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STERILIZATION IN PENNSYLVANIA

Phyllis W. Beck *
Carole W. Soskis **

INTRODUCTION

In recent years, voluntary sterilization has become an important method of birth control.[1] The increased use of sterilization [2] may be attributed to a number of factors, including improvements in medical procedures, changes in public policy, and increased demand for sterilization. This increased demand, in turn, stems from a number of perceived advantages to sterilization. First, unlike other birth control methods, the sterilization procedure involves a single monetary investment and a limited risk to one's health. Second, there are growing indications that other methods of contraception are neither as safe nor as effective as couples seeking long-term birth control methods had originally hoped.[3] Consequently, many individuals who have completed their families now choose to undergo sterilization.

* Judge of the Pennsylvania Superior Court; former Vice Dean, University of Pennsylvania Law School; A.B., Brown University; J.D., Temple University School of Law, 1967.

** Private practitioner, Bala Cynwyd, Pa.; Clinical Assistant Professor of Psychiatry (Legal Medicine), Temple University School of Medicine; B.A., Radcliffe College, 1963; M.S.W., Simmons College School of Social Work, 1966; J.D., University of Pennsylvania Law School, 1973.

1. Among couples in which the wife is in her thirties, voluntary sterilization—vasectomies for men and various surgical procedures, particularly tubal ligations, for women—is the most widely used method of birth control in the United States. Westoff, *Trends in Contraception Practice: 1965-1973,* 8 FAM. PLAN. PERSPECTIVES 54, 55 (1976). Among younger couples, voluntary sterilization is second only to the birth control pill as a contraceptive method. Brody, *Personal Health,* N.Y. Times, Nov. 8, 1978, § C at 9, col. 1.

2. In a period of 10 years, sterilization has become the "world's foremost contraceptive choice . . . ." ASSOCIATION FOR VOLUNTARY STERILIZATION, INC., AVS NEWS 1 (Dec. 1980).

3. *See, e.g.,* R. HATCHER, G. STEWART, F. STEWART, F. GUEST, P. STRATTON & A. WRIGHT, CONTRACEPTIVE TECHNOLOGY 22, 37, 48-50 (1978-1979); NAT'L CLEARINGHOUSE FOR FAM. PLAN., HEALTH SERV. AD., PUB. HEALTH SERV., U.S. DEP'T OF H.E.W., HEALTH EDUC. BULL. No. 6 (1978); *Patient Guide—Questions and Answers about the Pill,* 3 FEMALE PATIENT 127 (Sept. 1978).

Twenty or thirty years ago, such a choice would have been difficult because of persistent doubts as to the legality of voluntary sterilization. Such procedures were "seriously questioned . . . [as] . . . against public policy." [4] As recently as 1965, one study found many barriers to elective sterilization.[5] Hospitals often did not perform "sterilizations of convenience"—tubal ligations—without medical necessity. Every group of physicians seemed to have a different formula for determining whether a sterilization was indicated. Vasectomies, while less regulated, were also difficult to obtain.

While considerable changes have occurred during the past decade, the topic of sterilization, involving as it does the delicate areas of sexual relations and procreation, remains insufficiently explored. Because of changing birth control needs and changing social values, the need to examine sterilization more fully has become a social and legal imperative. Thus far, legal inquiry has concentrated mainly on eugenic sterilization.[6] This article will focus on voluntary sterilization. It is estimated that up to 1.3 million persons undergo a sterilization procedure in the United States annually,[7] many for contraceptive reasons. Despite the demand for these procedures, some political and religious groups advocate restricting both voluntary and involuntary sterilization. Some groups' opposition to contraception rests on religious or moral grounds. Other groups believe that the history of sterilization is characterized by callousness and that abuse will increase as sterilization becomes more acceptable. They argue that individuals are sterilized for questionable social purposes, such as limiting certain populations.[8] In contrast to those who would restrict the availability of sterilization on moral, political or religious grounds, other groups endorse sterilization as a safe birth control method.[9]

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4. Sharpe, *Consent and Sterilization,* 118 CAN. MED. A.J. 591, 591-93 (1978).

5. Note, *Elective Sterilization,* 113 U. PA. L. REV. 415 (1965). A survey of 18 non-Catholic hospitals with more than 200 beds revealed that three hospitals performed no sterilizations unless medically necessary. One of the three hospitals tried to find therapeutic indications for sterilization when there were already several children in the family. *Id.* at 419, 420.

6. *See* note 12 *infra* and accompanying text for an explanation of eugenic sterilization.

7. Association for Voluntary Sterilization, Inc., Press Release (June 8, 1979). Miriam Ruben, Director of Public Information for the Association, estimates that 435,000 men and 486,000 women were sterilized in 1979. AVS NEWS, *supra* note 2 at 1. In addition, the association estimates that over twelve million Americans have been sterilized. *Id.*

8. *See, e.g.,* Sherlock & Sherlock, *Voluntary Contraceptive Sterilization: The Case for Regulation,* 1976 UTAH L. REV. 115, for an argument in favor of restricting sterilization.

9. For example, the Association for Voluntary Sterilization, Inc., has actively supported access to voluntary sterilization.

As controversy over sterilization has increased, the availability of sterilization procedures, or access, has emerged as a crucial concern. This article will examine relevant Pennsylvania laws, regulations, and decisions that tend to encourage or interfere with access to sterilization. The article will focus primarily on voluntary sterilization and will examine the special concerns involved with sterilization of certain protected groups, such as minors and retardates. Our contention is that the opportunity to obtain a sterilization procedure should not be unduly limited by government.

I. Regulation of Sterilization in Pennsylvania

A body of federal and state legislation, regulation, and case law governs the availability of sterilization procedures. In addition, the policy decisions of individual hospital boards have a significant impact.[10] These laws, regulations, and decisions do not always acknowledge the different categories of sterilization: (1) Voluntary sterilization is elective and primarily a means of contraception. It is sought freely by an individual desiring to terminate his or her ability to procreate. (2) Medically necessary sterilization is also voluntary, but results from necessity, such as the treatment of a pathological condition, or as a prophylactic to prevent future family or health problems.[11] (3) Eugenic sterilization is usually an involuntary procedure, performed to bar procreation by those individuals whom society considers genetically flawed.[12] Such individuals include the insane, the retardate, the epileptic, or the defendant convicted of certain criminal offenses. Pennsylvania has neither legislation nor any consistent policy regarding eugenic sterilization.[13] In fact, the Pennsylvania General Assembly, like legislatures in many other states, has generally shied away from enacting laws relating to sterilization.[14] Legislative reluctance may be based on a number of factors. For

10. *See* Voe v. Califano, 434 F. Supp. 1058 (D. Conn. 1977); Ponter v. Ponter, 135 N.J. Super. 50, 342 A.2d 574 (1975); 42 C.F.R. §§ 50.101-.606 (1980); 55 Pa. Code §§ 1141.1-.81 (1981).

11. *See* U.S. Dep't of H.E.W., Program Guidelines for Project Grants for Family Planning Services under Section 1001, Public Health Service Act (1976) [hereinafter cited as Program Guidelines].

12. Beck, *Voluntary Sterilization*, J. Legal Med. 35, 35 (1977).

13. By statutory authority, many other states permit some form of eugenic sterilization. *See, e.g.*, Del. Code Ann. tit. 16, §§ 5701-5705 (1974); Ga. Code Ann. §§ 84-931 to -936 (1979); Me. Rev. Stat. Ann. tit. 34, §§ 2461-2468 (1978); Miss. Code Ann. §§ 41-45-1 to -19 (1972); N.C. Gen. Stat. §§ 35-36 to -50 (1976); Okla. Stat. Ann. tit. 43A, §§ 341-346 (West 1971); Or. Rev. Stat. §§ 436.010-.150 (1979); S.C. Code §§ 44-47-10 to -100 (1976); Va. Code §§ 37.1-171.1 to -178 (1976 & Supp. 1979); Wis. Stat. Ann. § 46.12 (West 1979).

