

INDIAN HEALTH SERVICE: STERILIZATION OF
NATIVE AMERICAN WOMEN,
1960s-1970s

By

JANE A. LAWRENCE

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Thesis Approved:

Michael G. Long

Thesis Advisor

Michael M. L. [unclear]

Joseph A. Stout, Jr.

Wayne B. Powell

Dean of the Graduate College

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NOMENCLATURE

ACLU	American Civil Liberties Union
AID	United States Agency for International Development
AIM	American Indian Movement
AIPRC	American Indian Policy Review Commission
BIA	Bureau of Indian Affairs
DHEW	Department of Health, Education, and Welfare
FDA	Food and Drug Administration
GAO	Government Accounting Office
IFCO	Interreligious Foundation for Community Organization
IHS	Indian Health Service
OEO	Office of Economic Opportunity
PHS	Public Health Service

Service sterilized at least 25 percent, and possibly up to 42 percent of the American women between the child-bearing ages

of Public Health Service and the Department of Health, Education and Welfare's federally funded sterilization program. A large number

On a November day in 1972, a twenty-six year old Indian woman entered Doctor Connie Pinkerton-Uri's Los Angeles office. The young woman asked Dr. Pinkerton-Uri for a "womb transplant." An Indian Health Service (IHS) physician had given the woman a complete hysterectomy six years earlier when she was having problems with alcohol abuse. She and her new husband wanted to start a family. The IHS physician had told her that the surgery was reversible so she believed she could get a new uterus. Dr. Pinkerton-Uri had to tell the young woman that it was impossible to have a "womb transplant." The woman left Dr. Pinkerton-Uri's office in tears.

Bertha Medicine Bull, a member of the Northern Cheyenne tribe in Montana, related how "two girls had been sterilized at age 15 before they had any children. Both were having appendectomies when the doctors sterilized them without their knowledge or consent."² The physicians also failed to inform the girls' parents. The girls would never have the chance to have children of their own. Medicine Bull continued with the statement that "there are 16-year-old Indian girls who refuse to go into a hospital for fear of being sterilized."³

What happened to these three females was a common occurrence during the 1960s and 1970s. The Indian Health

Service sterilized at least 25 percent, and possibly up to 42 percent, of Native American women between the child-bearing ages of fifteen and forty-four. The Public Health Service and the Department of Health, Education, and Welfare's federally funded family planning clinics also sterilized a large number of African American and Hispanic women during this time period. Teaching hospitals, such as the Los Angeles County-University of Southern California Hospital, sterilized many minority women on a large scale as well.

Why did these sterilizations take place? The main reasons doctors gave for performing these procedures were economic and social in nature. The majority of physicians were white, Euro-American males who believed that they were helping society by limiting the number of births in low-income, minority families. They assumed that they were enabling the government to cut funding for medicaid and welfare programs while, at the same time, lessening their own personal tax burden to support the programs. They considered the growing number of low-income, minority children to be an added burden to society. Physicians increased their own personal income by performing hysterectomies and tubal ligations instead of prescribing alternative methods of birth control. Some of them did not believe that minority women had the intelligence to use other methods of birth control effectively and that there were already too many minority individuals who caused problems in the United States, including members of the Black Panthers and the American Indian Movement. Others wanted to gain experience to specialize in obstetrics and

gynecology and used minority women as the means to get that entry experience at government expense. Finally, medical personnel of believed that they were helping the minority women because, by limiting the number of children they could have would help poor minority families to become more financially secure in their own right which would also lessen the welfare burden.⁴

Many minority groups have claimed that the actions of the federally funded family planning programs, teaching hospitals, and Indian Health Service facilities were acts of genocide. In December 1948, the United Nations held a conference in Geneva, Switzerland, that addressed the issue of cultural genocide. The Universal Declaration of Human Rights declared:

In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial, or religious group, as such;

- (a) Killing members of the group;
- (b) Causing serious bodily or mental harm to members of the group;
- (c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
- (d) Imposing measures intended to prevent births within the group; and
- (e) Forcibly transferring children of the group to another group.⁵

In 1948 all of the member nations of the United Nations, except the United States, signed the declaration. Forty years later the United States finally signed the declaration.⁶

While the actions of medical personnel in the practice of sterilization can be defined as genocide, the intent behind the majority of the sterilizations was not to eliminate the Native American, African American, or Hispanic populations in the United States. Most physicians who performed the sterilizations

believed that they were helping minority groups and the country as a whole. Unfortunately, their actions caused a great deal of harm to the women they sterilized, to the women's families, to the minority groups generally, and to the level of trust between the United States government and minority groups. As a direct consequence of the sterilizations, the victims of this action underwent psychological problems, alcohol and drug abuse, shame and guilt. Families fragmented because of conflicts that sterilizations caused within the unit. Men often wanted to have more children, and women were unable to handle marital problems at the same time that they were dealing with the ramifications of sterilization. Native American tribal communities faced a threat to their survival because of the sterilizations. Some tribal communities lost political power within the Indian tribe as a consequence of declining population. Today many Native Americans refuse to use Indian Health Service facilities for their health care needs because they no longer believe that the service will treat them with respect and honor their wishes.

This thesis examines the effects of sterilization on Native American communities. In order to understand what effect this had on Native Americans, it is necessary to investigate the eugenics movement within the United States in the twentieth century. This investigation leads to a comparison of the sterilization experience of other minority women with that of the Native Americans. This approach also leads to an examination of the actions of the government agencies involved and the doctrines of such organizations regarding sterilization,

evaluation of the specific sterilization practices of the Indian Health Service, an analysis of the actions and motives of the doctors involved in the sterilizations, and an analysis the impact that sterilization had on Native American women, families, and communities. Sterilization drastically affected all aspects of Native American communities. IHS practices harmed the relationship between Native Americans and the government, tribal communities, husbands and wives, mothers and their children, and friends. The operations also caused an inordinate amount of harm to individual Native American women whom the Indian Health Service physicians sterilized.

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CHAPTER ONE

Dr. Sir Francis Galton founded the Eugenics Education
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Eugenicists in the United States have advocated the use of
sterilization of the unfit and the poor since the early 1900s as
a method to strengthen the American population and the economy.
In the early 1950s, doctors performed eugenic sterilizations on
the mentally incompetent and on those incarcerated in prisons.
During the 1960s the belief in eugenic sterilization grew as
more and more Americans became upset with the amount of money
the federal government was spending on welfare programs. When
the United States government lifted the ban on sterilization
from federally funded family-planning programs in 1969, poor
Native American, African American, and Hispanic women became the
targets of population control programs.

Harold Becker, author of *New Dimensions in Criminal
Justice*, defines eugenics as "a science that deals with the
improvement of hereditary qualities in a series of generations
of a race or breed, especially by social control of human mating
and reproduction."¹ During the late 1800s and the early 1900s,
many scientists believed in the Malthusian proclamation that the
earth would not be able to produce enough food to feed the world
if population growth continued at such a high rate. These

scientists, along with political, intellectual, and economic leaders from Europe and the United States, began held declared conferences to discuss the possibility of population control programs.² They had long argued in favor of such a

In 1907, Sir Francis Galton founded the Eugenics Education Society, an international foundation with headquarters in England. The goals of the society were to encourage the biologically fit to reproduce and to discourage people of inferior stock from reproducing. Eugenics could also be described as a pseudo-science, as seen in Madison Grant's book, *The Passing of the Great Race*, published in 1916. American and British elitists held international eugenics conferences in London in 1912 and in New York in 1921. Attendees at these conferences included Winston Churchill, Herbert Hoover, the President-emeritus of Harvard, and the presidents of Clark University, Smith College, and the Carnegie Institute of Washington.³

Between 1907 and 1930, thirty states passed eugenics laws that allowed for sterilization of those believed to have a hereditary mental illness and for prison inmates whom prison officials judged as a continued threat to society. State legislatures designed sterilization laws to prevent births in groups they deemed to be harmful to the general welfare of the state. The government also passed immigration restriction legislation to limit the influx of those viewed as undesirable.⁴

The eugenics movement in the United States continued to gain momentum in the 1930s and 1940s. In 1932 the Third

International Congress of Eugenics held another conference in New York. In his opening speech, Dr. Russell Robie declared that approximately 14 million Americans should be sterilized because they had low I.Q. scores. His argument for such a massive sterilization project was that the people who had low intelligence scores were poor.⁴ Feminists also joined the eugenics movement. Prior to World War 1, Margaret Sanger wrote an article in a Socialist newspaper that called for limiting the number of children among the "unfit."⁶ The eugenic conclusion that the poor were stupid and immoral provided the impetus for a renewed sterilization campaign during the Great Depression. In 1936 Rabbi Sidney Goldstein proclaimed at a eugenics conference that "birth control or contraception cannot be depended upon to save us from the children of the very groups whom we are most eager to restrict." He continued by stating that sterilization was the only reliable method of restricting the birth rate of the poor and unfit.⁷ In 1942, the Birth Control Federation of America changed its name to the Planned Parenthood Federation of America and actively encouraged the use of birth control as a means to carry out the goals of the eugenicists. The board of directors of the Planned Parenthood Federation of America was comprised of individuals who were vigorous proponents of eugenics. Stephen Trombley, author of *The Right to Reproduce*, wrote that "From such roots grew a deep and continuing commitment to prevent the 'undesirable' surplus population from multiplying."⁸

The eugenics movement gained momentum despite the

sterilization practices of Nazi physicians during the Holocaust. Eugenicists in western Europe and the United States applied their vision of improving society to the criminal and mentally deficient groups; whereas, in Nazi Germany, Hitler's regime utilized the eugenics movement to purify the Nordic race. The eugenics movement in the United States only suffered a minor setback following the end of World War II.⁹

In June 1952 John D. Rockefeller III held a conference in Williamsburg, Virginia, to study the effects of an increasing population on the earth's resources. The contributors to the conference, mainly scientists, discussed rapid population growth, the ability of natural resources to maintain population growth, the possibilities of increasing food production through technological methods, and the effect of population growth on the economic development of the world. At the end of the conference, Rockefeller announced the formation of the Population Council as an international organization dedicated to the search for solutions to the population problems the conference addressed.¹⁰

The Population Council provided funding for research projects that studied demographics and reproductive physiology not only to scientists whom the council employed after 1957 but also to other organizations that met the council's requirements. The Population Council provided the eugenics movement with legitimacy and respectability that the movement had been lacking since the Holocaust. The council became an international leader in the population control studies that began in the 1960s as

more countries and organizations became concerned about population problems.¹¹

The Population Council took the lead in family planning research and developed many forms of birth control and improved sterilization surgeries. The council's research included studies on the effects of hormones on reproductive processes, on sperm production, on the physiology of the fallopian tubes and ovaries, and on the physiology of the male reproductive system. Their research produced the intrauterine device, an improved birth control pill, and improvements in sterilization methods such as hysterectomies, tubal ligations, and vasectomies.¹²

Beginning in the mid 1960s, the general public's concern over the population explosion and the effects it was having on the economic, environmental, and ecological resources of the world increased. Scientists, population control advocates, and others believed that the voluntary family planning programs that existed were not able to control population growth and that those programs had to be improved. Elaine Moss, the Population Council's historian, stated that "Some proponents of the critical need to reduce birth rates on environmental grounds raised for discussion possible direct or indirect coercive alternatives to voluntary family planning"¹³ throughout the world. The Population Council launched a program designed to bring physicians, medical associations and family planning program employees information concerning population growth and methods to limit further growth.

Helen Holmes, author of *Birth Control and Controlling*

Birth, defines population control as "a large scale social policy of (either encouraging or) limiting births throughout a whole society or in certain social groups for the purpose of changing economic, political, and/or ecological conditions."¹⁴ Champions of population control claim that this is the answer to eliminating poverty. They base their beliefs on the old Malthusian beliefs that "there are too many people and not enough resources and therefore the number of people must be reduced."¹⁵ During the 1970s, population control establishment spent immense amounts of money to develop techniques for limiting births. Supporters of population control subjected women to prostaglandin abortions, Depo-Provera, and birth control implants such as Norplant. These represent only a few of the abuses some women have faced in sterilization programs.¹⁶

With the beginning of President Lyndon B. Johnson's war on poverty, the welfare state in America grew larger as more people qualified for governmental assistance. Virginia Abernathy, a critic of Johnson, argues that the war on poverty "promised an easy and efficient lifestyle, set the poor . . . on a road to depending that did them no favor It can be no surprise that fertility did not fall, and even rose, among the poorest Americans."¹⁷ Many Americans believed that the increase in welfare rolls would only continue if something was not done to limit the birthrate among poor women.¹⁸

In 1969, population control became a matter of national importance for both the government and for physician's organizations. Newly elected president Richard M. Nixon

proclaimed that population control was a matter of concern for the government, and he named John D. Rockefeller III as chairman of the Commission on Population and the American Future. In the same year, Congress lifted the ban on sterilization in federally-funded family planning programs. Prior to 1969, physicians used the age/parity formula, or Rule of 120, to determine whether a woman should be sterilized. The rule was that a woman could be sterilized if her age multiplied by the number of children she had equaled 120. In 1969, the American College of Obstetricians and Gynecologists declared that the age/parity formula for female sterilization was outdated, for it did not allow for a sufficient number of sterilizations.¹⁹ Population control advocates now had governmental and medical backing to sterilize low-income, minority women.

