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STERILIZATION TECHNOLOGY AND DECISIONMAKING: RETHINKING THE INCOMPETENT'S RIGHTS

INTRODUCTION

Technological advancements produce unexpected, rapid changes in the fields of medicine, science, and the law. These three areas are inextricably related when one of the most fundamental rights, as defined by state and federal courts, involves biological functions of the human body. The best examples are the right to privacy in an abortion,¹ the right to procreate,² and the validity of authorizing organ transplants.³ Scientific innovations bring new meaning to definitions of the functions of the human body and should force the medical and legal fields to adapt to the changes. Law and science should complement each other in order for society and its members to reap the benefits.⁴

I. OVERVIEW

The court system guarantees that fundamental rights will be protected,⁵ and the scope of these rights is sometimes based on the current state of medical or scientific knowledge. Legal commentary suggests, for example, that the infamous *Buck v. Bell*⁶ decision would not have been decided as it was but for the then prevalent belief in the Mendelian and eugenic theory that mental deficiencies were solely hereditary.⁷ Present-day examples of similar cases which require reconsideration in light of technological advances include cases on abortion⁸ and cases on sterilization.⁹ In *Roe v. Wade*, the

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1. *Roe v. Wade*, 410 U.S. 160 (1973).
2. *Id.*; *Doe v. Bolton*, 410 U.S. 179 (1973); *Skinner v. Oklahoma*, 316 U.S. 535 (1942).
3. *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969).
4. *Bionic Human Is No Longer a Pipe Dream*, U.S. NEWS & WORLD REP. 12 (March 4, 1985).
5. E. BARRET & W. COHEN, CONSTITUTIONAL LAW 611-72 (1980).
6. 274 U.S. 200 (1927).
7. G. SMITH, GENETICS, ETHICS AND THE LAW 11, 20, 35-39 (1981); Burgdorf & Burgdorf, *The Wicked Witch is Almost Dead: Buck v. Bell and the Sterilization of Handicapped Persons*, 50 TEMP. L.Q. 995 (1977).
8. *Carey v. Pop. Services Int'l*, 431 U.S. 679 (1977); *Roe*, 410 U.S. 160; *Doe*, 410 U.S. 179. See also *Akron v. Akron Cent. for Reproductive Health*, 462 U.S. 416 (1983).
9. In the Matter of Truesdell, 63 N.C. App. 258, 304 S.E.2d 798 (1983), *appeal denied*, 310 N.C. 745, 315 S.E.2d 710 (1984); *Wentzel v. Montgomery General Hosp.*, 293 Md. 685,

1973 Supreme Court found that fetal viability represented the point at which the state's interest became more compelling than the woman's right to choose to abort.¹⁰ The state, however, need not exercise or assert any interest in the fetal life. The medical field urges today that viability, inclusive of some form of external aid, goes back to an age of sixteen weeks and a weight of 500-750 grams, a little over one pound.¹¹ Should the Court decide an abortion case today, the present medical definition of viability could force the twelve-week period to protect maternal health to be modified in order to preserve the legal reasoning behind the guarantee of the mother's right to privacy.¹² Obviously the definitional differences between 1973 and 1986 must give new meaning to the right to privacy in an abortion decision.

A second example is the right to sterilization. In medical terms, sterilization is usually defined as an irreversible procedure, rendering the male or female incapable of procreating.¹³ But the medical profession clearly states that "reversible technology is being developed satisfactorily . . . and many authorities feel that it would be useful to indicate . . . that reversibility is possible for those who may require it."¹⁴ The basis for the shift within the medical field favoring characterization of sterilization as reversible derives from three or four sources, each of which merits review. As scientific progress in this area continues, the courts will be required to reexamine the true meaning of both the rights to procreate and to be sterilized and the rights of parents to authorize such sterilization procedures.

The most significant advancements have occurred in microsurgical techniques, ovary transplants, and surgical restructuring with or without

447 A.2d 1244 (1982), *cert. denied*, 459 U.S. 1147 (1983); In the Matter of Moe, 385 Mass. 555, 432 N.E.2d 712 (1983); Matter of Terwillinger, 304 Pa. Super. 553, 450 A.2d 1376 (1982); Brode v. Brode, 278 S.C. 457, 298 S.E.2d 443 (1982); In the Interests of C.D.M., 627 P.2d 607 (Alaska 1981); In the Matter of A.W., 637 P.2d 366 (Colo. 1981); In re Grady, 85 N.J. 235, 426 A.2d 467 (1981); In re Guardianship of Eberhardy, 102 Wis.2d 539, 307 N.W.2d 881 (1981); P.S. by Harbin v. W.S., 443 N.E.2d 67 (Ind. App. 1982), *vacated*, 452 N.E.2d 969 (Ind. 1983); Matter of Guardianship of Hayes, 93 Wash. 228, 608 P.2d 635 (1980); Gooley v. Moss, 398 N.E.2d 1314 (Ind. App. 1979); In re Sterilization of Moore, 289 N.C. 95, 221 S.E.2d 307 (1976); A.L. v. G.R.H., 163 Ind. App. 636, 325 N.E.2d 501 (1975), *cert. denied*, 425 U.S. 936 (1983); In the Interests of M.K.R., 515 S.W.2d 467 (Mo. 1974); In re Cavitt, 182 Neb. 712, 157 N.W.2d 171 (1968).

10. "[f]etus becomes 'viable' that is, potentially able to live outside the mother's womb, albeit with artificial aid. Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." *Roe*, 410 U.S. at 163 (quoting L. HELLMAN & J. PRITCHARD, *WILLIAMS OBSTETRICS* 493 (14th ed. 1971)).

11. Interview with L. Dodson, R.N./Ecmospesialist at Georgetown University Hospital's neonatal unit, Washington, D.C. March 2, 1985.

12. *Roe*, 410 U.S. at 163.

13. Annot., 74 A.L.R. 3d 1210, 1211 n.1 (1976).

14. M. SCHIMA & I. LUBELL, *NEW ADVANCES IN STERILIZATION* 172 (1976) [hereinafter "SCHIMA & LUBELL"].

mechanical devices.¹⁵ Each of these procedures involves direct surgical adjustment of the sexual organs of the patient.¹⁶ While the mere mention of surgical adjustment to the sexual organs sounds intrusive, it is no more so than any other surgical procedure.

Additionally, the techniques of *in vitro* fertilization, surrogation, and frozen egg and sperm banks¹⁷ are included in the medical evaluation of the area of sterilization. Each of these techniques chips away at the notion that once one is sterilized one can no longer exercise his or her right to beget and bear children. With such progress, therefore, the courts should reevaluate the parameters of what is protected under this privacy right,¹⁸ since the failure to do so could render the right meaningless.

The primary goal of a physician counseling patients in this area is to assure that if the patient wishes to have a child, he or she is mentally and psychologically able to do so.¹⁹ This evaluation includes a consideration of the various options available to a parent who may choose not to actually bear the child — e.g., surrogate mothers or *in vitro* fertilization and gestation. Such a suggestion on the physician's part does not impinge on the patient's right to have a child because the underlying assumption of the guarantee to the procreational right is the *ability* to exercise the right — nothing more.

If this counseling is available to the competent adult, it should also be available to the incompetent adult. The physical and psychological traumas of pregnancy are heightened for an incompetent, who may be incapable of understanding the physical and emotional changes of pregnancy.²⁰ In order to guarantee the incompetent the right to exercise his or her procreational autonomy, sterilization must be a viable option.²¹ But because the incompetent is legally incapable of self-exercise, his or her parent (or guardian)

15. *Id.* at 192-193; G. KASIRSKY, VASECTOMY, MANHOOD AND SEX (1972); *Sterilization: Method of Choice for Many*, MED. WORLD NEWS 53 (February 16, 1981).

16. REVERSAL OF STERILIZATION 152-215 (J. Sciarra, G. Zatuchni & J. Speidel eds. 1978).

17. Annas, *What Should We Do with Surplus Potential Humans?* Wash. Post, March 31, 1985, at K1, col. 2; Smith & Iraola, *Sexuality, Privacy and the New Biology*, 67 MARQ. L. REV. 263 (1984); Sattur, *New Conception Threatened by Old Morality*, NEW SCI. 12 (Sept. 27, 1984); Hanahan, *Fertilization, Embryo Transfer Procedures Raise Many Questions*, 252 J. A.M.A. 877, 878 (1984).

18. *See infra* Section II.

19. *See* Hanahan, *supra* note 17, at 878.

20. *Id.*

21. *Wentzel*, 447 A.2d at 1261 (Davidson, J. dissenting). No one should have such an insurmountable legal burden placed before her as to deny effectively the rights the court so zealously sought to protect.

should be permitted to decide, based on either the best interests test²² or the substituted judgment test,²³ whether sterilization is appropriate. In medical terms, no procreational right is lost with sterilization because the procedures are now considered reversible and because the right to procreate may be exercised in a myriad of new ways. The guardian should be permitted to decide what is in the incompetent's best interest as he does with other medically indicated decisions. Since the incompetent's autonomy is medically maintained, the decision to sterilize falls within the scope of the patient-guardian-physician relationship.

The concept of the moral community is that:

Membership in that community means that a person is held to be morally responsible for his or her actions and life, and is to be held responsible by the rest of the community for assuming that responsibility.²⁴

The dignity accorded each person is contingent upon his being regarded as a member of that community.

