal speech development.
>
> At age 7 1/2, goiter was observed without hyperthyroidism, at age 10 thelarche, and at 10 1/2, menarche with heavy flow. During menses she became frightened and withdrawn, refusing to eat and going to bed or crawling under the bed. She did not understand repeated explanation of menses by her mother, could not cope with menstrual hygiene, and had to be kept home from school during menstrual periods.
>
> The patient had total abdominal hysterectomy under general anesthesia without difficulty at age 11. . . . In the three years after surgery, she was reported to have a happier personality at home with no episodes of withdrawal, and she did not miss school. There was no history of sexual activity or molestation.

Perrin, supra note 33, at 289.

54. See J. Mattinson, Marriage and Mental Handicap 201-02 (1971); Mickleson, The Feebleminded Parent, 51 Am. J. Mental Deficiency 644, 653 (1947); Mickleson, Can Mentally Deficient

While it may be difficult to imagine many cases in this category, instances of harm in two other categories that may constitute a compelling justification for sterilization are more readily apparent. A third category is harm to the child resulting from parental inadequacies. Capacity for parenting is variable in retarded persons, and little can be said beyond an intuitive generalization that caring for more than one or two children is beyond the ability of retarded persons. Many retarded persons have some degree of parental incapacity. In these cases a clearly "compelling state interest" can be found in avoiding the harms that a child born into such a household must suffer. This conclusion is reinforced by the growth of knowledge about the relation between very early development and subsequent cognitive abilities and skills.[55] By the time child neglect could be discovered and the child could be removed from the home, permanent damage may have occurred.

A fourth justification for sterilization is exemplified by the case of Daisy Levi.[56] In such a case the burden and harms of procreation by the retardate fall most heavily on the family. Retarded persons already are great burdens in many families, and many families seek institutionalization of retarded offspring to free themselves from the responsibility of continuous care, even though institutional personnel do not favor the placement of retardates in institutions in many cases, especially when they are of the opinion that institutionalization may adversely affect the retarded person. Moreover, there are families, such as Daisy Levi's, that are willing to care for their retarded children at home but are unable to care for the added grandchildren that may result without reproductive control. In these cases sterilization surely represents the least restrictive or onerous alternative from the family's viewpoint. Furthermore, relieving these emotional and financial burdens may serve to strengthen the already strained family unit.[57]

II. CONSTITUTIONAL ISSUES

Buck v. Bell,[58] the landmark Supreme Court decision upholding the constitutionality of sterilization, is now more than fifty years old, yet the constitutional dimensions of the problem of sterilization of retarded persons remain basically unclear, particularly in the recent climate of expanding constitutional

Parents Be Helped to Give Their Children Better Care?, 53 Am. J. Mental Deficiency 516, 532 (1949); Shaw & Wright, The Married Mental Defective, 278 Lancet 273, 274 (1960).

55. See Bradley & Caldwell, The Relation of Infant's Home Environments to Mental Test Performance at Fifty-four Months, 47 Child Dev. 1172, 1173 (1976); de Chateau, Parent-Neonate Interaction: Its Long-Term Effects in Early Experiences and Early Behavior 107, 110-12 (E. Simell ed. 1980); Freeber & Payne, Parental Influence on Cognitive Development in Early Childhood, 38 Child Dev. 65, 66-68 (1967).

56. See text accompanying notes 3-5 supra.

57. Concerning the effects of a retarded child on the family, see F. Grossman, Brothers and Sisters of Retarded Children (1972); Farber, Effects of a Severely Mentally Retarded Child on Family Integration, 24-2 Monographs of the Soc'y for Res. in Child Dev. 1 (1959). On the stresses leading to institutional placement, see N. Robinson & H. Robinson, supra note 49, at 413-31; Downey, Parent's Reasons for Institutionalizing Severely Mentally Retarded Children, 6 J. Health & Human Behavior 147 (1965).

58. 274 U.S. 200 (1927).

rights. The decision in *Buck* occurred before the development of the current "strict scrutiny/compelling interest" test for justifying the infringement of constitutionally protected rights[59] and correspondingly predates the recognition of a constitutionally protected right of procreation.[60] The decision also preceded the development of "suspect classifications" and the application of strict scrutiny to the review of cases involving such classifications.[61] Furthermore, the basis for much of the current legislation (that is, eugenic or epidemiological theories of retardation) has been largely or totally discredited.

A. Parent/Guardian Rights

It is well settled under current law that parents have a fundamental right to direct the care and activities of their children.[62] The welfare of the family and the protection of parental rights long have been recognized by courts as worthy of legal protection. As a Washington court recently noted: "A fundamental premise on which our society is based is that the courts will zealously guard the integrity of the parent-child relationship . . . . A parent's right to the custody and control of his or her minor child will not be abridged except for the most powerful reasons."[63] Consistent with this view, parents traditionally are charged with the responsibility of providing for,[64] and consenting to,[65] medical care of their children.

There may exist a further presumption that parents will act in the best interests of their children with respect to medical care, but any such presumption is not irrebutable. In a number of cases involving Jehovah's Witnesses,[66] courts have overridden parental refusal to consent to medically necessary therapy for their minor child. These cases, however, involved situations in which failure to obtain traditional medical treatment posed a threat to the life of the child. When nonlifesaving benefits to the child have been involved, courts have been widely divided on the question of the absolute discretionary power of parents to seek appropriate medical care for their children. In cases in which parental refusal was based on unorthodox views of a religious or quasi-religious nature, courts have intervened against parental wishes, particularly

59. See, e.g., Roe v. Wade, 410 U.S. 113 (1973); Shapiro v. Thompson, 394 U.S. 618 (1969); Skinner v. Oklahoma, 316 U.S. 535 (1942).

60. Skinner v. Oklahoma, 316 U.S. 535, 541 (1942).

61. See, e.g., Frontiero v. Richardson, 411 U.S. 677 (1973); Loving v. Virginia, 388 U.S. 1 (1967).

62. Quilloin v. Walcott, 434 U.S. 246, 255 (1977); Cleveland Bd. of Educ. v. LaFleur, 414 U.S. 632, 639-40 (1974); Prince v. Massachusetts, 321 U.S. 158, 166 (1944).

63. In re Welfare of May, 14 Wash. App. 765, 545 P.2d 25 (1976) (citations omitted).

64. E.g., Matthews v. Mississippi, 240 Miss. 189, 193, 126 So. 2d 245, 246 (1961) (parental obligation to furnish medical care to child).

65. E.g., Hart v. Brown, 29 Conn. Supp. 368, —, 289 A.2d 386, 391 (1972) (parental right to consent to kidney transplant from one identical twin to the other).

66. People ex rel. Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769 (1952); Morrison v. State, 252 S.W.2d 97 (Mo. App. 1952); State v. Perricone, 37 N.J. 463, 181 A.2d 751 (1962); Hoener v. Bertinato, 67 N.J. Super. 517, 171 A.2d 140 (1961); Santos v. Goldstein, 16 A.D.2d 755, 227 N.Y.S.2d 450 (1962); In re Clark, 21 Ohio Op. 2d 86, 185 N.E.2d 128 (1962).

when the expected benefits to the children were substantial.[67] In cases in which parental refusal was based on a substantial risk to the child or when the procedure could be delayed until the child was old enough to decide for himself, courts generally have honored parental wishes.[68]

Thus, there appears to be clear precedent for courts to override parental wishes with respect to medical care when those wishes (1) may harm the child by depriving him of needed medical care, and (2) are based on uncommon views concerning faith-healing or medically worthless alternative therapies. Analogous considerations are relevant in many court-ordered sterilization proceedings. When no compelling case for sterilization has been presented, a parent's desires for sterilization of the child may have needless irreparable consequences to the child if acted upon. Furthermore, this parental request for sterilization may be based on erroneous information and could be harmful to the best interests of the child.

In light of the fundamental ramifications of sterilization, this Article will propose a requirement of court authorization before a sterilization may be performed on a retarded persons, *even with parental consent*. To reach this conclusion, however, the question posed by petitioner in *In re M.K.R.*[69] must be resolved: "Is this court prepared to single out sterilization from other medical and surgical procedures which parents daily consent to and obtain for the benefit of their minor children . . . to second guess the best judgment of the child's own mother . . . ?"[70]

The apparent answer to this question must be "yes." First, sterilization is *not* analogous to most other medical procedures because it irreparably deprives a person of the capacity to exercise a fundamental right. Therefore, the most closely analogous cases involve parental or guardian consent to withdraw lifesaving therapy, because a fundamental right certainly is threatened immediately. To date only two state supreme courts have dealt squarely with the issue of parental consent and survival.[71] Although the decisions in *In re Quinlan*[72] and *Superintendent of Belchertown State School v. Saikewicz*[73] differ factually, they do converge in some respects. In both cases the courts held that the decision to withdraw therapy should not rest entirely with an interested third party and a physician. In these life-saving situations, the opportunities

67. See Sampson v. Taylor, 29 N.Y.2d 900, 328 N.Y.S.2d 686 (1972); In re Carstairs, 115 N.Y.S.2d 314 (Fam. Ct. 1952); In re Rotkowitz, 175 Misc. 948, 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941); Mitchell v. Davis, 205 S.W.2d 812 (Tex. Civ. App. 1947).

68. In re Tuttendario, 21 Pa. D. 561 (1911); In re Frank, 41 Wash. 2d 294, 248 P.2d 553 (1952); In re Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942). For a full discussion of these issues, see R. Veatch, Death, Dying, and the Biological Revolution 123-30 (1976); Note, Court Ordered Non-Emergency Medical Care for Infants, 18 Clev.-Mar. L. Rev. 296 (1969).

69. 515 S.W.2d 467 (Mo. 1974).

70. Id. at 469 (the court answered the question in the negative).

71. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976).

72. 70 N.J. 10, 55, 355 A.2d 647, 671-72, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976).

