

Sterilization, State Action, and the Concept of Consent

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A line demarking the propriety of state intervention into the lives of individuals has never been adequately drawn. It is not surprising that such a line is practically nonexistent, from the point of view of legal analysis, when the people subject to intervention are considered mentally retarded. Too infrequently the medical and privacy rights of these individuals go unrecognized and unheeded. There are several factors which collectively account for this.

First, there has been an historic absence of litigation¹ in this area, owing in part to the situation surrounding the putative plaintiff, and to the great difficulties in obtaining vigorous, competent counsel for the retarded. Secondly, state intervention in this area usually takes place in the context of medical care and habilitation, those therapeutic and merciful characteristics of state action which by their very nature have never been welcome subjects for judicial review, even when administered on an involuntary basis.

Moreover, state intervention among the retarded involves rights² which are often taken for granted by the population at large and are only compromised with respect to special groups. These include: the right to have sexual relations, to marry, and to have children; the right to receive adequate medical treatment, in the sense that the decision of whether life support systems should be maintained must not rest merely on whim or prejudice; and the

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1. Fewer than 25 cases involving sterilization of the retarded had reached appellate courts by 1968. See, e.g., Comment, *Compulsory Eugenic Sterilization; for Whom Does the Bell Toll?*, 6 DUQ. L. REV. 145 (1968).

2. The right to marry and procreate are parts of the "right to privacy" which is not guaranteed in so many words in the Constitution but has been held to be "so basic and fundamental and so deep-rooted in our society" as to come under the protection of the ninth amendment. *Griswold v. Connecticut*, 381 U.S. 479 (1965).

right to personal dignity, to be fed, clothed and sheltered in a manner which is neither brutalizing nor shameful. In its programs for the retarded, the state interferes with these rights in offhand ways, often without recognizing the existence of the right which has been abridged. In a sense, not only has our legal system condoned such approaches, but it has institutionalized the procedures and techniques which are used by the state to deprive retarded persons of their rights. In this article we wish to focus on the techniques of deprivation rather than on the specific rights involved.

The most flexible method used by states to deprive the mentally retarded individual of his rights, and then shield that deprivation from challenge, involves manipulation of the concepts of consent and voluntariness. In this discussion we will explore a most peculiar aspect of the doctrine of consent which is heavily used in the state's dealings with the mentally retarded—third-party consent.³ This type of consent is really nothing short of an extended conceit on the proposition of voluntariness. It is a fiction which authorizes the state to intervene because a party other than the subject provides the green light. Often that third party is the parent of the subject individual, but the doctrine is equally applicable when the third party is a doctor, the superintendent of a facility, a guardian ad litem, or a conservator. By characterizing the transaction as "consensual" rather than "compulsory," third-party consent allows the truly involuntary to be declared voluntary, thus bypassing constitutional, ethical, and moral questions, and avoiding the violation of taboos.⁴ Third-party consent is a miraculous creation of the law—adroit, flexible, and useful in covering the unseemly reality of conflict with the patina of cooperation.

The doctrine's administrative efficacy has caused it to play an important role, for good or ill, where mentally retarded persons are concerned. Admission to state hospital facilities, various forms of treatment, experimental drug programs, and state control of sexual behavior are all conducted under this rubric.⁵ In this discussion, we

3. Ordinarily a fully competent adult is able to give consent in his own behalf. *Pratt v. Davis*, 224 Ill. 300, 79 N.E. 562 (1906). Such consent involves two parties: the patient (1st-party) and the physician (2nd-party). Where a guardian renders consent for his ward, the guardian is the third-party consenter.

4. Lobotomized inmate of state mental hospital placed in custody of father to receive electroshock therapy at private facility; held, not an involuntary detention prevented by state Welfare and Institutions Code. *Farber v. Olkon*, 40 Cal.2d 503, 254 P.2d 520 (1953).

5. Another field of endeavor which is currently held in disrepute, but was once

will concentrate on the use of the device in the control of sexual behavior because there have been more sophisticated statutory approaches, more judicial decisions, and more public concern on this subject than on others. From an exploration of the law's experience with the regulation of consent in this area, generalized conclusions can be drawn with respect to the problems of the whole field.

Need for an Adequate Analytical Approach

Meaningful legal analysis sometimes lags behind events. This may be the case with respect to governmental intervention in the lives of the mentally retarded. Forms of state control and intervention change and become so sophisticated, appealing, subtle, and delicate that modern governmental action seems to be less and less restricted by an ordinary application of constitutional protections. For example, when government intervention primarily took the form of institutionalization, particularly compulsory institutionalization, certain ideals of due process which had developed in the criminal law system could be brought to bear (with modifications to be sure), to increase the protection of the individual from arbitrary state action at the level of the institution.

But times have changed, and the philosophy of care has changed as well. It is now at the budget and planning levels of state government where critical decisions are made, where individual rights are affected, and where ingenious arrays of government intervention are packaged. New delivery strategies, particularly those incorporating community care and the normalization of the environment, present novel problems in ascertaining an appropriate balance between the state interest and individual rights. Because of the appeal of the new strategies, it is sometimes difficult even to maintain a critical approach. When the asylum⁶ emerged in the nineteenth century as the idyllic answer to a major societal problem,

supported on third-party consent grounds, is child labor. See *Parlin & Orendorff Co. v. Webster*, 17 Tex. Civ. App. 631, 43 S.W. 569 (1897); *In re Hollingsworth*, 45 La. Ann. 134, 12 So. 12 (1893); *Brown v. Yaryan*, 74 Ind. 305 (1881).

