ELECTIVE STERILIZATION

I. INTRODUCTION

The desire for family planning has become a prevalent and widely accepted attitude in American marriage. Sterilization is a surgical procedure which offers a married couple a permanent means of limiting their family to its present size. However, it has significant moral and religious overtones for many members of the community, and the law in most jurisdictions has not provided the medical profession with any standards for a legally acceptable sterilization policy. The first half of this Note is the product of field research among doctors and hospitals in the Philadelphia area to discover whether sterilization is readily available for the purpose of family limitation and upon what grounds doctors tend to restrict its use for this purpose.[1] The second half of the Note analyzes the legal consequences of elective sterilization—a significant concern of many of the doctors interviewed—and suggests legislation which would relieve the medical profession of any inhibiting doubts as to the controlling legal standards.

The purpose of the field research project was not to obtain a complete statistical survey of sterilization practices, but rather to discover the prevalent attitudes of the medical profession by selective investigation. The method of field research consisted of interviews with thirteen obstetricians or gynecologists and six urologists, who were all hospital staff members or chiefs of service of their respective departments.[2] Since most of the doctors were affiliated with at least two hospitals, the survey represents an extensive cross-sampling of the larger metropolitan and suburban hospitals.[3] Information about female sterilization in six addi-

---

[1] The *Review* wishes to express its appreciation to the Thomas Skelton Harrison Foundation for allocating funds so that an interview method of research could be employed in this study.

[2] Because of the sensitive nature of this subject, none of the doctors or hospitals interviewed would permit their opinions or factual information about their sterilization practice to be made a matter of public record. The *Review* will keep the notes of the interviews and all correspondence of the research project on file and endeavor to obtain the consent of the parties interviewed to make this information available for further research in this area.

[3] No interviews were conducted with staff members of Catholic hospitals because preliminary inquiries revealed that these hospitals would not permit sterilizations of convenience. Compare text accompanying notes 25-26 *infra*.

There are sixteen non-Catholic hospitals with over two hundred beds in the Philadelphia area, and the doctors interviewed included staff members of thirteen of these hospitals. Most of the doctors were also affiliated with smaller hospitals and familiar with their sterilization policies.

Because vasectomy is usually an office procedure, each individual physician may determine his own standards for performing elective sterilization. For this reason a broadly representative sample of vasectomy practice would have necessitated a greater number of interviews than the resources of the research project permitted. However, the urologists interviewed indicated that their attitudes and practices reflected the approach of most of the Philadelphia urologists.

tional hospitals and about the private practice of one urologist was obtained through written responses to mailed inquiries.

When used in this Note, "elective" sterilization or "sterilization of convenience" designates surgical sterilization performed for the purpose of family limitation motivated solely by personal or socio-economic considerations. "Therapeutic" sterilization, on the other hand, is employed to protect the physical[4] or mental health[5] of the patient. "Voluntary" sterilization, performed with the consent of the patient, is used to distinguish the elective and therapeutic procedures from those operations performed pursuant to state statutes providing for compulsory eugenic sterilization of mental defectives and habitual criminals.

A. A Description of the Surgical Procedures

In female sterilization, called salpingectomy or tubal ligation, the abdominal cavity is opened and the fallopian tubes are cut and tied to prevent the uniting of sperm and egg. The operation requires general anesthesia and is generally designated as major surgery. Hospitalization is always required, but when a tubal ligation is done post partum, after delivery, a woman's hospital confinement is not appreciably lengthened. Moreover the post partum operation is simplified by the fact that the swollen uterus presses the fallopian tubes closer to the abdominal wall, thus requiring a smaller incision. In either case there is some risk of death as an immediate result of the operation.[6]

Male sterilization, vasectomy, is a simpler procedure which may be performed in the physician's office under local anesthesia. The vas deferens, the tube connecting the testes with the urinary canal, is severed and tied, preventing the sperm from thereafter passing into the urinary canal. However, for a short time after the operation sperm may still be ejaculated because the ejaculate will still contain sperm present from before the operation. The doctor should advise the patient to return for several weeks after the operation, until it is certain that no sperm remain. There may be some discomfort or a possibility of slight infection following the

---

[4] Medically indicated sterilization covers a wide range of possibilities. The doctors interviewed suggested three general categories: (1) diseases which would make pregnancy dangerous to the life or health of the mother, such as severe cardiac or kidney disorders; (2) diseases of a congenital or hereditary nature that make it probable that pregnancy will result in deformed or stillborn children; and (3) severe grand multiparity which increases the probabilities of complications with future pregnancies. There is no uniformity of opinion on whether this last factor should always constitute a medical indication for sterilization. However, doctors usually recommend sterilization after three caesarean sections if it is likely that the woman would not be able to have natural deliveries in the future.

[5] Compare note 21 *infra* and accompanying text.

[6] There was some disagreement among the doctors interviewed as to the seriousness of the risk to the patient. Some doctors reported that the danger of mortality was about one per thousand. However, other doctors indicated their belief that it was substantially lower.

operation, but usually the patient is not inconvenienced for more than a few days.

The permanence of surgical sterilizations is qualified by the possibility either of recanalization or a surgical reversal of the operation. Recanalization, which is more common in the case of vasectomy, occurs when the cut tubes grow together to permit the passage of sperm or egg. Due to the use of improved surgical techniques, this possibility has been greatly reduced. Surgical reversal is a difficult operation and is only successful in a small percentage of cases. Therefore, a patient contemplating undergoing the operation must consider it as a permanent, irreversible procedure.

II. The Elective Sterilization Problem

A. Individual Motives for Elective Sterlization

In view of the reasonably effective contraceptive devices presently available, it would seem unlikely that many people would undergo elective sterilization. However, recent studies on the effectiveness of contraceptive methods indicate that these devices do not completely eliminate the risk of accidental pregnancy. In one group composed of 5,788 couples who used several different methods of contraception, there were 1,437 accidental pregnancies.[7] Experts in the area of family planning suggest that the lack of complete success in the use of contraceptives is caused not by any technical failure of the devices, but rather by the individual couple's inability to employ them properly and consistently—primarily because of the inconvenience accompanying their use.[8] Although contraceptive pills are not subject to this objection, they may produce side effects of nausea and vomiting, and they are as yet so new that many women are afraid to use them.[9]

---

[7] Freedman, Whelpton & Campbell, Family Planning, Sterility and Population Growth 421 (1959).

In a compilation of studies on the rate of pregnancies of women using the diaphragm and jelly methods, the average pregnancy rate in fourteen reported studies was about 14%. Agarwala, *Population Control in India: Progress and Prospects*, 25 Law & Contemp. Prob. 577, 590 (1960).

[8] General acceptance of the two contraceptive methods given greatest medical approval, diaphragm and condom, is severely handicapped by complexity of the former, and the necessity to make adjustment of the latter coincide with the coital act. . . . [A] high degree of motivation is required to use either method consistently for a long period, a degree of motivation a large proportion of patients lack.

Guttmacher, *The Influence of Fertility Control Upon Psychiatric Illness*, 115 American J. Psychiatry 683 (1959).

In a recent study of vasectomy, fear of contraceptive failure and contraceptive interference with sexual pleasure were major reasons for seeking sterilization. Poffenberger & Poffenberger, *Vasectomy as a Preferred Method of Birth Control: A Preliminary Investigation*, 25 Marriage & Family Living 326, 327 (1963).

[9] The intrauterine coil, a new device which was being used experimentally by a few doctors interviewed, can be removed by a doctor when pregnancy is desired

On the other hand, in almost all cases surgical sterilization completely eliminates the risk of unwanted pregnancy and the inconvenience of contraceptive devices. However, there are several considerations which may inhibit an individual from choosing sterilization as a means of family planning. Some individuals may be reluctant to accept the risk and discomfort of the operation. Religious and moral attitudes, especially among Catholics, may also preclude elective sterilization. A more universally considered disadvantage of sterilization is the fact that it is almost always an irrevocable procedure. Thus many couples may feel that the loss of the ability to have children when they might be desired in the future is not compensated for by the elimination of the fear of presently unwanted pregnancies. Finally, some individuals, especially males, may reject sterilization because of the fear, perhaps unfounded, of an adverse psychological effect from the inability to reproduce.[10]

By weighing these competing considerations, a married couple may rationally decide upon sterilization if they feel that the risks inherent in the procedure are of lesser importance than the goal of effective family limitation. However, in some instances the decision to be sterilized may be made on the basis of transitory or irrational motives without adequate consideration of the future consequences of the operation. The most common illustration of this situation is where one of the parties seeks sterilization as a means to arrest the effects of an unhappy marriage or to punish an offending spouse. Similarly, sterilization may be decided upon after the birth of a retarded or deformed child although prognosis indicates that future births would probably be normal. Temporary emotional difficulties unrelated to marital problems may also cause a hastily considered decision to be sterilized.[11]

---

and may make sterilization obsolete once it is perfected. However, the medical profession is still unsure of the reason for its effectiveness and whether it may have any reaction on internal body tissue. Moreover, if the effectiveness of the coil is due to the fact that it produces an abortion of a fertilized ovum, rather than simply preventing fertilization of the ovum, it may incur the serious objection of both the Catholic and Protestant religions. See Medical World News, Nov. 6, 1964, pp. 110-11. And it might be held to be a device for procuring an abortion within the terms of many abortion statutes.

[10] However, the most extensive study on the sexual and psychological effects of sterilization indicates that it produced exhilarating or at least no depressive effects on sexual activities in about 95% of the cases studied. Koya, *Sterilization in Japan*, 8 EUGENICS Q. 135, 139 (1961).

