Masthead Logo

DePaul Law Review

Volume 18
Issue 2 *Issue 2 & 3 Summer 1969*

Article 13

Voluntary Sterilziation of Women as a Right

Peter R. Forbes

Follow this and additional works at: https://via.library.depaul.edu/law-review

Recommended Citation
Peter R. Forbes, *Voluntary Sterilziation of Women as a Right*, 18 DePaul L. Rev. 560 (1969)
Available at: https://via.library.depaul.edu/law-review/vol18/iss2/13

This Article is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Law Review by an authorized editor of Via Sapientiae. For more information, please contact wsulliv6@depaul.edu, c.mcclure@depaul.edu.

VOLUNTARY STERILIZATION OF WOMEN AS A RIGHT

PETER R. FORBES*

CONTRACEPTION IN the United States is an ever-increasing part of the national scene. Although we have not yet felt the bite of either the world over-population or the reproductive explosion in this country, if everyone married and had only two children, the population would double in a generation. Regardless of conscious awareness of the problem, most Americans use some technique to avoid or defer pregnancy. Simple techniques such as rhythm, withdrawal, or coitus while lactating have a high failure rate and many women are dismayed to have infants in rapid succession. Mechanical barriers erected by condoms, diaphragms, jellies and foams have a lower but still significant failure rate. The intrauterine devices, of assorted plastic or metal design, have no patient error except failure to report expulsion, but all have a greater or lesser method failure of roughly three pregnancies per one hundred women each year. Such devices also have a morbidity rate associated with hemorrhage or infection and an occasional reported death. The contraceptive pills, of varying chemical formulae, are a striking success. As a rule of thumb, no one gets pregnant on the pill, and responsibility for conception can usually be laid at the patient's door. However, the side effects can be miserable. In the short run, one sees nausea, easy weight gain, fluid retention and bloating, breakthrough bleeding, facial pigmentation and a tendency to fungus infection of the vagina. Long run side reactions include severe headache, personality changes of irritability and depression, and possible intravascular clotting defects. Fortunately, these are reversible upon discontinuing the medication. None of the preceding techniques is both reliable for contraception and free from danger, and therefore, more particularly, all are unsuitable for families where a decision has been made to terminate childbearing permanently.

Voluntary surgical sterilization is a permanent approach which can

* DR. FORBES *is the Chairman of the Department of Obstetrics and Gynecology at the Valley Presbyterian Hospital in Van Nuys, California. He is an Assistant Clinical Professor of Obstetrics and Gynecology at the University of California Medical School at Irvine.* DR. FORBES *received his A.B. and M.D. from George Washington University. He is a Diplomate in Obstetrics and Gynecology.*

be performed upon either men or women. The operation upon a man, vas ligation, is a quick and simple office procedure, but it has several disadvantages. First, coitus should not be performed until no sperm can be seen in the ejaculate under the microscope. Secondly, recanalization of the vas deferens with the re-establishment of fertility is a slim possibility. Thirdly, men who remarry after their spouses' death or after divorce seem to favor younger childless women who want to conceive and surgical anastomosis of the cut vas, particularly after three or four years, carries a low success rate for pregnancy even when sperm are present, as they are usually in markedly diminished numbers. Finally, men are often emotionally unstrung by the surgery. Confusing fertility, virility and masculinity, otherwise indolent husbands feel compelled to lift weights, wear crew cuts, jog, and flex their muscles to demonstrate their equality with men who can still impregnate their wives.

Women, on the other hand, are much more sensible from a psychological point of view. They do not usually confuse the feminine role with reproductive capacity after they have given birth to a number of children. By the time they seek relief from their physician, they have already decided that they want no more offspring, even if because of death or divorce they were to remarry. They do, however, in most of the states face a legal stone wall. Three states expressly prohibit voluntary elective sterilization except for medical indications.[1] Forty-four states have no law, except statutes relating to involuntary sterilization, which are not pertinent to this discussion. Only a few states have legislation that provides a procedure to obtain the voluntary operation.[2] The purpose of this article is to explore the rationale behind the lack of availability of doctors and hospitals for the sterilization surgery and suggest a remedy under the law to alleviate that vacuum.