6. The mentally retarded were among the last group of handicapped persons for whom states realized any responsibility to provide facilities. Schools for the blind and deaf, and hospitals for the insane all were established before the first permanent state school for the retarded opened in Massachusetts on October 1, 1848. A. A. Baumeister, *The American Residential Institution: Its History and Character*, in *RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED* (Baumeister and Butterfield eds. 1970).

delight in the approach it offered obscured what are now considered to be its obvious hazards. We are now in a similar period when the community approach goes virtually unchallenged: rhetoric of commitment is replaced with rhetoric of encouragement; voluntary, family-centered techniques replace the cold hand of the state. Yet, the professional must remember to maintain some sense of critical balance and open-mindedness.

When a modern state determines to intervene, for example by means of certain forms of treatment or sterilization, it offers modern justifications. "Positive eugenics"⁷ are no longer in vogue, but the intense competition for tax dollars has merely replaced genetic considerations with fiscal and psychological ones. Where the Holmes' statement, "three generations of imbeciles are enough," was sufficient to uphold the constitutionality of intervention by sterilization a half-century ago,⁸ we talk confidently in the compulsory 1970's about "parenting," of "breaking the vicious cycle" of three generations of welfare clients. Beyond these justifications, there is an additional factor which is the primary subject of this paper: through adroit statutory change and through nonstatutory efforts to confer power to consent on persons other than the individual directly affected, the always thin line between involuntary and voluntary action has been further attenuated to the point of disappearance.

On a formal level, there is a vast chasm between the voluntary and the involuntary in our law. Morally, ethically, and legally we distinguish, separate, and scrutinize more strictly those interventions by the state that are made without regard to the consent of affected persons. In criminal law, a test of the validity of a confession is whether it was "voluntarily" given;⁹ in essence, only if the judicial process finds the element of voluntariness present, may the confession be considered on the question of guilt. To search a home, in most circumstances, the police need probable cause and must obtain a warrant unless an appropriate person "consents" to the search.¹⁰ Consent is also an issue in torts and contracts: we are

7. Policy of improving the human race through sterilization of subnormal persons, based on theories that most defects are transmissible from parent to child and that defective persons breed more frequently than normal persons. Kindregan, *Sixty Years of Compulsory Eugenic Sterilization: "Three Generations of Imbeciles" and the Constitution of the United States*, 43 CHI.-KENT L. REV. 123 (1966).

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

9. *Spevack v. Klein*, 385 U.S. 511 (1966).

10. *Mapp v. Ohio*, 367 U.S. 643 (1960).

all familiar with the efforts of doctors to shield themselves from liability by having their patients sign "consent" forms prior to an operation. Involuntary commitment of the mentally ill is constrained and regulated in every state by means wholly distinguishable from procedures for voluntary admissions into a hospital or program: for an involuntary patient, the statute usually states at least a minimal diagnostic standard for admission and release, and provides a set of procedural safeguards usually including some sort of court review before a lengthy involuntary detention can be sustained. None of these safeguards are provided, however, if a patient's admission can be characterized as "voluntary."

Consent and voluntariness are vital doctrines. Enormous consequences can flow from a finding that they are present or absent. Despite this importance, we know surprisingly little about the mechanism of consent and the forms states have undertaken to delineate consent. In particular, there is an area of consent that is virtually *terra incognita*: where the state lodges the power to consent in a person other than the patient—a parent, the legal guardian, or the institution itself. A survey of the statutes suggests that third-party consent is a rather familiar process used by states to shift an activity from the involuntary to the voluntary category. Since categorizing an action as voluntary rather than involuntary has crucial implications, one might expect that there would be a well-developed analytical framework to determine whether truly involuntary approaches were being characterized as consensual. Unfortunately, no such analytical framework exists.

Motives, Intent, and Justifications

To understand the significance of "consensual" sterilization in the control of sexual behavior, it is useful to take a short backward glance at statutory attempts to make sterilization compulsory, and the declining use of these statutes as perceptions of "positive eugenics" changed through time.

Two years after the governor of Pennsylvania vetoed the first American attempt at sterilization legislation in 1905, Indiana became the first state to enact a compulsory sterilization law.¹¹ There are now twenty-nine states with statutory provision for compulsory sterilization in a variety of circumstances. The Association for Vol-

11. IND. ACTS ch. 215 (1907).

untary Sterilization reports that in the first half-century of its operation, these statutes compelled the sterilization of approximately 60,000 people on the basis that they posed a threat to themselves or to society. Compulsory sterilization as a form of criminal punishment has been disfavored and declared unconstitutional as "cruel and unusual."¹² There have also been intimations that a statute which compelled sterilization because of the potential financial drain on society posed by impecunious wards violates the Equal Protection Clause,¹³ but the general power of the state to compel sterilization for therapeutic or preventive reasons has been upheld.¹⁴

Today it is necessary to direct new attention to the compulsory sterilization statutes and the motives behind their passage. Such attention is required by contemporary emphasis being placed on alternatives to long-term institutionalization for mental retardates, opening to them prospects of normal and productive life in the community. Under these alternatives, motives supporting compulsory sterilization persist; for there is not general agreement that all retardates who can benefit from this new emphasis, and who are biologically capable of procreation should become parents. For some there are serious genetic risks of bearing sadly limited children, but the genetic risks in childbearing are neither the state's primary nor most widespread concern. Rather, emphasis is placed upon the fact that among retardates who will be living in sheltered settings, which give sufficient support for work and life in the community, one inevitably will find that certain of these individuals will lack those social and emotional attributes which are generally considered desirable or, at the very least, necessary for child rearing.