Of 235 women sterilized in Stockholm in 1951, 54% reported no change in capacity for sexual satisfaction, 33% improved and 13% reduced. 2 EXCERPTA CRIMINOLOGICA 735, 736 (1962).

For further studies dealing with motivation and results of vasectomies, see generally Poffenberger & Poffenberger, *supra* note 8, at 326; Rodgers, Ziegler, Rohn & Prentiss, *Sociopsychological Characteristics of Patients Obtaining Vasectomies from Urologists*, 25 MARRIAGE & FAMILY LIVING 331 (1963).

[11] Finally, an even more difficult motive to detect may be a desire for sterilization to gratify a wish for self-mutilation or self-destruction. MENNINGER, MAN AGAINST HIMSELF 308-11 (1938).

B. Present Medical Practice

1. Female Sterilization: Tubal Ligation

In many areas of hospital practice, the Joint Commission on Accreditation of Hospitals[12] promulgates certain procedural and substantive rules which a hospital must follow if it wishes to be accredited.[13] In December 1961 the commission responded to several inquiries from member hospitals on the proper procedure to be followed for sterilization operations and issued a bulletin on this subject.[14] The commission did not attempt to establish substantive criteria to be applied to requests for sterilizations. However, they did decide that certain minimal procedures should be followed "for the protection of the patient, hospital, and physician."[15] The commission requires that each hospital set and enforce its own substantive rules, with the approval of the governing board of the hospital and its legal counsel. Moreover, the hospitals' rules must conform to applicable state law and contain a requirement that another doctor be consulted before the operation is performed.[16]

Despite the freedom from regulation by the commission and the absence of Pennsylvania statutes on the subject, obstetricians and gynecologists in the Philadelphia area have established rules for their hospitals which greatly restrict the number of elective sterilizations. Three of the eighteen hospitals investigated will not perform sterilizations of convenience; they require a showing of medical necessity to justify the operation. In one of these hospitals, the committee which passes upon every application for sterilization often strains to find a therapeutic indication when there are already several children in the family. Where voluntary sterilizations are permitted, most hospitals have required that a woman have either conceived (gravity) or delivered (parity) a certain number of children at the time the operation is performed.[17] Age, too, is a determinative factor; there is much more hesitancy to sterilize a younger woman, regardless of the number of children she has.

---

[12] The commission's member organizations are the American College of Physicians, American College of Surgeons, American Hospital Association, and American Medical Association.

[13] The commission enforces its rules by periodic inspection of the hospitals and their records and disaccreditation of those hospitals that do not comply. Several of the hospital staff members interviewed said that the particular interest in sterilization records by the commission's investigators made them fear an adverse reaction by the commission if they performed "too many" sterilizations.

[14] Bulletin From Kenneth B. Babcock, M.D., Director of the Joint Commission on Accreditation of Hospitals, No. 28, Dec. 1961.

[15] *Ibid.*

[16] *Ibid.*

[17] The requirement that a certain number had been delivered or conceived seems to show more concern for the health of the mother, because after a certain number of conceptions or deliveries, future pregnancies become more complicated. A rule which requires that there be a certain number of living children reflects a greater concern for the possibility that a woman will change her mind or circumstances so that she desires additional children.

In order to accommodate both of these considerations, some hospitals have established age/parity formulae based upon the standards promulgated by Mount Sinai Hospital in New York. Under this formula a tubal ligation will be done at the request of a couple that has six living children. However, the required number is varied with reference to the age of the patient. If a woman is thirty to thirty-five years old with 5 living children, or over thirty-five with four living children, a sterilization can be obtained.[18]

The hospitals in Philadelphia generally apply more liberal standards. Only one hospital requires six living children. Four of the eighteen hospitals investigated require five living children, regardless of the age of the patient. One hospital requires five deliveries, another only five pregnancies. The other hospitals' standards are generally variations on the Mount Sinai model. One example of such a formula is: twenty-five years old, five living children; thirty years old, four living children; thirty-five years old, three living children.[19] The most liberal standard is three living children without any fixed-age requirement. However, a patient with this number of children is not automatically able to obtain a sterilization because the doctor must consult with another physician and exercise his discretion with reference to such factors as the age, mental and physical health, and financial position of the applicant. One hospital will sterilize any woman over forty years of age.

Most of the hospitals in Philadelphia employ a combination of procedures to review applications for sterilizations. When the standard is based upon an age/parity formula, permission to perform the operation is automatic, or consultation with another physician in the hospital's department of obstetrics and gynecology is required. The requirement of a consultation seems superfluous when the standard does not demand a doctor's discretion. But it probably is maintained to meet the commission on accreditation's standards. If there is a medical indication for sterilization, a consultation with at least one staff member who specializes in the disorder is usually required. Sometimes a committee passes upon every application, or at least those applications that do not comply with the accepted standards for that hospital.

2. Male Sterilization: Vasectomy

Two serious medical objections to female sterilization, the use of general anesthesia and the opening of the abdominal cavity, are not present in male sterilization. Since the cutting and tying back of the vas deferens can be done under local anesthesia in the doctor's office, male

[18] Guttmacher, *The Influence of Fertility Control Upon Psychiatric Illness*, 116 AMERICAN J. PSYCHIATRY 683, 685 (1959).

[19] Another hospital's standards require four living children at age thirty-five, five living children at age thirty-two, and six living children at age twenty-five.

sterilization generally is not regulated either by the hospitals or their departments of urology to the same extent as female sterilization. Several institutions require consultation with one or more doctors before the operation may be performed in the hospital, but usually it is up to the individual doctor to decide whether or not a sterilization is justified. In spite of the ease of the operation and the discretion in the individual doctor, the interviews suggested that urologists have imposed even more severe substantive restrictions on vasectomy operations than are present in female sterilization.

Five out of seven urologists interviewed reported that they will only perform sterilizations when therapeutic indications exist. Another doctor said he would relax the requirement of medical justification in cases of severe economic hardship, but suggested that in the past these exceptions have been very rare. Only one doctor said that he performed vasectomies on the basis of the number of children a couple had. He would sterilize a man, upon request, if he had three living children. However, this is not his sole criterion because he excludes Catholics, who may have adverse psychological reactions, and those applicants whom he feels are emotionally unstable. This doctor and the other members of the staff of the department of urology of the hospital with which he is affiliated do not perform vasectomies of convenience in the hospital because of the elaborate procedure that must be followed there.

Since it appears that most urologists will not perform sterilizations of convenience, the possible range of justifications for a vasectomy are quite limited. Medical necessity, such as repeated swollen epididymis, is the most frequent occasion for the operation. Usually no consultation or any other procedure is required. As an elective procedure, sterilization is performed by most doctors only in the case of an hereditary disease. However, some doctors will perform a vasectomy if requested by the family doctor or the wife's obstetrician in cases where it would be medically harmful for the wife to become pregnant and too dangerous for her to undergo surgery for the purpose of sterilization.

C. The Inhibiting Factors

The primary emphasis of the field research interviews was placed on the reasons by which doctors justify the imposition of restrictive standards on elective sterilization. Many of the considerations which may dissuade an individual from undergoing sterilization were also suggested as justifications for a restrictive policy. Each doctor interviewed was primarily concerned with the permanent nature of the operation and the possibility that something might happen to one or more of the couple's children or that the party to be sterilized might remarry and desire children by the second spouse.

Another important consideration, which significantly affects the practice in female sterilization, is the possibility of mishap during surgery.

Since the procedure is purely elective, doctors do not like to take even a small chance with the patient's life, especially in view of the availability of other reasonably effective contraceptive methods.

Finally, some doctors considered the possibility that vasectomy may produce adverse psychological reactions, such as diminution of pleasure in the sexual act or even functional impotence.[20]

In addition to these reasons, however, the interviews revealed several other factors which influenced some doctors to avoid sterilizations of convenience entirely or severely to limit their availability.

1. Loss of Reputation

The fear of community disapproval of a liberal sterilization practice may be a major reason for adopting a restrictive policy. Individual doctors and hospital staff chiefs evidenced a great concern for the possible loss of reputation in the community and in the profession which such disapproval, whether privately held or publicly expressed, may produce. They suggested that the loss of reputation may result in loss of patients and endowments and possible restrictions by the legislature. Two primary sources of community condemnation were indicated.

a. Sterilization and Abortion

When asked about sterilization, doctors would invariably bring up the subject of abortion, and it seems that the legal and moral prohibitions against abortion affect their attitudes towards sterilization. One doctor felt that this close identification of abortion with sterilization is one of the major reasons why the medical profession has restricted the availability of sterilizations. Moreover, the common association of the two problems has led hospitals to establish similar procedures for passing upon applications for sterilizations and therapeutic abortions.

However, the doctors recognized that sterilization can be distinguished from abortion by the attitude which the law has adopted toward the two procedures. In thirty-one states a doctor may perform an abortion only when it is necessary to preserve the life of the mother. On the other hand, sterilization, except for institutionalized persons, is generally not restricted by statute. Moreover, the medical profession seems to have distinguished between the cogency of the moral arguments against sterilization and abortion. Many doctors felt that abortion is as serious a public offense as murder, or that it is at least contrary to the purpose of the

[20] Although there is relatively little evidence to support the validity of this belief, see note 10 *supra*, it might be desirable for the doctors to refer certain applicants to a psychiatrist for his advice on whether the operation should be performed. This procedure would probably reveal the more severe psychological cases, and it would eliminate the need for an overly restrictive policy to compensate for this possibility. The one doctor interviewed who has had extensive experience with vasectomy said that he has never had a case result in severe psychological disturbance. However, he is careful to investigate the psychological attitude of his applicants and to refuse the operations to those whom he thinks would be subject to such a severe reaction.

practice of medicine because it takes away a life. Even though doctors have imposed restrictions on sterilization, most doctors interviewed did not view sterilization under certain conditions as morally wrong. These factors suggest that a primary reason that doctors associate sterilization with abortion is the fear that the public regards them with the same disapproval.