Within this communal relationship, sterilization can be utilized in a manner which will enhance the incompetent's ability to participate in the moral community. This occurs because the sterilized mental incompetent is afforded an opportunity to grow and develop psychologically at a pace commensurate with his or her physical development. Sterilization allows the incompetent to be free from close supervision at a time when such freedom

22. See *infra* note 104.

23. See *infra* note 105. Additional suggestions have been presented by scholars in the bioethical field, notably Father Richard A. McCormick, S.J., that the best interests test and the substituted judgment test are so inextricably tied that they represent *one* approach. While Fr. McCormick has not applied his approach to the area of sterilization particularly, it has been used in the field of dying incompetents. If his approach, as outlined below, is applicable to the authorization by substituted judgment for the removal of life sustaining means, surely the approach could be used in sterilization requests where the removal of the right is not as final as death. Fr. McCormick suggests that substituted judgment and best interests be melded into one category of proxy decisionmaking. Within this category, one may utilize one of two approaches to exercise judgment for an incompetent: (1) the incompetent preference—that is, the incompetent was competent at one point and clearly expressed a valid preference upon which the guardian may draw for guidance; and (2) the traditional substituted judgment idea—where the court or guardian attempts to discern the ward's preferences were he competent. The latter approach presupposes that the ward was never competent, never expressed a view and that the guardian's values are sufficiently similar to what the ward's would have been. Fr. McCormick's position, however, is beyond the scope of this paper since Sections III and IV adequately demonstrate that either of the existing approaches is suitable for the parents' role as guardian-decisionmakers. *Proxy Decisionmaking in the Death of Incompetents*, Lecture by Fr. Richard McCormick, Catholic University of America, Washington, D.C., March 12, 1985.

24. Neville, "The Philosophical Argument," in *Sterilization of the Retarded: In Whose Interests*, 8 HASTINGS CENTER REP. 33, 35-36 (June 1978). See generally Smith, *Genetics, Eugenics and the Family: Exploring the Yin and the Yang*, 8 U. TASMANIA L. REV. 4 (1984).

might otherwise lead to a series of problems if pregnancy occurred. It permits society to fulfill its obligations under the social contract, to maximize the incompetent's freedom, and to help the incompetent become a more complete person within the society by enabling him to take greater command over his own life without the fear of breaching the limited obligations his capacities require.

Part two of this comment investigates the philosophical underpinnings of the role that mental incompetents play in society. This role includes their participation in the social contract, within the limits of their capabilities, and the influence those limits have on their rights and responsibilities. As with other members of society, the mental incompetent may have his rights restricted when he is unable to uphold his part of the social contract.

Part three explains the present status of the medical and technological advancements which ensure that sterilization does not represent a complete and final curtailment of the right to beget. The evidence presented indicates that sterilization is a surgically reversible procedure, that transplantation can successfully restore fertility, and that alternative procreative methods exist to ensure procreative ability after sterilization surgery.

Part four outlines the law regarding the substituted judgment and best interests tests as applied to decisionmaking for the mentally incompetent. The focus remains on the desire for an increased use of the best interests test; but the decisionmaker should no longer be the courts and the legislatures but should be the parents and guardians.

Part five structures a conclusion regarding the safeguards essential to a thorough balancing between the interests of the mentally incompetent and the new decisionmaker. In essence, both the premise and thesis are one and the same: namely that the parent-guardian represents the best decisionmaker because he or she has the best interests of the incompetent in mind, and thus, legally may consent to the operation. Furthermore, the abuses recognized in the past *vis-a-vis* sterilization of incompetents may be significantly reduced because the operation is no longer irreversible. This places the decision to sterilize in the same category as any other surgical procedure to which the parent-guardian may consent under the guardianship statutes of each respective state.

II. PHILOSOPHICAL BACKGROUND

The theory of social contract has existed since the time of Socrates.²⁵ The

25. See PLATO, EUTHYPHRO, APOLOGY, CRITO esp. 60-65 (F.J. Church trans. 1979). Plato's remarkable and well-known CRITO recounts Socrates' discussion with the Laws, in which Socrates concludes that destroying the laws (and thus Athens) would be a grave injus-

social contract has evolved throughout history and has served to explain societal life. Generally, it is argued that without the social contract man would exist in a state of nature.²⁶ "Society," observed Locke, "is the product of a voluntary contract among men who were equal in a state of nature, but who have established a community, held together by political government, in order to better secure their natural rights."²⁷ This concept finds support in the Declaration of Independence: "We hold these truths to be self-evident: . . . that to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed."²⁸ The social contract, as the founding fathers realized, is best understood in terms of a balance, or struggle, between government, the "necessary evil," and the individual's need and right to be free.²⁹ This contract is fulfilled through the enactment of laws.

A contract is "a promise or set of promises for the breach of which the law gives a remedy, or the performance of which the law, in some way, recognizes a duty."³⁰ The elements which are necessary for a contract to exist include an offer, acceptance, consideration and capacity.³¹ Contracts by incompetents are voidable.³² The refusal of society to enforce contracts entered into by the mentally incompetent stems from the general belief that these persons lack the capacity to comprehend both the duties and obligations which the purported agreement requires.³³

As the Uniform Commercial Code and the Restatement (Second) of Contracts indicate,³⁴ the theory of contract rests on the presumption that the

· tice on Socrates' part when he has reaped the benefits of his agreement with Athens. The time period is the fourth century, B.C.

26. John Locke defines the state of nature as "a state of perfect freedom where men order their actions and dispose of their possessions and persons as they think fit, within the bounds of the law of nature, without asking leave or depending upon the will of any other man." *OF CIVIL GOVERNMENT, SECOND TREATISE* 4 (1955).

27. R. KIRK, *INTRODUCTION TO LOCKE*, *supra* note 26, at viii. While Locke's premise is of a peaceful natural state which the social contract improves, Hobbes suggests the same result but argues that it is much more a necessary result of the constant war-like conditions of the natural state. See T. HOBBS, *LEVIATHAN* Part I, Ch. 13 (1943).

28. The Declaration of Independence Preamble (U.S. 1776).

29. See, e.g., T. JEFFERSON, *ON DEMOCRACY: THE LIVING THOUGHTS OF AMERICA'S ARCHITECT OF FREEDOM* 5 (S. Padover ed. 1939).

30. *RESTATEMENT (SECOND) OF CONTRACTS* § 1 (1981). See also U.C.C. § 1-201 (1978) (a contract is the "total legal obligation resulting from an agreement").

31. See E. FARNSWORTH & W. YOUNG, *CONTRACTS* chs. 1 and 3. See also, e.g., U.C.C. § 2-206, *et al.* (1978).

32. 1 CORBIN, *ON CONTRACTS* §§ 6 and 7 (1963); *Restatement (Second) of Contracts* § 15 (1982).

33. See *supra* note 32. It may also be due to fear of overreaching by the other competent party.

34. See *supra* note 6.

parties are able to agree on a mutually beneficial exchange. Where this is not possible, no contract is recognized as existing. If these general rules of contract are applied to the theory of social contract, a dilemma arises. Certainly mental incompetents lack the capacity to recognize fully the duties and obligations which may be required of them by society, but it is not within reason to suggest that because they lack capacity they are not a *part* of society. [Few, if any, competent or not, have a choice *whether* to be a part of society. It is only a question of *which* society.] It is necessary to comprehend how these basic concepts of contract — the duties and obligations — fit within the framework of the social contract.

As with any other contract, the social contract creates duties and obligations.³⁵ Jefferson recognized these reciprocal duties when he wrote that “[n]o man has a natural right to commit aggression . . . on another, . . . every man is under the natural duty of contributing to the necessities of the society.”³⁶ This is the contract part of the social contract — the natural obligations which men place upon each other and which society places upon the individual. In the commercial world, as noted above, mentally incompetent individuals are absolved of these obligations. This is true also of the social world. Society does not expect of the mentally incompetent that which it expects of the rest of its members. Acts which are presumed to require the abilities of reason and rationality are not left to the incompetent to decide for himself. These “rights” or privileges include the franchise, contractual capacity, adoption, driving an automobile, and authorization of medical treatment.³⁷ The justification generally forwarded for limiting the freedom of the mentally incompetent is that they are unable to exercise these rights or privileges in a manner coincidental to the other members of society.³⁸ They cannot be part of the social contract because they know not of its bounds. The incompetent cannot participate in authorizing the society “to make laws for him, as the public good of the society shall require,” be-

35. See H. GILDEN, *ROUSSEAU'S SOCIAL CONTRACT* 26 (1983). Gilden argues that the social contract, for Rousseau, required mutuality. (“Each party must incur an obligation to the other, and each must acquire certain rights over against [sic] the other.”). See also R. ARDREY, *THE SOCIAL CONTRACT* 118 (1970) (“it is a contract in equity”).

36. See JEFFERSON, *supra* note 29, at 18. The natural right and duty to which Jefferson refers, however, is not natural law but expectations within social contract theory.

37. See, e.g., statutes restricting rights of mentally handicapped persons to marry: KY. REV. STAT. § 402.020 (1969); WASH. REV. CODE ANN. tit. 154 § 27 (1976). See also S. BRABEL & R. ROCH, *THE MENTALLY DISABLED AND THE LAW* 303-40 (1971) [hereinafter “BRABEL & ROCH”]. Currently forty-five states and territories disenfranchise some mentally disabled persons. 3 P.R. FRIEDMAN, *LEGAL RIGHTS OF MENTALLY DISABLED PERSONS* 1776-77 (1980). Some states also prohibit mentally disabled persons from participating in jury duty. *Id.* at 1779-81.