The United States Constitution does not include specific protection for the right to bear children. As early as 1927, in *Buck v. Bell*, the Supreme Court ruled that compulsory sterilization was legal for those determined to have a hereditary mental deficiency. Other cases protected the right of competent individuals to grant their informed consent or to have been informed about all aspects of the treatment they were to receive prior to any medical procedures. The federal court system originally based the right to informed consent on the right to be free from battery and, later on, the right to privacy or the right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear or beget a child."²⁰

The rulings of the Supreme Court on the legalities of performing sterilizations did not stop the population control or family planning agencies from carrying out such procedures. Between 1969 and 1974, the Department of Health, Education, and Welfare's (DHEW) budget for family planning increased from \$51 million to \$250 million. The DHEW reported that in 1970 the department funded 90 percent of all the sterilization costs of poor Americans. The rate of federally funded sterilizations increased almost 300 percent between 1970 and 1977, with 192,000 sterilizations performed in 1970 and 548,000 in 1977. This was a dramatic increase from the 63,000 sterilizations performed between 1907 and 1964 in the United States.²¹

The original eugenicists' belief in sterilization of the mentally enfeebled and the criminal element in society changed over time to sterilization of poor and minority women for several reasons. Although racism had always existed in America, the demands of African Americans, Native Americans, and Hispanic Americans for equal rights in employment, housing, and governmental decision-making; the sometimes violent actions of groups such as the Black Panthers and the American Indian Movement to gain their rights; and the increasing numbers of minority groups led many in the white majority to fear what would happen in the United States if the population of minority groups continued to grow. Family planning projects targeted non-Caucasian women on welfare for birth control and sterilization. The modern eugenics movement made these women targets of abuse. Lisa Ikemoto, Ohio law professor, argues that

"ethnic elitism, classism, and racism - all contribute to the fact that the sterilization rates for poor women and women of color are higher than for white people."²²

The growing number of people on welfare caused concern among middle-class citizens about the amount of taxes they were paying to support the public assistance programs. States provide sterilization services under the Medicaid program, and receive 90 percent of their expenses from the federal government. Poor women lack any alternatives to publicly funded health care services. The agencies that provide these services are understaffed and underfunded, and many employees view sterilization as a means to cut their case loads and to free resources "because sterilized patients will no longer need contraceptive or obstetric care."²³ Richard Friske, a state legislator from Michigan, asserted that "there is a need for curbing the growth of the drone population that weakens our society. Educated, propertied Americans need a vigorous pronatalist outlook, but the tax pressure on the middle class forbids this . . . while the ignorant dependent elements multiply."²⁴ Friske's opinion was upheld by U.S. District Court Judge Don J. Young of Dayton, Ohio, who argued in a paper presented to the National Council of Juvenile Court Judges that teen-age girls who have a second illegitimate child should have an intrauterine device implanted in order to relieve "the growing welfare burden."²⁵

When Congress allowed the Department of Health, Education, and Welfare and other federal agencies to provide funding for

sterilizations in family planning programs, they did not require that any guidelines be set for the procedures. Nevertheless, in 1971, the Office of Economic Opportunity (OEO) published sterilization requirements. The instructions emphasized that sterilizations must be completely voluntary, that the services be offered only to legally competent individuals who requested sterilization, that those requesting to be sterilized must fully understand the risks and consequences of the surgery, and that the use of coercion to gain consent was strictly prohibited. Although the OEO took six months to develop these regulations and did publish them, they were never distributed to the 2,000 family planning programs that received funding from the OEO.²⁶

An investigation conducted by the *Medical World News* disclosed that the OEO shelved the regulations because the White House did not want them to be released to the public. While the investigation did not reveal that President Nixon was directly involved in the decision, it did confirm that members of the White House staff were among those making the determination. Howard Phillips, acting director of the OEO until the summer of 1973, stated that "the people at the White House felt that the President was opposed to it, and that he didn't want OEO funds used for sterilization And all indications are that the President has very strong feelings against sterilization."²⁷ The medical journal's inquiry into the withdrawn guidelines also reported that the OEO, with pressure from White House staff, may have recalled the regulations because of political concerns. President Nixon was seeking the support of the Catholic Church

for his 1972 presidential campaign, and he did not want to be associated with any type of birth control, especially sterilization.²⁸

The OEO's retraction of the sterilization guidelines caused many uninformed women to be sterilized without their consent. The Health Research Group in Washington, D.C., an affiliate of Ralph Nader's consumer advocacy group, charged in October of 1973 that:

The patient's are not fully informed of all possible consequences, that many are not aware that the operation should be considered irreversible, that women are often scared into sterilization with unfounded threats of vaginal cancer or mortality from possible future caesarean sections, and that many women are encouraged to sign sterilization consent forms just prior to or after delivery, when still heavily sedated.²⁹

Following the 1974 court case of *Relf v. Weinberger* in the District Court of the District of Columbia, the DHEW did comply with Judge Gerhart Gesell's order to place stronger regulations on federally funded sterilization procedures. Prior to this, in 1973, the DHEW had published restrictions concerning the sterilizations of minors and the mentally incompetent. The regulations issued in 1974 stated that an individual must give his or her informed consent before a physician performed a sterilization procedure, that there must be a seventy-two hour waiting period between the signing of the consent form and the surgery, and that patients be informed that they would not lose any federal benefits if they refused to undergo the sterilization operation.³⁰ Despite these regulations, sterilization abuse has continued.

DHEW regulations do not affect the sterilization procedures performed in medical facilities, such as hospitals and clinics, on women who do not receive federal benefits. The American Hospital Association and American Medical Association journals include few articles on the responsibilities of doctors and hospitals to their patients. The articles contained in these journals focus on what physicians and medical establishments can do to avoid malpractice suits. Many teaching hospitals target minority women for sterilizations as surgical practice for interns and as a means of limiting the amount of tax dollars hospital physicians pay for welfare recipients, regardless of whether or not the women are on welfare at the time of sterilization.³¹

Sterilization causes grief, guilt, and remorse in 3 percent to 25 percent of the women who undergo the procedure following their informed consent. When the consent is not informed, the percentage is even higher. Social scientists and medical researchers use the term "post-sterilization regret" to describe this phenomenon. The risk factors for regret include a woman being unmarried at the time of the surgery, either marrying or divorcing following the operation, marital disharmony at the time of sterilization, a woman being younger than thirty, and an education level lower than that of a high school graduate. At least eighty percent of women who do not give their informed consent for the procedure experience regret over the operation. Sterilized women who did not receive enough information to grant an informed consent relate that they feel devalued as women and

as persons.³²

Since 1977 it has been possible to reverse tubal ligations, but hysterectomies are still a permanent form of sterilization. Only 30 percent to 70 percent of the women who receive tubal ligations are candidates for a reversal, and even they are not guaranteed that the reversal will be successful. Success depends on what type of tubal ligation the woman underwent and the overall condition of the fallopian tube at the time of the reversal. There is also a much greater risk of ectopic, or tubal, pregnancies following a reversal. The majority of women are unable to afford the procedure because it is extremely expensive and medical insurance does not cover any portion of the cost.³³

Allen Chase, author of *The Legacy of Malthus*, argued that the eugenics conferences held in the early decades of the nineteenth century were the precursors to the present escalation of sterilization. He stated that "these congresses advanced the cause of the compulsory gelding of the poor in many ways."³⁴ Chase contended that the treatises the conferences produced pushed the belief that the poor people in the world "constitute separate and distinct races of chronic pauper stocks, who are by heredity mental and physiological degenerates, and who have to be wiped out by steadily expanding programs of forced gonadal surgery."³⁵ According to Chase, the "sterilization epidemic" began in the United States in 1965 and the Medicaid system "has helped to make the eugenicist's dream of limiting such groups as the poor come true."³⁶

The eugenics and population control movements in the United States spawned a tremendous number of sterilizations of poor and minority women. The motivations behind these sterilization operations included the improvement of the general population and lessening both federal expenditures and taxation used to support the welfare system. But, as social scientist Thomas Shapiro wrote in *Population Control Politics*, it must also be remembered that "just as technological developments have been strongly influenced in any society by the class that is in power, so too are patriarchal interests embodied in the search for scientific solutions."³⁷ The racial motivation must be considered as well.

CHAPTER TWO

Targeting Minority Women

Physicians and family planning projects targeted poor and minority women for sterilizations during the 1960s and 1970s. The medical community and family planning programs performed the majority of federally funded operations on African American, Hispanic, and Native American women. Why were poor and minority women the victims of sterilization programs? The reasons behind the procedures included the status of the welfare system, economics, and racism. Medical, social service, and family planning personnel believed they were helping themselves to lessen their caseloads and tax responsibilities, and the general population, by limiting the number of children that poor and minority women could have. In doing so, the medical personnel and social workers caused immeasurable harm to the minority groups and fostered a greater misunderstanding between the dominant white society and the various minority groups.

The Department of Health, Education, and Welfare (DHEW) did not publish federal sterilization regulations until 1973 after Lonnie Reif filed a million dollar lawsuit against the DHEW and the Office of Economic Opportunity (OEO) for the sterilization of two of his daughters and the attempted

sterilization of his daughter, Katie. The federal court ruling in the Relf case deemed those regulations inadequate. The DHEW revised the regulations in 1974 and again in 1977.¹

In 1972, Lonnie Relf filed the case on behalf of his daughters, Katie, seventeen; Minnie, fourteen; and Mary Alice, twelve, in the Montgomery, Alabama, United States District Court. The case claimed that the sisters represented minority, underage, illiterate, and mentally incompetent women who lacked the ability to give their legal consent for sterilization and other methods of birth control, specifically the use of Depo-Provera injections. The suit claimed that the birth control goals of the DHEW and OEO deprived poor people, who were dependent on the federal welfare system, of their constitutional rights under the due process clause of the Fourteenth Amendment.²

According to the Relf's attorneys, Morris Dees and Joe Levin, Jr., the suit pertains to the actions of a federally funded agency, a Montgomery physician, and several others. The Montgomery Community Action Family Planning Clinic administered Depo-Provera to the Relf girls as a birth control method. The Food and Drug Agency (FDA) had approved the use of Depo-Provera in 1970 on a "limited" basis for women "who cannot reliably use other forms of contraception."³ The FDA admitted that the drug could cause permanent sterility and an increase in breast tumors. The Montgomery clinic gave the Relf girls the drug because the employees did not believe that the girls had sufficient intelligence to use other birth control methods. At

United States Senate hearings on the drug in August 1973, Charles C. Edwards, then commissioner of the FDA, testified that public family planning services' use of Depo-Provera on a widespread basis did not have governmental approval. The DHEW then ruled that Depo-Provera could no longer be used in federally funded programs. This ruling led the Montgomery clinic's physician, Dr. A. E. Thomas, to perform sterilization procedures on Minnie and Mary Alice Relf. Katie avoided this action by locking herself in her bedroom when the clinic's employees came to take the girls to the clinic for the surgeries.⁴

On August 1, 1973, U.S. District Court Judge Robert Varner dismissed the original suit filed in Montgomery, Alabama. He dismissed the case because the Relf attorneys claimed that he was prejudiced against blacks. Varner refused to step down, stating that he was not prejudiced.⁵ Before dismissing the case, Varner stated that the suit could be refiled in another U.S. District Court but that the Relfs would only be able to have the class action portion of the suit against national anti-poverty officials heard. The Relf's attorneys refiled the suit in the District of Columbia as *Relf, et al. v. Weinberger, et al.*⁶

Several weeks after the Relf's attorneys originally filed suit in 1972, the DHEW announced temporary sterilization regulations for federally funded facilities. The DHEW did not publish the temporary requirements until August 3, 1973. The restrictions prohibited the sterilization of anyone under the age of twenty-one and of legally incompetent individuals. The

Secretary of the DHEW, Casper Weinberger, amended the regulations in September of 1973 so that mentally incompetent individuals could only be sterilized if a committee determined that the sterilization was in the best interests of the individual.⁷

Judge Gerhart Gesell, who heard the Relf case in the United States District Court in the District of Columbia in March of 1974, did not believe that the regulations were adequate to prevent sterilization abuse and ordered the DHEW to make further amendments. He ruled that competent adults must be given all of the information regarding the procedure that was needed to make an informed decision. Patients had to be presented, orally and in writing, with the information that they would not lose any federal benefits if they refused to undergo a sterilization operation. "Federally-funded assisted family planning sterilizations are permissible," the court said, "only with the voluntary, knowing and uncoerced consent of individuals competent to give such consent."⁸ Judge Gesell stated that there was "uncontroverted evidence" that poor women on welfare had been coerced into accepting sterilization with the threat of losing any welfare benefits that they received. He then ordered that the DHEW ensure that all sterilizations performed by federally funded programs were done so only at the request of the patient and that there must be evidence of a legally effective informed consent.⁹

In April, 1974, the DHEW published the revised regulations that incorporated the changes that Judge Gesell had ordered.