14. For a discussion of restrictions on sterilization in countries outside of the United States, *see* Stepan & Kellogg, *The World's Laws Concerning Voluntary Sterilization for Family Planning Purposes*, 5 Cal. W. Int'l L.J. 72 (1974).

instance, legislators may be unwilling to become involved in issues which voters view as sensitive. They may also favor a policy of non-intervention in medical matters. Legislative restraint may also indicate respect for an individual's constitutional right to privacy in reproductive matters.[15]

Regardless of the reason for legislative temperance, its result has been to entrust broad discretion to boards of hospitals and other health care facilities to fashion policy regarding sterilization.[16] These policies usually relate to one or more of the following issues: whether the hospital board will permit doctors to use hospital facilities for sterilizations; whether the hospital board will mandate spousal consent as a precondition to the procedure; whether the hospital board will recognize substituted consent for those individuals who may lack legal capacity; and whether the hospital board will impose a waiting period between the time of consent and the time of surgery.

Along with these privately formulated policies, three governmental pronouncements may affect access to sterilization in Pennsylvania:[17] the Pennsylvania Good Conscience Clause,[18] the federal Church Amendment,[19] and the Pennsylvania Attorney General's Opinion on Sterilization.[20]

The Pennsylvania Good Conscience Clause seeks to safeguard health care facilities and personnel who, as a matter of conscience, refuse to perform sterilization procedures. Similar protection is provided by the federal Church Amendment, which insulates health care personnel and facilities that have received federal funds from the requirement of performing sterilizations. The Pennsylvania Attorney General's opinion notes that spousal consent is not a necessary precondition for the use of a facility or the performance of a sterilization procedure.[21] These three governmental statements have a substantial

15. *See, e.g.*, Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965); Note, *Fornication, Cohabitation and the Constitution*, 77 MICH. L. REV. 252 (1978).

16. *See generally* Sherlock & Sherlock, *supra* note 8. Prior to 1969, the American College of Obstetricians and Gynecologists followed the "120 Rule" in order to determine if a female was eligible for sterilization. This rule, adopted by many hospitals, required a certain relationship between the woman's age and number of children as a precondition of sterilization. The woman's age multiplied by the number of children she had borne must equal 120. For example, a twenty-year-old woman must have borne six children, a thirty-year-old woman, four. Although the rule did not have legal force, it was widely followed because it was a requirement for hospital accreditation. The rule was applicable only to females. *Id.* at 120-21.

17. In addition to these governmental pronouncements, provisions for governmental funding impact on the availability of sterilization. *See, e.g.*, 42 C.F.R. §§ 50.101-.210 (1980); 55 PA. CODE §§ 1141.51-.60 (1981).

18. PA. STAT. ANN. tit. 43, § 955.2 (Purdon Supp. 1980-1981).

19. Health Programs Extension Act of 1973, Pub. L. No. 93-45, § 401, 87 Stat. 95 (1973). *See* note 74 *infra* for the relevant text of § 401.

20. 5 PA. BULL. 3007-08 (1975).

21. *Id.*

effect on access; the first two limit the availability of sterilizations. The last attempts to remove what has been a troublesome barrier to sterilization. The following sections of this article will discuss each of these governmental pronouncements and their impact on access to sterilization.

II. The Good Conscience Clause and State Action

Pennsylvania's Good Conscience Clause[22] resembles those of other states.[23] The articulated goal of the statute is to shield individuals and institutions that refuse, as a matter of conscience, to participate in sterilization or abortion procedures. Although the statute does not prohibit sterilization, it may serve to discourage these procedures for two reasons. First, the statute supports the view that certain medical procedures can be designated as morally offensive.[24] Second, the statute condones blanket refusals to perform sterilizations regardless of patient need. The statute explicitly provides that public funds, licenses, certifications, and other approvals shall not be withheld because a facility or its personnel refuse to perform sterilizations or abortions.[25]

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22. Pa. Stat. Ann. tit. 43, § 955.2 (Purdon Supp. 1980-1981). Section 955.2 provides in part:

> No hospital or other health care facility shall be required to, or held liable for refusal to, perform or permit the performance of abortion or sterilization contrary to its stated ethical policy. No physician, nurse, staff member or employe of a hospital or other health care facility, who shall state in writing to such hospital or health care facility his objection to performing, participating in, or cooperating in, abortion or sterilization on moral, religious or professional grounds, shall be required to, or held liable for refusal to, perform, participate in, or cooperate in such abortion or sterilization.

Id. § 955.2(a).

23. At least twenty states in addition to Pennsylvania have enacted statutes that permit hospitals to refuse their facilities for certain procedures, usually abortions. *See, e.g.*, Cal. Health & Safety Code § 25955 (West Supp. 1981); Ga. Code Ann. tit. 26, § 1202(e) (1977); Idaho Code § 18-612 (1979); Ill. Ann. Stat. ch. 111½, §§ 5201, 5301-5312 (Smith-Hurd Supp. 1980-1981) (sterilization also included); Ind. Code § 16-10-3-2 (1976); La. Rev. Stat. Ann. §§ 40-1299.31-.33 (West 1977); Me. Rev. Stat. Ann. tit. 22, §§ 1591-1592 (1980); Md. Ann. Code art. 43, § 556E (1957) (sterilization also included); Mass. Gen. Laws Ann. ch. 112, § 12I (Michie/Law. Co-op Supp. 1981) (sterilization also included); Mo. Ann. Stat. § 197.032 (Vernon Supp. 1981); Neb. Rev. Stat. § 28-337 to -341 (1979); Nev. Rev. Stat. § 40-449.191 (1979); N.J. Stat. Ann. §§ 2A:65A-1 to -3 (West Supp. 1980-1981) (sterilization also included); N.D. Cent. Code § 23-16-14 (1978); Or. Rev. Stat. § 435.475-.485 (1979); S.D. Codified Laws Ann. § 34-23A-13 (1977); Tenn. Code Ann. § 39-305 (1975); Utah Code Ann. § 76-7-306 (1978); Va. Code § 18.2-75 (1975); Wyo. Stat. § 35-6-106 (1977).

24. Studies indicate that the citizenry's perception of right and wrong is shaped by its laws. *See* Tapp & Kohlberg, *Developing Senses of Law and Legal Justice*, 27 J. Soc. Issues 65 (1975). Laws suggesting that some medical procedures may be offensive could easily increase negative sentiment against these procedures, thus discouraging their use.

25. *See* note 22 *supra* for the language of the statute.

Pennsylvania's statute, which is wide in scope, appears vulnerable to constitutional challenge on a number of grounds. Its defined targets include both private and nonprivate facilities and all of their personnel: physicians, nurses, and staff members.[26] In analyzing the constitutionality of the statute, those clauses relating to personnel must be treated separately from those relating to facilities.

The statute notes that certain individuals may object to sterilization on moral, religious, or professional grounds, and thus seeks to immunize those persons from retaliation if they refuse to participate in the procedure. This section of the statute, dealing with health care personnel, adds nothing to the existing rights of the affected individuals. The Constitution protects against forced participation in work, particularly if that work offends one's conscience.[27] Aside from military or penal service, an individual cannot be commandeered into a labor force.[28]

Those sections of the statute which involve the facility itself, rather than its personnel, pose a different underlying issue. The statute has not been challenged in Pennsylvania. It can be argued that individuals may refuse to perform procedures, but the same is not true of health care facilities. A hospital that holds itself out as serving the public may not be able to refuse emergency treatment, including emergency sterilizations, unless it provides at least an appropriate referral.[29] In non-emergency situations, can a health care unit deny its facilities for routine voluntary surgical procedures because of moral or religious considerations? As to voluntary sterilization, that question appears to have been answered in the affirmative.[30] In *Poelker v. Doe*,[31] the Supreme Court found no denial of equal protection when a nonprivate city hospital refused to perform an abortion on an indigent woman, although it permitted its facilities to be used for

26. PA. STAT. ANN. tit. 43, § 955.2(a) (Purdon Supp. 1980-1981).

27. *See* Sherbert v. Verner, 374 U.S. 398, 403, 409, 410 (1963).