38. See FRIEDMAN, *supra* note 37. See also BRABEL & ROCH, *supra* note 37, at 303-13.

cause he is not able to meet his obligation, "the execution whereof his own assistance . . . is due."³⁹

Participation in the social contract requires, we have seen, the capacity to fulfill its obligations. Where one lacks that capacity society assumes his obligations for him.⁴⁰ As will be explained,⁴¹ the courts have wrestled for quite some time, with the question of whether, assuming the right to procreate exists, removing it through sterilization is a permissible end. The quagmire through which the courts dredge exists because of the competing interests of which Locke spoke:⁴² those between the society as a whole and its members individually.

There is a fundamental problem with the legal approach. Caught up in the fear of the slippery slope, that is, the fear that any action will lead to even more action ultimately terminating at some horrific point, the legal analyses tend to ignore the questions of moral responsibility which are raised when considering the mentally incompetent.⁴³ It is to this question the focus now turns.

The social contract requires that one make the right choices and accept responsibility where one fails. For early philosophers, such as Aristotle, responsibility was contingent upon the capability of deliberation (reasoning).⁴⁴ One was responsible whether or not he did in fact deliberate.⁴⁵ Aristotle believed that moral responsibility would attach even to those with "less discernment," because if it did not, "there could be no moral responsibility."⁴⁶ It is doubtful, however, that Aristotle's set of individuals, which focused on Athenian citizens, included the mentally incompetent.⁴⁷

Having granted the mentally incompetent a place in society, and realizing that they lack the capacity to make many crucial decisions on their own, an attempt must be made to discern what level of moral responsibility they are capable of assuming. The greater the amount of responsibility they can ac-

39. LOCKE, *supra* note 26, at 70-71.

40. The obligation is usually assumed by a guardian or guardian *ad litem*.

41. See *infra* section III.

42. See *supra* notes 37-39 and accompanying text.

43. Hallett suggests that moral issues are often neglected because they "are so complex, and people are so ill-prepared to deal with them, that they easily despair of" their solution. He goes on to suggest that people recognize "no difference between our being able to discover a solution and there being none." G. HALLETT, REASON AND RIGHT 40 (1984).

44. J. TRUSTED, FREE WILL AND RESPONSIBILITY 15 (1984).

45. *Id.*

46. *Id.* at 17. Aristotle would not go so far as to hold those for whom performance is beyond their capability responsible.

47. *Id.*

cept, the freer they shall be.⁴⁸ This freedom can be equated with membership in the moral community.⁴⁹

The system within which societal members operate presumes that the mentally incompetent require supervision because of their inability to reason; that is, they cannot be held responsible. But, membership in the moral community "means that a person is held to be morally responsible for his or her actions and life, and is to be held responsible by the rest of the community for assuming that responsibility."⁵⁰ The limitations of some people's capacity for "morally responsible behavior" require that their membership be partial.⁵¹ This limited social contract which applies to the mentally incompetent justifies society's assumption of responsibilities for the incompetent or denial of certain rights of the incompetent.⁵²

A more fulfilling life can be achieved by the mentally incompetent if barriers which prevent their physical, moral, and emotional development are removed. The procreative dilemma represents one such barrier. The responsibilities concomitant with procreation are demanding. Bearing and raising children are difficult tasks, which the mentally incompetent, even the mildly retarded, may not be capable of fulfilling. Deciding to procreate is a decision for which one *must* bear the responsibility.

The physical and emotional changes which occur during pregnancy may result in "disorienting and terrifying traumas" for both the incompetent woman and the incompetent man.⁵³ In addition, a variety of cases indicates that non-sterilization contraceptive techniques are not a very successful means of birth control among the mentally incompetent, due particularly to the same responsibility problems which they face in other aspects of their lives.⁵⁴ Sterilization is, then, actually a means of maximizing the freedom of

48. See generally W. MOBERLY, *LEGAL RESPONSIBILITY AND MORAL RESPONSIBILITY* (1965).

49. See Neville, *supra* note 24, at 33-37. (The moral community is, in its pure form, an ideal.) R. MACKLIN & W. GAYLIN, *MENTAL RETARDATION AND STERILIZATION: A PROBLEM OF COMPETENCY AND PATERNALISM* 88 (1981).

50. MACKLIN & GAYLIN, *supra* note 48, at 3.

51. See *supra* note 49.

52. In Neville's terms: "We usually regard people as fully human members of the moral community by according them the rights of responsibility where they do in fact have the capacity and by assigning to other people the responsibilities of proxy in areas of incapability." See *supra* note 24, at 35.

53. See *supra* note 24, at 34. See also *Matter of C.D.M.*, 627 P.2d 607 (Alaska 1981).

54. *Ruby v. Massey*, 452 F. Supp. 361, 363 (D. Conn. 1978) (unable to care for own hygienic needs; unable to use conventional contraception methods reliably); *Moe*, 432 N.E.2d at 721 (legally incompetent person unable to handle personal and financial affairs); *P.S. by Harbin v. W.S.*, 443 N.E.2d at 69 (unable to wash or bathe self with regularity); *Wentzel v. Montgomery General Hosp.*, 447 A.2d at 1247 (unable to care for own physical needs). On October 12, 1985, the California Supreme Court struck down the state's complete ban on

the mentally incompetent. This result follows because, without sterilization, the mental incompetent who is likely to become pregnant (or impregnate) because of the failure to practice contraception responsibly will be prevented from engaging in sexual activity. Rather than denying human dignity,⁵⁵ "remov[al of] the unbearable complications of potential pregnancy"⁵⁶ through sterilization will act to foster the incompetent's capacity for responsibility. Promoting the ability of the incompetent to interact more freely is one duty which the moral community must fulfill.⁵⁷

Sterilization of the mentally incompetent is within the terms of the social contract. The mental incompetent's contractual obligation to society encompasses the duty to be as responsible as his cognitive capabilities allow. This can only be accomplished by minimizing the need for supervision of the incompetent. Additionally, preventing the birth of children to persons who are unable to care for offspring because of their own limitations will serve to protect against these children becoming wards of the state. Society, though, also has an obligation: to "foster capacities for morally responsible behavior . . . through the institution of involuntary restrictive conditions [i.e., sterilization] in the case of basic human capacities that are undevelopable only in [the] future."⁵⁸

If the social contract is to be applied to the mentally incompetent with any meaning, the goal should be to maximize the participation of the incompetent within its provisions. Removing the barriers presented by the fear of potential pregnancy and childbirth will result in the assumption of greater self-responsibility by the mentally incompetent. Only in this manner can they be expected to widen their participation in the moral community.

The parent/guardian must play a prominent role in the decision to sterilize if the social contract is to work. The parent or guardian "contracts" with the state to care for the incompetent. Included in this care is the decision-making responsibility. Fulfillment of this responsibility requires the parent or guardian to decide what is in the best interests of the incompetent. Usur-

nontherapeutic sterilizations for the mentally incompetent. "By withholding from an incompetent woman the only safe and reliable method of contraception that may be suitable to her condition, the state necessarily limits her opportunity for habilitation and thereby her freedom to pursue a fulfilling life." *Mildred G. v. Valerie N.*, 54 U.S.L.W. 1077 (N.D. Cal. Nov. 19, 1985).

55. See generally HUMAN SEXUALITY AND THE MENTALLY RETARDED 145-46 (F. de la Cruz & G. La Veck eds. 1973); P. FRIEDMAN, THE RIGHTS OF MENTALLY RETARDED PERSONS (1976).

56. Neville, *supra* note 24, at 37. The social contract requires more from society than passive noninterference, especially where activity will yield greater overall freedom.

57. *Id.* at 36-37.

58. *Id.*

pation of this role by the state breaches its agreement with the guardian and violates that province of the intimate relationship of family decisionmaking. Maximization of the incompetent's rights is best achieved through the minimization of well-intentioned officious intermeddlers who are horrified at the mention of sterilization because of their inability to recognize medical advancements. If the incompetent is to have a chance to function socially and responsibly, the parent should be permitted to decide what is necessary to assist his or her development.

III. STERILIZATION TECHNOLOGY

Sterilization should no longer be defined in finite terms because it no longer represents a final decision. Surgical procedures for reversibility, especially microsurgical techniques, vary for males and females, but marked success has been reported in both areas.⁵⁹ This demonstrates that the irreversibility of sterilization is nearly obsolete.

Male sterilization is usually effectuated through the surgical procedure of vasectomy—a cutting of the *vas deferens*.⁶⁰ Physicians perform a vasovasotomy or reanastomosis to reverse the effects of the vasectomy.⁶¹ The purpose of the procedure is to anastomose, or rejoin, the *vas deferens*. A rejoining generates tissue repair which allows sperm to pass through the *vas deferens* again. Once sperm passes through the *vas deferens*, fertility returns⁶² or increases.

Two major techniques are used to achieve this result:

- (1) end-to-end anastomosis; and
- (2) side-to-side anastomosis.⁶³

A physician rejoins the *vas deferens* either side-to-side or end-to-end, splices dead or scarred tissue and sutures them together, instigating tissue regeneration. The success rate for each of these methods has been high: 80.87% for end-to-end, and 80.95% for side-to-side,⁶⁴ with success measured in terms of return of fertility. Proponents of the theory of irreversibility point out, however, that there still remains a twenty percent rate of irreversibility with

59. Young, *An Overview of Male Sterilization*, in NEW ADVANCES IN STERILIZATION 47-50 (M. Schima & I. Lubell eds. 1976); *Reversal of Vasectomy*, Association for Voluntary Sterilization, Inc., Pub. No. 2-1 (Nov. 1981).