Though many state laws give authority for compulsory sterilizations based on assessments of either genetic or social incapacities,¹⁵ it is false to give the impression that governments either frame adequate genetic and social standards or employ sufficiently skilled personnel to predict in advance who among the retarded should not become parents. Indeed, compulsory sterilization authority leads so readily to abuse that it is not surprising to find increased constitutional awareness making it less and less a power that is likely to be invoked. Statistical data, though sparse, tends to suggest that the

12. *Mickle v. Henrichs*, 262 F.687 (D. Nev. 1918). *But cf.* *State v. Feilen*, 70 Wash. 65, 126 P. 75 (1912).

13. *Cook v. State*, 9 Ore. App. 224, 495 P.2d 768 (1972).

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

15. *See, e.g.*, UTAH CODE ANN. § 64-10-7 (1968).

annual number of persons compulsorily sterilized has declined by almost half in the last twenty years.

Emergence of Constitutional Limitations

State laws which single out the mentally retarded as being specially unsuited for parenthood are often derived more from community fear and prejudice than from any sensible conviction regarding the particular incapacities of the retarded as a group. This special vulnerability to sexual activity and child rearing restrictions is not limited to those who are mentally deficient, but is shared with many groups in this society which are stigmatized and isolated as deviants—in particular the prison and mental hospital population.¹⁶ Indeed, half of the twenty-three state laws which authorize compulsory sterilization for mentally retardates have similar provisions for “hereditary criminals.” And virtually all the state statutes apply their sexual restrictions equally to the mentally retarded and the mentally ill.¹⁷

Furthermore, the stereotypes which are projected onto the mentally retarded, the mentally ill, and criminals are remarkably similar in their attribution of sexual appetite and dangerousness. The Supreme Court of Nebraska, in its 1968 opinion upholding the constitutionality of the state’s compulsory sterilization law for institutionalized mental defectives, stated, “It is an established fact that mental deficiency accelerates sexual impulses and any tendencies toward crime to a harmful degree.”¹⁸ This statement, unsupported by any observed data, neatly summarizes popular prejudice regarding not only the mentally ill and criminals, but other stigmatized groups.

This phenomenon is related to the prevalence of sexual imagery and fears regarding blacks in this country. The laws which forbade intermarriage among blacks and whites—rationalized by a potpourri of genetic and social arguments—have a close kinship with the restrictive laws applied to the mentally retarded. Indeed, one important attribute of slave status in this country was that slaves were forbidden to marry, and familial ties between parent and child

16. See MORRIS & HAWKINS, *THE HONEST POLITICIAN’S GUIDE TO CRIME CONTROL* 125-33 (1970).

17. See LINDMAN & MCINTYRE, *THE MENTALLY DISABLED AND THE LAW* (1961).

18. *In re Cavitt*, 182 Neb. 712, 716, 157 N.W.2d 171, 177 (1968). See *Meyer v. Nebraska*, 262 U.S. 390 (1932).

were disregarded as a matter of course.¹⁹ Mental retardates share with this other stigmatized group the popular perception of "less-than-humanness" and likewise become the target and repository of a cluster of fears that are felt to assault our humanness in general. Among these fears, unabated sexual appetite ranks high.

This special vulnerability of mental retardates as an irrationally feared and stigmatized group has important legal implications. It means that, as a group, they will require particular protection against the operation of unfair legislation, most notably that aimed at their sexual and child rearing behavior. Applying a legal analysis articulated by Chief Justice Stone in 1938, mental retardates are, "a discrete and insular minority . . . [against whom prejudice] tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities, . . . [on whose behalf] a correspondingly more searching judicial inquiry [may be called for]."²⁰

Since 1938, the Supreme Court has increasingly done battle for blacks—another such "discrete and insular minority"—deriving its task from a revised and clearer historical understanding of the purposes of the Fourteenth Amendment and from Chief Justice Stone's vision of the role of the courts as protector of minority rights. In this pursuit, the Court has ruled unconstitutional state laws prohibiting marriage between blacks and other races in a case appropriately denominated *Loving v. Virginia*.²¹ This result was directed by a prior series of Supreme Court holdings establishing the principle invalidating any form of state action that singled out blacks as a group for special derogatory treatment.²² Regardless of whether an equally broad principle should be recognized by the courts to protect mental retardates,²³ their rights to sexual freedom must be judicially protected.

Family and sexual conduct in our society, including the right "to marry, establish a home and bring up children,"²⁴ the right of "privacy surrounding the marriage relationship,"²⁵ and "the right to

19. See FRANK TANNENBAUM, *SLAVE AND CITIZEN* (1946).

20. *United States v. Carolene Products Co.*, 304 U.S. 144, 153 n.4 (1938).

21. 388 U.S. 1 (1967).

22. The progenitor was *Brown v. Board of Education*, 347 U.S. 483 (1954).

23. See Burt, *Legal Restrictions on Sexual and Familial Relations of Mental Retardates* in *HUMAN SEXUALITY AND THE MENTALLY RETARDED* (de la Cruz and La Veck eds. 1973).

24. *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

25. *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965).

satisfy [one's] intellectual and emotional needs in the privacy of [one's] home,"²⁶ have been acknowledged in various Supreme Court decisions as fundamental rights. However, for the mentally retarded, these familial and sexual freedoms are drastically infringed by laws requiring sterilization and prohibiting marriage.