28. *See* Hodges v. United States, 203 U.S. 1, 16, 17 (1906); Pierce v. United States, 146 F.2d 84, 86 (5th Cir. 1944).

29. For cases discussing a hospital's duty to provide emergency care, *see* Wilmington Gen. Hosp. v. Manlove, 53 Del. 338, 174 A.2d 135 (1961); Bourgeois v. Dade County, 99 So. 2d 575 (Fla. 1957); Ruvio v. North Broward Hosp. Dist., 186 So. 2d 45 (Fla. Dist. Ct. App. 1966); O'Neill v. Montefiore Hosp., 11 A.D.2d 132, 202 N.Y.S. 436 (App. Div. 1960); Barcia v. Society of N.Y. Hosps., 39 Misc. 2d 526, 241 N.Y.S.2d 373 (Sup. Ct. 1963).

30. While Poelker v. Doe, 432 U.S. 519 (1977), settled this issue for abortion, and by analogy, for sterilization, several important factors differentiate sterilization from abortion. Unlike abortion, family planning, including sterilization, is supported by legislative history and federal funding. Medicaid, under title XIX of the Social Security Act, has always included sterilization in its coverage. Title X of the Public Health Service Act allocates project grants specifically for sterilization, while prohibiting the use of such funds for abortion. *See* PROGRAM GUIDELINES, *supra* note 11, at 5, 11, 25. Whether a hospital that accepts federal family planning grants can absolutely refuse to perform sterilization procedures has yet to be decided.

31. 432 U.S. 519 (1977).

childbirth.[32] In *Poelker,* a city directive prohibited the use of city hospitals for abortions except when the mother was threatened by grave physiological injury or death.[33] This policy was challenged on behalf of a woman seeking an abortion. *Poelker* established that nonprivate hospitals could refuse to perform voluntary medical procedures for which they were equipped, without violating the equal protection clause.[34] The Court stated that the city of St. Louis could elect "to provide publicly financed hospital services for childbirth without providing corresponding services for non-therapeutic abortions." [35]

Factually, *Poelker* involved voluntary abortion; by analogy, its holding should be viewed as applicable to voluntary sterilization. The Court has not addressed the question of whether the equal protection clause would allow a nonprivate facility to refuse to provide a life-preserving or medically necessary abortion or sterilization. Even in the post-*Poelker* era, the Good Conscience Clause remains vulnerable to attack because it fails to distinguish among voluntary, medically necessary and life-saving procedures. *Poelker* is applicable only to voluntary abortions, but it seems clear that the Clause, which is applicable to all abortions and sterilizations, is overly broad. In *Beal v. Doe,*[36] the Court was careful to differentiate between nontherapeutic abortions and medically necessary abortions.[37] Precedent and logic dictate that the distinction be maintained.

Currently, Pennsylvania defines medically necessary abortions as those involving danger to the woman's life.[38] A broader legal definition of medical necessity could include economic, familial, and psychological factors, in addition to physical harm. Acceptance of an expanded interpretation of medical necessity could provide the legal foundation for a larger class of persons to obtain access to sterilization services in nonprivate hospitals.[39]

It can be argued that the equal protection clause requires nonprivate hospitals to treat individuals seeking medically necessary procedures similarly whether the procedure is a tonsillectomy or steriliza-

32. *Id.* at 521. *See also* Maher v. Roe, 432 U.S. 464 (1977), where the Court held that, while a state may not interfere with access to abortion, it does not have to encourage it and can therefore make a policy choice to fund hospital services for childbirth but not for nontherapeutic abortions. *Id.* at 474.

33. 432 U.S. at 520.

34. *Id.* at 521.

35. *Id.*

36. 432 U.S. 438 (1977). In *Beal,* the Court held that a state could refuse to fund the cost of nontherapeutic abortions in a Medicaid programs. *Id.* at 447.

37. *Id.* at 445 n.9, 447.

38. PA. STAT. ANN. tit. 35, § 6606(b) (Purdon 1977).

39. The authors have found no current figures on access to sterilization procedures in either private or nonprivate Pennsylvania hospitals. Similarly, the authors have found little concern in the medical community with the definition of a "medically necessary" sterilization.

tion. Under this reasoning, a nonprivate hospital could not allow access for one procedure and deny it for another medically necessary procedure, such as sterilization, unless the facility could establish a rational reason for its refusal.[40]

A series of cases has established that nonprivate hospitals fall within the state action doctrine, and are therefore subject to the same restraints as the state itself.[41] Consequently, the equal protection clause prevents nonprivate hospitals from arbitrarily denying access for medically necessary procedures. In contrast, private hospitals are not restricted by the fourteenth amendment. The purposes for which private facilities are used is within the discretion of the board of the facility without reference to constitutional standards.[42]

The Court in *Poelker* did not address the private/nonprivate dichotomy. The Court assumed that the actions of the St. Louis City Hospital constituted state action and were thus subject to the restraints of the equal protection clause.[43] The Court, however, found no offense to equal protection in the city's directive, because medically necessary procedures were not at issue.[44]

It can be argued that equal protection also prevents nonprivate hospitals from imposing additional burdens on the individual seeking sterilization as opposed to other types of routine medical care. Hospitals frequently require spousal consent, a prescribed waiting period, or the approval of multiple physicians when sterilization or abortion is involved. These unique requirements are notably oppressive. Unless the nonprivate hospital can establish a rational reason for differential preoperative regulations, equal protection would appear to prevent a facility from selecting one class of individuals and imposing special burdens upon them.

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40. The Supreme Court's recent decision in Harris v. McRae, 100 S. Ct. 2671 (1980), does not foreclose this argument. In *Harris*, the Court distinguished between the state setting up obstacles to a procedure (abortion) and encouraging an alternative activity (childbirth). *Id.* at 2687. Because the Hyde Amendment seeks to protect the fetus, a rational basis for denial of funding exists in all but a few categories of abortion. No such basis would seem available for limitations on sterilization.

41. *See* Nyberg v. City of Virginia, 495 F.2d 1342, 1347 (8th Cir.), *cert. denied*, 419 U.S. 891 (1974) (court struck down as unconstitutional municipal hospital resolution prohibiting use of hospital facilities for abortion); Hathaway v. Worcester City Hosp., 475 F.2d 701, 706 (1st Cir. 1973) (public hospital may not ban therapeutic sterilization operations while permitting other surgical procedures involving no greater patient risk or demand on staff and facilities); McCabe v. Nassau County Medical Center, 453 F.2d 698, 704 (2d Cir. 1971) (court allowed constitutional claim against county hospital which denied sterilization because of age-parity formula).

42. *Cf.* Grenya v. George Washington Univ., 512 F.2d 556, 559-61 (D.C. Cir.), *cert. denied*, 423 U.S. 995 (1979) (private university not a governmental entity for constitutional purposes).

43. 432 U.S. at 520.

44. *Id.* at 521.