60. To date there is no reversible procedure for castration, although this technique has not been used by most practitioners since Dr. Sharpe developed the vasectomy in 1890.

61. A vasovasostomy is "surgical anastomosis of *vasa deferentia*, to restore fertility in a previously vasectomized male." STEDMAN'S MEDICAL DICTIONARY 1536 (5th ed. 1982).

62. Fertility is measured either by the return of sperm count above 30 mil./tsp. or by incidences of impregnation. As used here, fertility refers to the former.

63. M. SCHIMA & I. LUBELL, NEW ADVANCES IN STERILIZATION 45-50 (1976).

64. *Id.* at 47.

which scientists must contend. Future technological advancements may succeed in dispelling these last vestiges of irreversibility.

In 1981, the Association for Voluntary Sterilization published the results of a forty-two-patient study on vasovasostomy.⁶⁵ Of the forty-two patients undergoing surgery, ninety percent regained a sperm count, and of these, seventy percent successfully achieved pregnancy within an 18-month span. According to the Association:

The secret of the success of this operation, besides the recently developed operating microscope equipment and improved techniques, is that the use of high-powered magnification enables the surgeon to thoroughly remove scar tissue on both ends of the *vas*. The 2 layers of the *vas* are then sutured with extremely fine (1/10 the thickness of human hair) material.

With further refinements, the success rate measured through term pregnancies should rise.⁶⁶ Additional refinements in the initial vasectomy procedures and the vasovasostomy techniques "will demonstrate easy reversibility."⁶⁷

In addition to surgical methods, doctors have developed mechanical reversal techniques whereby connectors are placed between the severed *vas deferens* to permit sperm to pass through and to enhance tissue growth⁶⁸ for eventual natural tissue reconnection. Other external devices can be easily reversed through removal: these include clips, intravasal chemicals, threads, catheters, plugs and valves.⁶⁹

Female anatomy necessitates a more elaborate procedure to effectuate reversibility due to the varied types of sterilization available.⁷⁰ There are four methods of sterilization: total hysterectomy, subtotal hysterectomy, tubal ligation, and ovary removal. At present, a total hysterectomy, which requires removal of ovaries, uterus and fallopian tubes is irreversible, being

65. As of September, 1985, no studies by the Association have been published updating its report.

66. M. SAIDI & C. ZAINIE, *FEMALE STERILIZATION: A HANDBOOK FOR WOMEN* 182 (1980).

67. Low pregnancy rates are due to several circumstances which affect the total usefulness of the study. These factors include pre-vasectomy semen quality, fertility status of the female partner and incompatibility between the husband and the wife. Each of these reasons is totally uncorrectable by surgery and not related to the true success or failure of vasovasostomies. The author cites these as "multiple, non-technical aspects." See Young, *supra* note 59, at 50.

68. SCHIMA & LUBELL, *supra* note 63, at 192-93. The ITT Research Institute in Chicago, Illinois has developed a connector which, when inserted in the *vas deferens*, acts as a valve to enhance tissue growth and to provide reversible *vas* occlusion.

69. G. KASIRSKY, *VASECTOMY, MANHOOD & SEX* 68-70 (1972).

70. Techniques of female sterilization include total hysterectomy, subtotal hysterectomy, fallopian tube tying, and ovary removal.

akin to castration in men.⁷¹

Subtotal hysterectomy is a surgical procedure involving the removal of either the ovaries or the uterus. The operation requires general anesthetic and a hospital stay, but promising studies indicate that the procedure may be reversible. In 1984, a successful ovary transplant restored fertility to a sterilized woman.⁷² A tubal ligation may be performed in a physician's office or in a hospital through the use of silicone plugs, or the Pomeroy method, which permits clips to be placed on the Fallopian tubes, or the application of silastic rings to both Fallopian tubes.⁷³ Outdated techniques of cauterizing laparoscopy, (splicing the Fallopian tubes by burning them) are rarely used due to the extensive damage and destruction of surrounding abdominal tissue which occurs.⁷⁴

For women who have undergone less than a total hysterectomy, both microsurgical and macrosurgical techniques exist to reverse the process.⁷⁵ Macrosurgery, which is nothing more than general surgery, is not the preferred method because the surgeon is limited in what he or she can and cannot do. Microsurgery requires greater skill, but with the capacity to manipulate organs precisely, reconstructions and replacement have greater success rates.⁷⁶

*Comparison of Recent Results of Macrosurgery and Microsurgery
in Tubal Reconstruction*

	Date of Reports	Number of Patients	Number of Pregnancies	Success Rate (%)
Macrosurgery	1973-1978	87	56	64
Microsurgery	1977	145	90	62

These statistics are over seven years old and still show a remarkable suc-

71. "Removal of both ovaries . . . [and] the uterus is a permanent check on reproduction." SCHIMA & LUBELL, *supra* note 63, at 156. *But see* Jackson, Barrowclaw, France, *et al.*, *A Successful Pregnancy Following Total Hysterectomy*, 87 BRIT. J. OBSTET. GYNECOL. 353 (1980); Niebgl, *Pregnancy Following Total Hysterectomy*, 119 AM. J. OBSTET. GYNECOL. 512 (1974).

72. Benowitz, *Ovary Transplant Restores Fertility*, SCI. NEWS 276 (Nov. 3, 1984).

73. "Clips (plastic, silicone, rings) need to be placed at the isthmus, preferably 1.0-1.5 cm. from the cornu, allowing a reversal operation to be carried out more easily . . . [s]uccess rates for this process are approximately 70%." *Female Sterilization: No More Tubal Coagulation*, 280 BRIT. MED. J. 1037 (1980).

74. *Id.*

75. *See* SAIDI & ZAINIE, *supra* note 66, at 88.

76. Success rate is usually measured by the term pregnancies and subsequent live births. *See supra* note 66.

cess rate of reversibility. Updated studies⁷⁷ show an even greater success rate due to a clearer understanding of the surgical and reconstructive techniques used.⁷⁸

The most advanced and successful of the microsurgical techniques involves a reconstruction of the Fallopian tubes, which had been blocked,⁷⁹ cut,⁸⁰ or burned.⁸¹ The microsurgical procedures are classified as either:

- 1) *Tubal Anastomosis*—where the Fallopian tube is rejoined and, like vasovasostomy, produces fertility;
- 2) *Tubocornual Anastomosis*—where the Fallopian tube is joined to the cornual opening of the uterus or implanted into the uterine wall.⁸²

A recent series of case studies indicates that the success rate of tubal or tubocornual anastomosis ranges from 18% to 100%.⁸³ Dr. Sherman J. Silber and Dr. Robert Cohen have examined the possibility of sterilization reversibility extensively and have determined that "the most significant factor affecting the likelihood of pregnancy may be the total length of tube on the longest side."⁸⁴ Both dismissed the duration of time since the sterilization as an irrelevant factor.⁸⁵

Previous and subsequent studies indicate that the "chances for a normal pregnancy were directly proportional to the length of the tube on the longest side Furthermore, the mean time to pregnancy was inversely proportional to total tubal length on the longest side."⁸⁶ The unarticulated assumption of the Silber-Cohen report is that reversibility is not only feasible,

77. See *infra* note 87.

78. The authors of the table do note, however, that: "High rates of successful reversal in a limited number of cases should not be taken as an indication that a sterilization performed this year could be easily, safely, economically, or effectively reversed within the near future." See *supra* note 65, at 91-92.

79. One procedure used to block the fallopian tubes is called hysteroscopic tubal occlusion with in-place silicone rubber plugs. A plug is placed in each tube under local anesthetic in a physician's office. The success rate for reversibility—*i.e.* removal of the plugs with minimal damage—is roughly 88%. Seiler, *The Evolution of Tubal Sterilization*, 39 *OBSTET. GYNECOL. SURVEY* 177 (April 1984). For a more exhaustive treatment of the topic, see Reed, Erb, & DeMaeyer, *Tubal Occlusion With Silicone Rubber: Update*, 26 *J. REPROD. MED.* 534 (1981).

80. See *supra* note 66, at 87.

81. *Id.*

82. *Id.* One additional method has been considered due to the upsurge in advancements in organ transplant and tissue regeneration: transplantation of ovaries. See Benowitz, *supra* note 72, at 86.

83. Silber & Cohen, *Microsurgical Reversal of Tubal Sterilization: Factors Affecting Pregnancy, With Long-Term Follow-Up*, 64 *OBSTET. GYNECOL.* 679, 680 (1984).

84. *Id.* at 679.

85. *Id.*

86. *Id.* at 680.

but successful. The statistical information below, used in their report, indicates the probable result of a microsurgical tubal reversal.

Relationship of Successful Pregnancy Rate to Total Tubal Length

Pregnant*	2 (18%)	8 (57%)	9 (82%)	12 (100%)
Not Pregnant	9	6	2	0 (9%)
Mean Time Until Pregnancy Occurred	33 mo.	10 mo.	10 mo.	5 mo.

*Pregnancy means term pregnancy with live birth.

If Cohen and Silber's studies continue to prove accurate, physicians may remove sterilization from the roles of irreversibility and consider it as simply another surgical procedure. The key factor appears to be to impress upon doctors the need to keep as much of the Fallopian tube as possible intact, since other studies adequately support the Silber-Cohen conclusion of proportionality.⁸⁷ Both physicians suggest that two procedures, in particular the ring or bipolar cautery, should produce extraordinarily high success rates following reversibility.⁸⁸ One study by Dr. R. M. L. Winston produced a reversibility success rate under a limited cautery procedure, which left four or more centimeters of Fallopian tube, of ninety-one percent.⁸⁹

For those who have undergone a subtotal hysterectomy or a tubal ligation, an additional, nonsurgical alternative remains: utilization of an egg bank. Although the procedure is still in nascent stages, the banks offer patients in this position another opportunity to conceive.