73. 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977).

for mistakes, for suspect motives and for misinformation are vastly increased. In *In re Quinlan* the New Jersey Supreme Court wrote favorably of the establishment of a hospital ethics committee.[74] In *Saikewicz* the Massachusetts Supreme Court mandated court review of such cases:

> We do not view the judicial resolution of this most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision—as constituting a "gratuitous encroachment" on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our reponsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.[75]

Thus, both courts appear to approach the same end. When the deprivation of a fundamental right is contemplated, the parent or guardian should not have absolute power to render a decision. Parental consent is not totally irrelevant to the decision, however. For example, in *Parham v. J.R.*,[76] the Supreme Court recently upheld a Georgia law that provided for parental consent to the institutionalization of a mentally disturbed minor. The Court held that parental consent, when combined with institutional screening and an evaluation by an independent medical representative, provided adequate safeguards for the minor's due process rights.[77] The Court reasoned that this review would be as likely to protect the best interests of the minor as would any court review procedure:

> Although we acknowledge the fallibility of medical and psychiatric diagnosis, we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real.[78]

This Supreme Court view appears to be relevant to our discussion. To adopt the Court's argument and conclude from this that court review is neither necessary nor desirable would seem reasonable. But, whatever its relevance to institutionalization, the *Parham* rationale is inapplicable to the sterilization

74. 70 N.J. at 49-50, 355 A.2d at 668-69.

75. 373 Mass. at 759, 370 N.E.2d at 435 (quoting In re Quinlan, 70 N.J. 10, 44, 50, 355 A.2d 647, 665, 669 (1976)).

76. 442 U.S. 584 (1979).

77. Id. at 607.

78. Id. at 609 (citations omitted).

cases. First, a commitment order is inherently reversible, unlike sterilization. Therefore, the need to protect the retardate's rights is greater than the need to protect the rights of the institutionalized minor.

Second, while the *Parham* Court recognized that parents may act unwisely, the traditional assumption that parents act in the best interests of their children should prevail nonetheless. The Court concluded, however, that protection of a child's rights and the nature of the commitment decision are such that parents cannot always have absolute and unreviewable discretion.[79] The situation described in *Parham*, however, is so different from that which we are considering that the relevancy of the *Parham* decision is greatly diminished. In the case of institutionalization, the parent must present his child to an institutional review committee or group, and the institution can be charged with the responsibility of providing a patient-advocate if the court demands. The institution provides a permanent place to locate responsibility for meeting the mandated review procedure. Furthermore, the *Parham* decision yields a strong inference that the review personnel should be specialists in the relevant fields of psychology, psychiatry and medicine.[80] While review by experts may not always be the case, it may be assumed that experts normally will be used. Finally, many mechanisms exist for penalizing institutions that fail to meet the review procedure, including a cut-off of state or federal funds.

In the case of sterilization, none of the above considerations is applicable. First, the parent need not present his child to a specified individual or hospital to be sterilized. If necessary, he can "shop around" for a physician willing to perform what is in most cases a fairly routine procedure. Chances of finding a cooperative doctor are substantial in most urban areas. Second, given the private nature of the transaction and the limited capacities of the retardate, the normal penalties for unjustified or negligent medical care (that is, malpractice suits) are unlikely to provide a useful means of protecting the sterilization candidate's rights. Third, a physician competent to perform a sterilization need not—and probably will not—know anything about retardation. It is unlikely that he would be competent to review the factors that are essential to a decision to sterilize.

B. Due Process Considerations

At present, state statutes concerning sterilization of the mentally retarded fall into two broad procedural categories. One type of statute, similar to that in effect in Mississippi,[81] provides for a nonjudicial review board to determine the advisability of sterilization.[82] Most of these statutes provide an appeal to

79. Id. at 604.
80. Id. at 607.
81. Miss. Code Ann. §§ 41-45-1 to -19 (1972).
82. For example, the Mississippi statute provides:

> After the notice required . . . shall have been so given, the board of trustees of mental institutions . . . shall proceed to hear and consider the said petition and the evidence offered in support of and against the same.

Id. § 41-45-7.

the judicial system if the board concludes that sterilization is proper.[83] A few of these statutes, however, allow the sterilization of institutionalized individuals solely upon the findings of boards of experts and superintendents of institutions, without any judicial approval or judicial review.[84]

The second broad category of state sterilization statutes includes those providing for sterilization to be performed only following a judicial determination in the first instance. These statutes[85] generally allow a court to utilize a board of experts, a referee or independent experts to make recommendations, but the board or individual experts do not pass upon the merits of the sterilization. Under these statutes the experts typically provide information to the trial court of general jurisdiction, which, after a hearing with right of counsel for the candidate, then makes a determination concerning sterilization.[86] Despite the modern status of procreation as a fundamental right, the Supreme Court has ruled that judges have immunity from suits for sterilization orders issued without judicial participation in the decision to sterilize.[87] This decision reversed a court of appeals ruling that because an Indiana judge's action in ordering sterilization of a fifteen-year-old girl without her knowledge had no basis in law or equity, it was without jurisdiction, and therefore the judge was without the protection of judicial immunity.[88]

State sterilization statutes are in danger of running afoul of the clear proposition that in the modern application of constitutional and administrative law principles the deprivation of a fundamental right is not a power delegable to a nonjudicial review board in the first instance.[89] Indeed, under the first category of state statutes that provide for a nonjudicial review board to determine the advisability of sterilization, the procedural requirements do not even meet minimum standards for administrative due process.[90] Under modern constitutional standards, therefore, the initial hearing should be made in a court of competent jurisdiction. As a matter of course, any state statute should provide that the nonconsensual sterilization of any retarded person, whether institutionalized or noninstitutionalized, initially must be resolved by a court rather than by a nonjudicial panel of any type.

> The board of trustees of mental institutions may deny the prayer of the petition. If the board shall find that the inmate is insane, idiotic, feeble-minded or epileptic, and by the laws of heredity is the probable potential parent of socially inadequate offspring likewise afflicted . . . and that the welfare of the inmate and of society will be promoted by such sterilization, the said board may order the director to perform or to have performed [the sterilization].

Id. § 41-45-9. This statute is typical of the category of state laws allowing boards of review to pass first on petitions for sterilization.

83. See, e.g., id. § 41-45-11.

84. Del. Code Ann. tit. 16, § 5701 (1974).

85. E.g., N.C. Gen. Stat. § 35-42 (1976); W. Va. Code § 27-16-1 (1980).

86. E.g., N.C. Gen. Stat. § 35-43 (1976); W. Va. Code § 27-16-1 (1980).

87. Stump v. Sparkman, 435 U.S. 349 (1978).

88. Sparkman v. McFarland, 552 F.2d 172 (7th Cir. 1977).

89. See, e.g., Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 724, 370 N.E.2d 417 (1977); Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980).

90. See 2 Am. Jur. 2d Administrative Law §§ 351, 353 (1962).

C. *Equal Protection*

The most difficult constitutional issue to be resolved in any statutory sterilization scheme relates to equal protection. The equal protection difficulties turn upon two separate points: first, the distinction between institutionalized and noninstitutionalized candidates, and second, the distinction between retarded, potentially unfit parents and nonretarded, potentially unfit parents. The resolution of these points likely will determine the constitutional validity of any sterilization statute.

It is reasonably well established that the "right" involved in sterilization, that is, the right to decide whether to reproduce, is a fundamental right of constitutional dimension.[91] As such, its abrogation, whether on behalf of a retarded person or of a nonretarded person, would require a showing of a compelling state interest in the sterilization. As recently stated in *Ruby v. Massey*:[92]

> What has been shown earlier in this opinion is more than ample to demonstrate that the right of the plaintiff's children to be sterilized is "fundamental" because it is rooted in the Constitution. . . .
>
> "Where certain 'fundamental rights' are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest' . . . and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake." Roe v. Wade, 410 U.S. at 155, 93 S. Ct. at 728. Furthermore, "under the Equal Protection Clause" the means chosen by the State . . [*sic*] must bear "a fair and substantial relation" to the object of the legislation.[93]

Similarly, in *In re M.K.R.*[94] the court stated:

> The courts are not faced in this case with a prayer for judgment authorizing ordinary medical treatment, or radical surgery necessary to preserve the life of a child; we are faced with a request for sanction by the state of what no doubt is a routine operation which would irreversibly deny to a human being a fundamental right, the right to bear or beget a child.[95]

In order to perform a sterilization on a mentally retarded candidate, the state must demonstrate a compelling interest in the sterilization. As noted, this interest formerly was found in the perceived need for eugenic control over retardation in the population[96] and was based on the widespread but erroneous belief that most, if not all, forms of retardation are hereditary. More recently this focus has shifted from the eugenic concepts implicit in the many earlier sterilization laws to the state's proper interest in the welfare of minor

91. Skinner v. Oklahoma, 316 U.S. 535, 541 (1942); In re M.K.R., 515 S.W.2d 467, 470 (Mo. 1974). See also Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

92. 452 F. Supp. 361 (D. Conn. 1978).

93. Id. at 368 (citations omitted).

94. 515 S.W.2d 467 (Mo. 1974).

95. Id. at 470.

96. See notes 42-47 and accompanying text supra.

children. It is urged that such an interest can be the basis of laws that seek to prevent the birth of children to individuals who are incapable of providing minimally adequate parental care.[97] These statutes, however, present a number of substantial equal protection problems.