No rational basis seems apparent for the imposition of these burdens. Arguments that they protect the mother's health, the family's integrity, and community morals have little validity. Yet, conditions that are imposed to protect the patient, such as a thirty-day waiting period, are likely to be upheld.[45] Any additional conditions, not directly related to the patient's protection, would seem to impinge upon the individual's right to privacy in procreational matters, a recognized constitutional guarantee.[46]

The preceding discussion requires a determination as to whether a facility is private or nonprivate. From the perspective of a purist, the private/nonprivate dichotomy, as applied to hospitals, is a relic of the past. Today, no hospital remains purely private. All hospitals, in one way or another, interact with government. Most receive or have received government construction funds,[47] medical assistance payments,[48] or research grants. Many hospitals operate pursuant to some form of governmental control, such as government-approved insurance plans.[49] Other hospitals enjoy some form of preferential tax treatment.[50] Nonetheless, courts continue to use this distinction, however artificial, and the question becomes how much government involvement or function is required before a so-called private hospital assumes nonprivate or public coloration.[51]

In Pennsylvania courts have defined nonprivate, as applied to hospitals, far more liberally than the federal courts.[52] The Pennsylvania Supreme Court has held that the acceptance of Hill-Burton construction funds is sufficient to render a hospital nonprivate in nature and to invoke the "state action" doctrine.[53] This broad definition of nonprivate hospitals, adopted by the state courts, was originated in Pennsylvania by the federal district court in *Citta v. Delaware Valley Hospital*.[54] Federal district courts in Pennsylvania have repudiated

45. Such a requirement was allowed to stand in California Medical Ass'n v. Lockner, No. 268009 (Cal. Super. Ct., Sacramento County 1978). In Voe v. Califano, 434 F. Supp. 1058 (D. Conn. 1977), a 20 year-old woman had had 10 pregnancies and wanted to be sterilized under Medicaid coverage, in spite of a federal regulation prohibiting the sterilization of those under 21. She had the sympathy of the court but did not prevail. *Id.* at 1063.

46. Eisenstadt v. Baird, 405 U.S. 438, 453 (1972).

47. *See* 42 U.S.C. §§ 291-291j-7 (1976); 42 C.F.R. §§ 53.111-.113 (1980).

48. *See* 42 U.S.C. §§ 1395-1396 (1976 & Supp. III 1979).

49. Contracts between Blue Cross and health facilities are subject to the approval of the Pennsylvania Department of Insurance. *See* PA. STAT. ANN. tit 40, § 477(b) (Purdon Supp. 1980-1981).

50. *See* I.R.C. §§ 501(c)(3), 501(e); PA. STAT. ANN. tit. 72, §§ 5020-204(c) (Purdon Supp. 1980-1981).

51. *See* Note, *State Action: Theories for Applying Constitutional Restrictions to Private Activity*, 74 COLUM. L. REV. 656 (1974).

52. *See, e.g.*, Adler v. Montefiore Hosp. Ass'n, 453 Pa. 60, 311 A.2d 634 (1973), *cert. denied*, 414 U.S. 1131 (1974).

53. *Id.* at 71, 311 A.2d at 640. *See also* Rackin v. University of Pennsylvania, 386 F. Supp. 992, 1004 (E.D. Pa. 1974) (state action doctrine applies to privately chartered university).

54. 313 F. Supp. 301 (E.D. Pa. 1970).

the participation theory and held that acceptance of federal funds does not convert a hospital's action from private to state action, thereby subjecting the institution to the restraints of the federal Constitution.[55]

Thus, a clear trend has emerged. In the federal courts, state action is found only in those factual situations in which a close nexus exists between the challenged activity and government involvement.[56] Receipt of federal funds by a hospital is no longer a sufficient basis for a finding of state action. Thus, a decade after it was decided, *Citta* no longer represents authoritative precedent in the federal district courts of Pennsylvania. A strict state action standard now prevails,[57] in which action will be considered private unless it is closely tied to government involvement.

In the state courts, however, the opposite may be true. A loose nexus between the hospital and the government may provide the basis for a finding of state action. The hospital would then be subject to the restraints of the fourteenth amendment.

Although Pennsylvania courts employ a more flexible standard,[58] they still may not find state action in nonprivate hospitals where access to sterilization is denied or unduly burdened. Many nonprivate hospitals will not perform sterilizations. While no statistics are available to indicate the number of hospitals that refuse voluntary sterilizations, such figures do exist for abortions. One may speculate that because the Good Conscience Clause applies to both abortions and sterilizations, the statistics on the availability of abortions may provide some insight into the availability of sterilizations. From 1975 through the first quarter of 1976, less than twenty percent of the nonprivate hospitals in the United States provided abortion services; in ten states, there were no nonprivate hospitals providing abortion.[59] Therefore, an urgent need exists to develop other theories upon which a right of access can be asserted.

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55. *See, e.g.*, Sament v. Hahnemann Medical College & Hosp., 413 F. Supp. 434, 439-41 (E.D. Pa. 1976), *aff'd*, 547 F.2d 1164 (3d Cir. 1977); Slavcoff v. Harrisburg Polyclinic Hosp., 375 F. Supp. 999, 1003-05 (M.D. Pa. 1974); Ozlu v. Lock Haven Hosp., 369 F. Supp. 285, 287-88 (M.D. Pa. 1974). In all three cases, physicians whose hospital privileges were curtailed or terminated challenged the actions under the due process clause. The courts held that receipt of Hill-Burton funds, Medicare, or Medicaid, as well as state regulation and accreditation by the Joint Commission on the Accreditation of Hospitals (JCAH), or any combination thereof, was not sufficient to establish state action.

56. *See* Holton v. Crozer-Chester Medical Center, 419 F. Supp. 334 (E.D. Pa. 1976), *vacated on other grounds*, 560 F.2d 575 (3d Cir. 1977). *Cf.* Rackin v. University of Pennsylvania, 386 F. Supp. 992 (E.D. Pa. 1974) (non-hospital case endorsing a broad definition of state action).

57. *See* Holton v. Crozer-Chester Medical Center, 419 F. Supp. 334 (E.D. Pa. 1976), *vacated on other grounds*, 560 F.2d 575 (3d Cir. 1977).

58. *See* text accompanying notes 52-54 *supra* for discussion of representative cases.

59. Sullivan, Tietze & Dryfoos, *Legal Abortion in the United States, 1975-76*, 9 FAM. PLAN. PERSPECTIVES 116, 121, 128 (1978).

III. State Common Law

State common law provides a vigorous alternative theory upon which access may be asserted.[60] Under certain circumstances, the courts possess the necessary power to regulate private businesses and professions for the common good, particularly where those businesses or professions enjoy monopoly-like status.[61] The courts' authority derives from their duty under the common law to regulate innkeepers, carriers, and ferriers, so that they serve all users on reasonable terms, and offer full services within their capability.[62] The law recognizes that certain businesses and professions are essential for the commonweal because of the nature of their services.[63] Commentators have noted that to allow these businesses to exclude or to discriminate in providing their services would disturb the equilibrium of society; maintenance of this equilibrium justifies judicial intervention.[64]

Another version of the common law theory is the "quasi-public trust" theory.[65] This theory, which originated in the context of railroad monopolies, requires the private sector to insure full service to all when it is providing a public service on a monopoly basis. Every member of the community is entitled to equal enjoyment of the service. Applying this theory to the access problem, one can argue that hospitals, like railroads, owe fiduciary obligations to the community, especially in those geographical areas where one facility operates as a monopoly. The fiduciary obligation must be fulfilled equitably and reasonably for the public good. Relying on this theory, the New Jersey Supreme Court, in *Doe v. Bridgeton Hospital Association*,[66] held that a hospital must serve all patients who could pay, and perform all services reasonably within its capacity.[67] The court stated that when no rational justification existed, the denial of abortions was un-

60. The common law of England was adopted through reception statutes by eleven of the thirteen original states between 1776 and 1784. *See* E. Brown, British Statutes in American Law, 1776-1836 (1964); M. Horwitz, The Transformation of American Law, 1780-1860, 4-9 (1977).

61. *See* Greisman v. Newcomb Hosp., 40 N.J. 389, 402, 192 A.2d 817, 824 (1963).

62. W. Prosser, Law of Torts 339 (4th ed. 1971).

63. *See* Lane v. Cotton, 12 Mod. 472, 484, 88 Eng. Rep. 1458, 1464-65 (K.B. 1701).