Technically, the surgical sterilization of a woman is more difficult than that of a man because it involves entering the abdominal cavity, either through the abdominal wall or in the upper reaches of the vagina. The former method is the simplest if done immediately at the time of delivery, using the same anesthetic. A small inch long incision

[1] CONN. GEN. STAT. REV. §§ 17-19, 53-33 (1958); KAN. GEN. STAT. ANN. § 76-149 (1964); UTAH CODE ANN. § 64-10 (1953).

[2] *See, e.g.*, N.C. GEN. STAT. §§ 35-36 to 35-57 (1966); VA. CODE ANN. §§ 32-423 to 32-427 (1950).

in the midline or in the transverse crease of the umbilicus will suffice for exposure to cut and tie the fallopian tubes, preventing, simultaneously, access of the sperm to the egg proximally and of the egg to the sperm distally. The vaginal approach is done through a colpotomy incision and may be used after the uterus has shrunk to a size too small for easy access through the abdominal wall, which may occur some days or some weeks after delivery. Both approaches carry a morbidity rate if not performed with great care, due to hemorrhage from the large blood vessels close to the tube, or due to infection. There is even a method failure rate of about one per cent where the cut tube opens and allows passage of the sperm or ovum. Nevertheless, tubal ligation is the better method for surgical sterilization of women, if performed at delivery and under the same anesthetic used for childbirth. It is fast (usually less than twenty minutes operating time) and ninety-nine per cent sure. Such surgery does not prolong hospital stay and eliminates patient failure with minimum subsequent morbidity. In actual practice, however, tubal ligation is difficult for the patient to secure because of resistance by physicians and hospitals in the states which have no legislative guide lines.

In most hospitals, a doctor with a patient who wants a tubal ligation performed with delivery must submit the evaluation of the case to a committee of physicians. Such committee is usually a combined therapeutic abortion-sterilization committee which immediately sets the tone. Because the two are equated, there is an unfortunate blending of the moral problems of abortion with an unrelated technique of family planning. Most of the board doctors are quite reluctant to accept an opinion on the part of the woman, her husband and her doctor that for socio-economic reasons alone the couple wants no more children. They will reject most proposals out of hand for unstated or obscure reasons. When the reasons are mentioned for rejecting applicants they include age, total number of pregnancies, "not enough" living children, possible improvement of economic level, possible death of a living child, and regret of loss of reproduction with present or subsequent marriage. The committee members often suggest a vas ligation for the husband because that does not appear in the hospital records since it is done in a private physician's office and almost never as an in-patient case. They often will suggest that the couple return to conventional contraceptives that have failed in the past, without considering that an additional mouth to feed dilutes the material support of the parents proportionately and creates economic injury. This dilution

could be enough to create a public charge at a time when we are interested in diverting public support of families from its spiral of increase.

The American College of Obstetricians and Gynecologists has recommended socio-economic sterilizations on an age/parity (number of children) ratio of 5 children at 25 years of age, 4 at 30 years, and 3 at 35 years. Before these guidelines were published, I had a patient who at age 29 wished a tubal ligation with the birth of her sixth living child and was denied by a sterilization committee because she had no medical illness. This is typical in hospitals that have not changed to or do not use the A.C.O.G. suggestions. At the other end of the spectrum, there are hospitals using such standards where because the patient does not fit the age-parity criteria, intellectual dishonesty is widely practiced. Minimal medical problems such as varicose veins are inflated to become medical indications for sterilization. Or a hysterectomy is done some weeks after childbirth for "prolapse of the uterus." This is literally a falling out of the uterus as if the vagina had begun to turn inside out like the finger of a glove. Many of these cases have no requisite relaxation of pelvic supports nor other clear indication for surgery, and are done primarily for sterilization, substituting the low morbidity technique of tubal ligation for one with much higher morbidity and even mortality.

Here is the quandary: We assume everyone has the "right" to marry and procreate. Can we not assume that the adult woman of sound mind with the consent of her spouse has the right not to procreate? Since tubal ligation is a surgical procedure quite like any other, how can one justify the attitude of the doctors sitting in commitee, who feel they can tell the patient that she may not decide to turn off her reproductive capacity by this means? The fact is that they do so tell her, without any direction from the American Hospital Association, the American Medical Association, their own hospitals (except where religion prohibits such operation), or the legislature of their states.