First, a medically demonstrable, compelling interest for nonconsensual sterilization can be shown with respect to some individuals if consent is obtained from a court of competent jurisdiction under the doctrine of substituted judgment.[98] As was shown earlier, there are at any given time a number of extremely compelling arguments for sterilization of retarded candidates.[99] As will be shown later, there should exist a procedure by which such sterilizations could be performed lawfully.[100] Even in such instances, however, there exist two substantial equal protection problems in any proposed statutory authorization. The initial problem, which also must be subjected to a "compelling interest" test, is the inherent equal protection problem in applying a sterilization statute only to institutionalized candidates. A number of current state sterilization statutes specifically are applied only to institutionalized individuals.[101] These statutes generally provide that the director (or other responsible individual) of a state-supported facility for the mentally retarded or "mentally ill"[102] may petition the court for permission to perform a sterilization "in the best interest of the . . . patient, or for the public good."[103] In order to determine the validity of sterilization statutes that explicitly apply a standard to those patients who are institutionalized that differs from that applied to those who are not institutionalized, an analysis must be made of the state interest purportedly protected by the sterilization. Only if the state's interest in this dual standard is found to be compelling can the statute be applied in a discriminatory fashion between institutionalized and noninstitutionalized mentally retarded persons.[104]

Beginning with the earliest state sterilization statutes, their application to institutionalized versus noninstitutionalized persons has been a matter for judicial concern. Many early cases held sterilization statutes unconstitutional when the statutes involved applied only to institutionalized persons.[105] In

97. See notes 53-57 and accompanying text supra.

98. For a discussion of the doctrine of substituted judgment, see Superintendent of Belchertown State School v. Saikewicz, 373 Mass. at 750-52, 370 N.E.2d at 430-31; In re Eichner, 108 Misc. 2d 184, 423 N.Y.S.2d 580, 595-96 (Sup. Ct. 1979); Robertson, Organ Donations by Incompetents and the Substituted Judgment Doctrine, 76 Colum. L. Rev. 48 (1976).

99. See notes 48-57 and accompanying text supra.

100. See notes 126-87 and accompanying text infra.

101. Del. Code Ann. tit. 16, § 5701 (1975); Miss. Code Ann. § 41-45-1 (1981); S.C. Code Ann. § 44-47-10 (Law. Co-op. 1977); Utah Code Ann. § 64-10-1 to -14 (1978).

102. The definitions of mental illness are wide and varied and may include psychoses, neuroses and other personality disorders, including some disorders such as manic depression and schizophrenia, which are treatable with drugs. Mental illness also includes mental disorders which are treatable through psychotherapy. The inclusion of "mental illness" itself raises, therefore, a serious possibility of abuse.

103. N.C. Gen. Stat. § 35-36 (Supp. 1981) (emphasis removed) (applies same standard to institutionalized as to noninstitutionalized retardates).

104. See notes 58-61 and accompanying text supra.

105. See note 13 supra.

1927 the Supreme Court reached an inventive resolution of this problem in *Buck v. Bell*.[106] Justice Holmes' opinion implied that the Virginia sterilization statute, which clearly applied only to institutionalized persons, did not violate the equal protection clause because Virginia was attempting to commit *all* its retarded population to its institutions.[107] Therefore, all retarded persons in Virginia eventually would come within the scope of the statute. This resolution of the problem, while inventive, is myopic and unrealistic and will not pass muster under current constitutional scrutiny. As a first consideration, the factual context has changed dramatically. States no longer seek to institutionalize all retarded persons as a matter of course. Professional policy nationwide now is geared toward finding appropriate community treatment and care for as many retarded persons as possible, preferably in family homes, work homes, or community centers.[108]

Second, under an equal protection analysis the reasons advanced for discrimination in the application of state sterilization statutes between institutionalized and noninstitutionalized candidates may no longer be found to be compelling.[109] Several reasons advanced for such discrimination have been summarized in *Ruby v. Massey*:

> The reasons advanced by the defendants in their brief to justify the state for treating residents in its two institutions differently from all other mentally incompetent children are:
>
> "Once institutionalized the state is responsible for the care of these individuals. To avoid problems of undesired pregnancy the state may rationally decide to sterilize some individuals. State officials might otherwise be subjected to liability for improper supervision if an institutionalized woman were to become pregnant. Some of the patients within the institution are wards of the state. Should one give birth, the state would be burdened by the additional expense of raising a child."[110]

It is clear, however, that none of these interests, although appropriate matters of state concern, are sufficiently compelling to allow the state to apply its sterilization statutes only to institutionalized persons. As the court concluded in *Ruby*:

> The interests which the state asserts may well justify it in establishing a method for obtaining authority to perform sterilization operations on *its* wards. The state is simply discharging a parental obligation. None of those interests will be jeopardized if the same statutory process is made available to those incompetent children who have not been institutionalized. If the state may rationally decide to sterilize some individuals to avoid incomprehensible pregnancy, it makes shamefully limited sense to contend that the same right should be

106. 274 U.S. 200 (1927).

107. See id. at 208.

108. N. Robinson & H. Robinson, supra note 49, at 24-25; W. Wolfensberger, The Principle of Normalization in Human Services 106-12 (1972).

109. Ruby v. Massey, 452 F. Supp. 361 (D. Conn. 1978).

110. Id. at 368 (quoting Brief for Defendant (page cite unavailable)).

denied to others in the same situation.[111]

This holding is sound, and any state law permitting sterilization of retarded persons in compelling cases must be available to institutionalized and noninstitutionalized candidates equally.

A second equal protection issue arises out of the justification for sterilization itself.[112] The justification of sterilizing some retarded persons because they are totally unable to provide care as parents raises central issues of underinclusiveness and suspect criteria. This equal protection issue can be illustrated by considering that (1) not all retarded persons will be unfit to provide parental care, and (2) not all of those who will be so unfit are retarded. The first point is not decisive; the second is decisive because it is a clear example of an underinclusive classification that violates fundamental rights. Should society not seek in principle to sterilize all persons who are unable to function as parents? The constitutional and policy absurdities of this notion serve only to highlight the problem.[113]

To establish a rational sterilization policy, the specific harm that the state is seeking to prevent—the birth of children to parents totally and permanently unable or unwilling to provide for their children—must be kept at the center of attention. In addition to sterilization, another path exists to prevent this harm—the enforcement of criminal sanctions. Specifically, if an unfit parent is competent to stand trial, he or she may be brought to account for failing to care for his or her children through the application of state criminal-neglect statutes.[114] Typically such statutes provide that certain broad categories of conduct, such as placing a child in circumstances that produce a substantial risk of death or injury to the child, or actions such as abandoning or failing to pay court-ordered support, may be punished by criminal conviction ranging in severity from minor misdemeanors through felonies.[115]

These criminal penalties may be seen as parallel remedies to the sterilization of the retarded, since Anglo-American jurisprudence considers criminal penalties to have not only retrospective but also prospective effect. Not only does the criminal justice system serve to mete out social retribution for conduct beyond the pale of that which civilization will tolerate; it also seeks to provide both general and specific deterrence to the commission of offenses.[116] Indeed, a principal concept of criminal jurisprudence is that by providing criminal sanctions of sufficient severity to match the degree of social unacceptability of the conduct, the actor will be deterred from the conduct in ques-

111. Id.

112. The proposals advanced in this Article will withstand, it is believed, a "compelling interest" test, but only if the inability of the retarded person to provide adequate parental care is given determinative status.

113. See, e.g., Ruby v. Massey, 452 F. Supp. 361, 367-69 (D. Conn. 1978) (statute allowed sterilization only for institutionalized individuals).

114. E.g., Ariz. Rev. Stat. Ann. § 13-3619 (1978); Utah Code Ann. §§ 76-7-201 to -202 (1978).

115. See statutes cited in note 114 supra.

116. See, e.g., Andenaes, The General Preventive Effects of Punishment, 114 U. Pa. L. Rev. 949 (1966); 1 The Works of Jeremy Bentham 402 (J. Bowring ed. 1962).

tion.[117] Hence, it clearly is appropriate to view the potential application of criminal sanction to certain conduct—in this case the failure to provide for or care for one's children—in order to determine the propriety of utilizing other measures to prevent the specific harm that the state is seeking to prevent.

When the applicability of these criminal sanctions is viewed with respect to the retarded, two factors become clear. First, for many retarded persons criminal law sanctions would be applicable and should be the sole instrument of the state in preventing the demonstrable harm of child neglect. Second, criminal sanctions should never be applicable to the most compelling cases of retardation in which the degree of retardation is sufficient to render the individual permanently incapable of standing trial (the individual would not understand the nature of the criminal proceedings against him and would be incapable of aiding in his own defense). It must be concluded that the deterrent aspect of criminal jurisprudence will not be present in such cases and that the social force of traditional criminal sanctions will be inapplicable. Hence, the traditionally less restrictive alternative of criminal sanction is not available to the state in dealing with many retarded individuals, and other alternatives must be found.

This distinction between cases in which criminal sanctions can be effective and those in which they cannot be, provides a legal basis for sterilization of the retarded candidate in a compelling case without requiring the state similarly to sterilize nonretarded unfit parents on equal protection grounds. Finally, the analogous application of judicially recognized "incapacity to stand trial" standards to the review of cases and candidates for sterilization will provide a greatly needed standard for identifying compelling cases for sterilization. This point will be developed later in this Article.

III. STANDARDS FOR COURT REVIEW

Because the candidate is presumed to be incompetent to give an informed consent, there must be some general standard of review for the third-party consent herein envisioned. We have identified three possibilities for such a standard: the "reasonable person," the "substituted judgment" and the "best interests" standard. Each has its own problems and strengths, and each reflects different areas of professional concern. Sometimes these three standards are grouped as different versions of the doctrine of "substituted judgment,"[118] but in this Article they are treated separately, preserving "substituted judgment" as a separate standard.

A. The "Reasonable Person" Standard

The current statement of the American Association on Mental Deficiency (AAMD) suggests that courts use a version of the judicially recognized "rea-

117. Bentham, supra note 116, at 400-01. See also Commonwealth v. Ritter, 13 Pa. D. & C. 285 (1930); Regina v. Wilson, 48 Crim. App. 329, 334-35 (1964).

118. See note 98 and accompanying text supra.

sonable person" test in sterilization decisions, based on the concept that pregnancy usually would not be intended by a competent person facing analogous choices.[119] This position is in conflict with other guidelines provided by the same document, however, that seem to develop a "best interest" test along the lines of traditional custody litigation.[120] These tests are not identical, particularly in their application to difficult cases. For example, a determination of what a reasonable person would do is difficult in cases involving certain specific retardation syndromes. In many cases there is only one chance in two or three that a person will have a child with the defect.[121] Given that possibility, what would a reasonable person choose? Many otherwise normal individuals would decide—for themselves—to take the risk. However, if asked what they would decide for the retarded individual, they might conclude, in light of other disabilities of the person and his inability to provide child care, that sterilization is best *for her*. The conclusion reached thus would be a determination of the "best interest" of the individual, *not* an assessment of what a reasonable person would do.