The revised regulations defined "informed consent" and the term "voluntary" and ordered that coercion must not to be used in gaining consent. The new regulations ordered that the legend, "NOTICE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects," appear at the top of all consent forms. Along with the written notice, the patient must be orally informed that they would not lose their benefits if they decided against sterilization.¹⁰ There must also be a seventy-two hour waiting period between the time a patient signed a sterilization consent form and the actual procedure. In spite of these improvements, the DHEW did not include any methods for verifying that family planning services followed the new regulations."

Coercive sterilization is a major problem; when medical personnel use coercion to obtain consent, they are claiming the right to interfere in the most intimate aspects of life. Coercion can be used in many ways to obtain consent for sterilizations. Simple deception is one method by which medical personnel simply perform the sterilization during surgery for another purpose or tell the patient that the surgery they are about to undergo is for another purpose, such as an appendectomy. Some judges, especially in California, required sterilization surgery as a prerequisite for an inmate's parole. The most common type of coercion is medical workers' threatening a patient with the loss of federal benefits. Other methods include violating the principals of informed consent, lying or

telling the patient that the surgery is reversible, and persuading a person who has not voluntarily sought the procedure to undergo sterilization.¹²

After the DHEW published the 1974 regulations, Congress evidently did not believe that there was enough protection against coercion in the restrictions. On July 29, 1975, Congress passed the "Anti-coercion" amendment which was included in the Family Planning and Population Research Act of 1975. The amendment reads:

Any (1) officer or employee of the United States; (2) officer or employee of any State, political subdivision of a State, or any other entity, which administers or supervises the administration or any program receiving Federal financial assistance, or (3) person who received, under any program receiving Federal financial assistance, compensation for services, who coerces or endeavors to coerce any person to undergo an abortion or sterilization procedure by threatening such person with the loss of, or disqualification for the receipt of, any benefit or service under a program receiving Federal financial assistance shall be fined not more than \$1,000 or imprisoned for not more than one year, or both.¹³

On December 13, 1977, the DHEW drafted new sterilization regulations that were more comprehensive than those published in 1974. The department printed the statutes on November 8, 1978, with an effective date of February 6, 1979. The federally funded family planning agencies had to discontinue using the myriad consent forms they had been using and replace them with a generic form that the DHEW designed. The standardized authorization spelled out the nature and consequences of sterilization operations in a simple and clear language that the patient could more easily understand. The DHEW would also issue the form in Spanish, and a family planning agency was required

to provide an interpreter, if necessary. The agencies must also certify that personnel, both orally and in writing, had furnished the patients with information that included an explanation of the operation, described alternative forms of birth control, and stated that federal benefits would not be revoked if they refused to be sterilized. The information must appear on a specific form that the DHEW had prepared. Another change in the regulations stated that the waiting period between the signing of the consent form and the actual sterilization surgery would be extended from seventy-two hours to at least thirty days, but not more than 180 days, and that patients could waive their consent at any time.¹⁴ Another amendment to the regulations proclaimed that "Consent may not be obtained from anyone in labor or childbirth, under the influence of alcohol or other drugs, or seeking or obtaining an abortion."¹⁵ The final addition to the regulations stipulated that federal funds would no longer be available for hysterectomies performed solely for sterilization purposes and that patients who underwent hysterectomies for therapeutic medical reasons must be informed, orally and in writing, that the operation would result in sterility.¹⁶

The new specifications still did not include methods to ensure that the family planning facilities would fulfill the regulations' requirements. By 1989, the DHEW was evaluating the effectiveness of state computer systems for monitoring sterilizations that were not in compliance with the regulations, but the department did not publish their findings or make them

public in any other way. The DHEW did not directly investigate any of the service providers to verify that they were complying with the federal regulations. Therefore, the effectiveness of the regulations and the providers' compliance with them are difficult to ascertain.¹⁷

Although the Relfs did not receive any monetary compensation, Judge Gerhart's ruling on the sterilization regulations brought sterilization abuse to the attention of other women. Upon closure of the Relf case, numerous women filed court cases claiming sterilization abuse. In Aiken City, South Carolina, two welfare mothers sued Dr. Clovis Pierce for the use of coercion in obtaining their consent for sterilization operations. Pierce, a former army physician who was the only private obstetrician in Aiken County, refused to deliver any pregnant woman who received welfare benefits if she already had two children unless she agreed to be sterilized. In 1973, Medicaid paid Dr. Pierce for performing eighteen sterilizations. He had sterilized two white women and sixteen black women.¹⁸

Two of the African American women Pierce had sterilized brought suit against him. Virgil Walker, a twenty-five-year-old woman, submitted to sterilization as a requirement for having Medicaid fund the delivery her third child. Officials at the Aiken County Hospital discharged Shirley Brown, twenty-six, from the hospital the day after she delivered her third child and refused to undergo sterilization. In the early 1970s, obstetrical patients normally spent between four and six days in the hospital following a birth. The federal court jury ruled

that Dr. Pierce had not violated Walker's civil rights. The jury, however, declared that Pierce and the hospital did violate Brown's civil rights, and they awarded her five dollars in damages for the violation.¹⁹

In Los Angeles, Hispanic women filed two separate lawsuits over sterilization abuse. Two Hispanic women and an African American woman filed the first suit, charging the Los Angeles County-University of Southern California Medical Center with sterilizing them without their knowledge or informed consent. They claimed that they gave their consent while they were in the midst of Cesarean births, in great pain, and under sedation. The physicians who performed the Cesarean sections also performed tubal ligations on the women. The hospital's physicians told two of the women that the sterilization was temporary; the physician who operated on the third woman, Melvina Hernández, did not tell her that she had been sterilized. Six weeks after Hernández's sterilization, she had an intrauterine device implanted that she used for two years before discovering that she had been sterilized. The women lost the case because they had signed consent forms and there were no written records revealing what the doctors had told the women.²⁰

Ten Hispanic women filed the second case against Los Angeles County Hospital because, between 1971 and 1974, the physicians had gained the womens' consent in English when they only spoke Spanish. The lawsuit also charged Dr. E. J. Quilligan, chairman of obstetrics and gynecology, and nine other doctors. The case claimed that hospital personnel obtained the

consents while the women were in labor, under sedation, or giving birth. A few of the women reported being told to sign a piece of paper if they wanted the pain to stop. A hand-writing expert testified at the trial that all ten women were "troubled" when they signed the consent forms and that there was a tremendous change in hand-writing between the signatures on their admission forms and sterilization consent forms. The lawsuit asked federal and state health officials to revise sterilization guidelines and sought \$170,000 per plaintiff. In October 1975, the court ordered that the DHEW and the California Department of Health create a consent form in Spanish, prepare it at the sixth-grade reading level, and provide counseling to patients in their native language. The monetary settlement phase of the trial began on May 30, 1978. The judge ruled against the plaintiffs, stating that the "case is essentially the result of a breakdown in communication between the patients and the doctors" and that the doctors were in the best position to determine the "validity" of a patient's consent.²¹

In Richmond, Virginia, four women brought a federal class-action suit against the Lynchburg Training Center and Hospital. Physicians at the hospital sterilized one of the plaintiffs, "Judith Doe," at the age of fifteen after her step-father had raped her. State records revealed that Ms. Doe was "not basically defective" at the time of the sterilization. "They didn't tell me when I went there," Ms. Doe said. "They did tell me I would be operated on, but not for what. They did say I would have my appendix taken out."²² Ms. Doe, forty-five at the

time the women filed the 1980 case, did not learn of the sterilization until her aunt and uncle told her she could not have any children when she arrived home from the hospital. She married when she was seventeen, but her marriage ended in divorce because of her inability to have children.²³

The suit charged that Virginia violated the constitutional rights of 7,200 women whom doctors sterilized without their consent at state hospitals from the 1920s through the early 1970s. The Virginia branch of the American Civil Liberties Union (ACLU) prepared the suit. The ACLU did not seek damages but requested that the court declared the sterilizations as a violation of the Fourteenth Amendment. They also wanted the state to be required to gain informed consent from women prior to sterilization procedures. The final desire of the ACLU was the notification of women sterilized between 1920 and 1980 of the sterilizations they underwent, the effects of the surgeries, and the possibility of reversals of the operations. ACLU attorney, Judy Goldberg, declared that "it was discovered during our investigation that the state sterilized these individuals without clear and convincing evidence that they suffered from a specific hereditary form of mental retardation or mental illness."²⁴ She continued her argument for notification with the proclamation that "the Commonwealth has refused to notify the victims of the nature, effects, and possible reversibility of the operations performed on them, thereby exposing them to severe and continuing medical and psychological harm."²⁵ Sterilization records disclosed that the state of Virginia was a

national leader in the number of sterilizations performed between 1920 and 1970.²⁶

The most publicized court case during the 1970s, other than the Relf case, was that of Norma Jean Serena, a thirty-nine year old Creek-Shawnee Indian woman, in Pittsburg. She filed suit against the Children's General Hospital of New Kensington, Pennsylvania, two of the hospital's doctors, three Armstrong County Child Welfare Service employees, and a Pennsylvania Department of Public Welfare caseworker for not only sterilizing her without her informed consent but also for illegally removing her three children from her custody. Richard Steven Levine, Serena's attorney, claimed that the defendants ignored his client's constitutional rights "to maintain a family relationship; to have the custody, companionship, services, and affection of her minor children; to procreate and bear children; and other rights as well."²⁷ Levine sought both punitive and compensatory damages for his client, although his main objectives were to gain the return of Serena's children and to set a legal precedent in court for the reproduction rights of poor people.²⁸

In 1973, the Western District Federal Court in Pennsylvania heard the first portion of Serena's case -- the removal of her children from her custody. In early 1970, an unidentified individual notified Child Welfare Services that Serena had a black boyfriend and expressed fear for neighborhood children "coming and going when black men were in the vicinity."²⁹ Caseworkers appeared at the Serena home and told

her that her two children appeared to be ill. They forced the family to go to the Children's General Hospital, claiming that "it is the law, you must go along." While the doctor who examined the children proclaimed that they were in good health, the caseworkers told Serena that the children were "seriously ill" and convinced her voluntarily, and temporarily, to place the children in foster care. But the caseworkers told the foster parents that the placement was permanent and that they would be able to adopt the children at a later date. When Serena gave birth to a son in August 1970, the Child Welfare Services and the Board of Assistance at the hospital also convinced her to put him in a foster home because of her exhaustion following the birth. Child Welfare personnel refused to let Serena visit her children or to regain custody. The court heard testimony that Levine had obtained in thirty depositions describing Serena as "an animal" . . . "too dumb to realize what's happening" and numerous statements that discussed "sterilizing the squaw." The court ruled that the social service departments had not used legal measures to place the Serena children in foster care and ordered that the children be reunited with their mother. Armstrong County Child Welfare officials deliberately delayed the return of the Serena children for almost a year until the court threatened to charge the agency with contempt of court in March 1974.³⁰ Altogether, the social service agencies illegally detained the two eldest Serena children for three years and the child born in August of 1970 for two and one-half years.³¹

The Western District Federal Court heard the second portion of Serena's case regarding her involuntary sterilization in January 1979. "We could have settled before with a malpractice suit, but we're more interested in getting a precedence set in court for other poor people," Levine stated.³² He continued by proclaiming that "this is the first case where we've been able to show that the state actually conspired to sterilize a person and got away with it."³³ Welfare officials told Serena before she gave birth in August 1970 that she "had had enough children" and that any future pregnancies could result in the birth of a retarded or deformed child. She refused to sign a consent form for sterilization at that time. The day after the delivery, when she was exhausted and on medication, she did sign a consent form, but the hospital had performed the surgery immediately following the birth the day before. Serena testified that she was "shocked to learn the nature of the surgery more than a year later when she was treated at another hospital in Pittsburg."³⁴ Levine discovered in a later investigation that the hospital records showed that the physicians performed the sterilization for "socio-economic reasons," or because she was poor. "The most difficult thing about this case," said Levine, "is getting people to believe it At least we have documentation of the racism and unethical deception practiced by these agencies," he continued. "These people [the defendants] yield enormous power in the name of benevolence. If this case does nothing else, it will put a bridle on that power."³⁵ In this portion of the case, the court

did not award Serena any monetary damages. The court did conduct an investigation into the sterilization regulations that the DHEW published in November of 1978. The court declared the new regulations satisfactory for protecting the reproductive rights of poor and minority women.³⁶

Numerous other allegations concerning sterilization abuse exist. In the late 1970s physicians in many northern cities such as Chicago, Detroit, and Cleveland still reported seeing African American women from the South who had been sterilized without their consent. Dr. Herbert Avery, a physician at the Watts Extended Health and Family Planning Group in Columbus, Ohio, believes the reason behind these sterilizations was "because they were having too many children."³⁷