The legislation we have been discussing does not impose disabilities uniformly on all institutionalized mental retardates as such. For example, some statutes require sterilization only of those retardates who are considered "not capable of performing the duties of parenthood."²⁷ This standard is no more precise than the standard which governs state interventions to redress child neglect or abuse among the general population, and it could be considered unconstitutionally vague as applied to a class limited to mental retardates. However uncertain its capacities to distinguish among good and bad parents generally, this society and its officialdom are clearly in the thralls of irrational attitudes toward the sexuality of the mentally retarded. Our officials share the inability of most people in this society to look at the retarded without fear or pity—to look at them with sufficient objectivity to permit sensible differentiation among them. Because the mentally retarded as a group are so readily victimized, compulsory interventions in their childbearing activities which might be constitutionally tolerable for the general population is intolerable if limited to the retardate group alone.²⁸

Mr. Justice Holmes' famous—indeed, notorious—1927 opinion in *Buck v. Bell*,²⁹ upholding a state compulsory sterilization law with the aphorism "three generations of imbeciles are enough," fails to appreciate this special role for the courts in protecting a vulnerable minority. Fifteen years later, in *Skinner v. Oklahoma*,³⁰ the Supreme Court's invalidation of a state's compulsory sterilization law for habitual criminals on grounds that it made irrational distinctions between those criminals who should and those who should not be sterilized, suggests a different court attitude. However, the Court has not yet seen fit to administer the *coup de grace* to the general principle of compulsory sterilization.³¹

26. *Stanley v. Georgia*, 394 U.S. 557, 565 (1969).

27. *See Buck v. Bell*, 274 U.S. 200 (1927).

28. *See Cook v. Oregon*, 9 Ore. App. 224, 495 P.2d 768 (1972).

29. 274 U.S. 200, 207 (1927).

30. 316 U.S. 535 (1942).

31. *In re Cavitt*, 182 Neb. 712, 157 N.W.2d 171, *rehearing denied*, 183 Neb. 243, 159 N.W.2d 566 (1968), *appeal dismissed sub nom. Cavitt v. Nebraska*, 396

A Potential Procedural Virtue Lost Through "Reform"

Even though there is an aggregate of ills surrounding compulsory sterilization statutes, and even though these statutes are generally based on unsound and unscientific motives and have the potential to be discriminatorily applied, they do possess one aspect which might be considered a virtue: procedural safeguards. If the state is required to follow a statutory route to achieve an interventionist goal, certain legal effects usually follow: (1) it can be determined whether an individual has a right to a hearing before this particular form of intervention can take place; (2) courts can determine whether it is so serious a matter that there is a right to counsel; (3) if the intervention is labeled as involuntary and as a deprivation of an important basic human right, it may be that the state will have to demonstrate that there is no less restrictive alternative which will achieve the same purpose. Thus, requiring an involuntary act to be so denominated gives a clear picture of what is occurring, demands a recognition of the procedures that must be followed, and preserves a sharper record, in a sense, of the pattern of state intervention. However, one must note that the flood of substantive reform in the care of the mentally retarded has caused compulsory sterilization statutes along with any procedural protection they might have offered to waste away through disuse; for just as society has been plagued by its fear of procreation by the mentally retarded, habitual criminal, and mentally ill, so also has society harbored a fear of empowering the state to engage in a program of eugenics. With the advance of communitization, there is increased pressure to restrict mentally retarded persons in their right to procreate. States may merely substitute techniques more palatable than compulsory sterilization to achieve much the same result.

It is here that the issue of consent arises, as one of several possibilities. First, there is the likelihood that so-called "voluntary" or "consensual" sterilization will occur with increasing frequency, possibly including sterilization as a condition for deinstitutionalization.³² Second, it is possible that upgraded contraception will be used to replace compulsory sterilization, and that reliance on therapeutic abortions may become more frequent. Finally, it is possible that public concerns about the parenting qualities of men-

U.S. 996 (1970). Prior to the case coming before the Court, Nebraska repealed its compulsory sterilization statute.

32. *Id.*

tal retardates can be assimilated into the general statutory enforcement powers concerning neglected children.

Consent

There are degrees of retardation, understanding, and consent. At some point, consent cannot meaningfully come from the retarded patient himself. Yet, it is quite clear that through a broad recognition of the status of the parent, "consent" is being obtained to legitimize sterilizations that do not comply with the minimum standards which would be constitutionally required for involuntary treatment. A methodology which will protect the retarded individual's interests must be developed. One must ask who may qualify as a third-party consentor, how might they be selected, and by what criteria. It is hoped that these questions will be answered in the following section.

The Role of the Patient

In many, but not all states, the mentally retarded person must be consulted before a "voluntary" sterilization occurs. In those states questions arise which naturally lead to the issue of third-party consent, for it must be acknowledged that there will be a class of cases, perhaps numerically large, where the consent of the patient himself will not meet minimum standards of knowing consent. But it is one thing to argue that the patient's consent is sufficient; it is quite another to argue that it is necessary. There are statutes that take each position, and they should be differentiated from others that allow the wishes of the third-party to be controlling regardless of the consent of the patient.

Under the California statute,³³ consent is manifested in the following manner: when the superintendent decides that an institutionalized mentally retarded person in his care can benefit from sterilization, he must notify that patient and other specified persons who may consent or object to the proposed procedure within thirty days. If no objection is received within this period, the patient is deemed to have consented. It appears from the statute that absent any objection, the consent of the patient, written or implied, suffices.