The point in the above example is that what a reasonable person would do is an abstract, highly speculative test that is difficult to apply in many situations because reasonable persons would differ over the course of action to follow. Furthermore, speculation about what a reasonable person would do avoids an evaluation of what is best for this individual.[122]

The reasonable person test does not account sufficiently for the reality that a retarded person often is not reasonable. The test itself was devised for an entirely different set of cases involving questions of tort liability, and later was adapted to test the adequacy of consent documents signed by patients and to determine the liabilities of the physician for failure to provide certain information to the patient. Although application of this test may be proper in cases in which an individual can be presumed to be "reasonable," such as in an informed-consent decision,[123] in retardation cases no such presumption is even remotely plausible. Moreover, since the patient cannot give an informed consent, the physician must obtain authorization to act from someone else. Thus, the reasonable person standard is inherently suspect because of its abstractness and is inapplicable to retardation cases.

B. Substituted Judgment

Another test that might be applied in proxy consent cases is the tradi-

119. AAMD, supra note 32, at 61.

120. Id. (see also the Official Commentary).

121. N. Robinson & H. Robinson, supra note 49, at 77-106.

122. Problems with the definition of a "reasonable person" have been recognized in other contexts as well. Justice Holmes, for example, argued that the "mental attributes" of the reasonable man were judged by an external standard. O. Holmes, The Common Law 108 (1909). Physical disabilities of the actor, however, were incorporated into the standard by which an actor's performance was judged in negligence cases. See W. Prosser, Handbook of the Law of Torts § 32 (4th ed. 1971).

123. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw. U.L. Rev. 628 (1970).

tional doctrine of substituted judgment. This standard was developed in cases involving disposition of estates of incompetent persons and asks the court to "substitute itself as nearly as may be for the incompetent, and to act upon the same motives and considerations as would have moved her."[124] In essence the court is asked to decide what *this* person, not a hypothetical "reasonable person," would do in these circumstances.

The problems surrounding this standard in sterilization cases are similar to those involved in the reasonable person test. The substituted judgment test also has been borrowed from a completely unrelated set of cases. In determining whether a presently incompetent man is to provide monetary support for his wife out of his estate, we have the man's previous life as a basis on which to render an informed judgment. Did he support her before? Did he express a written or verbal intention to do so? What kind of relationship did they have during the period of his competency? These inquiries might yield reasonable insights into this person's previous activities and into what he might do now were he competent. Certainly such an evaluation may be little more than guesswork, but just as surely some reasonable basis for informed speculation might be revealed.

In retardation cases, however, there is no reasonable experience upon which to draw, as the retarded adolescent being considered for sterilization is young and never has been competent. Her past decisions most likely have been spontaneous, reflecting desires of the moment or directions given by those caring for her. To ask, therefore, what she would choose to do is unreasonable and misleading. In the process of determining what the candidate would choose, one would most likely be trying to discover what a "reasonable person" would do. As previously noted, this latter test is inapposite to a determination of what should be done for this retarded individual, with her special needs and problems.

C. The Best Interests Standard

Therefore, there must be another model, one that avoids misleading applications of standards that have been devised for very different cases. The most promising alternative appears to be some version of the best interest test that already is employed in the analogous field of child custody and support litigation, in which the child legally and morally is in much the same status as the retarded. This test has two merits that recommend it. First, it focuses on the particular person affected by the decision and avoids the speculative considerations inherent in a reasonable person test. Second, it is widely applied in analogous cases such as custody decisions in which the affected individual is not competent to decide for himself.

---

124. City Bank Co. v. McGowan, 323 U.S. 594, 599 (1944). See also In re duPont, 41 Del. Ch. 300, 194 A.2d 309 (1963); In re Brice's Guardianship, 233 Iowa 183, 8 N.W.2d 576 (1943); State ex rel. Kemp v. Arnold, 234 Mo. App. 154, 113 S.W.2d 143 (1938); In re Carson, 39 Misc. 2d 544, 241 N.Y.S.2d 288 (Sup. Ct. 1962). For a complete review of cases and issues, see Robertson, supra note 98.

A best interests test is, by itself, rather vague[125] and consequently the difficult task of deciding what is in the best interests of the retardate has created legal uncertainties. Nonetheless, the concept of best interests can be adequately specified in a way to minimize possible abuses and avoid unreasonable vagueness. To meet this goal, this Article will propose a comprehensive assessment that should be undertaken in each case to determine whether the best interests of the affected person can be furthered through sterilization.

There is one major threshold question that must be resolved before applying the best interests standard to cases involving sterilization of the retarded. Because sterilization irreparably deprives a person of the capacity to exercise a fundamental right, it must be determined whether it can *ever* be in a person's interest to have that capacity destroyed. Even if there are some cases in which sterilization is the least harmful action for a particular person, there still will be a strong presumption against it. In this sense sterilization is dissimilar to custody and support cases in which no a priori assumptions about best interest seem reasonable and in which court orders are inherently modifiable.

There must be a reformulation of the best interests test to incorporate a presumption that sterilization is a last resort to be used only in a particularly difficult situation. Employment of this "best interests-last resort" test would serve to keep in focus the magnitude of the decision to be made. It would serve to highlight the crucial differences between sterilization cases and custody, support and care cases in which a best interests test usually is employed. Finally, this test would require courts to be convinced that no reasonable alternatives exist to solve the problems of the retarded individual, her family or her potential offspring.

It should be noted further that the best interests-last resort test focuses attention on the difference between sterilization and other contraceptive methods. The generally articulated justifictions for sterilization, discussed earlier, concerning the harms to the retarded person, her family and her potential offspring, can not in themselves justify sterilization over other means of preventing pregnancies. At most they demonstrate that it is justified to prevent procreation by some retarded persons. These reasons say little about justifications for the sterilization choice; this difference is highlighted in a best interests-last resort standard in which courts could authorize sterilization only after they were convinced that less drastic alternatives were not workable.

Though the best interests-last resort standard is acceptable as a general framework within which to view sterilization decisions, there are five factors that should be analyzed by courts in determining whether sterilization is justified.

125. For criticism in the area of child welfare, see J. Goldstein, A. Freud & B. Solnit, Beyond the Best Interests of the Child (1973).

1. Certainty of Irremedial Condition of Incompetency Based on Retardation

Although this factor may seem trivially obvious as a prerequisite to sterilization, previous cases and research demonstrate that such is not necessarily the case. For example, in *A.L. v. G.R.H.*,[126] an Indiana Court of Appeals denied a petition for sterilization from a parent of a fifteen-year-old boy with an I.Q. of eighty-three, which placed him in the "borderline" or "dull" category. Two years previously he had registered an I.Q. of sixty-five, and experts testified that further progress could be expected. Teachers at his special school felt that he might eventually hold an entry level job in private industry.[127] It seemed possible that this boy might one day be sufficiently competent to decide for himself whether or not to be sterilized.[128] His disabilities appeared to be improvable.

This case may not be unique. Several researchers have demonstrated wide fluctuations in the process by which individuals are labeled "retarded."[129] The most consistent finding is the link between the use of school performance as a process for identifying retarded children and the incidence of reported retardation.[130] There is a marked increase in incidence of reported retardation in any group of children as that group approaches school age, and there is a marked decrease in reported retardation after the same group leaves school.[131]

Those children with severe retardation are almost always noticed in the community and are assisted by appropriate agencies whether or not they are in school. However, a large number of persons are designated mildly retarded as a result of poor performance in school, and once removed from that setting they drift back into the community and seem to lead lives not much different from those of many others who never were labeled retarded.

Unfortunately, however, the vicissitudes of the labeling process carry enormous ramifications, particularly with regard to parental actions. Parents often have greatly exaggerated fears regarding the developing sexual capacities of their adolescent children. In light of these fears, erroneous or misleading information concerning the child's abilities may become a basis for exploring the possibility of sterilization. Moreover, what may be considered "retarded" to an intellectually gifted parent may be different from what is considered "retarded" to a parent who has a borderline I.Q. or who was a "slow learner" in school. It is not enough, therefore, simply to accept a parent's testimony that the child is retarded and will never be competent to decide for herself whether or not to be sterilized.

---

126. 163 Ind. App. 636, 325 N.E.2d 501 (1975) (mental disability caused by auto accident, not congenital defect).

127. Id. at —, 325 N.E.2d at 502.

128. Id.

129. B. Farber, supra note 51, at 43-68; R. Heber, supra note 49, at 3-36.

130. See J. Mercer, Labelling the Mentally Retarded 96-120 (1973).

131. Id. at 118-19.

It is at the point of determining whether the candidate for sterilization can become competent that the court should seek to apply the definitional standards suggested earlier concerning the scope of incompetency and degree of retardation necessary to validate a court-ordered sterilization. Vital to the granting of a sterilization petition must be a finding of incompetency tantamount to a conclusion that the person is permanently incapable of standing trial in any future child neglect prosecution.[132] This standard in fact parallels the existing standard of at least one state statute[133] which provides that before a court can "involuntarily" sterilize a retarded person, it must find the candidate unable to understand the nature and purpose of the operation and incapable of rationally making a decision whether to consent to the sterilization. Only in cases in which both aspects of the standard are met could the court permit the sterilization. If the candidate can meet this minimal test of competency, the court must respect the candidate's decision, thereby leaving punishment under the child neglect statute as a deterrent to procreation—the same deterrent for others who would be competent to stand trial.

It also should be noted that this competency to stand trial test may be substantially different from the standard to be applied judicially to determine competency to engage in other acts, such as capacity to contract or to make a will. Indeed, defining the test as the capacity to stand trial establishes a minimum level of rationality necessary to assure that retarded persons with even the most minimal capacity to participate rationally in making decisions concerning their own status will have those decisions respected when the permanent abrogation of fundamental rights is involved. Further, the application of a judicial standard of competency based on a finding of permanent incapacity to stand trial will be a necessary part of a determination that the sterilization meets the best interests-last resort standard and that the traditional deterrents to the procreation of neglected children—the criminal child-neglect statutes—are not available to deter the procreation of children that will be neglected.