The practice of recommending or even requiring that a woman be sterilized in some cases when a therapeutic abortion is performed indicates that doctors are willing to perform sterilizations where they feel that public opinion would not be unfavorable. This practice is reasonable when the therapeutic justification for the abortion indicates that the woman's life would be endangered by future pregnancies, because doctors do not want to be forced to perform repeated abortions. However, it may be objectionable when the indication for therapeutic abortion is an emotional disorder, because psychiatric care could enable many women to withstand the emotional strain of childbirth and parenthood.[21]

In the above situations the much stronger condemnation of abortion leads doctors to sterilize in cases where it is not requested and may not even be desired.

A comparison between legal regulations and medical practice in the fields of abortion and sterilization suggests that the medical profession attempts to reflect a consensus of community values in its attitudes toward controversial procedures. Although doctors recognize the legal and moral restraints on abortion, they have felt that the law is unnecessarily restrictive in light of prevalent public opinion, and there is evidence that the practice of therapeutic abortion is much broader than the law would seem to permit.[22] On the other hand, there are no statutory restrictions on sterilization in most states, and most doctors do not have rigid ethical objections to this procedure. However, doctors have invariably imposed their own restrictive standards for the operation, which have substantially reduced its availability.

b. Opposition by Religious Groups

Although some individuals may object to elective sterilization on ethical or moral grounds, there appears to be no strong opposition among Protestant[23] or Jewish[24] theologians to contraception in general, nor to sterilization in particular. According to present Catholic doctrine, how-

[21] One psychiatrist has stated that the insistence that a sterilization accompany a therapeutic abortion of a youthful patient must have certain punitive aspects, because her psychiatric condition may improve greatly. Laidlow, *Discussion*, 115 AMERICAN J. PSYCHIATRY 689, 690-91 (1959).

[22] See generally Packer & Gampell, *Therapeutic Abortion: A Problem in Law and Medicine*, 11 STAN. L. REV. 417 (1959).

[23] See FAGLEY, THE POPULATION EXPLOSION AND CHRISTIAN RESPONSIBILITY 207, 221 (1960).

[24] See generally Rachman, *Morality in Medico-Legal Problems: A Jewish View*, 31 N.Y.U.L. REV. 1205, 1217 (1956).

ever, sterilization is subject to the prohibition against artificial birth control and is not permitted in Catholic hospitals unless sterility is induced as the result of a necessary primary procedure. The Catholic Hospital Association's Directive to Catholic Hospitals states:

Procedures that induce sterility, whether permanent or temporary, are permitted when:

a) they are immediately directed to the cure, diminution or prevention of a serious pathological condition;

b) a simpler treatment is not reasonably available; and

c) the sterility itself is an unintended and, in the circumstances, an unavoidable effect.[25]

When asked about the hospital's sterilization practice, the administrator of one Catholic hospital in Philadelphia responded that sterilization is contrary to natural law and facilitates licentious living, undisciplined habits, and venereal disease. Because sterilization involves a surgical interference with natural bodily functions, a liberalization of Catholic doctrine on the subject of birth control would probably not affect the attitude toward sterilization.[26] At present this attitude not only affects the practice in Catholic hospitals, but has wide ramifications throughout the medical profession as a whole. The large percentage of Catholics among the total population has a significant effect on society's consensus as to the morality of a sterilization operation. Several doctors interviewed stated that the Catholic position was a definite inhibiting factor for individual practitioners, including non-Catholics. Although the same Catholic prohibition on other contraceptive devices does not affect most doctors, sterilization is distinguished because it may require major surgery and is usually irreparable.

The interviews suggested further restraints emanating from the Catholic position which affect non-Catholic doctors and hospitals. Catholic doctors on the staff of a hospital's obstetrics and gynecology department, or on a committee which is required to approve every sterilization, usually vote against a sterilization that would not meet the very strict requirements applied in Catholic hospitals. Sometimes Catholic nurses or residents refuse to aid a doctor performing a sterilization. Moreover, a reputation for a lenient sterilization practice may jeopardize a hospital's relations with nearby Catholic hospitals. Finally, doctors take into account the possibility that Catholics may not go to an obstetrician or gynecologist who is considered to have unacceptably minimal standards for sterilizations.

---

[25] CATHOLIC HOSPITAL ASS'N OF THE U.S. AND CANADA, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HOSPITALS (2d ed. 1959).

[26] There is some indication that it is because of the high rates of abortion and sterilization in some countries that some Catholic clerics are willing to accept other forms of family planning as a lesser evil. N.Y. Times, Aug. 5, 1963, p. 1, col. 3.

In Puerto Rico, despite the fact that 80% of the population is Catholic, sterilization has become one of the principal means of birth control. The demand for this operation is increasing so rapidly that there are not enough facilities to meet it. HILL, THE FAMILY AND POPULATION CONTROL 127 (1959).

The public controversy concerning the passage of Virginia's voluntary sterilization statute suggests that Catholic opposition to sterilization also may be able to affect doctors and hospitals through the pressure of organized public opinion. About five years ago the Facquier Hospital in Warrenton, Virginia, began to operate a clinic which gave free medical care for needy mothers—one of the services available being sterilization for married mothers of three children. Approximately sixty women had been sterilized in a two and one half year period.[27] In 1962, persuaded by the hospital staff at Facquier, the Virginia legislature enacted a statute protecting doctors from liability for the nonnegligent performance of a sterilization operation. About two months after the passage of the statute, a Catholic Archbishop denounced sterilization as immoral, directing many of his remarks at the Facquier Hospital. He said that sterilization "directly violates a natural right which is so profoundly sacred that it may not be taken away from the individual by the state and may not be voluntarily surrendered to the state by the individual." [28] In the ensuing controversy over sterilization, and in particular over the Virginia statute and the Facquier Clinic, the hospital was plagued with reporters, and its sterilization policy was discussed in newspapers for over a month. Since they have neither the time nor the desire to become involved in such a dispute, few hospitals and doctors are willing to risk being subjected to this kind of publicity.

2. Fear of Legal Liability

Almost all of the doctors interviewed expressed a fear of the possible legal consequences to themselves and to their hospitals of performing elective sterilizations. Among urologists this fear was a major factor in restricting sterilizations of convenience; gynecologists and obstetricians did not feel it was as significant a deterrent. In many cases this concern was not well defined in legal terminology, but the general apprehension was thought to inhibit a more liberal sterilization practice. Most of the doctors interviewed did not think that they would be criminally prosecuted. In Pennsylvania there is no statute either prohibiting or regulating sterilizations, but a few doctors suggested a possibility that the definitions of other crimes, such as assault, may encompass the procedure. The fear of becoming involved in a civil action was not directed solely at the payment of large damages or increases in insurance rates, because the loss of time, inconvenience, and possible damage to reputation that may result induce doctors not to perform elective sterilizations even if they feel they could

[27] N.Y. Times, Sept. 9, 1962, p. 60, col. 4.

[28] N.Y. Times, Sept. 10, 1962, p. 25, col. 2.

In reply to this attack, a Unitarian minister defended the Virginia law: "It is not a moral evil but a moral good, for it grants to the poor privileges they desperately need which are now enjoyed by the prosperous alone." N.Y. Times, Sept. 17, 1962, p. 26, col. 5. A second Unitarian minister called for "enlightened legislation permitting population control through the use of contraceptives, sterilization and therapeutic abortion." *Ibid.*

successfully defend a suit. This attitude is intensified by the sharp rise in malpractice suits, of which almost every doctor interviewed was aware.

Doctors and hospitals were primarily concerned with the possibility of civil tort actions by the patient founded upon the theory that the operation was performed without his consent. They believed that the consent which they always required before they would proceed may be held invalid, because a court might find that the operation is against public policy. One doctor suggested that the same public policy that underlies laws to prevent criminal abortion applies to sterilizations, even though that policy had not produced a statute specifically forbidding such operations. Another theory on which the consent might be invalidated is that the patient did not fully understand the serious and permanent consequences of the operation. This claim would be particularly common in situations where the patient had later become dissatisfied with the permanent results of the operation. One urologist, who avoids sterilizations of convenience because he believes the patient's consent will not be a valid defense, does not apply this restriction to sterilizations of doctors, since he feels that a judge or jury could never conclude that they did not fully understand the consequences of the operation. In the area of female sterilization, the fear of liability under this theory has been partially responsible for certain of the procedural requirements, such as obtaining the consent of both spouses, the concurrence of another doctor, or a committee's approval of each application. In one hospital "the absence of a clearly defined legal code and the inadequacies of medical custom in the perplexity of therapeutic abortion and sterilization necessitated the establishment of a Therapeutic Abortion-Sterilization Committee to adjudicate these problems." [29] The fact that other doctors, who are concerned with the same issues, have agreed that a particular operation should be performed makes the surgeon more confident in his decision that public policy would not be contravened by the procedure. Although the substantive standards in the area of female sterilization are primarily motivated by nonlegal considerations, there is some feeling that while a sterilization performed on a woman with five children would not be legally objectionable, a sterilization performed without regard to the number of children or the age of the patient may be declared to be contrary to public policy.