On the other hand, the Maine statute requires that where a

33. CAL. WELF. & INST'NS CODE § 7254 (1972).

sterilizing operation is indicated, the physician may recommend to the affected individual the advisability and necessity of the operation. At the outset, the patient himself may give written consent, but if the hospital seeks to proceed on the basis of that consent alone, a council of two doctors must be assembled to determine whether the person was "mentally capable of giving his consent."³⁴

In Michigan, the state can proceed to perform an operation when they have obtained the consent of a "defective person . . . of the age of 16 years or more and *not otherwise incapable* of giving consent," together with the consent of a guardian or near relative.³⁵ These two latter statutes, by not relying solely on the patient's consent, place the question of sufficiency in issue.

Other statutes seem to suggest that a "voluntary" operation can occur *without prior consultation with the patient*. For example, Section 256.07 of MINN. STAT. ANN. provides that the commissioner of public welfare may authorize a sterilization operation "with the written consent of the spouse or nearest kin" of the patient. The Connecticut statute similarly relies wholly on the responsible next-of-kin or guardian of the person involved.³⁶ Statutes of this type usually place the burden on third parties either to initiate a request for sterilization, to object to a state recommendation that sterilization take place, or simply to "consent" to the operation. These statutes are of various kinds.

In Minnesota the commissioner of public welfare serves as the legal guardian for all institutionalized retarded persons.³⁷ As such, he may provide the exclusive consent where there is not a spouse or near relative. In other states, a guardian ad litem must be appointed to provide a specific consent to an operation. In some states, the objection of the third person (guardian or relative) is conclusive. In others, such an objection is only a factor to be considered by the board of the hospital and later by the court.

Apart from specific procedures for sterilization outlined above, legal authority to make such choices on behalf of mental retardates appears in the guardianship laws in all states.³⁸ Some such laws

34. ME. REV. STAT. ANN. tit. 34, § 2461 (1964).

35. MICH. COMP. LAWS ANN. § 720.304 (1966).

36. CONN. GEN. STAT. ANN. §§ 17-19 (1960).

37. MINN. STAT. ANN. § 256.07 (1971).

38. This authority in Alabama now appears constrained by *Wyatt v. Aderholt*, 368 F. Supp. 1383 (M.D. Ala. 1974).

authorize the appointment of custodians for, among others, mentally deficient persons who are not institutionalized but are nonetheless regarded as incompetent to handle a portion or all of their affairs.³⁹ The potential for abuse of these guardianship laws is clear. A case recently decided by the Kentucky Supreme Court should serve as a warning. In *Strunk v. Strunk*,⁴⁰ the court authorized the appointment of a 27-year old institutionalized retardate's mother as his guardian in order to permit her to consent on his behalf to remove one of his kidneys to donate to his otherwise doomed, intellectually normal older brother. The court did not seem troubled by the fact that the mother's role in making this decision for her retarded son could, at best, be characterized as ambivalent.

In an early opinion of the Michigan Attorney General it was stated that parental consent to a sterilization operation is null and void because "the right to possess and retain the power of procreation is second only to life itself among the rights. . . guaranteed by the federal Constitution. It is a right that is personal to the child and is not merged with the right of control by the parent over the person of the child."⁴¹ It must now be asked how one can determine the circumstances when a parent or guardian third-party should be permitted to consent on behalf of the patient; and what factors should be considered in making this determination.

One answer could be that we should never characterize as "consent" any authorization for an operation where the subject individual has not provided his own informed consent or has been determined to be incompetent and unable to give knowing consent.⁴² However, this answer is perhaps too rigid. In *Strunk*, the evidence that the kidney transplant was a very low-risk surgical procedure for the donor while essential for preserving the life of the donee provides a circumstance in which this first solution might be too harsh. After all, does it truly serve an important social purpose to conclusively bar the "incompetent" donor from exercising the right that the "normal" population prizes as an ethical imperative—the right to give of one's self in order to help others?⁴³

39. See LINDMAN & MCINTYRE, note 17 *supra*, at 204-05.

40. 445 S.W.2d 145 (Ky. 1969).

41. OP. ATT'Y GEN. MICH. 230 (1921-22).

42. The debate over the testing of drugs in children may provide some guidance on the issue of third-party consent. See Address by Dr. Irving Ladimer, Ross Conference, 1968, *Problems of Drug Evaluation in Infants and Children*.

43. See Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964).

Perhaps the most compelling consideration militating against an absolute bar to sterilizations where the patient cannot give informed consent is that the doctrinal rigors of this concept may prevent one who truly desires such an operation from obtaining it. The right to elect sterilization is prized by many, and in the Supreme Court's recent decision on abortion, where various aspects of privacy within one's own person were discussed, one finds a constitutional dimension added to this attitude.⁴⁴ Thus, it would be troubling both in a practical and constitutional sense for the state to single out a class of people who are not considered to be sufficiently "competent" to make certain choices which the Constitution guarantees to others.

The state thus appears constrained by two competing commands regarding sterilization: it must scrupulously respect informed consent; yet, at the same time, it must give adequate scope for individual choice to be expressed and to prevail. Third-party consent can have some role in charting a line between these commands, to help those who clearly need help in choosing. But no matter how scrupulously we work, no person can ever stand wholly for another. Third-party consent will always be a fiction, will always be somewhat arbitrary, and thus must always be narrowly circumscribed.