2. Capacity to Reproduce

It is well known that many forms of genetically based retardation are associated with other disabilities such as reduced ambulation or motor control problems. It is less well known that many mentally retarded persons also are sterile. The most common genetic syndrome in this category is Downs' Syndrome, in which males always are sterile and females rarely are fertile.[134] Whereas Downs' Syndrome usually is associated with moderate to severe retardation, this is not always the case in other chromosomal syndromes associated with sterility. Several chromosomal disorders generally are not associated with retardation, and when they are coupled with retardation it is

132. See notes 114-17 and accompanying text supra.

133. See Va. Code § 54-325.10(4) (Supp. 1981).

134. L. Holmes, H. Moser, S. Helldorsson, C. Mack, S. Pant & B. Matzilevich, Mental Retardation: An Atlas of Diseases with Associated Abnormalities 150 (1972).

typically in the mild or borderline category.[135] Hence, in many instances persons who are both sterile and retarded because of these disorders will not be so severely retarded that institutional care is needed. In these cases, the person often will reside in the community, and parents, acting on misinformation and fear, may seek sterilization. In such cases the sterilization is superfluous and simply represents an unnecessary intrusion into the patient's body.

The necessity of evaluating the fertility of retarded persons before a decision to sterilize is made is increased by the fact that many mentally retarded girls have delayed onset of puberty, especially in genetically based retardation. Both sexual development in general and menarche in particular tend to occur later in retarded girls.[136] Sterilization is such a significant action, however, that it should be a last resort for a clear and present problem, not for a hypothetical problem that may surface years in the future.

3. Sexual Activity

The existence of a situation justifying sterilization depends on more than a capacity for procreation. In addition, the retarded person must be sufficiently sexually active to create a likelihood of pregnancy or paternity. The need for a review of the retarded person's sexual activity is suggested by several factors which tend to show that retarded persons do not engage in sexual activity at normal levels.

First, among severely retarded individuals, sexual drives appear to be lower than normal.[137] This leads to significantly decreased sexual activity among those at the lower end of the retardation spectrum.[138] Second, many genetically based retardation syndromes are associated with other abnormalities, often including physical deformities, that hinder heterosexual interaction and make intercourse less likely.[139] Furthermore, persons with severe or progressively developing handicaps may be cared for at home until adolescence or young adulthood, at which time the family often seeks permanent institutional placement. Under these circumstances the opportunities for sexual intercourse are severely limited.

Finally it should be noted that even for mildly retarded persons without significant handicaps (those capable of significant heterosexual activity), evidence from one study suggests a markedly lower rate of actual sexual con-

135. Id. at 150-70.

136. Dooren & van Gelderan, Studies in Oligophrenia, III: Somato-Sexual Development in Mentally Deficient Children, 52 Acta Paediatrica 557 (1963). The authors concluded that late maturation "is usually associated with mental defect of genetic and prenatal origin," whereas children with other deficiencies mature normally. Id. at 562.

137. Heald & Oberman, Perspectives on Mental Retardation in Adolescence, 174 Int'l Rec. Med. 224, 228 (1961); Meyerowitz, Sex and the Mentally Retarded, 5 Medical Aspects of Human Sexuality, November 1971, at 95, 96; Mosier, Grossman & Dingman, Secondary Sex Development in Mentally Deficient Individuals, 33 Child Dev. 273, 283-85 (1962).

138. Heald & Oberman, supra note 137, at 228; Meyerowitz, supra note 137, at 104.

139. Meyerowitz, supra note 137, at 104. In addition, "retardates may find themselves repudiated by peers due to the general gregarious cliquing of adolescents." Id.

tact.[140] Data from the Institute for Sex Research at Indiana University demonstrate that in a group of moderately and mildly retarded persons there was a significantly lower incidence of premarital petting and coitus and a lower capacity to be aroused by sexual stimuli.[141]

These facts lend support to the conclusions of the court in *North Carolina Association for Retarded Citizens v. North Carolina*.[142] In upholding the constitutionality of the main provisions of a North Carolina sterilization statute, the court held the statute not unconstitutionally vague or arbitrary since it specifically limited its application to those retarded persons "likely to bear a child" who would be either 1) retarded himself or 2) neglected by the parent because of the parent's retardation.[143] However, the court held the specific application of the law to those "likely to bear a child" necessitated a court finding that the person was likely to engage in sexual activity before sterilization could be ordered.[144]

Although the court's holding does move in the right direction, it is too vague in one crucial respect. The court held that petitioner must demonstrate a likelihood that the candidate "will likely be" sexually active.[145] This requirement is an invitation to abuse, especially when parents and guardians are involved in the decision to initiate the action,[146] because the statement that a person "will be" sexually active is much different from a statement that a person "is now" sexually active. The former is a mere projection of the future, the latter requires a much greater degree of precision in determining presently existing facts. Other courts have used some form of a "likely to be sexually active" standard.[147]

A demonstration should be required that the retarded person is sexually active to a degree sufficient to render procreation likely in the near future. It must be shown that procreation is *now* at risk, not that the retarded person once had intercourse or may potentially have intercourse in the future. The purpose of the drastic step of sterilization is to eliminate the possibility of a

140. Gebhard, Sexual Behavior of the Mentally Retarded 29 (de la Cruz & la Veck eds. 1973). In contrast to a control group, the retarded sample (consisting of 84 males) had 20% fewer persons involved in premarital coitus, id. at 37, and 40% who had no sexual arousal when presented with several different sexual stimuli, id. at 44. Results varied widely, depending on age of person and length of institutionalization. For example, from puberty to age 15, the retarded population had 17% more premarital coitus than did the control group. Id. at 37. Marital coitus was similar in both groups, but only 25% of the retarded sample had ever been married. Id. at 40.

141. Id. at 36-38, 44-46.

142. 420 F. Supp. 451 (M.D.N.C. 1976).

143. Id. at 457.

144. Id.

145. The court, however, added that "the judge must find that the subject is likely to engage in sexual activity without utilizing contraceptive devices." Id. at 456.

146. When confronted with this problem, the court in *North Carolina Association for Retarded Children* severed from the statute the authority for next of kin or legal guardians to initiate sterilization proceedings. Holding this section of the statute unconstitutional, the court described it as "an arbitrary and capricious delegation of unbridled power." Id.

147. In re Sallmaier, 85 Misc. 2d 795, 378 N.Y.S.2d 989 (Sup. Ct. 1976). See also Cook v. State, 9 Or. App. 224, 495 P.2d 768 (1972).

near-term event that would have severe adverse repercussions for the person, his family and his child.

4. Unworkability of Other Contraceptive Alternatives

The cornerstone of a last resort showing is a demonstration that alternative means of contraception will not work. This requirement was implied in much of the early legislative activity in the laws which specified that a state board could authorize sterilization in cases in which a candidate would likely produce a retarded child.[148] In practice, however, courts rarely tested such provisions and state boards seemed not to have concerned themselves with contraceptive alternatives. This may have been due partially to the prevailing opinion about the limited capacities of the retarded to administer contraceptive devices. It also should be noted that until the 1960s, alternatives to sterilization that were likely to be effective required a high degree of awareness and self control: condoms, diaphragms, spermicides, and the rhythm method. In the last two decades, however, newer forms of contraception have been developed that do not require as much capacity for self care and self control. Significantly, these newer methods (modern intrauterine devices (I.U.D.'s), birth control pills, injectables) approach sterilization in effectiveness.[149] Thus, it becomes imperative for a court to determine that these methods have been analyzed and are unworkable before ordering sterilization.

The most significant of these alternatives for use in retarded persons is the injectable progestagin Depo Provera. This agent can be injected at ninety-day intervals and produces both contraception and an absence of menstruation for the interval. This double effect may make it particularly useful in retarded girls for whom menstrual hygiene is sometimes as much of a problem as contraception. Once the drug has dissipated, menstruation and capacity for pregnancy will return after a prolonged interval. The medical literature strongly supports the use of Depo Provera as a contraceptive in patients who for a variety of reasons may not be able to use alternative means of contraception reliably but who do not wish to be permanently sterilized.[150] In much of the world the drug is widely used for contraceptive purposes, and studies done in various countries confirm its effectiveness and general safety.[151] In the United

148. See J. Landman, note 11 supra.

149. Edwards & Hakanson, Changing Status of Tubal Sterilization, 115 Am. J. Obstet. & Gyn. 347 (1973) (failure rate of 17%; citing to other studies having failure rates between .1% and 3.0% depending on the study and the type of operation); Ferber, Tietze & Lewitt, Men with Vasectomies, 29 Psychosomatic Med. 354 (1967) (4.3% failure rate determined by postoperative pregnancy three to fourteen months after surgery); Garb, A Review of Tubal Sterilization Failures, 12 Obstet. & Gyn. Survey 291 (1957) (failure rates between .04% and 2.89% depending on the study and the type of operation). See also Pots & Swyer, Effectiveness and Risks of Birth Control Methods, 26 Brit. Med. Bull. 26 (1970) (comparing sterilization with most other common contraceptive techniques).

150. Gardner & Mishell, Analysis of Bleeding Patterns and Resumption of Fertility Following Discontinuance of Long Acting Injectable Contraceptive, 21 Fertility & Sterility 286 (1970); Smith, Depo Provera (Injectable Contraceptive)—A Review, 23 Scot. Med. J. 223 (1978); Tyler, Levin, Elliot & Dolman, Present Status of Injectable Contraceptives: Results of Seven Year Study, 21 Fertility & Sterility 469 (1970).

151. Smith, supra note 150, at 225-26.

States, however, the Food and Drug Administration now refuses to grant permission for its general use as a contraceptive, although the FDA had earlier permitted its use for a limited target population.[152]

There are side effects with Depo Provera that make its continued use inadvisable for some patients. One side effect is the possibility of great disruption of the menstrual cycle and failure to fully inhibit menstruation.[153] In many cases, however, this drug could be used as a less drastic alternative to sterilization.