64. Wyman, *The Law of the Public Callings as a Solution of the Trust Problems*, 17 Harv. L. Rev. 156 (1904). *See also* Burdick, *The Origin of the Peculiar Duties of Public Service Companies*, 11 Colum. L. Rev. 514 (1911).

65. *See* Messenger v. Pennsylvania R.R., 36 N.J.L. 407 (Sup. Ct. 1873), *aff'd*, 37 N.J.L. 531 (1874).

66. 71 N.J. 478, 366 A.2d 641 (1976), *cert. denied*, 433 U.S. 914 (1977). *See also* Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963).

67. 71 N.J. at 487, 366 A.2d at 645.

reasonable, arbitrary, and a breach of common law duty.[68] In *Doe*, plaintiffs' access to hospital facilities was originally denied for first trimester abortions at three private nonprofit, nonsectarian hospitals. In finding for the plaintiffs, the court imposed a well-defined common law duty on hospitals, emphasizing that health care facilities which perform therapeutic abortions must also perform lawful elective ones.[69] The court noted that hospitals operate for the general commonweal and therefore cannot define the range of available services on moral rather than on medical grounds.[70] The court reasoned that an organization or institution which holds out the use of its facilities to the general public "must serve the public without discrimination, as an innkeeper must do. Consequently, moral concepts, such as a dislike of abortion, cannot be the basis of regulation." [71] The "quasi-public trust" theory imposes on a hospital a common law duty to serve the general public on a fair and equitable basis.[72]

If *Poelker* ends the constitutional duty of nonprivate hospitals to perform voluntary sterilizations on equal protection grounds, state common law may provide another route to opening health care facilities for voluntary sterilization.[73] Hospitals, like railroads, inns, and carriers, operate for the general good in supplying essential services. They should be charged with a duty to serve the public within the constraints of their capacity. As with railroads, there is often no other possible source of a particular service. The standard by which hospitals determine which services they will offer should be medical, rather than moral. The common law theory, in its several forms, may be useful in providing access to health facilities for voluntary sterilization.

IV. The Church Amendment

Health care facilities that choose not to perform voluntary sterilizations may draw support not only from the *Poelker* decision and the Good Conscience Clause, but also from the federal Church Amendment. This amendment provides that a hospital which receives federal funds is not required to perform abortions and sterilizations if

68. *Id.* at 490, 366 A.2d at 647.

69. *Id.* at 489, 366 A.2d at 647.

70. *Id.*

71. *Id.* This reasoning seems equally applicable to sterilization procedures.

72. A difficulty in relying on the common law is that it may be modified or abrogated by statute. *See, e.g.*, Collopy v. Newark Eye & Ear Infirmary, 27 N.J. 29, 42, 141 A.2d 276, 283-84 (1958).

73. *See* notes 60-72 *supra* and accompanying text for a discussion of the effect state common law may have in opening health care facilities for voluntary sterilization.

those procedures are contrary to the religious beliefs or moral convictions of the institution or its personnel.[74]

Like the Good Conscience Clause, the Church Amendment may be vulnerable to constitutional challenge. Decisions by some federal courts suggest that the Church Amendment may only apply to certain limited procedures, such as voluntary sterilizations.[75] Thus, it can be inferred that a facility may not be excused from performing medically necessary or life-saving procedures.

The Church Amendment, like the Good Conscience Clause, has not been the subject of much litigation in the Commonwealth. In other parts of the country, however, facilities have invoked the amendment successfully to deny patients voluntary abortion and sterilization procedures.[76]

Future challenges to the Church Amendment may rest on several grounds. It can be argued that the amendment is inapplicable to medically necessary or life-saving procedures.[77] Unfortunately, the Court's decision in *Harris v. McRae* [78] seems to foreclose future efforts to attack the Church Amendment as a violation of the first amendment's establishment and free exercise of religion clauses.[79] Even if this argument remained viable after *Harris,* there is little evidence that anti-sterilization forces represent a single religious group, or that

74. Health Programs Extension Act of 1973, Pub. L. No. 93-45, § 401(b), (c), 87 Stat. 95 (1973) (codified at 42 U.S.C. § 300a-7(a), (b) (1976)), which provides in part:

> The receipt of any grant, contract, loan, or loan guarantee under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Service and Facilities Construction Act by any individual or entity does not authorize any court or any public official or other public authority to require—
>
> . . . .
>
> (2) such entity to—
>
> (A) make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions . . . .

42 U.S.C. § 300a-7(a) (1976).

75. *See, e.g.,* Hathaway v. Worcester City Hosp., 475 F.2d 701, 706, 707 (1st Cir. 1973).

76. *See, e.g.,* Taylor v. St. Vincent's Hosp., 523 F.2d 75, 77-78 (9th Cir. 1975), *cert. denied,* 424 U.S. 948 (1976) (Church Amendment precludes reliance on Hill-Burton funding as state action if hospital chooses to limit sterilization on religious or moral grounds); Chrisman v. Sisters of St. Joseph, 506 F.2d 308, 310-11 (9th Cir. 1974) (same). *But see* Hodgson v. Anderson, 378 F. Supp. 1008, 1018 (D. Minn. 1974), *appeal dismissed sub nom.* Spannaus v. Hodgson, 420 U.S. 903 (1979) (state abortion statute, including "Conscience Clause," struck down as unconstitutional).

77. *See* note 29 *supra* and accompanying text for a discussion of this distinction as applied to the Good Conscience Clause.

78. 448 U.S. 297 (1980).

79. The Court, in refusing to find the Hyde Amendment violative of the establishment clause, stated that state action which may coincide with the religious tenets of a particular church does not necessarily contravene the establishment clause. *Id.* at 319-20.

their philosophy actually represents religious doctrine disguised as state policy. Sterilization implicates powerful religious, psychological and social prohibitions. The legal issues tend to be lost and distorted.

The Good Conscience Clause and the Church Amendment protect persons and institutions from the consequences of refusing to deliver abortion or sterilization services. In addition to these two legislative obstacles, the imposition of various consent requirements may prevent access to sterilization procedures. The remainder of this article will discuss these requirements, especially as they operate to prevent sterilization of different groups.

V. Spousal Consent

Pennsylvania, like most states, has no statute requiring spousal consent as a prerequisite to sterilization.[80] In 1975, the Pennsylvania Attorney General issued an opinion [81] on the subject of spousal consent and liability for sterilizations in response to questions raised by hospitals, physicians, and consumer groups. The opinion seeks to relieve from liability physicians and facilities that perform sterilizations without spousal consent. It states that "there is no case law or statutory law in Pennsylvania imposing liability on a physician or hospital for performing a voluntary sterilization on a patient without obtaining the consent of his or her spouse." [82]

Nevertheless, some private hospital boards continue to require spousal consent as a matter of hospital policy.[83] The District Court for the Eastern District of Pennsylvania reluctantly upheld such a policy in *Holton v. Crozer-Chester Medical Center*.[84] The plaintiffs involved in the action each faced one of the following situations: multiple children, a series of miscarriages, inability to rely on usual contraceptives, or medical contraindication to further pregnancy. All of plaintiffs' husbands either refused or were unavailable to consent. The hospital, on the advice of its attorney, denied its facility's use for sterilization. The court, although sympathetic to the plaintiffs, stated: "[T]he hospital's continued refusal to permit the sterilization seems unjust and unenlightened—but it is not illegal." [85] The court noted,

80. A few states have such statutes. *See, e.g.*, Ga. Code Ann. § 84-932 (1978); Va. Code § 54-325.3 (Supp. 1979).

81. 5 Pa. Bull. 3007-08 (1975).

82. *Id.* at 3008.

83. *See, e.g.*, Holton v. Crozer-Chester Medical Center, 419 F. Supp. 334, 335 (E.D. Pa. 1976), *vacated on other grounds*, 560 F.2d 575 (3d Cir. 1977).

84. *Id.* at 342.