In the occasional cases in which male sterilization is performed in a hospital, consultation with another doctor and consent of both spouses is required. However, since the operation is almost always performed in the doctor's office, there are no uniform consultation requirements. Only one of the urologists interviewed was unconcerned with the possibility of legal liability. He obtained the consent of the patient, but did not consult with any other doctor. The other urology specialists were primarily concerned with the legal consequences and felt that no procedures or

[29] Savel & Perlmutter, *Therapeutic Abortion and Sterilization Committee: A 3 Year Experience*, 80 AMERICAN J. OBSTETRICS & GYNECOLOGY 1192 (1960).

standards, except complete refusal to perform the operation, would adequately protect them.

A second theory upon which a doctor's liability could be founded is medical malpractice. Since the standard of reasonable care is generally what other doctors in the community would do,[30] consultation or committee approval is evidence of what is "accepted medical practice." These procedures are particularly valuable where sterilization is recommended by the physician after diagnosis of a therapeutic indication or where sterilization is restricted by state statute to cases in which there is a medical need for the operation.

Under any theory of liability, the fear of legal consequences is more troublesome to urologists because of the greater possibility of recanalization and the fact that a successful operation would not preclude the wife's pregnancy. A sterilized male whose wife becomes pregnant, whether as a result of natural reversal, the doctor's negligence, or intercourse with another man, might sue the operating physician. This greater likelihood of dissatisfaction with the operation and the fear that the patient's consent will not hold up in court have greatly limited the possibility of obtaining a sterilization of convenience from a urologist in Philadelphia.

III. A Legal Analysis of Elective Sterilization

A. Criminal Liability

Three states have enacted statutes declaring the performance or promotion of salpingectomy or vasectomy a criminal offense unless performed under the provisions of the compulsory eugenic statutes or by a private physician where there is a "medical necessity."[31] One of these statutes expressly extends the criminal liability to any person who knowingly submits to the operation.[32] The test of "medical necessity" applicable under these statutes is a novel one in the criminal law. The only analogous standards are those established by statutes prohibiting abortion except when necessary to preserve the life[33] or, under some statutes, the health of the mother.[34] It would seem that if the legislatures wished to limit the availability of sterilization to the same extent, they would have employed the more definite language of the abortion statutes. Their failure to do so indicates that the "medical necessity" test may allow doctors

---

[30] See Ball v. Mudge, 391 P.2d 201, 203 (Wash. 1964). Compare text accompanying note 85 *infra*.

[31] Conn. Gen. Stat. Rev. § 53-33 (1958); Kan. Gen. Stat. Ann. § 76-155 (1949); Utah Code Ann. § 64-10-12 (1961).

[32] Conn. Gen. Stat. Rev. § 53-33 (1958).

[33] See, *e.g.*, Cal. Pen. Code § 274 (abortion permissible "to preserve the life of the mother").

[34] See, *e.g.*, Col. Rev. Stat. Ann. § 40-2-23 (1953) (abortion permissible to prevent "serious and permanent bodily injury" to the mother).

more discretion. Whether this test will prove broad enough to permit voluntary sterilization for eugenic purposes or to protect the health of the patient's spouse must be determined by judicial construction as the cases arise.

With the exception of two other states which have granted doctors a statutory immunity from criminal liability for elective sterilization done under certain procedures,[35] no state has legislation dealing specifically with elective sterilization. In these states any criminal liability which might result from performance of or submission to the operation must be found in the general criminal provisions of the state. The only provisions which seem reasonably applicable to elective sterilization are those dealing with mayhem and assault.

At common law the crime of mayhem consisted of the unjustified infliction of an injury which rendered the victim less able to fight for the King, to defend himself, or to earn his own living.[36] Since the prohibition was established to protect the interest of the King, the consent of the person maimed was no defense, and a soliciting or perhaps merely a consenting victim was equally guilty of the offense.[37] Since neither vasectomy nor salpingectomy have any effect upon the physical capacity of the patient beyond the inability to procreate, they would not constitute mayhem at common law. However, the common-law definition has now been superceded by modern statutes, which vary in the extent to which they depart from the common law. The statutes extend the offense to include disfigurement, and some prohibit disabling any member or organ.[38] Moreover, the common law did not apply to women, but there is no doubt that the modern statutes apply equally to either sex.[39]

Commentators have suggested that a court could find surgical sterilization either legal or illegal under many statutes with equal propriety.[40] While the language of many mayhem statutes could support a finding that the operation constituted an offense, such a finding would seem to ignore the historical purpose of the prohibition from which these statutes evolved. Even if the statutes were read as prohibiting any injury which would render the injured party a less effective member of society—as broad a reading as any social interest would seem to require—sterilization would not seem to fall within the prohibition.

---

[35] See text accompanying note 99 *infra.*

[36] 4 BLACKSTONE, COMMENTARIES 205-06 (7th Oxford ed. 1775).

[37] See 3 THOMAS, COKE'S FIRST INSTITUTE OF THE LAWS OF ENGLAND 594-95 (1826) reporting *Wright's Case,* in which a young man procured a friend to cut off his hand in order that he might better beg for a living. Both men were convicted of mayhem.

[38] See, *e.g.,* OKLA. STAT. ANN. tit. 21, § 751 (1958); CAL. PEN. CODE § 203.

[39] See Kitchens v. State, 80 Ga. 810, 7 S.E. 209 (1888).

[40] Miller & Dean, *Liability of Physicians for Sterilization Operations,* 16 A.B.A.J. 158, 160 (1930); Smith, *Antecedent Grounds of Liability in the Practice of Surgery,* 14 ROCKY MT. L. REV. 233, 277-78 (1942).

While the requirement of most statutes that the injury be inflicted with malice might be satisfied if it were inflicted purposely or with intent to do the specific act,[41] some modern statutory definitions of mayhem require that the injury be inflicted by "lying in wait."[42] This requirement would seem to limit the applicability of the statute to cases of aggravated assault, and it is highly improbable that a surgical operation performed with the consent of the patient could be found to constitute a violation of such a statute.

Although the modern statutes defining mayhem often differ significantly from the common law, the statutes dealing with assault and battery are normally enactments of the common-law definition. Under this definition the consent of the alleged victim is a defense to the charge unless the act of the accused is otherwise unlawful.[43] Where the act alleged as constituting an assault is proscribed by law or is so clearly contrary to the public health, safety, or morals that it may judicially be declared to be against public policy, the victim's consent does not relieve the actor of criminal liability.[44] The sterilized patient is able to fulfill all his obligations as a member of the community and lacks only the ability to procreate. And since individuals and groups may differ as to whether this effect of the operation is contrary to a paramount social interest, the courts would not seem to be the proper forum to assess criminal liability solely on the basis of their own interpretation of public policy.[45] Moreover, the scrupulous concern which the Philadelphia doctors evidence for the rights and well-being of their patients in sterilization operations suggests that they would not be the proper subjects for any criminal liability based upon a potential threat to other members of the community.

---

[41] See Henry v. State, 125 Ark. 237, 188 S.W. 539 (1916) (intent to do act sufficient to establish malice); State v. Crawford, 13 N.C. 425, 428-29 (1830) (same). Compare People v. Bryan, 190 Cal. App. 2d 781, 787 (Dist. Ct. App. 1961): "Mayhem includes an act plus a prerequisite state of mind. . . . In mayhem, the actor must have a state of mind characterized by the words unlawful and malicious. Malice . . . imports an intent to vex, annoy, or injure another person, or an intent to do a wrongful act."

[42] See, *e.g.*, PA. STAT. ANN. tit. 18, § 4715 (1963).

[43] See Taylor v. State, 214 Md. 156, 133 A.2d 414 (1957).

[44] See People v. Gibson, 232 N.Y. 458, 134 N.E. 531, 532 (1922).

[45] The right of a court to declare what is or is not in accord with public policy does not extend to specific economic or social problems which are controversial in nature and capable of solution only as the result of a study of various factors and conditions. It is only when a given policy is so obviously for or against the public health, safety, morals or welfare that there is a virtual unanimity of opinion in regard to it, that a court may constitute itself the voice of the community in so declaring. . . . If, in the domain of economic and social controversies, a court were, under the guise of the application of public policy, in effect to enact provisions which it might consider expedient and desirable, such action would be nothing short of judicial legislation, and each such court would be creating positive laws according to the particular views and idiosyncracies of its members. Only in the clearest cases, therefore, may a court make an alleged public policy the basis of judicial decision.

Mamlin v. Genoe, 340 Pa. 320, 325, 17 A.2d 407, 409 (1941).

B. Civil Liability

1. Civil Assault

In the absence of the patient's consent, any operation would constitute a tortious invasion of his person for which the surgeon would be held civilly liable, unless it had been performed as a medical necessity under emergency conditions.[46] Where the patient has consented to sterilization with full understanding of the purpose and nature of the procedure, there would be no tort[47] unless the operation were held to be unlawful in itself, either under a specific statute limiting the permissible grounds for the operation[48] or under the general criminal provisions. Assuming that the operation is unlawful, the civil liability of the physician to a consenting patient might be expected to follow the results which have obtained in cases involving criminal abortion.[49] In these cases the courts have divided on the question whether the patient's consent bars a subsequent action. The courts which have allowed recovery for tortious assault[50] have held that the plaintiff's consent to an unlawful act cannot be legally effective, perhaps upon the theory that the punitive and deterrent policies of the criminal law ought to be supplemented by liability in civil actions.[51] The courts which have denied recovery have done so on the ground that the

[46] See, *e.g.*, Tabor v. Scobee, 254 S.W.2d 474 (Ky. Ct. App. 1952); Lacey v. Laird, 166 Ohio St. 12, 139 N.E.2d 25 (1956); Foley, *Consent as a Prerequisite to a Surgical Operation*, 14 U. CINC. L. REV. 161 (1940); Smith, *supra* note 40, at 234-48.