5. Sterilization as a Less Harmful Alternative to Reproduction

Even though the impact of pregnancy or childbirth on the family of a retarded person must be considered, the deprivation of rights involved in sterilization is a deprivation for the retarded person, not for others. Her welfare, therefore, must always be the primary consideration in a sterilization decision. In deciding to sterilize a particular retarded person, a court must assess very carefully whether sterilization will affect the candidate in a severely adverse manner.

Clinical evidence indicates that for some persons sterilization is a psychologically traumatic experience that produces detrimental reactions.[154] From studies of those who have had severe psychological reactions to sterilization, two fairly constant contraindications to the procedure have emerged and are stressed by physicians: (1) pressure by others (particularly a spouse) for sterilization, and (2) preexisting emotional disturbance, particularly involving psychosexual functioning.[155] Both of these are relevant to the case of the retarded individual.

The first contraindication is fairly obvious in its application to the retarded. Mildly retarded persons may be opposed to sterilization, but negative opinions from others may make them feel pressured into accepting it. Sterilization of these individuals could lead to serious emotional reactions far more severe than any additional burden of pregnancy. The second contraindication, although not as obvious, is no less real. Its relevance for retardation cases comes from the positive correlation between retardation and emotional distur-

152. 43 Fed. Reg. 28,555, 28,556 (1978). The FDA rationale for its action has come under strenuous criticism, based on questionable evidence for the ban and the supposedly political nature of the action. Congressional or public pressure is difficult to document. One study showing that high doses of Depo Provera caused cancer in dogs does not appear to be applicable to human beings, since the cancer appeared in types of cells not found in the human body. Smith, supra note 150, at 224-25. Furthermore, in the 60 countries where the drug is widely used as a contraceptive, no evidence of increased cancer risk has appeared after a decade of widespread use. Id. at 225-26. To the extent that the FDA ban continues it merely forces many parents, guardians and professionals to consider sterilizing the retarded when they otherwise may not do so.

153. Gardner & Mishell, note 150 supra; Tyler, Levin, Elliot & Dolman, note 150 supra.

154. Barlow, Pseudocyesis and Psychiatric Sequale of Sterilization, 11 Archives Gen. Psychiatry 571 (1964); Doty, Emotional Aspects of a Vasectomy, 10 J. Reproduc. Med. 156 (1973); Rodgers, Ziegler, Altrocchi & Levy, A Longitudinal Study of the Psycho-Social Effects of Vasectomy, 27 J. Marriage & Family 59 (1965); Ziegler, Rodgers & Kriegsman, Effect of Vasectomy on Psychological Functioning, 28 Psychosomatic Med. 50 (1966).

155. Doty, supra note 154, at 158, 160.

bance. This relationship is recognized universally by retardation experts, although they may disagree about the causal relationships involved and about the number of retarded persons who are emotionally disturbed.[156] A retarded individual with such a pre-existing emotional disturbance could be adversely affected by sterilization.

Thus, it must be concluded that a careful evaluation of the psychological state of the retarded person must be undertaken as part of the consideration of a sterilization petition. After such an evaluation, it would become a matter for the court's judgment whether the sterilization would so adversely affect the retarded person as to outweigh the possible benefits that will accrue to her. The preexisting emotional state of a given candidate for sterilization may suggest that sterilization would only lower an already precarious self-image and increase sexual fears and frustrations.[157] Such a result might be far more detrimental to growth and development, which should be one of the primary concerns in the sterilization of any mentally retarded person, than would be the possible damage caused by denying sterilization.

IV. THE ROLE OF PARENTS, GUARDIANS AND INSTITUTIONS

As noted earlier, statutory law in most states deals with the power of parents and guardians in a very ambiguous manner, and the limited case law is of relatively late origin. It has been argued recently, however, that parents should be the primary decision makers for incompetent retarded children, with minimal review by the courts.[158] The law, it is argued, should respect parental decision making in this instance if the parent's decision is substantiated by the codification of at least two experts that the child is in fact retarded.[159]

Arguments offered in support of parental decision making are weak and ill-conceived. In all these arguments the crucial assumption must be that parents possess a privileged knowledge of the details of their children's lives and the family situation that enables them to judge what is optimal.[160] While this may be true in some sense, it is insufficient to justify granting parents absolute, discretionary power in the matter. Knowing the situation most intimately is not the same thing as having the most comprehensive or objective view of what the right course of action should be. Intimacy breeds both knowledge and a distortion of knowledge. The very fact that parents are so drastically affected means that their motives will not always mesh with the needs and

156. N. Robinson & H. Robinson, supra note 49, at 196-210; Menolascino, Emotional Disturbance and Mental Retardation, 70 Am. J. Mental Deficiency 248 (1965).

157. See Erickson, The Psychological Significance of Vasectomy, in Abortion in America 57, 85 (H. Rosen ed. 1954). See also medical cases noted in Johnson, The Psychological Effects of Vasectomy, 121 Am. J. Psychiatry 482, 482-84 (1964).

158. Green & Paul, Parenthood and the Mentally Retarded, 24 U. Toronto L.J. 117, 123-24 (1974).

159. Id. at 124.

160. See, e.g., Green & Paul, supra note 158.

desires of the retarded child. It cannot be said, therefore, that they are inherently in the optimal position to know what is best for the retarded person.

As a corollary to the parental knowledge argument, the claim is made that the parents will be most directly affected by a resolution of the case, and that therefore they should have the primary role in deciding the outcome. This corollary is hardly accurate, since in most instances the candidate herself is affected even more drastically.

Furthermore, the argument advanced in favor of great deference to a parent's decision to seek sterilization for his or her child—that parents may have legitimate reasons that justify sterilization but which would not be convincing to the courts—is both dangerous and erroneous.[161] If a parent has adequate reasons that reflect a sound evaluation of the situation of the candidate, then those reasons ought to be convincing to a reasonable third party. Insofar as parental justifications would be inadequate to a third party, they may reflect only the fears of the parent or an incomplete knowledge of the child's specific disabilities. Unchecked parental discretion in these cases "grants the retarded person's next of kin or legal guardian the power of a tyrant . . . . We think such confidence in *all* next of kin and *all* legal guardians is misplaced."[162]

If unscrutinized parental authority is an unreasonable approach, an alternative must be found that provides for a comprehensive review of a parental petition for sterilization. Historically, numerous models for such a review have been generated, and several have been enacted into law. Many of the early involuntary sterilization laws created state administrative boards to act on petitions from wardens and directors of state facilities for the retarded.[163] Some of these laws did not for provide recourse from the board's decision to

---

161. Judicial intervention is an unnecessary invasion of a family's privacy . . . . If judicial intervention would be useful, the embarrassment to the family would be a minor issue. But we are unable to see how it could be useful. The judicial process in this context would work in a vacuum. In custody cases the best interests of the child test could be given content by courts and commentators; for the problem with which we are concerned it is impossible to formulate relevant factors to help guide decisions. A layman, asked to decide several custody cases, will probably refer to factors that the law considers relevant. What factors could be considered relevant in deciding whether sterilization of a retarded child is in that child's interests? Would any parent who sought sterilization for his retarded child be able to *prove* that it was in that child's best interests?

Green & Paul, supra note 158, at 123-24.

There is, however, a considerable body of clinical data suggesting that parents of retarded children frequently may have erroneous information about sterilization of the retarded, that they do have great fears regarding the developing sexuality of their retarded adolescents, and that they may be overly ready to seek sterilization. Bass, in Attitudes of Parents of Retarded Children Toward Voluntary Sterilization, 14 Eugenics Q. 45, 49-50 (1967), found that more than one-third of her sample of parents mistakenly thought sterilization was castration. Hammar and his associates have found significant fears centered on the developing sexuality of the retarded adolescent. Hammar, Wright, & Jensen, Sex Education for the Retarded Adolescent, 66 Clin. Pediatrics 621 (1967); Hammar & Bernard, The Mentally Retarded Adolescent, 38 Pediatrics 845, 846 (1966). Finally, the dangers of too ready an acceptance of sterilization are pointed up by the comments of sterilized, mentally retarded persons themselves. See Sabagh & Edgerton, Sterilized Mental Defectives Look at Sterilization, 9 Eugenics Q. 213 (1962).

162. North Carolina Ass'n for Retarded Children v. North Carolina, 920 F. Supp. 451, 456 (M.D.N.C. 1976).

163. See note 23 and accompanying text supra.

the courts.[164] However, if the boards acted in accord with minimal due process procedures such as notice of a hearing and right to cross-examine witnesses, their use was held to be a permissible method of making decisions in this field.[165]

Another alternative for comprehensive review of parental petitions for sterilization is illustrated by an Arkansas statute that provides for a hospital committee of three physicians (two of whom must be psychiatrists) to make a decision on a parental petition in what are termed "hardship cases."[166] The law states that the usual procedure is to petition the courts, but the physician panel may make the decision in the undefined category of "hardship" cases.[167] While the "hardship" caveat seems to render vacuous the idea of court jurisdiction, the notion of a hospital committee's being entrusted with the power to approve a parental petition is not unheard of. Such committees routinely approve many matters of substance, such as the appropriateness of certain experiments.[168] The Supreme Court of New Jersey even mandated their use in decisions on withdrawal of therapy in the celebrated *Quinlan* case.[169]

A third set of alternatives for third-party review requires direct judicial involvement in the decision-making process. Some of these approaches provide for administrative boards to serve as decision-making bodies, with provisions for court appeal.[170] Other statutes involve direct decisions by courts, generally probate courts charged with other matters of domestic or family relationships, including guardianship.[171]

Of these alternatives, the most reasonable is that providing for court decision making in the first instance. Administrative boards are notoriously informal in their procedures and often hold their meetings in situations that make public access difficult. This might be particularly true when the board meets

---

164. Conn. Gen. Stat. Ann. § 19-569g (repealed 1979); Wis. Stat. Ann. § 46.12 (repealed 1977).

165. See cases cited at note 14 supra.

166. Notwithstanding any of the provisions of Section 1 . . . and as an alternative to the Probate Court directives as described in Section 1, it is recognized that obvious hardship and environmental circumstances truly negate the protective measures intended in Section 1. . . . It shall be considered not unlawful for a legal guardian . . . or a parent . . . to seek sterilization for their charges through direct medical channels. Before any sterilization procedure will be performed . . . there must be filed with the approved hospital where the sterilization is to be performed the certificate of three Doctors of Medicine. . . . The certificate shall state that said Doctors have examined the woman, child or man and certify in writing that the element of incompetence . . . is truly present and that they believe a sterilization is justified.