85. *Id.*

however, that only the hospital's private status prevented a finding that the policy was unconstitutional.[86]

Although spousal consent mandated by a private institution has been upheld, legislative attempts to require spousal consent would undoubtedly fail. The United States Supreme Court has held spousal consent requirements as a precondition to abortion invalid.[87] The Court found such requirements violative of constitutional privacy and an unlawful delegation of authority by the state.[88] The state had no authority to interfere and thus could not delegate any authority to the husband to prevent the abortion. By analogy, it can be argued that statutorily imposed spousal consent requirements for sterilization are invalid.[89] Requiring spousal consent gives the spouse an opportunity to prevent the sterilization. The non-consenting spouse invades his or her mate's right to privacy, and the state delegates to the spouse a power that it has no authority to delegate.

A rule promulgated by the Pennsylvania Department of Health [90] prevents both private and nonprivate hospitals in the Commonwealth of Pennsylvania from imposing spousal consent requirements. Partly in response to women who were unable to obtain a desired sterilization, the Department promulgated the following rule: "A competent adult may authorize any surgical procedure to be performed upon his body, and the consent of no other person shall be required." [91] The rule does not set forth enforcement methods or sanctions (other than the unlikely ultimate sanction of withholding state approval or licensing). Along with the Attorney General's Opinion, however, the rule should help many hospitals to formulate their policies. Hospitals now have been put on notice that spousal consent requirements violate departmental regulations.

In practice, it appears that many hospitals still do require spousal consent for sterilizations.[92] This requirement has created a particularly troubling barrier to sterilizations. The consent requirement clearly

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86. *Id.*

87. Planned Parenthood v. Danforth, 428 U.S. 52, 67-71 (1976) (spousal consent requirement for abortion unconstitutional interference with privacy).

88. *Id.* at 69. The Court stated: "[S]ince the State cannot regulate or proscribe abortion during the first stage . . . the State cannot delegate authority to any particular person, even the spouse, to prevent abortion during that same period." *Id.*

89. For an argument advocating spousal consent, *see* Sherlock & Sherlock, *supra* note 8, at 129-31.

90. 28 PA. CODE § 135.16 (1981).

91. *Id.*

92. A recent survey found, for example, that 7 in 10 hospitals violated the Department of Health and Human Services' guidelines on informed consent for sterilization set forth in 42 C.F.R. § 50.204-.205 (1980) which do not require spousal consent. *See* 11 FAM. PLAN. PERSPECTIVES 366-67 (1979).

impinges upon an individual's privacy in a complicated and important decision, whether or not to produce offspring. Children may be viewed as a lifetime burden despite the satisfactions and rewards they may bring.[93] The intensely personal decision whether to bear children should not be subject to the veto of the patient's spouse. Proponents of spousal consent argue that it serves to strengthen the institution of marriage. This argument assumes, however, that the parties to the marriage are devoted to each other, and their mutual decision will inure to the ultimate benefit of the marriage. In many cases the unwilling spouse is a partner in a marriage that is failing or has failed.[94] Often the partners are no longer involved with each other, except for unhealthy, and perhaps even vengeful, motives. In these circumstances, requiring spousal consent presents a difficult and possibly insurmountable obstacle.

One commentator [95] argues, in the context of abortion, that the family will be strengthened if the husband has a limited legal right of consent. Such shared responsibility is certainly preferable, but should the right be a legal one? The commentator suggests that the spouse be given notice and an opportunity for consultation where reasonably feasible.[96] He does not, however, address the hard questions: the standard of adequate notice, the nature and safeguards of consultation, and the consequences of the spouse's refusal to consent after notice and consultation. The commentator's model of the family is a cohesive, cooperating unit, having rights as an entity separate from the rights of the individual family members. The commentator's proposal for notice and consultation may be desirable, as is his goal of fortifying the family. The means chosen for achieving this goal, however, are misdirected; legislation that forces one spouse to seek the consent of the other spouse strains the marriage, and may further weaken it. If the marriage partners disagree on the question of sterilization, the balance should be weighed in favor of the individual who wishes to control his

93. *See* Custodio v. Bauer, 251 Cal. App. 2d 303, 323-24, 59 Cal. Rptr. 463, 476 (1967); Troppi v. Scarf, 31 Mich. App. 240, 251, 187 N.W.2d 511, 516 (1971).

94. In Holton v. Crozer-Chester Medical Center, 419 F. Supp. 334 (E.D. Pa. 1976), *vacated on other grounds,* 560 F.2d 575 (3d Cir. 1977), one member of the class had been in hiding, separated from her husband for eight months. She alleged that he physically beat her whenever he saw her. The woman stated that she was unwilling to contact her husband to sign the sterilization consent out of fear for her life. In Ponter v. Ponter, 135 N.J. Super. 50, 342 A.2d 574 (1975), the plaintiff sought a declaratory judgment on the question of whether spousal consent was necessary prior to sterilization. Plaintiff, who had three children during her marriage, had been separated and living apart from her husband since 1969, was pregnant by another man, and desired to be sterilized after the delivery of her fourth child. *Id.* at 50-51, 342 A.2d at 574.

95. Etzioni, *The Husband's Rights in Abortion,* TRIAL, Nov. 1976, at 56.

96. *Id.* at 58.

or her reproductive system. In *Holton v. Crozer-Chester Medical Center,* the court articulated a rational position on spousal consent: "Instead of refusing in all cases to perform sterilizations without consent, . . . the hospital should have a policy that encourages the participation of the husband in the sterilization decision, but does not prevent a woman from obtaining a sterilization without his consent if she remains convinced that she wants to be sterilized." [97]

In addition to state policies, federal regulations now prohibit spousal consent requirements, and also attempt to insure [98] informed consent to sterilization.[99] As the preceding discussion indicates, spousal consent requirements tend to interfere with, rather than protect, the rights of the patient. Other kinds of consent requirements, however, may serve some protective function when minors and retardates are involved.

VI. Minor's Consent

Whether a minor should be permitted to consent to a sterilization procedure raises serious issues that differ from the context of adult consent. A strong argument exists for denying the minor the capacity to consent. The procedure is essentially irreversible.[100] When courts have been required to balance the minor's privacy interests [101] against the need to protect the minor from permanently depriving himself of procreative capacity, they have consistently supported protection of the minor.[102] Objections to the sterilization of minors do not necessarily imply disapproval of sexual activity or contraception. Deciding whether minors should be denied the capacity to consent to sterilization may involve very different concerns than a decision regarding the sale of contraceptives to minors.[103] In the former case, minors could permanently damage their ability to procreate. In the latter case, they would only frustrate it temporarily.

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97. 419 F. Supp. at 342.

98. 42 C.F.R. § 50.204(f) (1980). Comparable Pennsylvania regulations include nothing about spousal consent. *See* Pennsylvania Department of Health's Regulations on General and Special Hospitals, 28 Pa. Code § 135.16 (1981).

99. 42 C.F.R. § 50.204 (1980). *See* also 55 Pa. Code § 1141.55 (1981).

100. *See* L. Lader, Foolproof Birth Control 1 (1972); Hackett & Waterhouse, *Vasectomy Reviewed,* 116 Am. J. Obstetrics & Gynecology 438 (1973). Some doctors consider the procedure to be potentially, but not yet practically, reversible. *See* Langley, *Reversible Sterilization—Socio-ethical Considerations,* 25 Soc. Biology 135-44 (1978).

101. For a comprehensive analysis of the constitutional right of privacy as applied to minors, *see* Note, *Parental Consent Requirements and Privacy Rights of Minors: The Contraceptive Controversy,* 88 Harv. L. Rev. 1001 (1975).

102. *See, e.g.,* Relf v. Weinberger, 565 F.2d 722 (D.C. Cir. 1977); Voe v. Califano, 434 F. Supp. 1058, 1062 (D. Conn. 1977).

103. *See* Carey v. Population Serv. Int'l, 431 U.S. 678, 702 (1977) (statute forbidding sale or distribution of contraceptives to minors under 16 held unconstitutional).