While the fragility of the egg itself makes it difficult to maintain it cryogenically for long periods of time, greater success has been achieved through the freezing of embryos. The procedure has been widely accepted for use by infertile couples, offering them a chance at parentage. With minor adaptations, such as developing a program for obtaining valid consent, the technique could be offered to mentally incompetent persons who have undergone sterilization.

The frozen embryo may last two years or longer and tests indicate that the success rate is now about twenty-five percent. The procedure includes not only *in vitro* fertilization, but the freezing, thawing and eventual implanta-

87. Winston, *Microsurgery of the Fallopian Tube: From Fantasy to Reality*, 34 FERTIL. STERIL. 521 (1980); Gomel, *Microsurgical Reversal of Female Sterilization: A Reappraisal*, 28 FERTIL. STERIL. 59 (1977); Winston, *Microsurgical Tubal Cornual Anastomosis for Reversal of Sterilization*, 1977 THE LANCET 284.

88. Silber & Cohen, *supra* note 83, at 682.

89. See Winston, *supra* note 87; Silber & Cohen, *supra* note 83, at 682.

tion of the embryo into the mother's womb. The twenty-five percent success rate is ten percent higher than the rate achieved with non-frozen embryos. One of the factors responsible for the increased success is that a frozen embryo can be held in this state until the time frame for implantation in the womb is maximized.⁹⁰ The overall impact of this scientific advancement is to recharacterize the meaning, scope and use of sterilization.

Sterilization goes to the very heart of one of the most fundamental constitutional rights—the right to bear and beget children.⁹¹ If reversibility techniques continue to succeed, then the decision to sterilize gives new meaning to the right to bear children. While temporarily affecting the right to beget, sterilization could produce results no more permanent than the results produced by a woman's decision to take birth control pills. The fear of the courts, predicated upon the irreversible loss of a basic human right, should vanish because the right is not lost. As such, the legal system should prepare itself to deal with the medical aspects of the right to beget children. An initial step *vis-a-vis* the mentally incompetent would be to turn the decision-making process for this type of surgery back over to the parents or guardians of the mentally incompetent. In light of the state statutes which permit guardians or parents acting as guardians to make medical decisions regarding the health, care, and welfare⁹² of the incompetent, the decision to sterilize could adequately and constitutionally be fulfilled by the guardians without court intervention. The high degree of intrusiveness into the bodily autonomy of the incompetent is significantly reduced and the courts need not interfere with decisions which normally rest between patient and doctor.⁹³

IV. CONSTITUTIONAL ASPECTS

Some scholars maintain that the right to privacy derives from penumbras emanating from the fourth, fifth, sixth, and fourteenth amendments.⁹⁴ As with the penumbras themselves, however, courts have been reluctant to define privacy clearly, for fear, perhaps, of opening a Pandora's box of restrictions upon so precious a right. But the courts' refusal to do so has led to untold suits, especially in the areas of personal autonomy rights of procrea-

90. Hanahan, *Fertilization, Embryo Transfer Procedures Raise Many Questions*, 252 J. A.M.A. 877, 878 (1984).

91. *Roe*, 410 U.S. 160; *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 478 (1965).

92. Read more broadly, as the best interest of the incompetent ward.

93. See *infra* note 140 and accompanying text.

94. *Roe*, 410 U.S. 160; E. BARRETT, JR. & W. COHEN, *CONSTITUTIONAL LAW* 611-672 (1980).

tion, family, and sterilization.⁹⁵ In an ever-changing technological era, however, the courts must either step aside and let science dictate the meanings of rights or they must meticulously follow the progresses of science and adapt the parameters of these rights to scientific advances. In either case the result is the same. This interjects an element of reality into every court decision and dictates that the courts be receptive to change in order to protect the rights of society's members. The change need not be radical, but perceptible.

It may be asserted that the right to sterilization derives from the privacy right to procreational autonomy.⁹⁶ But the indefinite parameters of privacy render it difficult to specify the boundaries of the right to sterilization. The key question is, then, *what* does the right to privacy protect in the realm of procreative autonomy? Once this query is answered, the second step is to identify *who* may exercise this right, and the third is *when* may this right be limited.⁹⁷

The act of procreation has several components: the act of intercourse, the begetting of a child, and the bearing of a child. It behooves one to discern, then, which of these elements, if any, is protected under the right to procreational privacy. Four options exist to define this right:

- 1) the act of intercourse, intended or not, which could produce a child is protected;⁹⁸ or
- 2) the intentional act of intercourse to produce a child is protected;⁹⁹ or

95. See *Roe*, 410 U.S. 160; BARRETT & COHEN, *supra* note 94, at 611-72; SMITH, *supra* note 7.

96. In re Grady, 85 N.J. 235, 426 A.2d 467 (1981); *Wentzel*, 447 A.2d at 1262 (Davidson, J., dissenting); see also *Skinner*, 316 U.S. 535; *Eisenstadt*, 405 U.S. 438; *Hathaway v. Worcester City Hosp.*, 475 F.2d 701 (1st Cir. 1973).

97. For the sake of consistency, we refer to the limitation of the procreative right rather than the deprivation since Section III of this paper establishes the "non-finalness" of the sterilization process.

98. The theological position in this area is briefly summarized in the following fashion: Every person is endowed by God with certain "goods." These goods include one's body and its organs and the power to give life to new persons. May, *Contraceptive Sterilization: No Panacea for Human Problems*, 61 HOSP. PROGRESS 38 (Sept. 1980). Dr. May goes on to explain that this gift of giving life is "a precious gift from God . . . enabling [us to share in His] creative activity." *Id.* The nature of this good leads Dr. May to reject sterilization except where it is "indirect"—a necessary *result* of a lifesaving operation. *Id.* Dr. May's statements were in support of the July 3, 1980 brief of the National Conference of Catholic Bishops entitled "Statement on Tubal Ligation." See also N. LOHKAMP, *THE MORALITY OF HYSTERECTOMY OPERATIONS* 11-29 (1956).

99. While the theological perspective also tends to support this proposition generally, there appears to be a growing number of theologians who would qualify this absolute protection. See, e.g., Bayer, *Defensive Sterilization for Severely Retarded Women: A Moral Option?* 2 THE MED.-MORAL NEWSLETTER 1 (Feb. 1984) ("[S]ound moral principles do not absolutely rule out defensive sterilization as an intrinsic evil"; for example, sterilization may even be

- 3) the act and the ability to beget and bear offspring are protected; or
- 4) the ability to beget is protected.

Each of these possibilities becomes more and more restrictive in nature, and decisional law indicates that procreational autonomy involves primarily the fourth option—the ability to beget.¹⁰⁰ Using any definition but the fourth permits the exclusion of certain classes from “fundamental rights” protection because they lack the capacity to understand the right.¹⁰¹

Courts consistently refer to the right to beget and bear.¹⁰² Arguably this reference accepts the unarticulated assumption that the core right protected under procreational privacy is the ability to do so. If the *ability* to beget is protected then, arguably, the right to choose *whether* to procreate is insured.

The case of the mentally retarded, however, is especially difficult to define within the parameters of privacy because of their inability to give legally recognized formal consent. In order to support a right to be sterilized, those who elect this procedure must give valid consent, defined as the ability of the subject to understand rationally the:

- a) nature of the procedure;
- b) risks; and
- c) other relevant information.¹⁰³

Since a mentally incompetent person is legally incapable of deciding whether to be sterilized, the available courses of action are limited to the following:

- 1) The right could be denied to the incompetent under a theory that it is a personal right which no one else may exercise for him or

permissible to protect against “unjust impregnation”). Fr. Bayer notes that the Church did not object to temporary sterilization of nuns who were likely to be raped in the Belgian Congo War. *Id.* See also Bayer, *Defensive Sterilization for the Severely Retarded: Follow-Up*, 22 THE MED.-MORAL NEWSLETTER 1-4 (Feb. 1983) (advocating ‘defensive’ sterilization for women so severely retarded that any act of intercourse would, by definition, constitute rape); McCormick, *Restatement on Tubal Ligation Confuses Policy With Normative Ethics*, 61 HOSP. PROGRESS 40 (Sept. 1980) (the principle of totality allows for sterilization which is ‘direct,’ or contraceptive where totality includes psychological and familial well-being); MEDICAL ETHICS 90 (M. Tides & J. Christian, eds. 1975) (“sterilization can receive its justification from valid medical reasons . . . , and if from a medical point of view sterilization is the best possible solution, it cannot be against the principle of medical ethics, nor is it against the ‘natural law’”).

100. Matter of C.D.M., 627 P.2d at 616 (“any restrictions on the fundamental right to bear and beget children”); *Ruby v. Massey*, 452 F. Supp. at 370 (“The right to ‘bear or beget a child’ is a salient right . . .”); *In the Interests of M.K.R.*, 515 S.W.2d at 470-71 (“a right to bear and beget. . .”); *Carey v. Pop. Services*, 431 U.S. at 685 (“ . . . a fundamental right, the right to choose whether to beget a child. . .”) (emphasis added).