Ark. Stat. Ann. § 59-502 (1971).

167. Id. § 59-501.

168. See generally N. Hershey & R. Miller, Human Experimentation and the Law (1976).

169. In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976).

170. Del. Code Ann. tit. 16, §§ 5701-5705 (1974) (providing for board authorization without appeal to the courts); Me. Rev. Stat. Ann. tit. 34, §§ 2461-2468 (1964) (providing specific authorization for appeal to the courts, but not mandating court review); Miss. Code Ann. §§ 41-45-1 to -19 (1976) (same); Okla. Stat. Ann. tit. 43A, §§ 341-346 (West 1936) (same); Or. Rev. Stat. § 436.010 to .150 (1979) (same); S.C. Code Ann. §§ 44-47-10 to -68 (Law. Co-op 1976) (same).

171. Mandating court determination of sterilization of the retarded: Ga. Code § 84-933 (1979); N.C. Gen. Stat. § 35-36 (Supp. 1981); Utah Code Ann. § 64-10-4 (1978); Va. Code §§ 54-325.10 to -325.11 (Supp. 1981); W.Va. Code § 27-16-1 (1980).

only infrequently. Moreover, any order of any board ought to be subject to appeal to a court, and once in the court system, normal judicial procedures would govern. Hence, prior review by a board may be considered superfluous.

It might be urged, however, that a hospital review committee should be entrusted with the authority to decide sterilization petitions since such a committee will be composed of experts in the field. Their expertise could be brought to bear on an individual case in a much more detailed fashion than is possible by a court. Only cases of egregious error on the part of the committee would need to be appealed to the courts. Despite its strengths, this alternative is unattractive for the simple reason that in sterilization cases, professional expertise, while relevant, is not determinative. Clinical expertise may be a necessary factor for consideration by a court in deciding a case; however, this expertise represents only one variable in reaching a decision on a sterilization petition. At a minimum the court needs to know the concerns and desires of the candidate. Furthermore, clinical expertise is a notoriously varying ingredient. One physician's experience may be much different from another's, especially with such a multifaceted problem as mental retardation. Trying to specify further the precise nature of the expertise that should be represented on these committees would be extremely difficult as a matter of codification.

A proper regard for the seriousness of the decision mandates a de novo court decision in *all* sterilization cases. In light of the enormous consequences of sterilization, there must be the strictest possible scrutiny of the proposed operation and the supposed "compelling interests" that justify it. In our society this scrutiny has been entrusted to the courts. It would set a dangerous precedent if decisions of this magnitude were entrusted to a committee of practicing professionals. Medical professionals have no expertise in ensuring that minimum requirements of due process have been met, nor are they uniquely skilled to evaluate the large amounts of nonclinical data that must enter into a decision such as this. A professional committee also may not provide an open forum in which the affected candidate may express her views. The candidate may be intimidated in such a setting, especially if her intellectual capacities are moderately to severely limited. Finally, we note that the most important procedural requirement from the candidate's point of view is the appointment of a competent guardian ad litem.[172] This is more than just an appointment of a "patient advocate" or representative. The guardian ad litem must ensure procedural fairness in the initial hearing and must be prepared to appeal the decision if necessary. The legal competency of the guardian ad litem in ensuring such procedural fairness is not likely to be judged better by a committee of physicians than by a court.

Vesting the ultimate decision-making authority in a court, however, does not eliminate the need for consideration of the possible roles of both the par-

172. "A guardian ad litem is a special guardian appointed by the court to prosecute or defend in behalf of an infant or incompetent, a suit to which he is a party, and such guardian is considered an officer of the court to represent the interests of the infant or incompetent in the litigation." Black's Law Dictionary 635 (rev. 5th ed. 1979).

ent/guardian and the candidate herself in the decision. The need to obtain consent from a parent or guardian is obvious, as they will bear the hardships that would follow from any pregnancy or childbirth. Moreover, the parent or guardian can supply intimate, special knowledge of the candidate that is not easily obtainable from other sources. If they are willing to run the risks entailed by failure to sterilize, or if they believe that sterilization is unnecessary, then they should be allowed to act on that assessment.

Although this requirement of obtaining consent from the legal guardian of the candidate is fairly obvious, a more difficult policy question concerns those retarded individuals who are not under legal guardianship. Should guardian consent be uniformly required, or should it be held to apply only to those currently under guardianship? On balance, the best alternative is to require consent of a parent or guardian in all cases. Parents do, and guardians may, have special knowledge concerning the lives of those in their care. This knowledge very often will be highly significant in rendering intelligent decisions regarding sterilization. Moreover, this sort of information is not likely to be duplicated by knowledge obtainable from the various social agencies involved with a candidate. Furthermore, if a guardian has not been appointed for a noninstitutionalized retarded person, a presumption of competence must follow. To allow state agencies to present a noninstitutionalized candidate to the court reverses the presumption of competence. This reversal could set a dangerous precedent, leading to abuses of other retarded persons and their rights.

The emerging doctrine of limited guardianship[173] provides courts and policy makers with an appropriate vehicle for requiring third-party consent for sterilization, while allowing the widest possible liberty to the candidate. For those persons incapable of understanding adequately the implications of sterilization and perhaps other activities with long-term consequences, a properly designed, limited guardianship order should preserve the freedom of the person as much as possible and yet prevent her from harming herself or others through her incompetence.[174]

The situation of institutionalized persons presents a special case. Their institutionalization may create a presumption of incompetence, but that is only a presumption and is not universally valid.[175] Before court authorization for sterilization could be obtained, the incompetence of the candidate would need

173. Under the concept of limited guardianship, an incompetent is allowed to exercise all rights other than those specific rights that he is deemed incapable of managing. See Hodgson, Guardianship of Mentally Retarded Persons: Three Approaches to a Long Neglected Problem, 37 Albany L. Rev. 407 (1973).

174. On limited guardianship, see id. See also the Model Guardianship Act drafted by the Mental Health Law Project of the National Institute of Mental Health, 2 Mental Disability Law Reporter (ABA) 441, 449 (1978).

175. At law a competency hearing is not the same as a commitment hearing, and the recommendation of most experts is that the hearings should be kept separate since they concern themselves with distinct issues. See R. Allen, E. Ferster & H. Weihofen, Mental Impairment and Legal Incompetency (1968); Am. Bar Ass'n, The Mentally Disabled and the Law (S. Brakel & R. Rock eds. 1972). For examples of seemingly competent comments by retarded persons on this matter, see Sabagh & Edgerton, note 161 supra. Also see text accompanying note 177 infra.

to be demonstrated. For cases necessitating third party authorization, concurrence of the guardian or parent should be obtained. This position is favored because of the specially coercive setting of the institution and the need to ensure that the candidate has the benefit of advice from someone outside the institution who is charged specifically with the responsibility for her welfare. It is probable that a parent or guardian will not have as detailed a picture of the institutionalized candidate as will the institutional staff. Nevertheless, the staff itself may have other concerns, such as convenience or the welfare of the institutional arrangement, that may not be congruent with the interests of the candidate. While courts can screen institutional requests for sterilization and reject those that do not meet the interests of the candidate, courts cannot concern themselves as intimately with the welfare of a specific candidate as can a parent or a guardian. Therefore, parents and guardians who have this relationship of special care should be brought into the decision-making process. If these persons fail to give consent when it is warranted for therapeutic or hygienic reasons, recourse can always be had to the courts, as a substantial line of cases suggests.[176]

V. THE ROLE OF THE CANDIDATE

The most difficult problem of consent for sterilization concerns the appropriate role for the candidate in the decision-making process. This is a complicated and not easily resolved issue because retardation is not a uniform or specific set of disabilities. It is a many-faceted problem that involves a great range of abilities and behaviors among those affected. Especially at the higher I.Q. end of the retardation spectrum, one might find individuals labeled retarded who are capable of understanding the significance of sterilization and who can voice informed opinions on the matter. In an excellent study, Sabagh and Edgerton found many examples of lucid, precise comments on sterilization from persons who had been sterilized in state institutions.[177] When individuals can offer such comments and can understand the meaning of sterilization for themselves, we see no reason to deem them incompetent to make the decision for themselves.

The most difficult choices must be made concerning those persons who do not appear to understand the significance of sterilization but who may be able to voice objections to it. Should we consider the comments of a retarded person in making the decision, especially when he is not competent to make a decision for himself? Should a hostile response from the candidate be determinative? As to the first question, the candidate certainly should be heard on the matter. To allow otherwise would be a gross denial of due process.[178]

176. See, e.g., cases cited in notes 66-67 supra.

177. Sabagh & Edgerton, note 161 supra.

178. "Due process of law means that every person must have his day in court. . . ." Davis v. Berry, 216 F. 413, 418 (D. Iowa 1914) (holding unconstitutional Iowa's eugenic sterilization law on due process grounds). See also Wyatt v. Aderholt, 368 F. Supp. 1383, 1385 (M.D. Ala. 1974) (developing guidelines for sterilizing residents of Alabama institutions and requiring discussion with the patient).

However, on the second question, a negative or hostile response from a candidate should not preclude sterilization if a "last resort" test, as outlined above, has been met.