Sterilization abuse occurs not only in the United States but also in poor Third World countries around the world. The director of the United States Agency for International Development (AID), R. T. Ravenholt, stated, "Without our trying to help these countries with their economic and social development, the world would rebel against the strong U.S. commercial presence."³⁸ In an interview with the *St. Louis Post Dispatch*, Ravenholt continued that, "Population control is necessary to maintain the normal operation of U.S. commercial interests around the world."³⁹ He declared that the United States' goal is to sterilize 100 million women in the world, or roughly one-quarter of the world's females. The Washington University Medical School and John Hopkins University train doctors from Third World countries in "advanced fertility

management techniques," including sterilization. In these cases, there is also evidence that the physicians sterilizing women do not obtain their informed consent. AID reported that it has four reasons for carrying out these sterilizations:

"a decline in [the] growth rate of poor countries will increase their standard of living, [the] U.S. has a 'moral responsibility to take leadership' because American medical advances created the population explosion by lowering death rates, population control is needed to maintain a normal operation of U.S. commercial interests around the world, and continuation of the population explosion would result in terrible socio-economic conditions that would result in revolutions harmful to the United States."⁴⁰

In 1976, the San Francisco Sterilization Clinic, a division of the San Francisco General Hospital, opened and began offering women free tubal ligations if they qualified for federal financial assistance. The DHEW funded the clinic's family planning program while cutting funding for child care centers, Head Start programs, and community health programs. When women receiving federal funding inquired about day care or Head Start, the social service agencies referred them to the San Francisco Sterilization Clinic for free sterilizations. The clinic required its counselors to obtain twenty-five consents for sterilization a week.⁴¹

Sterilization is the most extreme method of birth control because, in most cases, it is irreversible. Sterilization abuse occurs whenever medical personnel convince women to undergo a sterilization procedure under circumstances where duress and/or pressure are present. Teaching hospitals push sterilization to train new physicians, and the doctors use terms such as "tying the tubes" and "bandaid surgery" to describe the procedure to

their patients. These terms cause women to consent to sterilization in the belief that the surgery is a temporary method of birth control. Hospital employees often obtain a woman's consent during times of duress, such as when the woman is in labor or about to undergo an abortion. Sandra Serrano Sewell, a social scientist who studies mainly Chicana women, asserts that "Female sterilization presents unique opportunities for abuse because women can be subject to coercive pressures merely by virtue of the fact that they must come to a hospital for childbirth or abortion."⁴²

Medical and family planning personnel give many reasons for their actions, but the majority of the motives given have racial and economic overtones. The "Ethnic Group and Welfare Status of Women Sterilized in Federally Funded Family Planning Programs" study published in *Family Planning Perspectives* in 1974 revealed that the women sterilized in DHEW funded programs "were more likely to be Latin American or black and to be public assistance recipients."⁴³ Population studies reported that the white race was not growing, whereas the African American, Hispanic, and American Indian minority groups were increasing. While sterilization is a legal form of birth control, during the 1970s many middle and upper class white women had difficulties finding physicians who would sterilize them. At the same time, doctors sterilized a great number of minority and poor women against their will. Johan Elliot questioned whether "nonwhite women, more often served in public facilities are offered the option [of sterilization] more frequently than white women."⁴⁴

He further stated that "nonwhite Americans are not unaware of how the American Indian came to be called the vanishing American [Sterilization is] this country's starkest example of genocide in practice."⁴⁵ In 1968, the national director of the Congress of Racial Equality, Floyd B. McKissick, told a liturgical conference that, according to a survey conducted by the Congress of Racial Equality, many white Protestants believe that "if poor people and Black people stop having children, the whole problem will go away. In a few more generations, there will be no more poor people and no more Black people."⁴⁶ He concluded his speech with the statement that "they seem to conceive of birth control as a sort of painless genocide."⁴⁷ Thomas Littlewood, author of *The Politics of Population Control*, wrote that "if blacks, Latinos, and other groups deemed inferior, defective, troublesome, costly, etc. can be induced to stop multiplying, either voluntarily or involuntarily, the middle and upper classes think they would rest more easily."⁴⁸ The DHEW sterilization programs subjected minority women to a calculated endeavor to limit the growth of minority groups.

While racism was a factor in the sterilization abuse that occurred, economic reasons were a much more important rationalization for the procedures. Family planning services and hospitals, both public and teaching, supported the belief that poor and minority women wasted taxpayers money in federally funded programs. Dr. Bernard Rosenfeld, a member of the Health Research Group, conducted a study in Los Angeles that exposed some of the doctors' attitudes toward poor women. One doctor

said, "Well, if we're going to pay for them we should control them."⁴⁹ When Rosenfeld told the doctor that the patient he sterilized was not on public assistance, he replied, "Well, her children will be."⁵⁰ Over 30 percent of the doctors Rosenfeld interviewed made statements similar to this. Other doctors, especially at teaching hospitals, claimed to have performed the surgeries to get practice in performing sterilizations. Family planning services and hospitals compelled women to be sterilized because the federal government reimbursed states for sterilization procedures. In addition, physicians believed that they were not only decreasing the number of welfare recipients but also discovered that they would gain higher reimbursements for sterilization than for prescribing other methods of birth control. On one hand, family planning program and hospital personnel, especially in southern states, frequently told white workers that the reason they had so many taxes deducted from their paychecks was that they were supporting "all those non-white women and their welfare children. On the other hand, non-white people are told they are poor, not because of job and education discrimination, but because they have too many children."⁵¹ The study conducted in 1974 and published in *Family Planning Perspectives* concluded by stating that "there remains, therefore, a positive correlation between receipt of welfare assistance and the rate of sterilization, even after age and parity [regarding number of children and income] are controlled."⁵² Because the welfare system relied partially on federal funding to pay for its services, family planning center

and hospital personnel believed that they were not only lowering the amount of federal funds supporting poor families, but they also surmised that they were lowering their taxes and increasing the amount of money they would receive in their paychecks.⁵³

The DHEW distributed pamphlets to family planning centers to induce women to undergo sterilization procedures. One pamphlet showed a Native American couple with ten children and one horse and another couple who had one child and ten horses, thereby implying that fewer children meant a higher income (see Appendix 1). Two pamphlets claimed that women could achieve a higher level of sexual gratification once they submitted to sterilization. While the pamphlets stated that tubal ligations were almost guaranteed to cause permanent sterility, they also declared that "you never have to worry about getting pregnant again That brings peace of mind to many women, who may also experience greater sexual pleasure after they have been sterilized."⁵⁴ Studies have shown that sterilization "does not increase the sex drive and no other nostalgic pleasures are experienced as a result of sterilization."⁵⁵ The use of propaganda in government sterilization pamphlets was directed at minority and low-income women. None of the pamphlets contained depictions of white women.⁵⁶

While sterilization abuse has not been reported recently on the scale that occurred during the 1970s, the possibility still exists for mistreatment to occur. Regulation alone is not enough incentive to stop the abuse. The DHEW does not audit the family planning programs or the public hospitals funded by the

department; it audits only the computer records on reported sterilizations that do not meet the guidelines' requirements. Statistics have shown that sterilization abuse victimizes minority and poor women. These actions have caused minority women to file court cases seeking to gain their constitutional rights. Another result is that the women, aware of the racial and economic implications of sterilizations, distrust white physicians, family planning employees, and other medical workers. Therefore, sterilization practices during the 1970s caused not only a reduced number of children for minority women but also expanded the separation between white Americans and the minority populations.

CHAPTER THREE

The Indian Health Service: History and Sterilization Practices

Native Americans accused the Indian Health Service (IHS) of sterilizing 25 percent, or more, of Native American women between the ages of fifteen and forty-four during the 1970s. Allegations included the failure of the IHS to provide women with the necessary information regarding sterilization, the use of coercion to get the women to sign consent forms, the utilization of improper consent forms, and the lack of an adequate waiting period between the signing of a consent form and the surgical procedure. Unfortunately, a lack of communication between the various levels of governmental agencies led to discrepancies in how the IHS carried out the federal sterilization regulations. This chapter investigates the historical relationship among the IHS, Indian tribes, and other federal agencies; the right of the United States government to sterilize women; the government regulations pertaining to sterilization; and the efforts of the IHS to sterilize American Indian women.

The government began providing health care for American

Indians during the early 1800s. Under the auspices of the War Department, "Army physicians took steps to curb smallpox and other contagious diseases of Indian Tribes living in the vicinity of military posts" during the 1800s.¹ Army physicians used medical procedures, such as vaccinations, to prevent the military men, who came in contact with the Indians, from being infected with the diseases, rather than to protect the health of the Indians. The United States signed the first treaty that included medical services with the Winnebago Indians in 1832. Other treaties that included health care provisions followed, usually with a time limit of five to twenty years for health services. The federal government ignored the time limit and continued to provide services after the expiration dates in the treaties. In 1832 Congress passed the first appropriations bill for Indian health care in the amount of twelve thousand dollars.²

In 1849 Congress transferred the Bureau of Indian Affairs (BIA), along with the responsibility of providing health care for the Indians, from the War Department to the Department of the Interior. The transfer "stimulated the extension of physicians' services to Indians by emphasizing non-military aspects of Indian administration and by developing a corps of civilian field employees."³ By 1875, half of the federal Indian agencies had physicians; the BIA built the first federal hospital for Indians in Oklahoma during the late 1880s. The BIA began hiring nurses in the 1890s to provide health services at Indian boarding schools. By 1900 the BIA began a concentrated

effort to construct hospitals or infirmaries on all reservations and at all boarding schools.⁴

After the turn of the century, the BIA created the position of chief medical supervisor, formed a separate Health Division, and appointed district medical directors. The Health Division started control programs for tuberculosis and other diseases and established health education classes to support these programs.⁵ The Snyder Act of 1921 included congressional authorization for the BIA to provide Indian health care "for the benefit, care, and assistance of the Indians throughout the United States."⁶ The BIA contracted with the Public Health Service (PHS) in 1928 to provide sanitation engineers to investigate water and sewage problems at BIA facilities.⁷ In 1950 the PHS expanded its services to improve the sanitation in reservation homes.

In 1955 Congress passed legislation that transferred the responsibility for Indian health from the Department of the Interior to the Public Health Service. A condition of this transfer was that "all facilities transferred shall be available to meet the health needs of the Indians and that such health needs shall be given priority over that of the non-Indian population."⁸ The PHS, a division of the Department of Health, Education, and Welfare (DHEW), formed the Division of Indian Health, which was renamed the Indian Health Service in 1958. At the time of the transfer, there were not enough physicians or medical facilities available to provide the proper medical care for American Indians. Congress believed that the PHS would be

able to recruit a greater number of physicians by offering more attractive salaries and fringe benefits and to increase and improve medical facilities with higher Congressional appropriations for the DHEW.⁹

The PHS has improved the health of Native Americans and the medical treatment facilities in the years since 1955. Congress appropriated more money for health concerns to the DHEW and its subsidiaries than it did to the BIA and, according to Alan Sorkin in *Public Policy Impacts on American Indian Economic Development*, "congressional appropriations increased nearly twelve-fold on a per-Indian basis between 1955 and 1983."¹⁰ Deaths from diseases such as tuberculosis and gastroenteritis have dropped significantly, and infant mortality has declined tremendously. Illnesses caused by a lack of proper sanitation have also been reduced greatly. More Indian people are using the medical services of the IHS as their primary care-giver. The number of IHS doctors increased from 125 in 1965 to 600 in 1980. During the same time period, the number of registered nurses increased from 725 to 1700.

Even though there have been increases in the number of medical personnel, statistics show that the number of doctors and nurses in relation to the number of Indians seeking service from the IHS has actually decreased since 1966. The actual number of patients per physician dropped from 2,200 in 1955 to 1,220 in 1966, but the number of patients rose to 1,500 in 1980 because of the increase in the Native American population. The number of patients per registered nurse decreased from 400 in

1955 to 330 in 1966, but in 1980 the number climbed to 529. In 1980 the general population had one doctor for every 494 patients, and one nurse for every 182 patients.¹¹ Despite the low ratio of medical personnel to Native American patients, it must be remembered that the IHS improved the overall health of Native Americans following its inception in 1958.

The IHS implemented family planning services for Native Americans in 1965 under the guidelines of the DHEW and the PHS.¹² Family planning services not only provide birth control supplies and medical examinations but also provide women with information on contraception and sterilization, the different methods of birth control and how to use them, how the various products work, and assistance in determining which form of contraceptive is right for the individual.¹³ Family planning methods include the birth control pill, the intrauterine device, spermicidal jellies and creams, and sterilization. Family planning is supposed to give women the right to choose whether or not they wish to participate in the program and what type of birth control they wish to use.