The Pennsylvania Minors' Consent to Medical, Dental and Health Services Act [104] provides that a person under the age of eighteen lacks the capacity to give informed consent unless he or she has graduated from high school, has married, or has previously been or is now pregnant. The statute prevents most adolescents from consenting to a sterilization procedure; there is an excepted group, however. This excepted group, while small, appears to be increasing. As the number of teenage pregnancies increases, more adolescents become capable of consenting to sterilization.

With certain exceptions, the Pennsylvania legislation uses age of a person to differentiate those with capacity from those without. In the context of abortion, however, the Supreme Court has rejected legal capacity to consent based on age.[105] The Court has relied upon maturity, rather than age; whether a minor has capacity to consent to abortion depends primarily on whether the minor knowingly is capable of acting on his or her own behalf.[106] Although the concept of the mature minor may have initial appeal, courts should examine carefully the context in which a mature minor will be permitted to make his or her own decision. For example, it may be desirable to allow a mature minor to consent to an abortion, a decision that would not carry with it irreversible consequences. In the context of sterilization, however, the decision does involve permanent consequences. It is argued, therefore, that no minor should be able to consent to sterilization unless he or she has the consent of a parent [107] or of a court. A minor should be considered presumptively incapable of assessing his or her future welfare regarding the bearing or siring of children. Courts should not extend the concept of the mature minor from the area of abortion to sterilization.

Federal regulations regarding the funding of sterilizations prohibit sterilization of individuals under the age of twenty-one,[108] even in cases of severe hardship.[109] Consequently, only those minors who fall within one of the excepted categories of the Pennsylvania act, and who are able to pay for surgery themselves, or are covered by insur-

104. PA. STAT. ANN. tit. 35, § 10101 (Purdon 1977).

105. Planned Parenthood v. Danforth, 428 U.S. 52, 74 (1976) (state may not constitutionally impose blanket parental consent requirement for abortion involving a minor child).

106. *Id.* at 74. *See also* Bellotti v. Baird, 428 U.S. 132, 140 (1976) (Massachusetts statute may be interpreted as not allowing absolute parental veto over minor child's abortion).

107. *See* MONT. CODE ANN. § 41-1-405(4) (1979) for an example of a parental consent requirement.

108. 42 C.F.R. § 50.203 (1980). *See also* 55 PA. CODE § 1141.55(2) (1981) (Pennsylvania funded sterilization only if individual is at least 21 years old).

109. *See* Voe v. Califano, 434 F. Supp. 1058, 1059 (D. Conn. 1977) (20 year-old woman found ineligible for Medicaid funding of sterilization despite ten pregnancies and history of medical problems).

ance programs, are now eligible for sterilization. The Pennsylvania Legislature should eliminate this possibility by amending the Minors' Consent Act to provide that individuals under eighteen do not have the capacity to consent to sterilization.

VII. Consent of Persons Without Legal Capacity

When minors are denied the capacity to consent to sterilization, they suffer a delay in their access to the desired procedures. In contrast, the presumption that retardates are incapable of giving informed consent may result in severe and lasting hardships. Many families who have been able to cope with moderately or severely retarded children find their resources strained beyond endurance when these children reach adolescence.[110] Retarded adolescent females who encounter problems with menstruation may be extremely difficult to manage, and parents have frequently requested court approval for hysterectomies.[111] Even where less drastic measures would be helpful, government regulations often make it impossible to obtain sterilization. For example, federal guidelines absolutely prohibit sterilization of retardates, presuming that all are incapable of informed consent, and that no substituted consent is adequate.[112] Such a policy is unenlightened; in the guise of preventing abuses, it may cause substantial hardship. In addition, it may not further the best interests of the retardate. Current professional thinking encourages social and sexual interaction among retardates.[113] It now appears that the least protective custodial supervision of the retardate is important to his welfare.[114]

110. *See, e.g.,* Ruby v. Massey, 452 F. Supp. 361 (D. Conn. 1978). The plaintiffs in *Ruby* were parents of three severely retarded girls. They petitioned the court to authorize hysterectomies because care of girls had become even more difficult due to problems with menstruation. The court stated that the parents could "neither veto nor give valid consent to the sterilization of their children." *Id.* at 366. The court also concluded, however, that equal protection required the parents to have the same opportunity to seek sterilization that guardians at a state institution would have. *Id.* at 369. Federal and state regulations prohibit funding of hysterectomies solely for sterilization purposes. *See* 42 C.F.R. § 50.207 (1980); 55 Pa. Code § 1141.59(7) (1981). Although sterilization of women may be accomplished by various tubal litigation procedures, cases involving retarded adolescent girls usually involve requests for hysterectomies because of problems with menstruation.

111. *See, e.g.,* Ruby v. Massey, 452 F. Supp. 361 (D. Conn. 1978); *In re* Guardianship of Tulley, 83 Cal. App. 3d 698, 701-02, 146 Cal. Rptr. 266, 267 (1978), *cert. denied,* 440 U.S. 967 (1979) (court would not authorize sterilization in absence of statutory direction even though procedures were available for those in state institutions).

112. 42 C.F.R. § 50.206 (1980). Pennsylvania Medical Assistance regulations contain no comparable provision.

113. *See generally* R. Koch & K. Koch, Understanding the Mentally Retarded Child (1974).

114. *See generally* R. White, The Special Child: A Parent's Guide to Mental Disabilities (1978).

The growth and development of the retardate, like all persons, depends, in part, upon allowing the individual maximum independence in decision making and optimum freedom of action. Sexual encounters may play an important role in the biological and social development of the retardate.[115] The retardate may be unable to cope with the consequences of a sexual encounter, however. Sterilization may therefore be in the best interest of the retardate; to further this interest, a permissive policy toward substituted consent may be attractive.

In a recent decision, the New Jersey Supreme Court affirmed the ability of its courts to consent to sterilization on behalf of those lacking capacity. *In re Grady*[116] involved a nineteen-year-old woman suffering from Down's Syndrome whose parents requested her sterilization in order to allow her to enter a group living arrangement without the risk of pregnancy or the burden of contraception.[117] The court rejected the argument that it lacked jurisdiction to order the sterilization of an incompetent, even when the procedure was in her best interest.[118] Finding their inherent *parens patriae* power[119] adequate for such a decision, the court found that substituted consent should come from the court rather than from the parents.[120] In reaching this decision, the court noted that the constitutional right of privacy included the right to undergo voluntary sterilization.[121] This constitutional right must not be discarded simply because of the individual's inability to choose. Therefore, the court reasoned that it must exercise the freedom to choose on behalf of the incompetent.[122] The court observed that having the choice made in the incompetent's behalf produced "a more just and compassionate result" than allowing her no way to exercise a constitutional right.[123]

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115. *See generally* R. Koch & K. Koch, *supra* note 113.

116. 85 N.J. 235, 426 A.2d 467 (1981).

117. *Id.* at 240-42, 426 A.2d at 469-70.

118. *Id.* at 258-59, 426 A.2d at 479.

119. The court described *parens patriae* power as the authority of the sovereign to protect individuals who are unable to protect themselves. *Id.* at 259, 426 A.2d at 479.

120. *Id.* at 252, 426 A.2d at 475.

121. *Id.* at 247-48, 426 A.2d at 473-74. The court also noted that a decision to be sterilized implicates the individual's right to autonomy—the ability to control his or her own body. *Id.*

122. 85 N.J. at 250-52, 426 A.2d at 474-75.

123. *Id.* at 261, 426 A.2d at 481. The court established procedural safeguards including the appointment of a guardian *ad litem*, medical and psychological evaluations, and clear findings of the incompetent's permanent incapacity. Moreover, a court ordering sterilization must be persuaded by clear and convincing evidence that the procedure will serve the incompetent's best interests. *Id.* at 264-67, 426 A.2d at 482-83.