A person judged incompetent to give a full, informed consent to sterilization may have inaccurate information about sterilization or she may have unjustified fears about sterilization. However onerous it may be to sterilize someone over his objections, to do otherwise may be a graver injustice. If sterilization has met the stringent last resort test proposed herein, then it can be said to be in the best interests of that retarded individual to be sterilized. If this is so, then it is simply irresponsible to allow the retardate's unjustified fears or inability to understand the nature of sterilization to prevent a sterilization that, on balance, is for the candidate's and society's benefit.

Unwilling sterilization of incompetents is likely to be a rare occurrence, for several reasons. First, many supposedly retarded persons may be able to understand and agree with sterilization if it is explained to them properly.[179] Second, when a candidate voices objections, sterilization may be more likely to do harm than good and a last-resort test would not be met. As noted above, there is a significant correlation between mental retardation and emotional disturbance.[180] This correlation suggests that sterilizing such a person over her objections, irrespective of how irrational she may be, simply may increase her disturbance, further lower already precarious self-image and hinder the retardate's development in general. These possibilities should be carefully considered before sterilization is performed.

The AAMD statement[181] and the model sterilization act drafted by the Association for Voluntary Sterilization (AVS)[182] propose a unique approach requiring court review for those persons who have not been judged incompetent but whose competence may be questioned with respect to the decision whether he or she should be sterilized. Such a law was in force in Montana[183] and met with favorable comment from some physicians in that state.[184] Nonetheless, there are extreme difficulties with such a law. In the first place it is very difficult to state in a manner that is not either subject to abuse or hopelessly vague who should be covered by such a law. The Montana law provided for court review for all those "who, under appropriate standards would be diagnosed as capable of consent to sterilization but whose capacity to consent has been questioned by a licensed physician."[185] If the purpose of the law is to provide for sterilization for that class of "borderline" individuals who could benefit from involuntary sterilization procedures, the above formulation

179. Meyerowitz, supra note 137, at 108.

180. See text accompanying notes 156-57 supra.

181. See note 32 supra.

182. The AVS bill appears in Neuwirth, Heisler & Goldrich, Capacity, Competence, Consent: Voluntary Sterilization of the Retarded, 6 Colum. Hum. Rts. L. Rev. 447 (1974).

183. Mont. Code Ann. §§ 53-23-101 to -105 (1979) (originally § 69-6401) (repealed 1981).

184. For favorable comment on the Montana law, see Pallister & Perry, Reflections on Marriage for the Retarded: The Case for Voluntary Sterilization, 24 Hosp. & Community Psychiatry 172 (1973).

185. Mont. Code Ann. § 53-23-102 (1979) (repealed 1981).

will not satisfy this intent. Many such borderline individuals may present themselves to physicians so as not to call their competency into question. The same or similar individuals presenting themselves to different physicians might produce different results. Thus, many individuals that could benefit from sterilization will pass unnoticed. The statute simply fails to provide enough breadth to apply reasonably to all those individuals it supposedly is designed to help.

The reverse criticism can be made of the AVS model bill. It provides for court review in all cases in which a person's competency either has been challenged or "might be challenged" by a licensed physician.[186] The "might be challenged provision" is inherently vague and impossible to apply with any consistency. Its ambiguity creates the potential for cutting too deeply into the class of individuals presumed to be competent to manage their own affairs.

Aside from their hopelessly vague nature, the standards in the AVS, AAMD and Montana statutes are both dangerous and unnecessary. Court proceedings such as envisaged therein could provide a basis for a later claim that the candidate was legally incompetent for purposes other than deciding whether sterilization is proper. Although such a judgment certainly would be based on more than the sterilization hearing alone, the suspicions of a physician in a sterilization hearing should not be used as a foundation for a far-reaching and possibly erroneous judgment of legal incompetency. Moreover, existing tort remedies render unnecessary such a "separate treatment" for some legally competent persons. If a physician acts without the informed consent of the patient in sterilizing a competent individual, he is subject to a number of different legal penalties, primarily malpractice suits. These remedies, while not perfect, are at least as adequate as those envisioned above but do not have the defect of subjecting a subclass of presumably competent persons to a court proceeding to determine, not its members' total incompetency, but rather their capacity to consent to one medical procedure. Such a subclass could be expanded almost indefinitely, with potentially serious and unwarranted consequences.

VI. CONCLUSION

State laws providing for the sterilization of mentally retarded persons in the United States are, for the most part, woefully inadequate and are premised upon eugenic concepts long since discarded by medical and genetics professionals. These laws, products of the early twentieth century, were built upon the need to prevent passage of "defective genes" to future generations. More recently, they have been based upon the perceived state interest in preventing procreation of children by individuals totally incapable of providing for sustenance and care of their children. Existing laws, however, fail to further this interest in a substantive and procedural context that will protect the retarded person's fundamental right to procreate yet simultaneously permit sterilization

186. Neuwirth, Heisler & Goldrich, note 182 supra, at 465.

in compelling cases and prohibit the abuses that often have attended sterilization of the retarded.

This Article has proposed a procedural and substantive framework to achieve these goals. In summary, the authors have proposed a procedure having the following components:

1. *Initiators of a Sterilization*: Parents, guardians and institutions may propose sterilization in appropriate cases, but such proposals shall not be determinative.
2. *Candidate for Sterilization*: A person who, by reason of mental defect or retardation, is permanently incapable of understanding the nature of the sterilization operation and its effects, or of rationally consenting or withholding consent to the operation. If a person labelled "retarded" is capable of understanding and evaluating the operation, the person's decision is determinative and no further attempt to sterilize may be made.
3. *Forum for Determination*: A court of competent, trial-level jurisdiction, by de novo hearing, with no preceding administrative hearing or review.
4. *Role of Parents/Guardians*: In all cases the consent of the parents or legal guardians must be obtained. If a retarded person is not a minor or has not been placed under guardianship, he shall be presumed to be competent and his wishes shall be determinative.
5. *Standard for Court Review*: If the candidate meets the foregoing criteria for a court to "substitute judgment" for the sterilization, the court may authorize the operation, *only* if *all* of the following criteria are met:
   (a) Sterilization must be in the best interests of the candidate, irrespective of the interests of the parents or guardians.
   (b) Sterilization must be the least restrictive alternative usable to solve the problem and still meet the state's interest, as measured by the following factors:
      (1) There must be total certainty that the candidate's permanent and irremediable retardation precludes any possibility of future capacity to care adequately for children;
      (2) The candidate must have present capacity to reproduce;
      (3) The candidate must be sexually active;
      (4) Other methods of contraception must be impractical or unworkable; and
      (5) Sterilization must be the least harmful alternative to reproduction.

In 1980, the Washington Supreme Court handed down an important ruling directly concerning the issues treated in this Article. In *In re Hays*,[187] the

187. 93 Wash. 228, 231-34, 608 P.2d 635, 637-39 (1980).

court held as a matter of law that the superior courts of the state have the power to issue sterilization orders on the petition of a parent and in the absence of any state statute expressly authorizing the issuance of such an order. As a matter of policy it further ordered the superior courts to follow a detailed procedure for reviewing such cases,[188] which largely mirrors the one worked out in sections three, four and five of this Article.

The Washington court held that several cases from other state appellate courts holding to the contrary were not controlling, because they merely expressed opinions and offered no substantive principle of law to support their deference to legislative initiative.[189] This argument may not be as persuasive as it appears. As the divided opinions on this question suggest, it is at least debatable whether or not courts have, or should have, the power to invade summarily the fundamental rights of citizens without express legislative or constitutional authorization to do so, especially when, as here, such an invasion possibly will result in the irremediable elimination of the power to exercise a fundamental right.

Aside from this point, the policy adopted by the court for consideration of such petitions is wholly commendable and represents a major advance in judicial consideration of this matter. Procedurally, the court requires that the incompetent individual be represented by counsel, that his views be heard and taken into account, and that the court be afforded expert evaluations of the physical, mental and social state of the candidate.[190] Substantively, it requires that

> [t]he judge must find that the individual is 1) physically capable of procreation, 2) likely to engage in sexual activity at present or in the near future in circumstances likely to result in pregnancy and must find in addition that 3) the nature and extent of the individual's disability . . . renders him or her permanently incapable of caring for a child even with reasonable assistance . . . . Finally, there must be no alternatives to sterilization.[191]

This policy is entirely reasonable and is consistent with that developed in this Article. Unlike this Article, however, the Washington court offers no resolution to the difficult equal protection problems caused by its third requirement, nor does it offer a detailed rationale for its specific requirements. Nevertheless, as an outline the policy is laudable.

A word must be added about the standard of review to be applied by the court in its fact-finding efforts. Various statutes establish burdens of proof ranging from mere preponderance of the evidence[192] to a "clear and convincing evidence" standard.[193] Most statutes provide no standard whatsoever.[194]

188. Id. at 237-40, 608 P.2d at 640-42.
189. Id. at 231, 608 P.2d at 637.
190. Id. at 238, 608 P.2d at 641.
191. Id.
192. E.g., Ga. Code Ann. § 84-933(c)(iv)(1979).
193. E.g., Conn. Gen. Stat. Ann. § 45-78y(6) (West 1981); Va. Code § 54-325.12.A (Supp. 1981).

To adequately protect the candidate's right to procreate, it may be appropriate to require a criminal-law burden of proof: "beyond a reasonable doubt."

Perhaps the most difficult task facing the judicial system is to make decisions in those ever-increasing areas in which the law has little expertise and which represent problems in human relations surrounding fundamental rights. Indeed, in these cases more than others, "hard cases make bad law." However, by the development of clear and concise standards such as those proposed in this Article, in one area of legal involvement in human relationships—sterilization of the mentally retarded—the hard cases may no longer make bad, unworkable or inhumane law. Although the wisdom of Solomon cannot be created legislatively, the proposed standards may provide a humane and just resolution of the most compelling cases for sterilization, yet protect the mentally retarded from the abuses that have occurred in the past.

194. E.g., Ark. Stat. Ann.§ 59-502(k) (1971); Okla. Stat. Ann. tit. 43A, §343 (West 1979); S.C. Code Ann. § 44-47-60 (Law. Co-op. 1976); W. Va. Code § 27-16-1 (1980).