Our first line of defense against the dangers of this fiction should be to forbid third-party consent to the sterilization of full-time residents in state institutions. The reasons which previously led us to reject compulsory sterilization of institutionalized persons⁴⁵ apply equally to the purported "consensual" case. The weight of state coercion is often concealed behind the paperwork evidencing a guardian's choice to sterilize his institutionalized ward. The documented practice of parents admitting their children to Willowbrook in New York demonstrates that consent to a potentially harmful course of drug experimentation may be accepted by parents as the price for obtaining state institutionalization.⁴⁶ Further, the deep-seated social prejudice against the retarded—which led us in the first place to argue that they are a "suspect class" requiring protection against state-imposed sterilization—is often equally, or even more passionately, felt by the parents of these unfortunate children.

44. *Roe v. Wade*, 410 U.S. 113 (1973).

45. See notes 21-31, *supra* and accompanying text.

46. See *Wade v. Bethesda Hospital*, 356 F. Supp. 380 (S.D. Ohio 1973).

The general legal rule that guardians may dictate their ward's medical treatment is made tolerable in the context of the normal parent-child relationship by most parents' narcissistic identification with their children and by powerful social attitudes against abuse of children.⁴⁷ It has been traditionally believed that the parent will act for the benefit of the child, but for retarded children, most particularly those who are institutionalized, both of these constraints are often seriously eroded. Where the guardian is not a parent, such constraints may be even further attenuated.

In addition, when consent for something as drastic as sterilization is to be given, a different line of defense, beyond that of questioning parental concern, has appeared. The sterilization guidelines of *Wyatt v. Aderholt* withhold sterilization from institutionalized minors except in case of medical emergency.⁴⁸ The question must now be asked: why should sterilization for any minor, institutionalized or not, be permitted at parental discretion? The availability of less drastic birth control techniques suggests that individual autonomy and personal privacy regarding sterilization would best be protected by forcing postponement of this irreversible decision until the socially sanctioned "age of discretion" is reached. Only at that age should the state distinguish between who can be considered "competent" and "incompetent" decision makers. By this analysis the truly unique characteristics of sterilization as a bodily intrusion are highlighted: its irreversibility, its general inadvisability except as a last resort, and its compelling psychological significance. Newspaper accounts alleging that state officers coerced a welfare mother into consenting to her daughters' sterilizations suggests an added social reality that dictates protecting children by conclusively withholding sterilization from them.⁴⁹

The discussion thus far has centered upon two competing concerns in regulating the proper use of third-party consent where state action otherwise would be characterized as an impermissible, involuntary intervention. In analyzing either of these, where the subject is institutionalized or is a minor, the relevance of apparently less intrusive alternatives to accomplish similar purposes must be considered. While application of this "less restrictive alternative" prin-

47. 64 Pa. D. and C. 14 (1948).

48. *Wyatt v. Aderholt*, 368 F. Supp. 1383, 1384 (M.D. Ala. 1974) (Standard 2).

49. N.Y. Times, Je. 27, 1973, at 43, col. 3.

ciple appears to merely postpone rather than conclude the hardest issues, and the rhetoric surrounding this concept may lead to abuse by obscuring what is less or more "restrictive", one must, due to the inherent nature of sterilization, examine such alternatives.

Less Restrictive Alternatives

One alternative that has enormous appeal is to replace the cumbersome and taboo-laden procedure of sterilization with non-permanent contraception. In particular there is great hope in some quarters that there will soon be approved a self-executing contraceptive, an injection for example, that will not rely on patient management. However, there could be opposition to the use of such an innovation, heralded for the mainstream of the population, on a class of retarded patients.

Zeal has a way of converting counseling and encouragement into something not dissimilar to coercion. We must ask ourselves whether a practice which is a virtue when elected, becomes a vice when compelled. For the problem of voluntariness in a contraception program may be no easier than the problem of voluntariness in regard to sterilization. There are, however, differences that are striking enough to create a distinction. Contraception is not so drastic an intervention as is sterilization; it is reversible; and it bears no stigma. Further, the decision to renew contraception can be taken at frequent intervals.

But these are reasons only why compulsory contraception is constitutionally more palatable than compulsory sterilization; they do not begin to suggest why it is palatable enough. One must still face all the problems discussed above in administering any program leading to a nonvoluntary bodily intrusion, no matter how preferable this program might be to other alternatives. Undoubtedly, involuntary (or semi-involuntary) contraception will be a technique increasingly used in the next decade as pharmacological advances are made and as the emphasis on community placement is reinforced. We view the trend cautiously and with trepidation, not so much because of the danger to individual rights of mentally retarded persons as because of the precedents created.

Here, the problem of categorization rises again. We must be sure that in styling the reasons why we make mentally retarded persons subject to a particular kind of involuntary treatment, we do not state reasons that in their breadth would bring in a large portion of the "normal" population. Fiscal irresponsibility and bad parent-

ing are excellent reasons why persons should indulge in a program of contraception, but to use those criteria to mandate contraception would be inconsistent with our constitutional system.

More difficult questions are presented by involuntary or semi-voluntary abortions, particularly in the absence of known genetic defect in the fetus. The Supreme Court decision in *Roe v. Wade*⁵⁰ might have been a great victory for a woman's right to control the decision whether or not to bring her child to term; but to contend that doctors, guardians or parents have such a right to make a similar decision for a minor daughter or incompetent female ward would indeed strain the exegesis of that decision. Minor children in many jurisdictions have the right, without parental consent, to obtain an abortion, but it is doubtful that there is a single jurisdiction in which a hospital would be allowed by law to permit an abortion at the parent's wish in disregard of the child's objection.⁵¹ Although the ethical problems are greater (depending on one's definition of the status of the fetus) in abortion than in contraception, it is possible that involuntary abortion will become increasingly common for mentally retarded pregnant women, who would formerly have been institutionalized but are now in the community.