[47] See PROSSER, TORTS § 18, at 82 (2d ed. 1955). Compare Ford v. Ford, 143 Mass. 577, 578, 10 N.E. 474, 475 (1887) (Holmes, J.): "[T]he absence of lawful consent is a part of the definition of an assault."

[48] CONN. GEN. STAT. REV. § 53-33 (1958); KAN. GEN. STAT. ANN. § 76-155, § 155 (1949); UTAH CODE ANN. § 64-10-12 (1961).

[49] Abortion is the only other area of medical practice to which the criminal law speaks specifically. Other operations, such as amputation of a limb, might be criminal under the prohibitions of mayhem or unlawful wounding, if performed without medical justification or at least for an unlawful purpose.

[50] See, *e.g.*, Pleak v. Cottingham, 94 Ind. App. 365, 178 N.E. 309 (1931); Joy v. Brown, 173 Kan. 833, 252 P.2d 889 (1953); Millikin v. Heddesheimer, 110 Ohio St. 381, 144 N.E. 264 (1924). *But see* Glovka v. Fortun, 29 Ohio App. 278, 163 N.E. 309 (1928) (dictum).

[51] The theory stems from the early common law in which the actions of trespass served primarily to bring breaches of the public peace within the jurisdiction of the King's courts. The action was brought by the aggrieved party, who was induced to act by the prospect of gain at the defendant's expense. However, a fine was imposed in the King's name in the same suit, which thus served to vindicate both the private interest and that of the Crown. Since vindication of the Crown's interest depended upon suit by the injured party, the action could not be defeated by his consent to the defendant's act. Bohlen, *Consent as Affecting Civil Liability for Breaches of the Peace*, 24 COLUM. L. REV. 819, 825-27 (1924). Today, when the interest of the state and that of the injured party are vindicated in separate criminal and civil actions, there would seem to be little reason for importing the interest of the state into the latter action. See *id.* at 829.

Courts in this country have divided upon the continuing applicability of the "breach of the peace" doctrine. *Compare* Strawn v. Ingram, 118 W. Va. 603, 191 S.E. 401 (1937), *with* Hart v. Geysel, 159 Wash. 632, 294 Pac. 570 (1930). Nevertheless, a decreasing minority of courts has extended the doctrine by analogy to cases of criminal abortion. See RESTATEMENT, TORTS § 60, illustration 4 (1934) for a rejection of this position.

plaintiff cannot base an action upon an unlawful act in which he participated.[52]

If elective sterilization is not prohibited by the criminal law, consent would seem to be effective to render the operation nontortious with respect to the patient.[53] However, it has been suggested that the courts may find that the consent is legally ineffective, not because the operation is unlawful, but because sterilization is contrary to public policy.[54] Statutes limiting the availability of contraceptive drugs and devices have been read as evidencing this public policy.[55] However, these statutes are often the product of an earlier era, and there is evidence that the authorities have not seen fit to enforce them in recent years.[56]

Another statement of a public policy against nontherapeutic sterilization might be found in the saving clauses appended to some state eugenic

---

[52] See, *e.g.*, Hunter v. Wheate, 55 D.C. App. 206, 289 Fed. 604 (1923); Nash v. Meyer, 54 Idaho 285, 31 P.2d 273 (1934); Castronovo v. Murawsky, 3 Ill. App. 2d 168, 120 N.E.2d 871 (1954); Szadiwicz v. Cantor, 257 Mass. 518, 154 N.E. 251 (1926); Miller v. Bennet, 190 Va. 162, 56 S.E.2d 217 (1949).

This theory has been employed to bar recovery either for assault or for negligent performance of the operation. *Cf.* Andrews v. Coulter, 163 Wash. 429, 1 P.2d 320 (1931) (recovery allowed for postoperative neglect, although no recovery could be had for the performance of the abortion, whether or not negligent). RESTATEMENT, TORTS § 60 (1934) rejects this position as well as that allowing recovery for civil assault. It recognizes consent as a bar to recovery for assault while allowing recovery for negligence on the theory that the plaintiff did not consent to negligent performance. *But see* Sayadoff v. Warda, 125 Cal. App. 2d 626, 271 P.2d 140 (Dist. Ct. App. 1954), in which the court accepted the *Restatement* view on consent as a bar, but deemed it unwise to attempt to establish standards of skill in cases of criminal abortion.

RESTATEMENT, TORTS § 61 (1934) provides for recovery regardless of consent where the legislative proscription of the act alleged was primarily intended to protect persons in plaintiff's position from their own indiscretion. Should the three state statutes prohibiting elective sterilization be so construed, an operation in violation thereof might well result in liability even though the patient's consent was obtained. The courts have divided on whether the abortion statutes were enacted to protect the patient or to protect the unborn child and society. See PROSSER, TORTS § 18, at 87 (2d ed. 1955).

[53] See note 47 *supra*.

[54] See Smith, *supra* note 40, at 278-79.

[55] *Ibid.*; Miller & Dean, *supra* note 40, at 160.

Regulation of contraceptives assumes three basic forms: (1) total prohibition of distribution and use, Commonwealth v. Gardner, 300 Mass. 372, 15 N.E.2d 222 (1938); CONN. GEN. STAT. REV. § 53-32 (1958); MASS. ANN. LAWS ch. 272, § 21 (1956); (2) regulation of quality and means of distribution, see DEL. CODE ANN. tit. 16, §§ 2501-04 (1953); IDAHO CODE ANN. §§ 39-801 to -810 (1961); (3) prohibition of public display and advertising, see IND. ANN. STAT. § 10-2806 (1956); PA. STAT. ANN. tit. 18, § 4525 (1963). The first form, in force in only two states, may well be construed as establishing a public policy against any form of birth control. One of these states already has declared elective sterilization a criminal offense. CONN. GEN. STAT. REV. § 53-33 (1958). The second and third forms may at most seek only to prevent contraceptives from contributing to promiscuity among youth. See DEL. CODE ANN. tit. 16, § 2503 (1953), which prohibits sale of contraceptives to persons less than eighteen years of age. The permanence of surgical sterilization renders it highly improbable that youths would resort to it for temporary safety, even were they able to find a physician willing to perform the operation.

[56] See Bickel, *Foreword: The Passive Virtues, The Supreme Court, 1960 Term*, 75 HARV. L. REV. 40, 60-61, 64 (1961).

sterilization statutes.[57] After prescribing the procedures and standards by which the state may compel sterilization of mental defectives or habitual offenders, these statutes provide that "nothing in this Act shall be so construed as to prevent the medical or surgical treatment for sound therapeutic reasons of any person in this state, by a physician or surgeon licensed by this state, which treatment may incidentally involve the nullification or destruction of the reproductive functions." [58] Although this provision does not expressly proscribe surgical sterilizations done for purposes other than those expressed in the statute, the fact that it negates such a prohibition only in the case of sterilization incidental to therapeutic treatment has been read as evincing a public policy against sterilization absent such reasons.[59] However, this line of reasoning raises several problems of statutory construction. First, the fact that these provisions appear in acts providing for administrative and judicial supervision of compulsory sterilization operations upon mental defectives and habitual criminals suggests that they are intended only to assure that the statutes do not prevent or delay therapeutically necessary medical or surgical treatment of these same persons.[60] Second, even if they may be read as intended to apply to the general public, it is unlikely that the legislature fully considered, in this context, whether it would be in the public interest to impose any restrictions upon elective sterilization. A failure expressly to sanction nontherapeutic sterilization should not be interpreted, in the light of diverse opinions on the subject within the community, as establishing an affirmative policy against it.

If the state does not have a statute which could be construed as establishing a public policy against nontherapeutic sterilization, the ultimate question is whether the courts are competent to declare such a policy in the absence of legislative action. *Shaheen v. Knight*,[61] the only case which has presented the opportunity for a judicial pronouncement of public policy with respect to elective sterilization, arose in a lower Pennsylvania court in the context of an action against a surgeon for breach of a contract to sterilize the plaintiff. The defendant contended that a contract action could not be maintained because such an agreement was in violation of public policy. However, the court refused to hold that there was such a policy against the operation on the ground that there was "no virtual

[57] See, *e.g.*, N.H. REV. STAT. ANN. § 174:12 (1964); OKLA. STAT. ANN. tit. 43A, § 346 (1954); S.C. CODE ANN. § 32-679 (1962).

[58] OKLA. STAT. ANN. tit. 43A, § 346 (1954). The provisions of other statutes differ only insignificantly in wording, except the Indiana provision which adds: "Provided, that such treatment shall be that which is recognized as legal and approved after due process of law." IND. ANN. STAT. § 22-1606 (1964).

[59] Compare note 55 *supra*.

[60] The additional proviso of the Indiana statute, see note 58 *supra*, would seem to lend added weight to this analysis. Although the meaning of "approved after due process of law" is certainly unclear in any context, its applicability to authorities charged with the care of incompetents would appear more probable than any possible applicability to private medical practice.