101. The mentally retarded, the old and senile, minors or infants.

102. See, e.g., *Carey*, 431 U.S. 678.

103. CONN. GEN. STAT. § 45-78p(b) (Supp. 1984).

her;¹⁰⁴ or

2) the courts, as protectors of the weak and incapable, may step in and decide for the incompetent, based on either a theory of best interests¹⁰⁵ or substituted judgment,¹⁰⁶ whether to authorize a sterilization; or

3) the decision may rest with the parents/guardians, rooted in either the common law parents' right to care for the health and welfare of their children¹⁰⁷ or in the statutory grant of authority to guardians to make medically indicated decisions for the incompetent;¹⁰⁸ or

4) the legislature may specifically provide the procedures necessary for the exercise of the right to be sterilized and if no legislative expression exists, the right cannot be exercised by or on behalf of the incompetent.¹⁰⁹

A discernible thread found in all the court decisions supporting any of the above options is that the sterilization procedure is irreversible.¹¹⁰ Thus,

104. In re Eberhardy, 307 N.W.2d at 892-93 ("Is there a possibility of genuine choice when that choice cannot be exercised? No. A decision made by others for someone else is under no circumstances a personal choice of the one to be sterilized.") ("... a free choice is an empty option for those who cannot exercise it."). *Id.* at 887.

105. TERWILLIGER, 304 Pa. Super. 553, 450 A.2d 1376 (1982); Matter of C.D.M., 627 P.2d 607 (Alaska 1981); In re Eberhardy, 102 Wis.2d 539, 307 N.W.2d 881 (1981); In re Grady, 85 N.J. 235, 426 A.2d 467 (1981); P.S. by Harbin v. W.S., 443 N.E.2d 67 (Ind. App. 1983).

106. *Moe*, 432 N.E.2d 712; Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 320 N.E.2d 471 (1977).

107. A.L. v. G.R.H., 163 Ind. App. 636, 325 N.E.2d 501 (1975).

108. ALASKA STAT. § 13.26.150(a)(3) (1983); ARIZ. REV. STAT. ANN. § 14-5312 (1977); ARK. STAT. ANN. § 57-801 *et seq.* (Supp. 1984); CAL. PROB. CODE § 2353 (West 1984); COLO. REV. STAT. § 15-14-312 (1984); CONN. GEN. STAT. § 45-329(e) *et seq.* (1985); MD. ANN. CODE art. 13, § 708 (1983); PA. STAT. ANN. tit. 46, § 601(47) (Purdon 1969); VT. STAT. ANN. tit. 18, § 8701 (1984).

109. In the Matter of A.W., 637 P.2d at 368 (individual must be afforded the opportunity to choose not to be the source of another life and the government should provide the guidelines); *Moe*, 432 N.E.2d at 719 ("We think that the government deprives a mentally retarded individual of his or her right to privacy if it denies the person the opportunity to exercise that right"); Matter of C.D.M., 627 P.2d at 610 (in deferring someone's right to bear offspring the decision should come from the elected body); In the Interests of M.K.R., 515 S.W.2d at 470 (jurisdiction to authorize the sterilization of an infant may only be conferred by the legislature); In the Matter of Guardianship of Hayes, 608 P.2d at 642 (Stafford, J. concurring and dissenting) (the court has jurisdiction but should defer its exercise to the legislature, due to the complex social issues involved); In the Matter of Terwilliger, 450 A.2d at 1380 ("no statute exists in Pennsylvania that specifically authorizes a guardian to consent . . .").

110. Relf v. Weinberger, 372 F. Supp. 1199 (D.D.C. 1974), *vacated as moot*, 565 F.2d 722 (D.C. Cir. 1977) ("Sterilization of females or males is irreversible"); *see also Moe*, 385, 432 N.E.2d at 716 (Courts view sterilization as an "extraordinary medical treatment" requiring judicial oversight for protection from abuse); In re C.D.M., 627 P.2d at 612 (Matthews, J. dissenting) (sterilization "involves a request for elective surgery which would irreversibly de-

great care must be taken in choosing who may decide on behalf of the incompetent, if anyone. This choice requires balancing the interests of the incompetent against the interests of those charged with the responsibility of caring for the incompetent.

The fears of the courts and legislatures regarding past abuses of sterilization procedures must be reexamined for three reasons. Primarily, the rapidly expanding technological advances clearly indicate that sterilization is no longer an irreversible denial of a human right.¹¹¹ Secondly, because sterilization no longer represents an insurmountable obstacle to the incompetent's exercise of a fundamental right, the decisionmaking process for the procedure should be shifted to the parents, acting within the scope of their guardianship duties and in concert with the incompetent's physicians. Lastly, the courts and legislatures must openly recognize that the medical profession itself represents one of the most valuable and reliable checks on arbitrary or capricious action by the parents-guardians. Surgeons not only have professional standards to uphold, but hospital¹¹² and personal¹¹³ standards as well, each of which presents assurances that a physician's assent to a sterilization procedure will not be given lightly.¹¹⁴ Courts and legislatures must recall that the doctor is an indispensable party to the operation; apart from the patient, no sterilization occurs without his participation.

Based on these assertions, permitting the decision to rest with the parent-guardians and the physicians involved represents the most logical choice for achieving the most efficient, economic, and just results for the incompetent.

prive a human being of a fundamental right"); In the Interests of M.K.R., 515 S.W.2d at 470-71 ("permanent deprivation of a right to bear and beget"); A.L. v. G.R.H., 325 N.E.2d at 502 (vasectomy is painless, simple and irreversible, rendering one "permanently sterile"); In re Cavitt, 157 N.W.2d at 178 (sterilization is "inhuman, unreasonable and oppressive"); P.S. by Harbin, 443 N.E.2d at 69 ("the highly intrusive, permanent nature of sterilization which renders the treatment extraordinary"). *But see* Matter of A.W., 637 P.2d at 368 n.4 ("one type of male sterilization, vasectomy, is reversible on occasion. . ."); Note, *Protection of the Mentally Retarded Individual's Right to Choose Sterilization: the Effect of the Clear and Convincing Evidence Standard*, 12 CAP. U.L. REV. 413, 420 (1983); Note, *Sterilization, Retardation and Parental Authority*, 1978 B.Y.U.L. REV. 380, 398 (the countervailing consideration of the greatest impact is the fact that sterilization is "the permanent deprivation of the ability to procreate").

111. See *supra* section II.

112. See generally Note, *Elective Sterilization*, 113 U. PA. L. REV. 415 (1965); May, *Contraceptive Sterilization: No Panacea for Human Problems*, 61 HOSP. PROGRESS 38 (Sept. 1980).

113. See *supra* note 111.

114. Surgeons are not infallible, completely objective creatures, but human beings quite capable of making totally subjective judgments. This observation is worthy of note since the medical community is not immune from the desire to make money or the desire to do what is right. But overall, this paper argues that the surgeons will be strongly influenced in their decisions by the ramifications of making a hasty, ill-motivated decision.

The framework for the decisionmaking process could be drawn from those which the courts presently utilize:

- 1) the best interests theory;¹¹⁵ and
- 2) the substituted judgment theory.¹¹⁶

Each of these represents cogent methods to apply to an incompetent if the result is to be one which will enhance the incompetent's ability to function within the social community.¹¹⁷ The balancing of the incompetent's interests still takes place in the same manner indicated in the subsequent cases but the decisionmaking process is completed within a more personal realm. Drawing from the cases below,¹¹⁸ parents, guardians, and physicians should be able to safeguard adequately the interests of the incompetent, plus the interests of the family and society, all with a minimum of sacrifice.

V. CURRENT STATE OF THE LAW

The present state of the law acknowledges two types of decisionmaking processes acceptable for use as decisional structures on behalf of the mentally incompetent. The best interests test, the more widely used of the two,¹¹⁹ is defined as: when a vicarious decisionmaker determines what actions would be in the ward's best interests.¹²⁰ The values applied are those of the guardian-decisionmaker.¹²¹ The substituted judgment theory, growing in popularity due to a renewed insistence on recognition of the incompetent's preferences,¹²² is defined as: when the decisionmaker tries to decide vicariously what the ward would do if the ward were competent.¹²³ The values applied appear to be those which the ward did express when compe-

115. See *supra* note 105.

116. See *supra* note 106.

117. See *supra* section I.

118. See *infra* notes 116-151 and accompanying text.

119. *Buck v. Bell*, 274 U.S. 200 (1927); *Ruby v. Massey*, 452 F. Supp. 361 (D. Conn. 1978); *In the Matter of Terwilliger*, 304 Pa. Super. 553, 450 A.2d 1376 (1982); *Wentzel v. Montgomery General Hospital*, 293 Md. 685, 447 A.2d 1244 (1982); *Brode v. Brode*, 278 S.C. 457, 288 S.E.2d 443 (1982); *Matter of C.D.M.*, 627 P.2d 607 (Alaska 1981); *In re Guardianship of Eberhardy*, 102 Wis.2d 539, 307 N.W.2d 881 (1981); *In the Matter of Guardianship of Hayes*, 83 Wash. 228, 608 P.2d 635 (1980); *In re Sterilization of Moore*, 289 N.C. 95, 221 S.E.2d 307 (1976); *In re Marcia R.*, 136 Vt. 47, 383 A.2d 630 (1978); *A.L. v. G.R.H.*, 163 Ind. App. 636, 325 S.E.2d 501 (1975); *In the Interests of M.K.R.*, 515 S.W.2d 467 (Mo. 1974); *In the Matter of Truesdell*, 63 N.C. App. 258, 304 S.E.2d 793 (1983); *Gooley v. Moss*, 398 N.E. 2d 1314 (Ind. App. 1979).