A final least restrictive approach to the issues presented by sterilization and its alternatives involves child neglect statutes. Almost every state has a statute broad enough to compel removal of a child from a parent who is regarded as incapable of child rearing because of mental deficiency. The Minnesota child neglect statute, for example, authorizes the state to take custody of any child "whose . . . condition, environment or associations are such as to be injurious or dangerous to himself."⁵² Inevitably the fears and prejudices that stigmatize mental retardates will intrude on the otherwise sound judgment of court and social agency personnel who apply these statutes. The numerous procedural guarantees—such as right to counsel and opportunity to rebut all adverse evidence—should be provided to all parents, including the mentally retarded, who are defendants in child abuse or neglect proceedings. Still, it is doubtful that statutory standards for state intervention can be so perfectly defined as to eliminate any possibility of misap-

50. 410 U.S. 113 (1973).

51. See *In re Smith*, 16 Md. App. 209, 295 A.2d 238 (1972), noted in 7 SUFFOLK U.L. REV. 1157 (1973).

52. MINN. STAT. ANN. § 260.015 (Supp. 1965). See also Paulson, *The Legal Framework of Child Protection*, 66 COLUM. L. REV. 679, 693-94 (1964).

plication without the risk of prohibiting state intervention to help children who are in serious jeopardy from inadequate parenting.⁵³ The prophylactic principle which led to the argument that compulsory sterilization laws should be overturned cannot properly be applied to invalidate general child abuse and neglect laws. The opportunity for victimizing the mentally retarded in the application of these laws will thus, regrettably, remain a reality. This circumstance creates an obligation on the part of those agencies planning new modes of introducing retardates into community life to defend their clientele by family planning, contraceptive counseling, and appending special plans for intensive child rearing services to any plans for sheltered community living in which normal heterosexual contacts are envisioned. The need for such programs may be more urgently required for the retarded than for those parents in the "normal" population who share the child rearing disabilities of a portion of the mentally retarded population. The label of retardation threatens loss of rights to all who bear it. Special programs are needed to protect this entire group, not just those within it whom all "right-thinking people" would agree are incapable parents.

We are not too far removed, in time or in ideology, from Justice Holmes and *Buck v. Bell*.⁵⁴ We are, however, too sophisticated to talk eugenics, at least out loud. The language of "fiscal responsibility" and "parenting environment" has a more appealing case than the rhetoric of "wards of the state" and "menace to society." There is little need now, and there will be less in the future, to resort to compulsory sterilization. More modern and more acceptable interventions—contraception and abortion—will eventually take its place. But we should realize that larger issues are at stake, involving the limits of proper societal intervention to restrict or encourage childbearing. For Justice Holmes, the principle that supported compulsory vaccination supported the salpingectomy. It is yet unclear what a newfound principle of compulsory contraception of the mentally retarded might support. This uncertainty must give us all cause for concern.

Selecting the Third-Party Consenter

Finally, we turn to another critical element to be considered in

53. See Burt, *Forcing Protection on Children and Their Parents*, 69 MICH. L. REV. 1259 (1971).

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

regulating third-party consent to justify state-sanctioned interventions: the method of choosing the third party. Who should be considered and what guidelines should be used to select the one who will be allowed to substitute his consent for that of the individual against whom the intervention will be made? For some "incompetents," namely children, the law readily accepts parental consent for a vast range of interventions with virtually no external accountability, either before or after the decision, to protect children. The law has embraced the presumption that parents are more than adequately dedicated to their children's interest and may therefore, without question, exercise this power. However, as with the theory of juvenile justice, it is now patent that this dream has little to recommend it in many important matters, and it appears to serve little purpose except to obfuscate analysis. Yet, with the mentally retarded, we are only beginning to reject the idea that parents can adequately act as surrogates for their children.

Where the parent is not the guardian, the standard consenter is likely to be no different from the state itself. In Los Angeles it is the Public Conservator, which, like most other "helping" agencies, is a huge bureaucracy. This is not to say that the Public Conservator is bad *per se*, but one must acknowledge that third-party consent by any state-employed conservator is virtually the same as involuntary intervention by the state. There is no indication that the state's standards for commitment or sterilization are any different from those used by the conservator. However, it must be admitted that, even with the potential for great abuse, reliance on parents or on ordinary state bureaucracies to give consent for "incompetents" is sometimes appropriate.

The propriety depends on *what* is proposed, *where*, and to *whom*. Thus, for example, a simple therapeutic operation such as a child's tonsillectomy can easily be seen to lie within parental discretion. At the other extreme, sterilization, where solely intended as birth control, might be properly unavailable in any circumstance. Likewise, participation in experimental drug programs may be at parental discretion only for those children who do not reside at state institutions; while for institutionalized children or for "retarded" adults, new agencies might be devised to provide adequate third-party consent for a wide range of interventions. In situations where parents are not considered to be reliable protectors of their child, as when their personal involvements too readily obscure the proper perspective and where there is a danger that the programmatic

administrative considerations of an operating staff may mislead their discretion, new arrangements are needed. In effect, these agencies could be analogous to public defenders, adequately staffed and trained to see the matter as much as possible as an alter ego for the disabled party. While perhaps it is more comfortable and less expensive to pretend that parents or existing state employees can be totally trusted to act on behalf of their wards in all the matters discussed herein, it is time to recognize that this is a mere pretense.