[61] 11 Pa. D. & C.2d 41 (C.P. Lycoming County 1957).

unanimity of opinion regarding sterilization." [62] In a similar context in the case of *Christensen v. Thornby*,[63] the Minnesota Supreme Court was asked to find that public policy nullified a contract for the performance of a vasectomy upon a man whose wife had been advised that pregnancy would endanger her life. The court held that the operation was not against public policy under these circumstances, but expressly reserved the question of public policy as applied to sterilizations performed in the absence of any therapeutic reason.[64]

As a matter of sound judicial process, the reasoning of the Pennsylvania court seems correct. The function of the court is to recognize and enforce values upon which there is a consensus in the community, especially in cases involving the consensual relationships between private parties. The resolution of conflicting views is within the particular competency of the legislature.

2. Breach of Contract

In the three reported cases involving the liability of a physician resulting from the performance of a nontherapeutic sterilization,[65] the actions were based upon breach of contract to sterilize; plaintiffs sought recovery because of a failure to sterilize successfully, rather than the impropriety of the purpose of the operation. Even if the rationale of the *Shaheen* case is accepted and a contract to perform a nontherapeutic sterilization is found not to be against public policy, a plaintiff proceeding under this theory still has the burden of establishing both a warranty that the operation will be successful and compensable damages resulting from its breach.

Although there is generally no implied "warranty of cure" in contracts to perform surgical operations,[66] the doctor and patient are at liberty to contract for a particular result.[67] The likelihood of the existence of an express agreement on the success of the operation is particularly great in cases of nontherapeutic sterilization, because the patient requests the operation for particular purposes and would reasonably demand some assurance from the doctor that the procedure would accomplish these ends. Moreover, the courts may be more willing to construe a doctor's statements on the probable results of the operation as constituting a

---

[62] *Id.* at 43.

[63] 192 Minn. 123, 255 N.W. 620 (1934).

[64] *Id.* at 125, 255 N.W. at 621.

[65] Shaheen v. Knight, 11 Pa. D. & C.2d 41 (C.P. Lycoming County 1957); Christensen v. Thornby, 192 Minn. 123, 255 N.W. 620 (1934); Ball v. Mudge, 391 P.2d 201 (Wash. 1964).

[66] Goheen v. Graber, 181 Kan. 107, 112, 309 P.2d 636, 639 (1957); Grainger v. Still, 187 Mo. 197, 213-14, 85 S.W. 1114, 1119 (1905); McCandless v. McWha, 22 Pa. 261 (1853); SHARTEL & PLANT, THE LAW OF MEDICAL PRACTICE § 1-04, at 8 (1959).

[67] See, *e.g.*, Giambozi v. Peters, 127 Conn. 380, 16 A.2d 833 (1940); Robins v. Finestone, 308 N.Y. 543, 127 N.E.2d 330 (1955).

promise that it will be successful because of the absence of a therapeutic purpose. When there is a medical necessity, the patient has less reason to conclude that the doctor's recommendation of an operation is a promise that the disorder will be cured.

All of the reported cases deal with contracts to perform vasectomy operations. Male sterilization poses more difficult problems for doctors in subsequent breach-of-contract actions than does sterilization of the female, because of the significantly greater possibility of natural reversal of the operation, recanalization.[68] Since doctors have not as yet been able to preclude natural reversal,[69] plaintiffs may rely on this possibility to support their allegations that they have fathered a child. In *Ball v. Mudge*,[70] expert testimony was introduced on the plaintiff's high degree of fertility before the operation to prove that recanalization had taken place.[71] Moreover, sterilization of the male does not assure that a woman with whom he has sexual relations will not become pregnant. If pregnancy does occur, the patient may sue the doctor for failure of the operation. And since there is a recognized possibility of recanalization, the doctor may be placed in the difficult position of having to prove that the patient is not the father.[72]

Liability for breach of contract may easily be defeated if the physician has sufficiently documented his understanding with the patient. All doctors and hospitals interviewed required sterilization patients to sign written consent forms authorizing the operation. However, not all of these forms contained the patient's acknowledgment that the success of the operation was not guaranteed and that he or she understood the possibility of natural reversal.[73] The ease with which such a disclaimer could be included in the consent form and its value in the event of litigation, would seem to make its inclusion most advantageous. However, to prevent a finding that the patient did not understand the disclaimer, the use of technical terms such as "recanalization," which might not be readily understood by the layman, should be avoided.[74]

---

[68] See p. 417 *supra*.

[69] There have been improvements in technique, such as tying one or both ends of the severed tube back upon themselves, which have probably done much to reduce the probability of recanalization. However, physicians are not yet able to guarantee permanent sterility.

[70] 391 P.2d 201 (Wash. 1964).

[71] *Id.* at 203-04.

[72] Any evidence on this issue will normally be within the sole knowledge of the plaintiff and the impregnated woman. Moreover, if the woman is plaintiff's wife, the court may be unreceptive to the allegation of adultery. Such a finding would not only establish immoral conduct on the part of the wife, but would incidentally establish the illegitimacy of the child.

[73] The field research revealed a wide variation in the content of the consent forms. They ranged from a one-sentence request for the operation to a full exposition of request, acknowledgment of explanation and understanding, and disclaimer of liability.

[74] Some consent forms contained disclaimer clauses couched in language of such breadth as to be a waiver of any and all liability of the physician arising from the

Although plaintiffs may be able to establish an express warranty of permanent sterility, the cases suggest a reluctance by the courts to permit the recovery of damages. In the reported cases the plaintiffs sought to recover either the expenses incident to the birth of a child or the anticipated expense of rearing it, or both. In *Shaheen* the court held that "to allow damages for the normal birth of a normal child is foreign to the universal public sentiment of the people." [75] A similar public-policy argument was employed in *Ball v. Mudge*, where the court held that the jury could reasonably have found that the plaintiff's expenses were "far outweighed by the blessing of a cherished child, albeit an unwanted child at the time of conception and birth." [76] The court in *Christensen* did not rely on public policy in stating that the plaintiff was not entitled to recover the costs of the child's birth. Instead, it found that the purpose of the operation was to save the wife from the hazards of childbirth and that the expenses of her pregnancy were not within the contemplation of the parties.[77]

According to basic contract principles the court's analysis in *Christensen* is correct, and it would not seem to preclude recovery for the expenses claimed if the plaintiff had expressed a different purpose in requesting the operation. However, the finding of public policy in *Shaheen* would leave plaintiffs without redress when they incur the very expenses which they contracted to avoid. The rationale of the court, that "the paramount purposes of the marriage [are] the procreation and protection of legitimate children," [78] would seem logically to compel a holding that a sterilization contract to defeat these purposes would be completely unenforceable—a result which the court specifically rejected. If the contract is held to be enforceable, the courts should at least award damages for the costs of the delivery of the child, or else a promise of a successful operation would be read out of the contract.

The expense of rearing and educating a child poses a more complex problem because there is general recognition of the intangible rewards of parenthood. The difficulty with using the benefits of parenthood to offset financial costs is the failure to recognize that, for the segment of the community which resorts to sterilization, the values of having a child do not outweigh financial or other considerations.[79] The *Shaheen* court's

operation, including that for negligent performance. Such sweeping disclaimers should be avoided because of the possibility that a court would find it unreasonable that a patient would knowingly waive all claims for negligence and strike down the entire clause—leaving the physician open to a claim of warranty of permanence.

[75] 11 Pa. D. & C.2d 41, 45 (C.P. Lycoming County 1957).

[76] 391 P.2d 201, 204 (Wash. 1964).

[77] 192 Minn. 123, 126, 255 N.W. 620, 622 (1934).

[78] 11 Pa. D. & C.2d at 45.

[79] Moreover, the fact that the parents love the child and feel responsible for its welfare once it has been born does not mean that they would not have been generally happier without it or that its birth constitutes a "blessed event" in every way. An inability to provide for and educate their previously born children as they had anticipated or to maintain a higher standard of living once contemplated may be a constant source of sorrow for which the joy derived from the newest child compensates only inadequately.

answer to this contention would appear to be that the parents could put the child up for adoption.[80] However, the suggestion that a couple would be willing to do this ignores the possibility that the parents may feel a responsibility to keep an unwanted child once it is born. Moreover, if the injured parties to the contract were able to avoid these additional expenses only in this way, it would have the undesirable result of encouraging the separation of children from their natural parents.

3. Negligence

Although sterilization operations are less intricate than many other surgical procedures, a physician may still be liable in a malpractice action for damages resulting from his negligence. Moreover, even if a plaintiff's consent would be held to bar an action based upon the illegality of the operation, there would be no reason to hold that the plaintiff had consented to the physician's negligence.[81]

Since natural reversal of the operation is more common in male sterilization, an unsuccessful female sterilization would more likely have been caused by the doctor's negligence. Should physicians and hospitals begin to require that the consent forms contain adequate disclaimers of any guarantee of permanence, the only theory upon which a civil action might be founded would be negligence. But in these cases the possibility of recanalization operates in the doctor's favor, because it would prevent the plaintiff from employing the doctrine of res ipsa loquitur.[82]

The continuing presence of sperm in the ejaculate for a period following the operation upon the male,[83] as well as the possibility of recanalization, presents an opportunity for an allegation of postoperative negligence. In *Ball v. Mudge*,[84] the plaintiff contended that the physician had been negligent in not performing postoperative tests to determine whether he was producing sperm on the ground that such tests were required by the standard of medical practice in the community. Expert testimony showed that because vasectomies were commonly performed in the physician's office rather than in a hospital, there was no standard of practice in the matter.[85] On this evidence the supreme court upheld the jury's verdict for the defendant physician. Although a doctor cannot compel the patient to return for periodic sperm tests after the operation, courts may find in other cases that the standard of practice in the community requires that he at least make the patient aware of the advisability that such tests be

[80] See *id.* at 46.
[81] See note 52 *supra*.
[82] The fact that the operation may not result in permanent sterility even though skillfully performed would mean that one of the prerequisites for the application of the doctrine was not met—the result would not be one which does not ordinarily occur in the absence of negligence. See generally PROSSER, TORTS §§ 42-43, at 199-217 (2d ed. 1955).
[83] See p. 416 *supra*.
[84] 391 P.2d 201 (Wash. 1964).
[85] 391 P.2d at 203.

procured.[86] For this reason it would be desirable that the consent form contain an acknowledgment of such an awareness.