120. Appelbaum & Gutheil, *Substituted Judgment: Best Interest in Disguise*, 13 HASTINGS CENTER REP. 8 (June, 1983).

121. *Id.*

122. *Id.*

123. *Id.*

tent,¹²⁴ or might express¹²⁵ if competent. In each of these tests, two usually competing values appear: altruism and self-interest. Altruism applies more readily to the substituted judgment test and self-interest remains integral to the best interests test. The following cases clearly indicate the tension between these two values.

In the Matter of Moe,¹²⁶ Mary Moe's mother filed a petition as her daughter's guardian, seeking permission to authorize and consent to her daughter's sterilization by tubal ligation.¹²⁷ The probate judge appointed a guardian *ad litem*, who promptly objected to the sterilization procedure on the basis that the probate court had no statutory authority to rule on the petition.¹²⁸ The judge reported the matter without opinion to the Court of Appeals in Massachusetts requesting a response to whether the probate court had jurisdiction to decide the petition absent statutory authorization.¹²⁹ The Supreme Judicial Court of Massachusetts concluded that as a court of general jurisdiction, the probate court had the equity power to authorize the sterilization.¹³⁰ The Supreme Court proceeded to expound on the criteria required to achieve a result which would be in Mary's best interest.

Mary was a mentally retarded twenty-six year old woman who functioned at the emotional, intellectual and developmental age of four.¹³¹ The health professionals involved in her case felt "it would be in the best interests of the ward to have an abdominal tubal ligation."¹³² The Court stated that "sterilization is an extraordinary and highly intrusive form of medical treatment that irreversibly extinguishes the ward's fundamental right of procreative choice."¹³³ Therefore all guardians must be required to obtain proper judicial orders prior to authorizing such surgery.¹³⁴ In determining the ward's best interests, the law must first afford them a forum in which to exercise their rights¹³⁵ and second, grant those powers to the proper persons broadly and flexibly enough "to afford whatever relief may be necessary to protect [the ward's] interest."¹³⁶ Ironically, however, the court then authorized a

124. *Saikewicz*, 320 N.E.2d 471.

125. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 63 (1981).

126. 385 Mass. App. 555, 432 N.E.2d 712 (1982).

127. *Id.* at 715.

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.* at 716-17.

134. *Id.* at 717.

135. *Id.* at 718.

136. *Id.* at 719, quoting *Saikewicz*, 373 Mass. at 755-56, 370 N.E.2d at 417.

substituted judgment approach to Mrs. Moe's petition. The majority stated that:

because a competent individual has a right to be sterilized, . . . "[t]o deny this right to persons who are incapable of exercising it personally is to degrade those whose disabilities make them wholly reliant on other, more fortunate individuals. . . .' [T]he State must . . . afford to that person the same panoply of rights and choices it recognizes in competent persons. [citations omitted] This is accomplished through the doctrine of substituted judgment.¹³⁷

The articulated value supporting the use of this doctrine is the desire to "maintain the integrity of the incompetent person."¹³⁸ The court is the final arbiter of what decision the incompetent would or would not have made. In the balance between the need for an incompetent to have a forum in which to exercise his or her rights and the expression of the incompetent's preferences, the Massachusetts court consistently favored the availability of the forum.¹³⁹ When the values of the incompetent are not known, however, the court paternalistically applies its own values to determine the incompetent's judgment.¹⁴⁰ In fleshing out possible alternatives, the judge must contend with medical opinions,¹⁴¹ the incompetent's competence level,¹⁴² the likelihood of the incompetent's sexual activity,¹⁴³ the probable trauma of pregnancy, and of course the interests of the parties involved,¹⁴⁴ which include the opinion of the parent-guardian as to what is best for the incompetent. An analysis of these factual conditions permits the court to substitute its judgment for the incompetent's.

Succinctly stated, substituted judgment is a legal fiction used to justify the court making the decision for the incompetent in lieu of any other qualified party. The court perceives itself as the most objective and selfless of the parties involved and therefore the most qualified to decide.¹⁴⁵ But just as the parents' values or interests may be inapposite to those of the ward's, so may the court's, especially in light of the fact that the judge wears his robes in order to decide for the incompetent, additionally tainting his values with some imbued form of justice. Consequently, the court fails to take note of

137. *Moe*, 385 Mass. App. at 1001, 420 N.E.2d at 720.

138. *Id.*

139. *Id.*

140. *Id.*

141. *Id.* at 722.

142. *Id.*

143. *Id.*

144. *Id.* at 723.

145. Appelbaum & Gutheil, *supra* note 120, at 9.

the most important considerations required in the delicate balance of decisionmaking under substituted judgment: 1) empathy, and 2) an intimate knowledge of the patient and his history. Courts have criticized the capacities of parents-guardians as being substantially handicapped when faced with such a decision, due to their parental roles. Yet, the judiciary does nothing more than attempt to step into the role of the parents.

If an *in toto* review of a patient's history, needs, desires, or preferences is required to exercise sufficiently substituted judgment, then surely the courts must defer to those who spend their lives with the patient—the parents. In the name of their own “objective values,” judges succumb to those same influences parents do, but they can never gain the lifelong familiarity with the ward which the parents possess. Now that modern technology has put into question the myth of irreversibility, the courts should step aside and relinquish the decisionmaking power to those best able to satisfy the criteria of substituted judgment.

*In the Matter of Terwilliger*¹⁴⁶ involves a 1982 Pennsylvania Superior Court decision which issued guidelines for the application of the best interests test to the mentally incompetent. Mr. and Mrs. Terwilliger petitioned the Court of Common Pleas to appoint them guardians and permit them to order the sterilization of their daughter, Mildred, by tubal ligation.¹⁴⁷ The court approved their appointment as guardians and granted authorization to sterilize her.¹⁴⁸ The Superior Court determined that the appointment was validly made and that the authorization of sterilization petitions was well within the exercise of the judiciary's *parens patriae* power.¹⁴⁹ More importantly, however, the best interests of Mildred were the focus of the decision.¹⁵⁰ The court decided that a determination of Mildred's best interests involved an appointment of a guardian *ad litem*,¹⁵¹ a full adversarial process, including the opportunity to “present evidence and cross-examine witnesses at the hearing,”¹⁵² and to receive a complete presentation of medical, psychological and social evaluations of the incompetent.¹⁵³ The majority concluded:

More importantly, the incompetent should be given the opportunity to express his or her own views on the subject being reviewed,

146. 480 A.2d 1376 (Pa. 1982).

147. *Id.* at 1378.

148. *Id.*

149. *Id.* at 1379-80.

150. “[A] court should consider only the best interest of the incompetent person not the interests or convenience of the individual's parents, the guardian or society.” *Id.* at 1382.

151. *Id.* at 1383.

152. *Id.*

153. *Id.*

and, albeit not controlling, his or her wishes not to be sterilized must weigh heavily against authorizing the procedures [citations omitted]. Despite the fact that the individual may be labelled [sic] an incompetent person, does not mean that his or her apparent preferences can be totally ignored.¹⁵⁴

In light of Mildred's preferences, however, the court had to balance the existence of an illegitimate child born to her in December of 1980.¹⁵⁵ In summation, the decision stated that the interests of the child, Mildred, and the family would be better served if Mildred were sterilized. The equities in the court's decision fell on the side of Mildred being saved from the trauma of future pregnancies and of being given the opportunity to rear and raise an already existing child. The incompetent's best interests were served adequately.

VI. INTERACTIONS

The foregoing analysis has presented the foundations of the social contract,¹⁵⁶ the technological advances in sterilization techniques,¹⁵⁷ and the current state of the law as it related to the sterilization of the mentally incompetent.¹⁵⁸ It is now necessary to analyze how these factors interact. In doing so, the focus will be on how the failure of the law to recognize medico-technological advances in the area of sterilization runs counter to society's desire to find a moral answer to the dilemma posed by the courts' usurpation of what is generally perceived an area of parental authority. Before the courts stepped in, the decisionmaking process rested with the parents. But when the spectre of abuses and irreversibility were raised, courts used the *parens patriae* power to wrest the decision from parents.

When considering the role of the mentally incompetent in society, courts often refuse to admit or recognize the true cognitive inabilities of these persons.¹⁵⁹ The evidence of this surfaces most clearly in cases where the court attempts to "determine" what the individual would do were he or she competent [substituted judgment test].¹⁶⁰ Such decisions can only further the canard that these people may one day become competent to the extent required to assume the responsibilities of pregnancy and parenthood. Generally, if the mentally incompetent have not "the capacities for managing

154. *Id.*

155. *Id.* at 1385.

156. *See supra* section I.

157. *See supra* section II.

158. *See supra* section III.

159. *See supra* note 104.

160. *See supra* note 105.

[their] own affairs . . . it is doubtful that [they] will possess" the capacity to care for their children.¹⁶¹ When this fact is coupled with the fact that "[t]he prevention of conception by usual forms of contraception is often difficult for retarded individuals to manage,"¹⁶² it becomes evident that "sterilization is the only form of contraception . . . which will free the [incompetent] from all risk of pregnancy."¹⁶³ Additionally, the impact of success in reversing sterilization, permits physicians to view the decision to sterilize as something other than a most drastic means to be avoided.

With the cloud of irreversibility dissipating rapidly, sterilization of mentally incompetent persons must be reconsidered in a new light. It is no longer sufficient to dismiss the procedure as a means of "last resort" only.¹⁶⁴ It is now a means to an end.¹⁶⁵ It is not the person's body which is the means, but the procedure of sterilization.¹⁶⁶ The end is not reducing society's burden, as some suggest it should be, but actually removing from the incompetent a potential which, unattended, will necessitate stricter supervision and tighter control over the incompetent.¹⁶⁷ The end sought is greater freedom for incompetents; and those best qualified to make these decisions on behalf of the mentally incompetent person are the incompetent's parents (or guardian). For who is in a better position to understand and determine what is in the best interest of the incompetent than those closest to him or her? In an area where decisions must be made, the difficult decisions are best left within the family.