A different question, however, is presented in asking whether parents should be permitted to veto a proposed state intervention even though they are not empowered unilaterally to consent to it. Symmetry should not be seen as a requisite aesthetic standard in the development of legal rules. Just as there are good reasons to deny parents the power to consent unilaterally, there may be good reason to provide the family's and guardian's objections with substantial weight. A parental objection to an operation probably should have more weight than a parental consent. The parent may be expressing a religious or philosophical norm that is important to the family and to each member of it. This objection should be persuasive, though not conclusive.

The issue of what would constitute an appropriate tribunal remains unresolved. Basically, a panel is needed that has no conflict of interest and that can separate the question of desirability of the operation from the question of capacity of the person to consent.⁵⁵ After all, the inappropriateness of involuntary sterilization is partly a consequence of the inappropriateness of the decision making pro-

55. "No sterilization shall be performed without the prior approval of a Review Committee formed in accordance with this paragraph. The Review Committee shall consist of five members, and shall be selected by the Partlow Human Rights Committee and approved by the Court. The members shall be so selected that the Committee will be competent to deal with the medical, legal, social, and ethical issues involved in sterilization; to this end, at least one member shall be a licensed physician, at least one shall be a licensed attorney, at least two shall be women, at least two shall be minority group members, and at least one shall be a resident of the Partlow State School (the foregoing categories are not mutually exclusive). No member shall be an officer, employee, or agent of the Partlow State School, nor may any member be otherwise involved in the proposed sterilization.

Any fees or costs incurred by reason of services performed by the Review Committee, including reasonable fees for the physician and the attorney, shall be paid by the Alabama Department of Mental Health upon a certification of reasonableness by the Partlow Human Rights Committee." *Wyatt v. Aderholt*, 368 F. Supp. 1383, 1384-85 (M.D. Ala. 1974) (Standard 5).

cess which forces persons to make decisions which are incapable of ethical resolution.

Third Party Consent: Some Conclusions

It is clear that the control of sexual behavior is not the only pressing issue involving third-party consent and mentally retarded persons. Medical decisions relating to the giving or withholding of treatment, the form of treatment decided upon, drug experimentation, and admission to hospitals raise problems that are equally significant. However, the purpose of this paper has been to develop an analysis by which aspects of third-party consent in the sterilization issue can be applied to other areas of mental health. For example, third-party consent to drug experimentation that is not designed to benefit the patient as an individual should not be an adequate warrant for such experimentation to proceed. There is fear enough that disadvantaged populations, such as the institutionalized retarded, are singled out for drug experimentation. Providing the opportunity for third-party consent makes it more likely that non-competent groups will be increasingly the subject of such tests. If testing must take place, it should be according to ethics—moral and constitutional standards that are non-discriminatory both in form and in application.

Admission and status in hospital facilities also pose interesting issues. There is no suitable way of differentiating between third-party consent admissions and involuntary admissions unless it can be confidently assumed that the third party is a fit and conflict-free surrogate for the patient. If one were able to design fine and discrete levels of procedural safeguards, it would be possible to say that the protections surrounding involuntary admissions can be derogated to the extent that the third party can be said to be harmoniously identified with the patient's best interests.⁵⁶ Certainly, patients admitted under third-party consent procedures should not have diminished review rights in comparison with persons who are involuntarily committed. It is an irony of the present system that persons "voluntarily" committed by a guardian or conservator may never

56. Of course this analysis presupposes that there are safeguards surrounding the involuntary admissions process. We appreciate that there is something formal about this analysis in that the procedural standards in many jurisdictions are either inadequately developed or imperfectly administered. It is, however, most likely, that third-party consent techniques are used most frequently in those states where involuntary admissions are the most difficult to obtain.

have judicial review of their custody while "involuntary" patients may have very certain limits to their stay. This class of detainees is in a sense "twice-cursed." There is neither the assumed personal control over release and treatment that is the basis for regular voluntary status nor the growing set of protections for those involuntarily detained. There is nothing in their status which justifies this discrimination.

In conclusion, the outstanding aspect of third-party consent is that it usually includes the hazards of a purely involuntary state intervention without the cluster of safeguards that have been developed to surround state action in other fields. Our predictive (though not empirically demonstrated) conclusion is that there is a trend toward third-party consent to cover many transactions that would have been justified by pure state intervention at a time when such action was more palatable and available. In some circumstances, and to us they are in current practice among the most outrageous, a third party can consent to an action that is actually forbidden to the state acting with proper procedural safeguards. Third-party consent may have been an attempt to humanize and render more informal and more individual a system that seemed rigid and unyielding, but in the course of development, the technique may well have led to automatic, unreviewable state interventions. And often, resort to third-party consent may be a way of avoiding the "less restrictive alternative" analysis.

We do not mean to suggest in this article that there is no room for a third-party authorization of state intervention in the lives of persons who are mentally ill or mentally retarded. We are suggesting, rather, that the identity of persons so authorized, the process by which they come to have such power, and the restrictions or choices open to them must be much more closely analyzed. At present, the technique of third-party consent is a burgeoning failsafe, resorted to more and more frequently as other routes to state intervention become difficult to follow. However, the fictitiousness of current justification for the practice suggest that there will be more and more attacks upon it in the future. Courts must begin to wonder who a guardian is and how his selection gives him life and liberty depriving powers.