4. Actions by a Nonconsenting Spouse

Physicians and hospitals uniformly require the consent of the patient's spouse to the performance of sterilization operations. The reason given for this requirement was a fear of liability to the spouse if his or her consent is not obtained. In this context liability would have to be based either upon a tortious injury to the patient resulting in a loss of consortium[87] or a tortious interference with the marital relationship of the patient and the nonconsenting spouse.[88] The first theory would not support a cause of action for a nonnegligent operation to which the patient lawfully consented because the consent would render it nontortious.[89] The second theory, however, does not require a personal injury to the patient, but rather an injury to the nonconsenting spouse himself. The action for tortious interference with marital rights has generally been based upon conduct within the broad classification of "alienation of affection."[90]

However, this cause of action has heretofore been limited to cases in which the conduct is intended or has a natural tendency to undermine the affection which the spouse to whom the defendant's acts are directed has for the plaintiff.[91] Although a patient's request for sterilization without the agreement of his spouse may reflect an already existing loss of affection,[92] there is no reason to believe that the operation itself would produce such a result. Therefore, if a nonconsenting spouse is to recover for alienation of affection, the theory would have to be extended to include conduct which tends to undermine the affection of the plaintiff for his sterilized spouse.

However, the courts may be reluctant to recognize this type of injury because of the unreliability of the evidence that could be used to prove the plaintiff's assertion that the operation substantially affected his love for his spouse and the overwhelming difficulty that the defendant would have in refuting this claim. In order to hold the physician liable for the injury, the courts would also have to find that a loss of affection on the part of

---

[86] The physicians interviewed who performed vasectomies in any appreciable number were in agreement as to the advisability of postoperative tests.

The danger arising from the continuing presence of sperm for a short period following the operation might be avoided by advising either that the patient return for postoperative tests or that he continue to use contraceptives for a sufficient time for the sperm to disappear.

[87] See generally PROSSER, TORTS § 119 (3d ed. 1964).

[88] See generally *id.* § 118.

[89] See note 47 *supra* and accompanying text.

[90] See PROSSER, TORTS § 118, at 898 (3d ed. 1964). See generally Brown, *The Action for Alienation of Affections*, 82 U. PA. L. REV. 472 (1934).

[91] See PROSSER, TORTS § 118, at 898 (3d ed. 1964).

[92] See p. 418 *supra*.

the nonconsenting spouse was a natural effect of the operation. This decision would necessitate a complex inquiry into what would constitute a reasonable reaction by the plaintiff and what effects could be reasonably foreseen by the doctor—an analysis that the courts may be reluctant to undertake. However, although the doctor may have no legal duty to obtain a spouse's consent, his professional duty to act only in the best interest of his patient would seem to require this procedure.

Unilateral elective sterilization may give rise to an action for annulment or divorce by an unconsulted or dissenting spouse. In a majority of jurisdictions, sterility, where there remains capacity for natural intercourse, has generally been held an insufficient ground for divorce or annulment.[93] However, one court has found that a refusal of "natural uncontracepted" intercourse constitutes "constructive desertion" on the ground that the primary purpose of marriage is procreation[94]—a rationale which would be equally applicable to unilateral sterilization.

A generally recognized ground for annulment of a marriage is that of fraud in the contract, which has been defined as a fundamental misrepresentation as to a basic premise underlying the marital relationship.[95] In this context the courts that have considered the question have not hesitated to find that the procreation of children is such a basic premise. Where a spouse, before marriage, professed a desire to establish a family, having the intention at the time never to do so, the other party to the marriage may secure an annulment upon discovering the contrary intention.[96] On the other hand, a change of mind after marriage, resulting in a refusal to have children, will not entitle the other party to an annulment,[97] nor to a divorce in most jurisdictions.[98] Under this reasoning unilateral elective

[93] See, *e.g.*, Gibbs v. Gibbs, 156 Fla. 404, 23 So. 2d 382 (1945); Payne v. Payne, 46 Minn. 467, 49 N.W. 230 (1891); Smith v. Smith, 206 Mo. App. 646, 229 S.W. 398 (1921); Wilson v. Wilson, 216 Pa. Super. 423, 191 Atl. 666 (1930).

[94] Kreyling v. Kreyling, 20 N.J. Misc. 52, 23 A.2d 800 (Ch. 1942).

Some courts have held that a total refusal by one spouse constitutes "constructive" desertion if persisted in for the statutory period. See Evans v. Evans, 27 Ky. 1, 56 S.W.2d 547 (1938); Jones v. Jones, 186 Md. 312, 46 A.2d 617 (1946); Rector v. Rector, 78 N.J. Eq. 386, 79 Atl. 295 (Ch. 1911). However, the weight of authority is to the contrary. See, *e.g.*, McCurry v. McCurry, 126 Conn. 175, 10 A.2d 365 (1939); Hinkel v. Hinkel, 209 Ga. 554, 74 S.E.2d 657 (1953); Lambert v. Lambert, 165 Iowa 367, 145 N.W. 920 (1914); Pollard v. Pollard, 98 S.W.2d 132 (Mo. Ct. App. 1936); Taylor v. Taylor, 142 Pa. Super. 441, 16 A.2d 651 (1940).

[95] See Yanoff v. Yanoff, 237 Mich. 383, 211 N.W. 735 (1927).

[96] See Stegienko v. Stegienko, 295 Mich. 530, 295 N.W. 252 (1940); Thurber v. Thurber, 186 Misc. 1022, 63 N.Y.S.2d 401 (Sup. Ct. 1946). See also Maslow v. Maslow, 117 Cal. App. 2d 237, 255 P.2d 65 (Dist. Ct. App. 1953); Pisciotta v. Buccino, 22 N.J. Super. 114, 91 A.2d 629 (App. Div. 1952) (actions failed for insufficiency of proof).

The California courts have held that where one spouse was sterile at the time of marriage and knowing this fact did not disclose it, the other party to the marriage may secure an annulment upon discovery of the condition, whether or not there were positive misrepresentations. Vileta v. Vileta, 53 Cal. App. 2d 794, 128 P.2d 376 (Dist. Ct. App. 1942); Aufort v. Aufort, 9 Cal. App. 2d 310, 49 P.2d 620 (Dist. Ct. App. 1935).

[97] See Longtin v. Longtin, 22 N.Y.S.2d 827 (Sup. Ct. 1940).

[98] See note 94 *supra*.

sterilization, shortly after marriage and before the birth of any issue, could constitute grounds for annulment if it could be shown that the operation was procured pursuant to an intention formed prior to marriage.

Because of these possibilities, a consideration for the interests of the patient would result in continuing the requirement that the spouse's consent be obtained.

C. Statutory Authorization of Elective Sterilization

1. Virginia and North Carolina Voluntary Sterilization Statutes

Two states, Virginia in 1962 and North Carolina in 1963, have enacted statutes expressly negating civil or criminal liability of physicians for the nonnegligent performance of surgical sterilizations in accordance with prescribed procedures.[99] Neither statute purports to restrict the purposes for which the operation may be performed. To come within the protection of these statutes the doctor must perform the operation pursuant to the written request of the patient and, if married, of his or her spouse, in a licensed hospital, after giving the patient a full and reasonable medical explanation of its nature and consequences. He must obtain the concurrence of at least one consulting physician and may not operate until thirty days after the request. Although these statutes would seem to preclude any action based upon the illegality of a properly documented operation, they do not automatically insure that the physician will not incur civil liability just because the operation is not negligently performed. He must continue to protect himself against the claim of a warranty of permanent sterility.[100] Another source of uncertainty is the failure of the statutes to specify where the burden of establishing the nonexistence of a spouse shall lie. The statutory requirement of the consent of both spouses may lend support to a claim that sterilization of the patient without such consent was an actionable wrong as to the nonconsenting spouse. However, in the absence of circumstances which would reasonably place the doctor on notice to the contrary, it would seem that he would be found justified in relying upon the patient's representation that he or she was unmarried.

Each physician interviewed during the field research was asked his opinion on various provisions of the Virginia and North Carolina statutes, as well as the probable effect of a similar statute upon sterilization practice in Pennsylvania. The reactions of obstetricians and gynecologists were generally favorable; the primary objection expressed was directed at the requirement of a thirty-day waiting period. Some physicians pointed out that most salpingectomies are performed post partum, and that the decision to undergo the operation often is not made until late in pregnancy. If the operation could not be performed at delivery because the waiting period

[99] N.C. GEN. STAT. §§ 90-271 to -275 (Supp. 1963); VA. CODE ANN. §§ 32-423 to -426 (Supp. 1962).