The United States government agencies, including the DHEW, PHS, and IHS, targeted American Indians for family planning because of their high birth rate. The 1973 census report stated that every 1,000 Indian women bore a total of 3,799 children, whereas the total fertility rate for all groups in the United States was 1,799.¹⁴ The number of actual births per 1,000 Indian women in 1973 was 30.4, down from 43.0 in 1963.¹⁵ The 1970 and 1980 censuses included specific information on Indian

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tribes, including family size and fertility rates for women in the childbearing years (fifteen to forty-four). The data show that the average number of children per woman in specific tribes were as follows:

<u>Tribe</u>	<u>1970</u>	<u>1980</u>
Navajo	3.72	2.52
Apache	4.01	1.78
Zuni	3.35	1.90
Sioux (combined)	3.41	1.94
Cherokee (Oklahoma)	2.52	1.68
Ponca/Omaha	2.73	1.51 ¹⁶

White women averaged 2.42 children in 1970 and 2.14 births in 1980, a significant difference from the rate of change that occurred within the Native American community. In their separate studies on Navajo, Cherokee, and Apache tribal demographics, Cheryl Howard, Russell Thornton, and Veronica Tiller contend that the lower number of children per woman in 1980 may have been affected by the higher educational levels of the women and by the provision of family planning education.¹⁷ They do not mention sterilization as a partial cause of the decline, but anyone who investigates this population decline must consider sterilization as a factor.

Informed consent is a necessary part of any medical procedure. Physicians are required to tell their patients about the nature and purpose of the procedure, the risks of treatment, the possible side effects, and any alternative treatments.¹⁸ The Supreme Court has made several rulings on the issue of informed consent.

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The Supreme Court and the District Court in the District of Columbia set legal precedents regarding informed consent and sterilization between 1914 and 1973. The first case in 1914, *Schloendorff v. Society of New York Hospital*, concerned a surgeon who performed an operation which left a man partially paralyzed. The court based its ruling on the belief that any individual who physically touches another person without that person's consent commits battery. Justice Benjamin Cardozo spoke for the majority of the court when he stated that "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault."¹⁹ This case provided a constitutional right for individuals to govern their own body on the same basis by which the Constitution grants them the right to determine their own religion, employment, and place of residence.²⁰

The Supreme Court heard the case of *Skinner v. Oklahoma* in 1942. Jack Skinner was an inmate in an Oklahoma prison, convicted of armed robbery, and the state had passed legislation that allowed for the sterilization of inmates considered to be a threat to society. Justice William Douglas wrote that the crime Skinner committed did not merit sterilization and ordered the state not to sterilize the inmate. The court also expressed concern over the possibility of abuse arising from the sterilization legislation. Justice Douglas continued that "the power to sterilize, if exercised, may have far reaching and devastating effects . . . [and in] evil hands it can cause races

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or types which are inimical to the dominant group to wither and disappear."²¹

In the Matter of Earle Spring in the early 1970s, the Supreme Court ruled that informed consent constituted more than a protection against battery, as the ruling in the *Schloendorff v. Society of New York Hospital* had stated in 1914. The court asserted that the legal concept of battery was no longer appropriate to "the factual realities of the doctor-patient relationship."²² In a unanimous decision, the court stated that informed consent was based on "the constitutionally protected right of privacy which has been held to extend to unwanted infringements upon the bodily integrity of patients."²³ The new definition of informed consent strengthened the patient's right to control what a physician could, or could not do, to the patient's body. The later cases of *Eisenstadt v. Baird* in 1972 and *Roe v. Wade* in 1973 strengthened the argument that the "right of privacy entails the right of the individual 'to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear or beget a child.'"²⁴

In March 1974 the District Court in the District of Columbia combined two cases that directly concerned the DHEW's sterilization regulations. The two cases were *Relf, et al. v. Weinberger, et al.* and *National Welfare Rights Organization v. Weinberger, et al.* Judge Gerhart Gesell declared:

Regulations of Department of Health, Education and Welfare governing human sterilizations are arbitrary and unreasonable in that they fail to implement

congressional command that federal family planning funds not be used to coerce indigent patients into submitting to sterilization. . . . [and that] Federally assisted family planning sterilizations are permissible only with the voluntary, knowing and uncoerced consent of individuals competent to give such consent.²⁵

Judge Gesell then explained that the legislation providing funds for family planning services to the poor did not mention sterilization specifically, but that the secretary of the DHEW, Casper Weinberger, considered sterilization to be covered by the statute. The judge admonished Secretary Weinberger for not following the regulations as written.

The judge continued by observing that:

Congress had insisted that all family planning programs function on a purely voluntary basis, [but] there is uncontroverted evidence in the record that minors and other incompetents have been sterilized with federal funds and that an indefinite number of poor people have been improperly coerced into accepting a sterilization under the threat that various federally supported welfare benefits would be withheld unless they submitted to irreversible sterilization.²⁶

The final conclusion of the court was that:

Federally assisted family planning sterilizations are permissible only with the voluntary, knowing and uncoerced consent of individuals competent to give such consent. . . . [and that] the regulations must also be amended to require that individuals seeking sterilization be orally informed at the very outset that no federal benefits can be withdrawn because of a failure to accept sterilization. This guarantee must also appear prominently at the top of the consent document already required by the regulations.²⁷

The published regulations in the *Federal Register* in 1973 and 1974 were not sufficient to protect women from sterilization abuses. The DHEW appealed the decision, but the court upheld the ruling later in the year.

All of the aforementioned cases dealt with the issue of

informed consent and the patient's right to make an informed decision about what could be done to his or her body. Informed consent cannot be given unless the doctor discloses the nature and purpose of the procedure, the likelihood of success, the risks involved, and any alternative treatments.²⁸ The patient then decides if the procedure the physician recommends is the right treatment for his or her own personal well-being. Marc Basson and Eli Bernzweig, specialists in medical law and ethics, both argue that it is the physician's obligation to reveal all necessary information to the patient and that the failure to provide such information is a violation of the doctor-patient relationship and is a form of malpractice.²⁹ Marc Hiller, another expert on medical law and ethics, agrees but also asserts that "informed consent reflects one of our highest ethical values -- individual autonomy; it implicates strong emotional needs both for control over our own lives and for dependence upon others; and it deals with a subject of fundamental importance, our health."³⁰ Accurate information is a vital component of informed consent, and although there were court decisions that proclaimed the necessity of providing informed consent until 1973, the DHEW did not publish any directives protecting an individual's right to receive informed consent.

The Office of Economic Opportunity (OEO), the government office with direct control over federal family planning programs, issued the first regulations regarding sterilization in 1971. The rules included providing the patient with the information necessary to constitute informed consent, a waiting

period between the time the patient signed the consent form and the doctor performed the surgical procedure, and a moratorium on the sterilization of women under the age of twenty-one and women considered mentally incompetent.³¹ The OEO withdrew their guidelines on February 2, 1972. The *Denver Post* reported that "the speculation in some public health circles is that President Nixon or his aides . . . don't wish the administration to be involved in a federally subsidized sterilization program, even with rigid regulations to assure that all persons undergoing the operations did so freely."³² The *Denver Post* also mentioned that the reasons could be in-fighting among OEO officials. Whatever the OEO's reasons were for withdrawing the guidelines, it is important that they recalled the guidelines at a time when the sterilization practices of government agencies needed to be regulated.

The DHEW publishes its regulations in the *Federal Register*, and the PHS and IHS, as subsidiaries of the DHEW, are required to adhere to those regulations. On August 3, 1973 the DHEW established a moratorium on the sterilization of anyone under the age of twenty-one and on anyone doctors had declared mentally incompetent. Another DHEW notice, published on September 21, 1973, announced that the Secretary had approved the proposed regulations with minor amendments to the original guidelines. The regulations stated that a committee may determine if sterilization was in the best interests of a mentally incompetent person, that competent individuals must grant their informed consent, that there must be a signed

consent form in the possession of the agency performing the sterilization showing that the patient knew the benefits and costs of sterilizations, and that a seventy-two hour waiting period must occur between the time of consent and the surgical procedure.³³ The ruling in *Relf, et al. v. Weinberger, et al.* responded to the deficiencies in the guidelines: the need for a definition of the term "voluntary," the lack of safeguards to insure that sterilizations were voluntary, and the absence of prohibitions against the use of coercion in obtaining consents.³⁴

The DHEW published the revised regulations on April 18, 1974. The new requirements included the changes that Judge Gesell ordered regarding the definition of terms, the methods necessary to guarantee informed consent, and protection against the use of coercion. The amended regulations define informed consent as:

- The voluntary, knowing assent from the individual on whom any sterilization is to be performed after he has been given (as evidenced by a document executed by such individual):
1. A fair explanation of the procedures to be followed;
 2. A description of the attendant discomforts and risks;
 3. A description of the benefits to be expected;
 4. An explanation concerning appropriate alternative methods of family planning and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.
 5. An offer to answer any inquiries concerning the procedures; and
 6. An instruction that the individual is free to withhold or withdraw his or her consent to the procedure at any time prior to the sterilization without prejudicing his or her future care and without loss of other project or program benefits to which the patient might otherwise be entitled.³⁵

The revised regulations also dictated that every sterilization

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consent form exhibit prominently at the top of the form the legend, "NOTICE: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects."³⁶ The DHEW restricted the performance of any sterilization unless the patient voluntarily requested the operation and unless agency personnel advised the patient verbally that no benefits would be denied if he or she refused to be sterilized.³⁷

Congress and the general public believed that the revised regulations would help protect women from involuntary sterilizations but accusations soon arose that the Indian Health Service was sterilizing women without their informed consent and without following the regulations to which the IHS was subject. Senator James Abourezk of South Dakota, chairman of the Senate Interior Subcommittee on Indian Affairs, received letters from Native American doctors and hospital personnel in Oklahoma and New Mexico. Initially, Senator Abourezk's staff believed that some of the allegations originated from actual events. The senator, on April 30, 1975, requested the Government Accounting Office (GAO) to conduct an investigation on both Indian sterilization and the experimental use of drugs on reservations.³⁸

The Government Accounting Office released its report (hereinafter referred to as the GAO Report) on November 6, 1976. Although the GAO Report did not verify that the IHS had performed coerced sterilizations, it did state that the IHS had not followed the necessary regulations and that the informed

consent forms were in violation of the standards set by the DHEW.³⁹

The GAO conducted its investigation of IHS sterilization practices in four of the twelve IHS program areas: Aberdeen, Albuquerque, Oklahoma City, and Phoenix (see Appendix II). The Albuquerque area hospitals and health centers do not perform sterilizations in their own facilities; they send patients to contract physicians for sterilization operations. The GAO investigated the practices of the contract facilities regarding sterilizations.⁴⁰ The GAO Report examined IHS records, which showed that the IHS performed 3,406 sterilizations during the fiscal years 1973 through 1976. GAO personnel did not interview any Native American women who had been sterilized during this period because they said they "believe[d] that such an effort would not have been productive."⁴¹ The introduction to the GAO Report revealed that the IHS performed twenty-three sterilizations of women under the age of twenty-one between July 1, 1973, and April 30, 1974. The GAO Report revealed that thirteen more under-age sterilizations occurred between April 30, 1974, when the DHEW published new regulations in the *Federal Register*, and March 30, 1976, despite the DHEW moratorium on such sterilizations. The GAO discovered that the consent forms used were not in compliance with IHS regulations, and that IHS medical providers used several different forms. The majority of the forms "did not (1) indicate that the basic elements of informed consent had been presented orally to the patient, (2) contain written summaries of the oral presentation, and (3)

contain a statement at the top of the form notifying the subjects of their right to withdraw consent."⁴² The GAO Report then proceeded to add detail to the initial overview.

The IHS records did not specify what type of sterilizations had taken place. There are two acceptable types of sterilizations, voluntary and therapeutic. The DHEW defined voluntary, or nontherapeutic, sterilizations as "any procedure or operation, the purpose of which is to render an individual permanently incapable of reproducing."⁴³ When the purpose of a sterilization is to treat a woman for a medical ailment, such as uterine cancer, it is a therapeutic sterilization. The GAO Report revealed that "as of August 1976, however, IHS was unable to supply us with complete and statistically reliable data on whether or not the sterilizations were voluntary or therapeutic."⁴⁴

The DHEW regulations required that a waiting period of at least seventy-two hours elapse between the signing of the consent form for a voluntary sterilization and the actual operation. The investigators found thirteen infractions of the regulations applying to the required seventy-two hour waiting period.⁴⁵ Medical records reveal that "several" consent forms were dated the day the woman had given birth, usually by Cesarean section, while she was under the influence of a sedative and in an unfamiliar environment. Medical documents also disclose that a "few" women signed consent forms on the day following their sterilization operation.⁴⁶

In July 1973 the DHEW initiated a moratorium against the

sterilizations of women under the age of twenty-one and of women considered to be mentally incompetent. The DHEW regulations published in the *Federal Register* in April 1974 continued the moratorium. Between April 1974 and March 1976, the IHS sterilized thirteen women who were younger than twenty-one. The violations occurred apparently because "(1) some Indian Health Service physicians did not completely understand the regulations and (2) contract physicians⁴⁷ were not required to adhere to the regulations."⁴⁸

Despite the claims that some physicians did not understand the regulations, the notice sent to the area directors on August 2, 1973, stated clearly that "there is, effective immediately, a temporary halt in the IHS sterilization procedures performed on an individual who is under the age of 21 or who is legally incapable of consenting to sterilization. This policy does not apply when the operation is performed for the surgical treatment of specific pathology of the reproductive organs."⁴⁹ A memorandum to the area directors reconfirmed the moratorium on October 16, 1973, and again on April 29, 1974. The IHS sent all of these notices by telegram so that there was no delay in receiving them.⁵⁰