Much of the criticism levied against sterilization in the recent past has hinged upon a limited number of reasons: (1) the eugenic justification for sterilization has been discredited;¹⁶⁸ (2) sterilization represents an intrusion into the physical autonomy of *any* individual;¹⁶⁹ (3) sterilization is an irreversible procedure;¹⁷⁰ and (4) involuntary sterilization violates a fundamen-

161. MACKLIN & GAYLIN, *supra* note 49, at 85.

162. *Id.* at 86. The authors attribute this difficulty to two basic reasons: (1) some incompetents "do not fully understand the significance of contraception," and (2) many incompetents have difficulty in "taking into account [the] long-term consequences and in delaying gratification." *Id.*

163. *Id.*

164. *See, e.g., Moe*, 420 N.E.2d 712. *See generally* SMITH, *supra* note 7, at 35-39.

165. This statement is not a rejection of Kant's premise that a person should not be used as a means to an end, but only as an end.

166. *See, e.g., MACKLIN & GAYLIN, supra* note 49, at 85.

167. *See, e.g., Neville, supra* note 24, at 35-36; MACKLIN & GAYLIN, *supra* note 49.

168. Burgdorf & Burgdorf, *supra* note 7; *See also* In the Matter of A.W., 637 P.2d at 368; Kindregan, *Sixty Years of Compulsory Eugenic Sterilization: 'Three Generations of Imbeciles' and the Constitution of the United States*, 43 CHI.-KENT L. REV. 123, 134-40 (1966).

169. *See, e.g., Moe*, 432 N.E. 2d at 719; N. LOHKAMP, THE MORALITY OF HYSTERECTOMY OPERATIONS 11 (1956).

170. *See, e.g., supra* note 110.

tal right and therefore seems to limit rather than expand the freedom of the incompetent victim by destroying his or her right to procreate.¹⁷¹ Assuming, *arguendo*, that arguments one and two are correct, and recalling that argument three is no longer viable,¹⁷² the question of whether to sterilize the mentally incompetent depends on whether argument four is credible. If the fourth argument fails, it must then be balanced against the second contention before a final justification can be reached.

The concept of freedom, in terms of the social contract, is not absolute.¹⁷³ The individual, through the social contract, strives to maximize his own freedom, but also assumes responsibilities to the society which enable the society to maximize its collective freedom. Earlier it was suggested that sterilization, by removing the burdens associated with pregnancy and parenthood, would free the incompetent from unnecessary and, perhaps, unwanted supervision.¹⁷⁴ American society, while valuing freedom, also values equality—especially equality of opportunity. If sterilization serves both of these ends it will not only make the social contract a more meaningful proposition to the mentally incompetent, but it will also serve the greater, albeit nebulous, principle of justice.

Determining whether a goal will serve the purposes of justice requires a balancing of the competing concepts of liberty [freedom] and equality.¹⁷⁵ The tension which exists between these two values, in Rawls' view, results in the "difference principle."¹⁷⁶ In balancing these values, Rawls hopes to achieve what he sees as the primary social good, a sense of one's own worth or self-respect.¹⁷⁷ As with any competing interests, where the goal is one other than the interests themselves, one must occasionally yield to the other when the end requires it. According to Rawls' theory, equality is a desirable factor, but one which should yield to other factors where necessary.¹⁷⁸ Inequalities are permissible if such inequalities work out best for those worst off, if equality of opportunity is provided in some form, and if civil and political rights are equal to the extent they are consistent with the primary social goal.¹⁷⁹ Such "trade-offs" among social values are permissible as long as

171. Compare Neville, *supra* note 24. See also Golding & Golding, *Ethical Value Issues in Population Limitation and Distribution in the United States*, 24 VAND. L. REV. 495 (1971).

172. See *supra* section II.

173. See Locke, *supra* note 26.

174. See *supra* notes 25-57 and accompanying text.

175. J. RAWLS, A THEORY OF JUSTICE (1971).

176. *Id.*

177. *Id.*

178. See Michelman, *In Pursuit of Constitutional Welfare Rights: One View of Rawls' Theory of Justice*, 121 U. PA. L. REV. 962 (1973).

179. *Id.* at 870-71. Compare Beauchamp, *Distributive Justice and the Difference Principle*,

they satisfy the difference principle.¹⁸⁰ In situations where equal liberties cannot be fully enjoyed:

it is not ultimately repugnant to the priority of liberty to allow . . . restrictions of liberty *now*, if these measures are found necessary to boost productivity to the point where full and equal liberty can be truly realized *later*.¹⁸¹ (emphasis in original)

Viewed in this fashion, justice is best served by a system which acknowledges the needs for current limitations in order to ensure future expectations. When this theory is applied to sterilization of the mentally incompetent it becomes evident that these procedures fulfill the difference principle. Since the mentally incompetent are legally disqualified from making decisions in their own behalf, the fulfillment of the difference principle will depend on the decision made by another. That 'other' should be the persons closest to and most sympathetic with the situation, the parents. It is undisputed that, under current legal definitions, the right to procreate exists. However, curtailment of this right in mental incompetents, through the only practicable means, sterilization, will result in increased opportunity, by alleviating the need for close supervision of potentially sexually active incompetents. Removing this barrier will also yield greater opportunity, through increased independence, for the mentally incompetent to function in society.

When a person is legally incompetent the law generally appoints another to make his decisions—a parent or guardian. The responsibility for fulfilling the social contract then falls on the decisionmaker's shoulders. Thus, the parent or guardian of the mentally incompetent assumes a pivotal role in the interplay between society and the incompetent. If the parent is to accomplish this task, he or she must be credited with the ability to decide whether sterilization is in the best interest of the incompetent. By removing the decision to sterilize from the realm of the parents, the courts have relieved parents of their role in assisting the incompetent to function successfully in society. The parents no longer function as parents, but merely as wardens of the court who, from behind the bench, believe that those furthest removed are best able to determine what is best for the incompetent. This forces back into the courts the very decisions which the family structure, via the guardian relationship, was intended to remove from their purview, denying the incompetent the right to have his decision made for him by those closest to him.

reprinted in J. RAWLS, *THEORY OF SOCIAL JUSTICE: AN INTRODUCTION* 135, 136 (H. Block & E. Smith eds. 1980); Katzner, *The Original Position and the Veil of Ignorance*, reprinted in *id.*, at 48-49.

180. See Michelman, *supra* note 178, at 989.

181. *Id.* at 1000.

VI. CONCLUSIONS

In light of the above analysis, it can thus be seen that sterilization presents great opportunities for the mentally incompetent. When this is weighed against the relatively minor imposition the procedure poses on physical autonomy, it seems clear that the balance tips in favor of such procedures. But, the focal question in the quest for opportunity and freedom for the incompetent, remains: who should decide? An argument has been introduced that the parent-physician combination is best suited for this purpose.¹⁸² This argument is as sound morally as it is legally.

Since the parent-guardian has been determined to be the person best able to uphold the interests of the incompetent in a variety of areas,¹⁸³ the extension of this power to the decision of sterilization rests on sound judgment and policy. The family, as an institution, has been said to play a vital role in society.¹⁸⁴ As such, the courts should not hesitate to return the power to decide to parents in lieu of permitting an impersonal court, which is rarely able to understand the true problems facing an incompetent, to decide.¹⁸⁵ Additionally, as the Supreme Court has noted, the physician acts as a conscientious and knowledgeable check on parental activity:

Due process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer . . . Thus, a staff physician will suffice, so long as he or she is free to evaluate independently the [patient's] mental and emotional condition and need for treatment.

* * * Pitting the parents and child as adversaries often will be at odds with the presumption that parents act in the best interests of their child. It is one thing to require a neutral physician to make a careful review of the parents' decision in order to make sure it is proper from a medical standpoint; it is a wholly different matter to employ an adversary contest to ascertain whether the parents' motivation is consistent with the child's interests.¹⁸⁶

The right not to procreate is at least as strong as its counterpart.¹⁸⁷ Permitting the sterilization of mentally incompetent persons where the parents find it to be in their ward's best interests will expand freedom and opportuni-

182. See *supra* section III.

183. See *supra* notes 28-30.

184. Smith & Iraola, *Sexuality, Privacy and the New Biology*, 67 MARQ. L. REV. 263, 289 (1984); Smith, *Quality of Life, Sanctity of Creation: Palliative or Apotheosis?* 63 NEB. L. REV. 709, 740 (1984).

185. See *supra* note 29.

186. *Parham v. J.R.*, 442 U.S. 584, 607-10 (1979).

187. See *supra* notes 20-21; *In re Storar*, 420 N.E.2d 63, 52 N.Y.2d 363, (1981); *Matter of Hofbauer*, 47 N.Y.2d 648, 383 N.E.2d 1009, 419 N.Y.S.2d 936, (1979).

ties of the incompetent. These procedures introduce an element of self-respect which would otherwise be quelled through supervision and fear. [Balanced against the great price paid when courts interfere in family affairs, the net gain of family privacy far outweighs the social costs of pitting mother against son and father against daughter]. The courts have never been the best place for determining the interests of the incompetent, who is better served by his or her parents whose decisions are apt to consider the best interests of the incompetent, and who are now, in the light of new, successful reversibility techniques, able to make a decision which can allow for the possibility of changed circumstances.

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