[100] See text accompanying notes 66-69 *supra*.

had not elapsed, the expense and inconvenience of another hospitalization would be necessary and the optimum physical conditions produced by pregnancy would be lost. If the delivery were by caesarean section, postponement would mean an additional and otherwise unnecessary abdominal incision. However, a waiting period to insure against unconsidered decisions would seem appropriate even in cases of female sterilization because of the emotional stress incident to awaiting the birth of a child. Any undesirable effect this restriction might have upon the performance of the operation could be cured by the obstetrician's informing the couple during the early months of pregnancy of the availability of a post partum sterilization.[101] Some urologists interviewed expressed dissatisfaction with the statutes' requirement that the operation be performed in a hospital. Since vasectomy may be performed as an office procedure,[102] they felt that hospitalization would only add expense and inconvenience for the patient and place the doctor under the substantive restrictions imposed by his hospital.

Both urologists, obstetricians, and gynecologists objected to the requirement of consultation in nontherapeutic cases. Since the physician is not required to exercise any medical judgment in such cases,[103] any limitations upon the availability of the operation will be those imposed by the hospital or by the individual doctor based upon their own interests and social values and an estimation of what is in the patient's best interest. Moreover, it was thought that the requirement would not serve as an effective incentive to self-regulation by the medical profession, since the statutes' expression of public policy sanctioning the operation would insure that two physicians who agreed on any particular case could easily be found. Therefore, this requirement also was seen as merely adding unnecessarily to the expense of the operation.

When asked about the probable effect of a Pennsylvania statute similar to those passed in Virginia and North Carolina, the doctors interviewed expressed differing opinions. About half of the doctors thought that a statute would liberalize present standards, especially in those hospitals that permit sterilization only for therapeutic reasons or require an extremely large number of children. They said that the enactment of such a statute would have a liberalizing effect partially because of the removal of any legal inhibitions a doctor might feel and most importantly because of the evidence of public policy condoning the procedure.

On the other hand, the doctors who felt that a statute would not influence the existing practice suggested that the reason why sterilization had been restricted was not the fear of incurring legal liability or an uncertainty about public policy. In their own practice they were more

---

101 Since the request or consent may be withdrawn at any time prior to the operation, the couple could enter their request before making a final decision.

102 See p. 416 *supra.*

103 See pp. 420-21 *supra.*

concerned with the irreparable nature of the operation and the militant opposition of religious groups. In view of these factors and the availability of other contraceptive means and the possibility of mortality in female sterilization, they would continue to impose the same restrictive policy, regardless of the passage of such a statute.

Although there was disagreement as to the probable effect of the statute, most doctors were in favor of its enactment. They said that they would feel much safer in performing whatever sterilizations they felt proper. Many mentioned their concern with the recent upsurge of malpractice suits and their concomitant desire for as much protection as possible.

A few doctors expressed some concern that if such a statute were passed, sterilization would become too readily available, and that some unscrupulous doctors might encourage the operation for the purpose of their own financial gain. This result is highly improbable. As evidenced by the present restraint and internal regulation of sterilization, the medical profession generally sets very high ethical standards for itself and is usually quite conservative. Since the possibility of legal consequences is only one of several inhibiting factors, it is doubtful that the passage of a statute, such as was passed in Virginia and North Carolina, would result in the wholesale availability of sterilizations or the misuse of the statutory immunity by the medical profession.

2. A Proposed Statute

A statute imposing a minimum of rational restrictions would enable the medical profession to develop standards of reasonable practice. On the other hand, premature consideration by the legislature, before the medical profession and the general community have reached a consensus of opinion on the subject, could produce a statute imposing restrictions on sterilization which may later prove overly stringent. And experience has shown that it is extremely difficult to obtain the repeal or amendment of an outdated statute, especially when it deals with a subject having a moral or religious overtone for some segments of the community.[104] For these reasons, even a proponent of a liberalized sterilization procedure has not advocated legislative action at this time.[105] In its view the possibility of adverse legal consequences are so slight, even in the absence of meaningful authority, that education of the profession and the community and a case-by-case development of the law would be most desirable.

However, many doctors have been deterred from performing elective sterilizations because of the fear that the unsettled state of the law may encourage patients and pressure groups to involve them in legal contro-

[104] See Bickel, *supra* note 56, at 61-64.

[105] Human Betterment Ass'n of America, Inc., The Lawyer Speaks on Sterilization, 1964 (Statement by Harriet F. Pilpel, HBAA Legal Counsel).

versy. The action of the Virginia and North Carolina legislatures may cause other states to meet this problem by comprehensive statutes. However, the information derived from the field research interviews suggests that several changes in the already existing designs would be necessary to formulate an optimum statute. The following proposal reflects the basic practical and policy considerations revealed by the legal and field research.

PROPOSED VOLUNTARY STERILIZATION ACT

§ 1. Sterilization operation upon person twenty-one years of age or older.—It shall be lawful for any physician or surgeon licensed by this State, when so requested by any person twenty-one years of age or over, to perform upon such person a surgical interruption of vas deferens or fallopian tubes provided a request in writing is made by such person at least thirty (30) days prior to the performance of such surgical operation; and provided, further, that prior to or at the time of such request a full and reasonable medical explanation is given by such physician or surgeon to such person as to the nature and consequences of such operation; and provided, further, that a request in writing is also made at least thirty (30) days prior to the performance of the operation by the spouse of such person, if there be one, unless the spouse has been declared mentally incompetent, or unless a separation agreement has been entered into between the spouse and the person to be operated upon, or unless the spouse and the person to be operated upon have been divorced from bed and board or have been divorced absolutely.

§ 2. Sterilization operation upon person under twenty-one.—Any such physician or surgeon may perform a surgical interruption of vas deferens or fallopian tubes upon any person under the age of twenty-one years when so requested in writing by such minor and in accordance with the conditions and requirements set forth in section 1 of this act, provided that the juvenile court of the county wherein such minor resides, upon petition of the parent or parents, if they be living, or the guardian or next friend of such minor shall determine that the operation is in the best interest of such minor and shall enter an order authorizing the physician or surgeon to perform such operation.

§ 3. Thirty-day waiting period.—No operation shall be performed pursuant to the provisions of this act prior to thirty (30) days from the date of consent or request therefor, or in the case of a minor, from the date of the order of the court authorizing the same, and in neither event if the consent for such operation is withdrawn prior to its commencement.

§ 4. No liability for nonnegligent performance of operation.—Subject to the rules of law applicable generally to negligence, no physician or surgeon licensed by this State shall be liable either civilly or criminally by reason of having performed a surgical interruption of vas deferens or fallopian tubes authorized by the provisions of this act upon any person in this State.

§ 5. Prohibition of sterilization operations not performed in accordance with this act.—Any person who shall perform a surgical interruption of vas deferens or fallopian tubes upon any person in this State, except as authorized by this act [or by a eugenic sterilization statute] shall be guilty of:

(a) a misdemeanor where the person performing the operation believes that the person upon whom such operation is performed consents to its performance;

(b) a felony where the person performing the operation does not believe that the person upon whom such operation is performed consents to its performance.

§ 6. Therapeutic and eugenic sterilizations excepted.—Nothing in this act shall restrict the performance of a surgical interruption of vas deferens or fallopian tubes for sound therapeutic reasons [or affect the provisions of a state eugenic sterilization statute].

Pursuant to the suggestions of the doctors interviewed, the proposed statute does not contain provisions, such as the requirement of consultation, which serve no valid purpose in cases of elective sterilization. Other principal innovations of the suggested statute are the provisions for criminal liability for failure to conform to the prescribed procedures and for the waiver of the required procedures in cases of therapeutic indications for the operation.

It has been argued previously that the clauses in eugenic sterilization statutes which waive the procedural requirements in cases of a medical indication should not be construed to preclude lawful sterilizations for other than therapeutic purposes. This argument was based upon the rationale that it would be unwarranted to conclude that the legislature had considered and disposed of the controversial subject of elective sterilization in the context of a eugenic statute. However, a statute such as the one presently proposed would demand full consideration of the entire problem. In this context a legislature should properly devise procedures for elective sterilization which are intended to be exclusive, and they should express this purpose in the statute so that the courts are not faced with the dilemma of searching for their intent or the force of public policy whenever the procedures are not followed.

The insertion of a provision which relieves a physician of the statutory requirements in situations where there is a medical reason for the operation may be overly cautious. It is unlikely that a court would hold a doctor criminally liable for performing the operation immediately upon the discovery of a serious physical disorder. However, the absence of such an exemption in the statute may have the undesirable effect of deterring doctors from performing needed therapeutic surgery because of their uncertainty as to how the statute would be interpreted by the courts.

IV. Conclusion

The restrictions which the medical profession has imposed upon elective sterilization seriously limit the individual's choice. Wherever these restrictions have been caused by a fear of legal liability, the analysis in this Note and perhaps the enactment of the proposed statute should cause a reevaluation of the doctors' policy toward sterilization. In other cases the restrictions have been justified by the doctors' desire to protect the patient from future unhappiness or to avoid public controversy which would be damaging to their professional standing. No attempt has been made to assess the validity of the latter reasons when balanced against the individual's right to employ this means of family limitation. However, the fact that important social and economic considerations may motivate the individual choice for sterilization would indicate that doctors should at least hesitate before imposing their own values upon their decisions as to what would be in the best interest of their patients.

Linda K. Champlin

Mark E. Winslow