On August 12, 1974, the IHS sent a memorandum directly to the IHS physicians stressing the importance of the DHEW regulations, along with a copy of the regulations and copies of the Director's telegrams to the area directors. On December 15, 1975, the IHS Director again notified the area directors and hospital and health center personnel that the DHEW regulations

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must be followed and that the sterilization of women under the age of twenty-one or women judged mentally incompetent, "is permissible only when 'the procedure is carried out for medical reasons unrelated to the primary intent to sterilize the individual.'" ⁵¹ The IHS justified the exceptions to the sterilization moratorium reported to the GAO in several ways: IHS doctors continued to believe that they could perform these sterilizations until they received the notice dated April 29, 1974; they misunderstood the policy; they performed the sterilizations for medical reasons but intended to render the patients incapable of having children; or the patients would be turning twenty-one in a few weeks time. ⁵² Two cases were not included in these numbers ⁵³, increasing the total sterilizations in violation of the moratorium to thirty-eight. The Deputy Director of Program Operations reported to the investigators that, while the IHS had established surveillance over the sterilizations of women under the age of twenty-one, physicians may not have reported these cases knowing that there was a moratorium against them. ⁵⁴

The GAO investigators examined 113 of the 3,406 consent forms for sterilizations procedures. They discovered that IHS medical facilities used three different versions of the form and that all three forms were variations of the short-form. In ninety-one cases doctors used Form MSM-83; this form is supposed to be used for medically required sterilizations, not for voluntary sterilizations. Physicians used Standard Form 522 for ten of the consent documents. Neither of these forms provided

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all of the necessary information required by the DHEW regulations. The consent forms did not record whether or not medical personnel orally informed the patient of the risks, dangers, and alternatives to the procedure; they did not include written summaries of any oral information that may have been given; and they did not incorporate the required statement alerting patients to their rights if they decided to forego sterilization.⁵⁵

IHS personnel used the third form, Form HSA-83, in twelve cases, and this form appeared to the GAO to comply with most of the DHEW regulations. The GAO revealed that Form HSA-83 was also inadequate because it did not contain enough detail to ascertain whether the patients received all of the necessary information. The form also did not have a written disclosure of all of the elements of informed consent and did not include a section where medical personnel could add a summary of the oral presentation.⁵⁶

In order to assess the justification for the surgeries, the GAO investigating committee also reviewed fifty-four sterilizations performed at the Phoenix Indian Medical Center between April 1 and September 30, 1975. While most of the cases revealed valid cause, the reasons behind nineteen were questionable. The GAO Report stated that investigators discussed these sterilizations with the Chief of Obstetrics and Gynecology at the center and that the reasons for the nineteen sterilizations remained unresolved.⁵⁷ The GAO did not explain why the nineteen cases were questionable.

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The GAO Report gave two causes for deficiencies found in the sterilization practices of the Indian Health Service. First, the IHS area offices failed to follow the DHEW regulations pertaining to sterilization procedures. Second, IHS headquarters did not provide specific directions to the area office by neglecting to create a standard consent form for all of its facilities, by failing to revise its manual to reflect the new DHEW regulations, and by not providing guidelines for the area offices to use in implementing the procedures. The GAO Report also stated that IHS headquarter officials attributed the above deficiencies to the DHEW's "inability to develop specific sterilization guidelines and a standardized consent form for all its agencies to use."⁵⁸

The weaknesses in the sterilization consent forms included the failure to divulge fully the required information on the risks involved in the procedure and the alternative methods of birth control that the individual could use. The GAO Report declared that "The forms also failed to include the required statement 'Your decision at anytime not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects.'⁵⁹ The IHS officials in the areas examined did not monitor the sterilization practices of contract care facilities. The contracts they signed with outside doctors did not stipulate that those doctors had to follow the DHEW regulations. Yet the regulations declared that "the provisions of this subpart are applicable to programs or projects for health services which are supported in whole or in

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part by Federal financial assistance, whether by grant or contract, administered by the Public Health Service."⁶⁰ The regulations required that the IHS monitor the sterilization activities of the doctors with whom they had contracts.

The GAO Report ends with recommendations for improvements in the IHS sterilization practices:

We recommend that the Secretary of HEW direct IHS to (1) expedite its efforts to have a standard consent form which provides for full disclosure of the information required by the regulations [see Appendix III], (2) provide training to their physicians and administrators so that they fully understand the requirements concerning (a) sterilization of persons under 21 and persons who are mentally incompetent and (b) obtaining informed consent, (3) include in the contracts with non-IHS physicians and facilities, provisions to insure that contractors comply with the HEW sterilization regulations, (4) continue to monitor compliance with the moratorium on sterilization of persons under 21 years of age, and (5) develop monitoring procedures to assure compliance with the regulations by contract physicians and facilities.

We also recommend that the Secretary of DHEW direct that HEW sterilization regulations be amended to (1) conform with the ruling of the U.S. district court order that a patient, regardless of the consent form document used, be informed orally that no Federal benefits can be withdrawn and (2) require that the signature of a person obtaining a patient's consent appear on the consent form.⁶¹

Other organizations and individuals also carried out investigations and made reports on the sterilization practices of the IHS. The Health Research Group, a non-profit public interest organization funded by Ralph Nader's Public Citizen, Inc., analyzed the regulations developed by the DHEW. The groups' report, published on October 29, 1973, stated that women "don't have to be *legally* incapable of giving informed consent . . . in order to be victimized by eager surgeons. . . . in many cases, only the *doctor* is fully informed and the *patient*

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consents."⁶² The report also contended that the regulations proposed by the DHEW in 1973 failed to protect an individual's right to privacy and right to have children, which the decisions in *Roe v. Wade* and *Skinner v. Oklahoma*, among others, proclaimed the Constitution guaranteed. They recommended that the regulations include stronger protection against coerced sterilizations, a comprehensive informed consent form, and a method of verifying that all sterilizations performed with government funds were voluntary unless the doctors performed the procedures for therapeutic reasons, in which case a second opinion from another licensed physician should be required.⁶³ While this study did not pertain specifically to the IHS, its findings are applicable to the IHS because it is a division of the DHEW.

The American Indian Policy Review Commission (AIPRC), Task Force 6 on Indian Health conducted a study on the overall health of Native Americans and on the facilities and services offered to them through the Indian Health Service. They presented their report to the United States Senate, Select Committee on Indian Affairs in January and February 1977. The AIPRC reported that, while the overall health of American Indians had improved a great deal since the transfer of Indian health care to the Public Health Service, there were still major problems in the service, especially "a lack of oversight and accountability at all levels of [the] Indian Health Service."⁶⁴ They recommended that the IHS improve its management, that the communications between the different levels of authority be

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strengthened, and that the responsibility among the area offices, IHS hospitals, and health centers be defined clearly. The AIPRC also recommended that contract care providers be subject to the same regulations that the IHS was required to follow and that the contracts throughout the IHS be uniform in nature.⁶⁵ The proposals that the AIPRC made pertain to the entire IHS, but they are similar to the recommendations made in the GAO Report on Indian sterilizations.

Dr. Constance Pinkerton-Uri, a Choctaw-Cherokee Indian physician, was one of the doctors who brought the sterilization issue to the attention of Senator Abourezk. Pinkerton-Uri conducted her own investigation of IHS sterilization practices at the Claremore Indian Hospital in Claremore, Oklahoma. Through interviews with women who had been sterilized and through hospital records, she determined that "more than 25 percent of all Indian women have been sterilized since 1962 . . . [and] that at one IHS hospital in Claremore, Okla., for every four Indian babies born, one woman was sterilized."⁶⁶ The Association of American Indians conducted a study that also showed that IHS physicians and contract physicians sterilized 25 to 35 percent of Native American women in the child bearing age group.⁶⁷

Tribal Judge Marie Sanchez, a Cheyenne, interviewed women in her tribe after she learned about the sterilization practices of the IHS. During the week following the release of the GAO Report in November 1976, she questioned fifty women and discovered that IHS doctors had sterilized twenty-six of them.

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She announced her belief that the number of women the GAO reported sterilized was too low and that the percentage was much higher than 25 percent.⁶⁸

All of the investigations and their accompanying reports demonstrated that the Indian Health Service carried out a high number of sterilizations during the 1970s, and that the IHS did not explicitly follow the necessary regulations. The IHS did not comply with the requirements regarding the moratorium on sterilizations of women under the age of twenty-one, the informed consent forms and in several cases, the seventy-two-hour waiting period. In other cases, IHS medical personnel pressured women to sign consent forms under adverse conditions. The distribution of information between the different levels of the Indian Health Service lacked consistency. IHS officials placed the blame for their actions on other areas within the IHS and on the Department of Health, Education, and Welfare. The Government Accounting Office stated that physicians did not understand the DHEW regulations. All of these circumstances led IHS physicians to perform a high number of sterilizations.

The Indian Health Service has been responsible for the health care of Native Americans since 1955. The service inherited the responsibility from treaties, the War Department, the Interior Department, the Bureau of Indian Affairs, congressional legislation, and the Public Health Service. That responsibility includes insuring that IHS patients are properly treated and that their rights are protected. The IHS did not meet that responsibility in its sterilization practices.

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CHAPTER FOUR

"Never Do Harm To Anyone"

Every physician takes the Hippocratic Oath upon graduation from medical school. The Oath contains the phrase "I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone In every house where I come I will enter only for the good of my patients."¹ The Hippocratic Oath provides the foundation for medical ethics and law. Yet, physicians during the 1960s and 1970s routinely placed their own welfare and the well-being of the majority, or white, population before that of their individual patients when those patients were minority women who received federal assistance.

"I will . . . never do harm to anyone." What precisely does this statement in the Hippocratic Oath mean to physicians? From the late 1960s through the 1970s, physicians routinely sterilized Native American, African American, and Hispanic women, especially those women who received federally funded medical care. The physicians' actions did harm the women by rendering them barren and incapable of having children. Investigations and interviews revealed that the physicians sterilized the women without their informed consent for racial and economic reasons. The physicians' attitudes toward the sterilization of poor, minority women mirrored the attitudes of the general population at the time. The doctors believed that

they were helping to lower the federal government's monetary responsibility for providing medical and welfare services to poor, minority families; that the sterilizations would lower the income taxes physicians and others had to pay out of their wages for welfare benefits; that sterilizing minority women would relieve the racial problems the country was experiencing; that the physicians who performed many of the sterilizations were gaining the needed experience to become obstetrical and gynecological specialists; and, finally, that the doctors would earn more personal income for performing sterilizations, rather than prescribing other methods of birth control, on women who received federal funding for medical expenses. Medical personnel also believed that they were helping the women because fewer children meant lower costs for child care and child medical expenses.

African American, Hispanic, and Native American women all complained that they had signed consent forms for sterilizations without being fully informed about the surgery. The patient is supposed to be the primary decision maker in any medical procedure. The doctor's duties include determining what patient's problem, the various forms of treatment, and the possible side-effects of the treatment. The physician is then required to convey that information to the patient, who makes the final decision to accept or reject the treatment based on his or her own personal values and preferences. Marc Hiller, an expert on medical ethics and law, wrote that "Decisions about medical care are not to be made exclusively by doctors because

they do not, indeed they cannot, have access to other information highly relevant to the making of the decision. Only the patient has access to such information."²

The classical elements of informed consent include the risks, benefits, alternatives, and nature of the treatment; and doctors are required to explain these things to their patients. The failure to disclose such information is in violation of the doctrine of individualistic purposes - "the promotion of individual self-determination, human dignity, and rational decision making."³ Dr. Isaiah Berlin, a prominent physician and medical professor, said that "to lie to men [or women] or to deceive them, that is, to use them as means for my, not their own independently conceived ends, even if it is for their benefit, is, in effect, to treat them as subhuman."⁴ Informed consent is one of the highest ethical values in the United States, yet many physicians tended to ignore this part of the ethical code during the 1970s.⁵

Doctors wield a great deal of power over their patients, especially regarding any treatment that they may prescribe, including sterilization. Intelligent adults, who are normally accustomed to making all the decisions necessary for their own welfare, "regress psychologically" and become dependent on their physician, whom they often view as a parental authority figure. A. Edward Doudera, an authority on the topic of informed consent, stated that "The doctor-patient relationship unavoidably provides for a great deal of coercive power on the physician's side."⁶ Population control advocates provide medical journals with articles designed to inform physicians about population control

sanctions on such things as the use of forced sterilization after a woman has had a certain number of children. Linda Gordon, author of *Woman's Body, Woman's Right*, argues that "The more common use of material incentives is merely another form of coercion, especially when the rewards are accompanied by incomplete explanations."⁷ The Department of Health, Education, and Welfare (DHEW) pamphlet advocating the sterilization of Native American women is an example of the use of economic motivations (see Appendix I).⁸

Dr. Bernard Rosenfeld, a physician for the Health Research Group, conducted a study in Los Angeles to determine doctor's attitudes toward sterilization. He interviewed fifty doctors from the University of Southern California regarding sterilization abuses and found that about 25 percent of the physicians practicing at the Los Angeles County-University of Southern California Hospital "actively pushed sterilizations on women who either did not understand what was happening to them or who had not been given the facts regarding their operations."⁹ Excerpts from some of Dr. Rosenfeld's interviews are included in the following paragraphs.