There exists a remedy. If a patient were to apply well in advance of delivery, setting forth her knowledge of the availability of alternative contraceptive techniques and of the possible method of failure of the operation, requesting with the consent of her husband for socio-economic reasons only a surgical sterilization following the impending birth, and the request were rejected, action could and should be instituted in the state courts for relief. The nature of the action or proceeding would be determined by the procedural laws of the jurisdiction.

Relief from capricious and arbitrary action by the medical commit-

tees would seem to be available by virtue of the decision of the Supreme Court in *Griswold v. Connecticut*,[3] establishing the constitutional protections afforded by the ninth amendment and by the due process clause of the fourteenth. The lines of reasoning in the court opinion reversing the Connecticut contraception law were diverse, but to my non-legal mind, the several routes followed were orderly and sequential in arriving at the same conclusion. The first eight amendments to the Constitution were presented as spelling out certain rights, which have been broadened to include certain other "rights" by prior decisions of the court. The first route, pursued by Mr. Justice Douglas, implied that a law forbidding the *use* of a contraceptive violates the married couple's right of privacy as protected under the first amendment, has a "destructive impact upon their relationship,"[4] and "sweeps unnecessarily broadly."[5] Mr. Justice Harlan did not agree with this, but felt that the Connecticut law infringed upon the due process clause of the fourteenth amendment by violating basic values "implicit in the concept of ordered liberty."[6] Mr. Justice White similarly felt that the fourteenth amendment was infringed.

The opinion of Justice Goldberg, with Justices Warren and Brennan concurring, was even more germane to the present discussion. Justice Goldberg contended that a law outlawing voluntary birth control "would unjustifiably intrude on rights of marital privacy which are constitutionally protected."[7] Such reasoning was based on a previous Court decision which held that among the rights not spelled out in the first eight amendments is "the right . . . to marry, establish a home and bring up children,"[8] thus confirming marital privacy as constitutionally protected. The protection is additionally extended by the ninth amendment, which reads: "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." Further, Justice Goldberg's evaluation of the intent of the framers of the Constitution was that the first eight amendments did not exhaust the basic fundamental rights guaranteed to the people.

[3] 381 U.S. 479 (1965).

[4] *Id.* at 485.

[5] *Id.*

[6] *Id.* at 500; *see also* Palko v. Connecticut, 302 U.S. 319, 325 (1937).

[7] *Supra* note 3, at 497.

[8] Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

To hold that a right so basic and fundamental and so deep-rooted in our society as the right of privacy in marriage may be infringed because that right is not guaranteed in so many words by the first eight amendments to the Constitution is to ignore the Ninth Amendment and to give it no effect whatsoever.[9]

Since the fourteenth amendment has been held to prohibit the states from abridging fundamental personal liberties, this application of the ninth would similarly protect penumbral rights from state infringement. "The entire fabric of the Constitution and purposes that clearly underlie its specific guarantees demonstrate that the rights to marital privacy and to marry and raise a family are of similar order and magnitude as the fundamental rights specifically protected."[10] If one believed that marital privacy was not protected from infringement, state legislatures would be free to experiment with the fundamental liberties of citizens. This argument is hypothetically advanced to include the possible passage of a law demanding sterilization after two children, which the Court holds to be a shocking violation of personal liberty.

Yet, if upon a showing of a slender basis of rationality, a law outlawing voluntary birth control by married persons is valid, then, by the same reasoning, a law requiring compulsory birth control also would seem to be valid. . . . [B]oth types of law would unjustifiably intrude upon rights of marital privacy which are constitutionally protected.[11]

Accordingly, if the Supreme Court believes that a law preventing voluntary birth control, in the absence of compelling state interest, is unconstitutional and violates fundamental human rights, a suit in the state courts would be similarly decided against a hospital committee which usurped legislative function by denying a petitioner a voluntary surgical sterilization. This would leave the field clear for state legislatures to enact laws spelling out the procedural techniques. A model law would hopefully include: requirements for initial application sometime in advance of delivery, allowing a cooling off period; an informed consent in non-technical language, detailing possible failure of the procedure; alternative methods of family limitation; and a clear statement that usually the patient will never again be able to have a child. Under these circumstances, the law would then prohibit doctors and hospitals from barring a voluntary surgical sterilization upon a patient.

[9] Griswold v. Connecticut, 381 U.S. 479, 491 (1965).

[10] *Id.* at 495.

[11] *Id.*