State laws that allow substituted consent only for institutionalized individuals have been held constitutionally impermissible.[124] These statutes have been held to deny equal protection: "By narrowly limiting access to a process for securing consent so as to deny it to these plaintiffs, the state has denied them the equal treatment which is required to meet the standard of the equal protection clause." [125] Equal protection requires that provisions for the sterilization of institutionalized individuals be extended to the non-institutionalized.[126]

In addition to constitutional flaws, laws dealing with sterilization of the retardate often fail to recognize gradations among members of the class. Many existing statutory schemes classify all retardates together and make no provision for varying degrees of competency. Retardates are not a uniform group, however; they span a broad continuum as to capacity. While profoundly and severely retarded persons may not be able to understand the consequences of sterilization, most mildly or moderately retarded individuals can understand the meaning of parenthood and sterilization.[127] These persons should be excluded from restrictive statutory provisions.

The same gross classification of retardates underlies federal funding provisions regarding sterilization. Although many retardates are capable of informed consent, Department of Health and Human Services funding guidelines do not distinguish among degrees of competency; instead, there is a blanket prohibition of funding for sterilization of all retardates.[128] This undifferentiated grouping is unfortunate. The purpose of the regulation may be constructive, but it may result in denying sterilization to many mildly retarded individuals for whom the operation would provide substantial benefit in the form of greater social and sexual freedom.

In addition to the benefits for the individual retardate, the ability of parents to maintain their retarded children outside of institutions is an important factor in the sterilization decision. Those retardates who lack the capacity to consent, but cannot cope with contraception, pregnancy, and childbirth, may reap a great benefit from sterilization, especially if it helps them remain at home.[129] For these individuals, provisions should be made for court-ordered substituted consent on

124. *See* Ruby v. Massey, 452 F. Supp. at 369.

125. *Id.*

126. *Id.*

127. *See* Roos, *Psychological Impact of Sterilization on the Individual*, L. & PSYCH. REV. at 45 (1977).

128. 42 C.F.R. § 50.206 (1980).

129. *See, e.g.*, Ruby v. Massey, 452 F. Supp. at 363; *In re* Grady, 170 N.J. Super. 98, 126, 405 A.2d 851, 865-66 (1979), *vacated and remanded*, 85 N.J. 235, 426 A.2d 467 (1981).

behalf of the retardate by a parent, legal custodian, or guardian *ad litem*. For individuals who have the capacity and desire to consent, such consent should be recognized.

Pennsylvania has no statute regarding sterilization of the retarded, whether institutionalized or not. The legislature's attempt to establish a policy relating to non-voluntary sterilization was aborted in 1905, when the Governor vetoed a compulsory sterilization bill aimed at "the prevention of idiocy." The veto message revealed dazzling wit, but little understanding of the complexity of this problem:

> This Bill has, what may be called with propriety, an attractive title. If idiocy could be prevented by an act of Assembly, we may be quite sure that such an act would have long been passed and approved in the State . . . . [B]ut it is such an operation as [doctors] shall decide to be "safest and most effective." It is plain that the safest and most effective methods of preventing procreation would be to cut the heads off the inmates, and such authority is given by the bill to this staff of scientific experts.[130]

In the absence of legislation, Pennsylvania courts have not decided whether they have inherent authority to approve sterilization of incompetent minors or adults.

A persuasive argument for the existence of such authority can be made,[131] based on the *parens patriae* jurisdiction of the courts. This jurisdiction grants courts the power to protect those who are incapable of protecting themselves. To deny that such inherent authority exists would mock the courts' *parens patriae* power where substituted consent is impermissible. Whether the source of the courts' authority is inherent or legislatively granted, however, it is essential that the courts considering requests for sterilization be guided and restrained by strict standards that protect the retardate.[132]

In considering requests for sterilization of retardates, courts must remain alert to potential conflicts of interest. The needs and concerns of the retardate and his guardian or caretaker may not be the same. The parent may be overly frightened by the child's sexuality, and conclude that sterilization is in the best interests of the child. The retardate may be unable to articulate his needs. To protect the retardate, the court must assess whether he or she is capable of maturing into an individual who can assume the responsibility of bearing and

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130. Vetoes by the Governor of Bills Passed by the Legislature, Session of 1905, Veto No. 12 of Original Senate Bill No. 35, at 26 (March 30, 1905).

131. *See, e.g., In re* Grady, 170 N.J. Super. 98, 117-22, 405 A.2d 851, 861-62 (1979), *vacated and remanded*, 85 N.J. 235, 426 A.2d 467 (1981).

132. 170 N.J. Super. at 125-26, 405 A.2d at 865.

raising children. In *Wyatt v. Aderholt*,[133] the court suggested the following guidelines:

1. Determination that no other birth control measures will adequately meet the needs of the individual.
2. The incompetency is permanent.
3. All procedural safeguards have been satisfied including appointment of a guardian *ad litem* to act as counsel for the incompetent during court proceedings with full opportunity to present proof and cross-examine witnesses.
4. Demonstration by the petitioners that their primary concern is for the best interests of the incompetent rather than their own or the public's convenience.[134]

Although a persuasive argument can be made for the existence of the power, many courts do not recognize inherent authority to grant sterilizations for minors and those incapable of consent.[135] This reluctance may result from a belief that procreation is a fundamental right that should not be infringed by the state. One court has reasoned that substituted consent involves a deprivation of the fundamental right to bear children; thus, no person or authority can consent in the absence of a statute.[136]

The Supreme Court's decision in *Stump v. Sparkman* [137] seems to weaken the argument that courts lack jurisdiction without an express legislative grant. The Court noted that a statutory provision is not the sole jurisdictional authority available to a court to act on a petition for sterilization: "The statutory authority for sterilization of institutionalized persons . . . does not warrant the inference that a court of general jurisdiction has no power to act on a petition for sterilization of a minor in the custody of her parents . . . ." [138]

In view of the many variations that may be involved in petitions for the sterilization of retardates, neither blanket prohibitions nor judicial avoidance make sense. Instead, a flexible approach should prevail: those who are capable of informed consent and want to be sterilized should be allowed access to the necessary procedures after a hearing where standards such as those used in *Wyatt* have been satisfied. For the retardate who cannot consent, substituted consent or judicial authorization should be available.

133. 368 F. Supp. 1383 (M.D. Ala. 1974).
134. *Id.* at 1384. *See also In re* Grady, 170 N.J. Super. 98, 126, 405 A.2d 851, 865 (1979), *vacated and remanded*, 85 N.J. 235, 426 A.2d 467 (1981) (similar standards for allowing parents to consent to sterilization procedure for retarded child).
135. *See, e.g., In re* Tulley, 83 Cal. App. 3d at 704, 146 Cal. Rptr. at 270.
136. *Id.*
137. 435 U.S. 349 (1978).
138. *Id.* at 358.

Conclusion

Individuals have increasingly relied upon voluntary sterilization as a desirable method of birth control. Until recently, policy regarding sterilization has more often emanated from hospital boards than legislatures or courts. Health care units have often been overly cautious, refusing to approve the use of their facilities for this purpose. Some facilities have refused access to sterilization completely; others have imposed unique burdens on persons seeking sterilization that are not required of individuals seeking other kinds of surgical intervention. Special problems arise when minors and retardates seek sterilization procedures. When and whether these individuals can consent to sterilization has troubled both the legislatures and the courts.

The Commonwealth of Pennsylvania has thus far been spared the volume of litigation that has taken place in other jurisdictions, possibly because of the Pennsylvania Legislature's remarkable restraint in this area. As increasing numbers of people seek sterilizations, the continued refusal of hospital facilities to perform these procedures seems likely to generate an increasing volume of litigation. The Commonwealth's position of silence will predictably be challenged. Individuals and groups who endorse voluntary sterilization will demand legislative and judicial action. The legislature and the courts will be forced to articulate policy.