One intern at the hospital stated that, "What they did to minority group women there, particularly Mexican-Americans, really turned me off . . . They would get a young woman, maybe 19 or 20, who was having a baby and start right in on her in the delivery room, urging her to have her tubes tied. This would continue when the physician was on morning rounds. They kept telling her it was 'simply a matter of having your tubes tied

and then you won't have to hassle with the pill anymore'
[The patients] had no idea that the procedures being forced on them was permanent. They probably thought that they could simply have their tubes 'untied' later.¹⁰

A young doctor from a university hospital in Michigan expressed his belief that he did not "think the department had a policy. It was up to the particular M.D. [Rosenfeld then asked if they requested consent during labor.] Sure, after the eighth pain. That's how it's done, isn't it? Some house staff would routinely ask women if they wanted their tubes tied during labor. Some were as young as fourteen."¹¹

A doctor who interned at a Virginia hospital revealed that sterilization "was pushed there. They were just told that tubal ligation was best for them. They didn't actually force them, but I never saw a woman refuse after she was talked to. I would say that many of the women didn't really understand what was going on."¹²

An intern at the Los Angeles County Hospital declared that "Yes, they pushed them (tubal ligations). They would get the students to push them too. If the students talked the patients into them, they got to do them. The guy that was really hungry to do some surgery, that's all he did - push, push, push."¹³

A doctor comparing sterilization practices in Florida to Los Angeles contended that "There it was worse by far. They would just go ahead and do it (during a Cesarean delivery.) 'Hey this tube is bleeding a little, better tie it off.' It got to be a standing joke. Here, at least, we get them to sign

something."¹⁴

A doctor in his forties who trained in Texas claimed that "I used to make my pitch while sewing up the epistotomy [a small incision to facilitate the birth of a baby], when the anesthesia started wearing off. 'Want any more children?' 'No, No!' 'We can help you very easily tomorrow.' It was staff [resident] policy. They used to wear buttons saying 'Stop at two, damn it.'"¹⁵

A doctor who trained in San Diego claimed that "Some of the guys would push them real hard, especially if a woman was having an illegitimate baby or if they were very hungry for surgery. It varied between residents. One resident would be so furious if a woman declined that he would say 'We know you're here illegally, and if you don't consent to have a tubal, we'll call the feds and get you deported.'"¹⁶

An Ohio doctor stated that "[We used to do a] soft sell, sort of fatherly advice: 'you really shouldn't have any more kids. Do you really think it's fair for someone else to pay for your kids?' The approach to the white middle-class patient was much different than the approach to the black welfare recipient. It wouldn't surprise me if some of the women didn't entirely understand the procedure or the alternatives. The alternatives were rarely gone into with a black welfare mother who had two or more kids."¹⁷

Rosenfeld drew several conclusions from his investigation. The first was that the doctors used their position of power as a means of convincing women to undergo sterilization without

revealing all of the details to the patients. His second conclusion was that the doctors did it as a financial matter. "They get \$250 or \$300 for a fifteen to twenty minute operation, while they get nothing for putting a woman on the pill and maybe \$25 for fitting her with an IUD."¹⁸ Rosenfeld claimed that one study showed that 94 percent of gynecologists believed that welfare recipients should either be sterilized after having two children or should be taken off of welfare. He claimed that when doctors discuss developing "better human beings [through population control methods] what they're really talking about is white, prosperous ones."¹⁹ Rosenfeld's final conclusion was that interns and residents used training hospitals as a place to gain the required surgical expertise necessary for becoming licensed obstetricians and gynecologists. They used minority women on welfare as their guinea pigs.²⁰

The physicians' racial attitudes and economic concerns further induced them to perform sterilizations. Some physicians disregarded their patients' preferences and refused to try to understand the different cultural attitudes about family size and legitimacy. The doctors considered the "excessive" childbearing of minority women as being deviant or inappropriate behavior. Medical personnel believed that poor, minority women should not have children because they cannot afford them; they did not realize that a large family was often the only gratification that these women received in their lives and that children often provided the only means of financial support for the parents when the children grew older. Sherrill Cohen and

Nadine Taub, authors of *Reproductive Laws for the 1990s*, recounted how "a Boston clinic serving primarily black clients reported that 45 percent of its black clients 'chose' tubal ligation as a method of birth control after their first child was born."²¹ The attitudes of physicians pertaining to the intelligence of minority women also led them to urge sterilization on women they believed would be unable to use other forms of birth control effectively. Economic propaganda also influenced physicians to push sterilization procedures on minority women who received welfare benefits. In the belief that the "welfare problem" would go away if minority women quit having children and that they would have fewer taxes deducted from their wages, physicians sterilized welfare women, the majority of whom were members of minority groups.²²

Prior to 1969, many physicians and hospitals were wary of performing sterilization procedures, but in 1969 a federal court of appeals heard the case of *Jessin v. County of Shasta* that then encouraged doctors to perform more of the procedures during the 1970s. The case involved a woman who sued her county hospital for performing a sterilization operation on her after she had signed a consent form. The judge ruled that "voluntary sterilization is legal when informed consent has been given, that sterilization is an acceptable method of family planning, and that sterilization may be a fundamental right requiring constitutional protection."²³ Prior to this case, many physicians had assumed that sterilization as a birth control method was not legal.

The Health Research Group in Washington, D.C. published a study in 1974 that revealed that the number of sterilizations increased dramatically following this ruling. The report stated that physicians performed over one million sterilizations in 1973, a tremendous increase from the total of 63,000 sterilizations performed between 1907 and 1964. The study also disclosed that the major American teaching hospitals had doubled the number of sterilizations performed in both 1972 and 1973 and that doctors who performed tubal ligations did so on twice the number of black women as they did on white women.²⁴

In 1978, the DHEW held a public hearing in Boise, Idaho, to discover how doctors would react to proposed changes in the sterilization regulations. The proposed modifications included a thirty-day waiting period between the signing of a consent form and the actual surgery; the prohibition of sterilizations of people under the age of twenty-one, of inmates in penal institutions, and of the mentally incompetent; and a restriction on federal funding for hysterectomies performed to cause infertility. In the 1970s, doctors advocated hysterectomies over tubal ligations for women they believed had too many children and as a teaching experience for interns and residents. While the 1974 regulations included the ban on sterilizations of people under the age of twenty-one, the other changes proposed advanced the protection of women, and men.²⁵

The doctors at the public hearing criticized the proposed regulations. Dr. W. L. Blackadar stated that "I couldn't believe that knowledgeable people would put this trash out" when

commenting on the added protection welfare recipients would receive under the regulations.²⁶ He also claimed that the seventy-two hour waiting period established in 1974 already caused abuse of the regulations to occur and that a thirty day waiting period would only increase the abuse. He did not explain how the waiting period set in 1974 caused abuse. "We don't need a 30-day waiting period," said Dr. Zsolt Koppanyi, director of the DHEW Bureau of Child Health. "I can see increased pregnancies if you try it."²⁷ The restriction on sterilizations of women under the age of twenty-one also caused the physicians to malign the regulations. Dr. Robert Bailey objected to the age limit, stating that if a person could not consent to a sterilization at the age of twenty-one, it should also be illegal for that person to be able to donate their organs or to join the armed forces. Blackadar agreed with him, stating, "I've got a nineteen year old patient now who has four children - all illegitimate - and she wants to be sterilized. Must I have to tell her she has to wait until she's old enough?" He continued his argument with the words: "Clearly, you need to keep Health and Welfare out of the practice of medicine."²⁸ While the doctors who attended the hearing opposed the proposed regulations, the DHEW received over forty letters from physicians who could not attend the hearing who agreed with the proposed changes in the regulations. Apparently, the physicians at the hearing had forgotten the sterilization abuses that had already occurred during the decade. Despite the negative response, in November of 1978 the DHEW published the proposed

regulations that would take effect in February of the following year.²⁹

In 1966, Eli P. Bernzweig, an attorney for the Public Health Service (PHS), a division of the DHEW, wrote a book entitled *The Legal Aspects of PHS Medical Care*. He described malpractice as the "failure on the part of a physician . . . to perform in a proper manner the legal duties incumbent upon him in carrying out his professional responsibilities to another, resulting in a legally cognizable harm to the latter."³⁰

Bernzweig wrote that patients of PHS doctors would file any legal actions against the government, unless a reason existed for which a patient could not sue the government. In those cases, an employee of the PHS would receive legal representation from the Department of Justice at no cost, thereby avoiding the expense of litigation as well as having the "legal and investigative resources of the Government" at his or her disposal as an added benefit.³¹

Bernzweig then explained how physicians could avoid personal liability in their medical practice. He stated that patients who brought liability suits against the PHS usually sued the young and relatively inexperienced doctors who joined the PHS right out of medical school. The most common type of liability suit occurred because of the physicians' "failure to warn the patient of the risks of hazardous therapy or surgical procedures, or to obtain his informed consent thereto."³²

Bernzweig defined informed consent and described exactly what informed consent required of physicians. The 1974 DHEW

sterilization regulations used Bernzweig's descriptions and explanation of informed consent almost verbatim. In the final chapter, Bernzweig recounted the various court cases that emphasized the legal requirements of informed consent and discussed the importance of each case. He closed his book with a statement that physicians could avoid legal problems if they paid attention to the legal requirements that Congress, the courts, and governmental departments placed on medical practitioners.³³

During the late 1960s a large number of physicians entered the Public Health Service, and the department then assigned them to the Indian Health Service (IHS). Almost 70 percent of the doctors who entered the PHS did so as an alternative to going to Vietnam. The doctors usually left the IHS as soon as they completed the two-year period they had to serve in lieu of military duty.³⁴

The majority of the physicians who applied for the IHS positions had recently received their medical degrees, had not yet completed the requirements for their specialties, and did not have any knowledge about the Indian cultures they would enter. For many of the young recruits, the conditions and problems that they faced at IHS facilities proved to be too much of a change from what they were used to, and they were unable to adapt to the different cultures they encountered.³⁵ Others used the IHS hospitals and clinics as training grounds for their future specialties, especially in the gynecological and obstetrical fields. The rapid turnover rate of reservation

physicians did not allow the doctors to establish good relationships with their patients.³⁶

When the draft ended in 1973, the IHS experienced difficulties in recruiting new physicians. While they once received seven applications for every two positions, in 1974 they received fifty applications for 200 open posts. The service also encountered hardship in retaining physicians past the required two-year commitment. The problems with recruitment and retention have continued through the 1980s and 1990s. The reasons that physicians have given for leaving include "dissatisfaction with the IHS bureaucracy, administration, and lack of support for the clinical program," poor pay, isolation, unsatisfactory facilities, and the desire of their families to leave the reservations.³⁷

The doctors who gained employment with the IHS often sought to broaden their experience, especially in the fields of gynecology and obstetrics. John Schultz, author of *White Medicine, Indian Lives* argues that "The Indian Health Service provides an opportunity for a wide range of practical applications of medical skills in a relatively short period of time."³⁸ While some dedicated physicians gave up lucrative private practices to provide qualified health care for Native Americans, other doctors came to the IHS because they wanted to gain the necessary experience for their specialties, especially in the fields of gynecology and obstetrics.³⁹ One physician explained that the sterilizations of minority women resulted from medical greed rather than from racism. He said, "If there's a doctor

and a uterus around, the two will get together. Let's face it, if you're a gynecology resident, how are you going into practice if you ain't yanked some utes?"⁴⁰

Physicians did not join the IHS as a way to increase their personal wealth, although IHS contract doctors did provide their services for monetary gain. From 1969 through 1975, the IHS did not receive the increased funding allocated to the service by Congress. President Nixon impounded the IHS money, "causing a shortage of funds for pay increases, and allowing IHS facilities to fall into deplorable condition."⁴¹ Therefore, there was no financial motivation for doctors to stay in the direct employ of the IHS. For several reasons, however, outside physicians signed contracts with IHS hospitals and clinics to provide specialized services for Native Americans and to furnish medical care that IHS clinics could not grant, such as surgical procedures. During the 1970s, contract doctors did not have to follow the regulations published by the DHEW. The IHS paid contract physicians up to \$800 for a hysterectomy, whereas a doctor who performed a tubal ligation received only \$250. Contract physicians did not follow those guidelines until after the Government Accounting Office Report in November of 1976 recommended that the IHS state in its contracts with outside physicians that the DHEW regulations must be followed, or the physicians would not be paid for their services.⁴²

Racism also played a part in the sterilization procedures that took place in the 1970s. The physicians that the IHS hired came from a culture different from the one he or she encountered

on the reservation or at other IHS facilities. The physician "carries with him the biases of the white American culture," according to John L. Schultz.⁴³ The biases included the training they received at teaching hospitals where their teachers sterilized minority women in an attempt to lower the number of people receiving welfare, the population control activists belief in sterilization as a method to reduce the number of people they deemed harmful to society and the ecology, the majority culture's fear of minority groups, and medical school requirements to read the views of established physicians that medical journals, such as *Contemporary ob/Gyn*, published. *Contemporary ob/Gyn* printed one article a doctor wrote that stated: "As physicians, we have obligations to our individual patients, but we also have obligations to the society of which we are a part. The welfare mess . . . cries out for solutions, one of which is fertility control."⁴⁴ He then recommended sterilization as the most effective form of fertility control for welfare and minority women.⁴⁵

Physicians and hospitals that served minority women did not abide by the statement in the Hippocratic Oath to "never do harm to anyone." They sterilized poor, minority women because they believed it would relieve the country's welfare burden and to increase their personal income through lowered income taxes and payments received for sterilizations. They followed the doctrines of the early twentieth century eugenicists who advocated the sterilization of those "inferior" to the majority population, and of the population control establishment's

doctrine that the number of poor people, generally from minority groups, had to be decreased. The physicians used minority women to further their career goals, especially in the fields of gynecology and obstetrics. Did they have to perform sterilizations? No, they did not. The "'conscience clause' of the 1973 Health Programs Extension Act allows anyone who does not want to be involved with sterilization or abortion activities to be exempt on the grounds of religious or moral convictions."⁴⁶

CHAPTER FIVE

Impact on Native Americans

Cheyenne saying:
A nation is not conquered
Until the hearts of its women
Are on the ground.
Then it is done, no matter
How brave its warriors
Nor how strong its weapons.¹

The Indian Health Service (IHS) sterilized between 25 and 42 percent of Native American women between 1970 and 1976. The impact on Native Americans was disastrous. National pan-Indian groups such as the American Indian Movement (AIM) and the Native American Women's Caucus joined other national multi-ethnic groups, including the Interreligious Foundation for Community Organization, to protest the government's sterilization practices. Tribal communities lost up to 50 percent of their ability to reproduce, the respect of other tribal entities, and political power in the tribal councils. The sterilization of Indian women affected their families and friends; many marriages ended in divorce and numerous friendships became estranged or dissolved completely. The women had to deal with higher rates of marital problems, alcoholism, drug abuse, psychological difficulties, shame, and guilt. Sterilization abuse affected the entire Indian community in the United States.

The Government Accounting Office (GAO) Report released in November 1976 revealed an alarming number of federally financed sterilizations that the IHS conducted on Native American women. On November 23, 1976, the senator who requested the report, James Abourezk of South Dakota, released a press statement that stated: "Since the GAO investigation covers only four of the twelve IHS service areas in the United States we do not know how many sterilizations were performed on Indian people throughout the whole country."² According to census reports, there were only 85,000 Indian women of child-bearing age in the United States in 1970. The GAO study reported that physicians sterilized 3,406 Indian women in one-third of the IHS areas in just over three years.³

After the release of the GAO Report, a congressional coalition demanded a more thorough investigation. The letter the congressmen sent to the GAO stated that the 1976 report "raise[d] questions about government participation in sterilization."⁴ The letter also requested the GAO to conduct an investigation to determine the total number of men, women, and children sterilized in federally funded programs since 1970; the age, ethnic data, and racial backgrounds of those sterilized; the number of offspring each woman had prior to sterilization; whether doctors performed hysterectomies on women they sterilized and, if so, whether the hysterectomies were for therapeutic or sterilization purposes; and whether the Department of Health, Education, and Welfare (DHEW) 1974 regulations had lessened sterilization abuse. Generally, only

one member of Congress requests a GAO report; in this instance nine senators signed the bipartisan letter to the GAO. These included Robert Young of Missouri, John Conyers, Jr. of Michigan, Joshua Elber of Pennsylvania, Tennyson Guyer of Ohio, Margaret Heckler of Massachusetts, Henry Hyde of Illinois, Jerry Patterson of California, James Scheuer of New York, Harold Volkner of Mississippi, and Henry Jackson of Washington. Senator Jackson also raised specific questions about the IHS role in Native American sterilizations; such as: Did the shortage of doctors at IHS facilities cause physicians to violate the medical code of ethics?, and What steps did the IHS take to ensure that sterilization abuse did not occur? Senator Young told the press that the coalition believed that the 1976 GAO Report "revealed only the tip of the iceberg" of federal sponsored sterilizations conducted on American Indians and other minority groups.⁵

In the spring of 1977, the United Nations held a conference in Geneva, Switzerland, and released the Social and Cultural Report. The report stated that "the indigenous population of the Americas must be protected from the following practices by government . . . : sterilization operations in the absence of free and informed consent; adoption; sponsorship; and foster-home programs."⁶ The conference issued the report not only because of the 1976 GAO Report but also because of the 1948 Convention on the Prevention and Punishment of the Crime of Genocide, which stated that "imposing measures intended to prevent births within the group" was a crime of genocide.⁷ The

United States was did not sign the 1948 agreement until 1988.⁸

In September 1977, the National Council of Church's Interreligious Foundation for Community Organization (IFCO) held a conference in Washington, D.C., to plan strategies for a "fight for survival" against sterilization abuse. Over sixty delegates from Native American, African American, Hispanic, civil rights, religious, and other groups attended the conference. While the conference addressed the abuses that all minority groups faced, it focused on those that Native American and Hispanic women underwent.⁹

Mary Ann Bear Comes Out, a member of the Northern Cheyenne tribe, conducted a survey on the Northern Cheyenne Reservation and Labre Mission grounds. Following the release of the GAO Report in November 1976, she investigated Indian Health Service sterilization of women over the age of thirty in her tribe. She found that in a three-year period, the IHS sterilized fifty-six out of 165 women between the ages of thirty and forty-four in the survey area. She wrote, "The data indicates that the same rate of sterilizations would reduce births among this group by more than half over a five-year period."¹⁰ She did not inquire into the younger age brackets. An examination of the data for younger women in the survey area would probably reveal an even higher rate of sterilization because other investigations have found that doctors sterilized younger women more frequently than they did older women. The reports of federally financed family planning programs that performed sterilizations indicated that less than half of the women sterilized were thirty or older.¹¹

The IHS damaged tribal communities in several ways. Tribal communities represent sections of the entire tribe, much as a precinct represents a specific area within a city. The population of a community reflects the number of representatives it can elect to the tribal council and to national pan-Indian organizations. Therefore, a community's level of power within the tribal government is affected by the number of people in the community. Other tribal communities may believe that a community with a high number of sterilized female residents is incompetent to take care of its people, a belief that affects the community's pride.¹²

Some Indian leaders believe that the sterilization of Native American women also affects the tribe's economic base and sovereignty. Lee Brightman, President of United Native Americans Inc., argues that "the sterilization campaign is nothing but an insidious scheme to get the Indians' land once and for all."¹³ Large amounts of natural resources such as uranium, coal, oil, copper and other resources are found on Indian land. Brightman believes that "by killing off the unborn" the government can take away Indian lands without legislation because "there will be no more Indians to hold the land."¹⁴ Everett Rhoades, past president of the Association of American Indian Physicians, argues that there is a non-Indian backlash that "seems to have arisen from the recent gains made by Indians" in the sale of natural resources.¹⁵ The Women of All Red Nations state that "the real issue behind sterilization is how we are losing our personal sovereignty" as Native

Americans.¹⁶ Members of the organization assert that communities having large number of sterilizations lost the respect of other tribal communities because of their inability to protect Native American women. The Sioux members of the Women of All Red Nations maintain that the Pine Ridge Reservation lost a large measure of the esteem it normally received from the Rosebud Reservation. The organization claims that Indian women have allowed governmental agencies to determine the future of the tribes and that native women need to stand up to physicians who try to take away that future.¹⁷

Dr. Connie Pinkerton-Uri, a Choctaw-Cherokee physician, conducted a study in 1974 that indicated that 25,000 Native American women would be sterilized by the end of 1975. The information she gathered revealed that IHS facilities singled out full-blooded Indian women for sterilization procedures. Native sources reported to Pinkerton-Uri that the IHS had sterilized all of the full-blooded Indian women in one tribe in Oklahoma, although no proof was given with the report. Based on her findings, Uri estimated that as of the release of the GAO Report in November 1976 there were only 100,000 Native American women of child-bearing age able to procreate. Pinkerton-Uri stated that "we have only 100,000 women of child-bearing age total - that's not per anything. The Indian population of this country is dwindling no matter what government statistics say to the contrary."¹⁸ Uri's study also discovered that Indian women generally agreed to sterilization when they were threatened with the loss of their children and/or their welfare benefits, that

most of them gave their consent when they were heavily sedated during a Cesarean section or when they were in a great deal of pain during labor, and that the women could not understand consent forms because they were written in English at the twelfth-grade level. Dr. Uri told the *National Catholic Reporter* that she did not believe the sterilizations occurred from "any plan to exterminate American Indians," but rather from "the warped thinking of doctors who think the solution to poverty is not to allow people to be born."¹⁹ At a meeting held with IHS officials in Claremore, Oklahoma, Pinkerton-Uri criticized the argument that "a poor woman with children was 'better off' sterilized." She maintained that "She's still going to be poor. She just won't be able to have children."²⁰

Tribal Judge Marie Sanchez of the Northern Cheyenne Reservation in Lame Deer, Montana, disagreed with the number of Native American women that the GAO Report reported the IHS had sterilized. The week after the GAO published the report, she talked to fifty women in her tribe and found that IHS physicians had sterilized twenty-six of them. The population of the reservation at the time of Sanchez's inquiry totaled 4,500. Sanchez reported that IHS personnel told several women that "it's time you stopped having children," and that they could still have children after the surgery.²¹ Sanchez attended the United Nations Conference in Geneva, Switzerland, in the spring of 1977. She claimed that "the Indian women of the Western Hemisphere are the target of the genocide that is still ongoing, that is still the policy of the United States of America," and

that "we are undergoing the modern form called sterilization, which has been going on for hundreds of years, to totally exterminate the Red man."²² In an interview with Brint Dillingham, Sanchez charged, "There are less than 5,000 of us. Why should we limit that number? This is another attempt to limit our population - but this time they're trying to do it in the noble name of medicine."²³

Children are very important to Native American women for economic reasons, tribal survival, and to secure their place in the tribe. In tribal societies where agriculture is the main economic endeavor, the more children there are, the better able an extended family is able to survive economically. Margot Liberty claimed in her study on the Omaha that all family members are expected to share their financial resources with other family members, especially when the family's resources "fluctuate by season by the number of family members employed."²⁴ Studies done in the 1970s and 1980s of Omaha, Navajo, Cherokee, and Apache life, among others, have shown that as children become adults, they are expected to support their mother financially, and the more children a woman has, the better off she will be in her old age.²⁵

Native American tribes value mothers because they ensure that the tribe will survive. Marie Sanchez declared that "the Native American woman is the carrier of our nation."²⁶ Mary Crow Dog, a member of AIM, claimed that the women members of AIM did not believe in using birth control because they maintained that there were not enough Indians left in the United States. She

stated that "like many other Native American women, particularly those who had been in AIM, I had an urge to procreate, as if driven by a feeling that I, personally, had to make up for the genocide suffered by our people in the past."²⁷ Emily Moore and Ann Clark, in their studies of numerous Native American cultures and family structures, both found that children were important not only for the joy they gave the parents but also because group survival was an important aspect of tribal culture.²⁸ At a conference on birth control in 1979, Katsi Cook, of the Mohawk Nation, proclaimed that "women are the base of the generations. Our reproductive power is sacred to us."²⁹

On a personal level, children are important to Native American women not only because the children are part of the mother's flesh and blood but also because children help to strengthen a woman's status in the tribal community. When coupled with age, the number of offspring a woman has determines the amount of prestige and power she has within the tribe. Rose Mary Barstow, a member of the White Earth Ojibwe, explained that a woman "attained dignity in the process of giving birth, no matter who she was. Even if a girl was known to be irresponsible, if she married someone and then gave birth, she'd redeem herself."³⁰ Lois Steele, a member of the Fort Peck Assiniboine, asserts that "it's a status symbol to be a grandmother. It implies that you've lived long enough to have some wisdom."³¹ She also claims that tribal members believe a woman's wisdom increases with the number of grandchildren she has. Many Indian women have not revealed that the IHS

sterilized them because of "the risk of losing one's place in the Indian community, where sterilization has particular [negative] religious resonance."³²

Native American women's importance to tribal survival is celebrated with puberty rites and other ceremonies. While all tribes do not have puberty rites for girls, the Apache, Navajo, and Lakota, among others, have ceremonies celebrating a girl's transformation to womanhood. The ceremonies recognize a girl's ability to procreate and give her a higher status within the community. Carole Anne Heart Looking Horse, a member of the Lakota Rosebud Reservation, states that "the Womanhood Ceremony is a sacred ceremony that lets you know that you are making a transformation from child to woman, you're able to bear children, you have to have respect for yourself, you have to be modest, you have to think about choosing the right husband."³³

Despite the belief of IHS doctors that Indian women were incapable of properly using birth control, Native Americans have used different methods of birth control successfully for centuries. Native American women controlled their own fertility because they wanted to space their children for personal reasons, to limit the growth of their community in years when the food supply was scarce, and to alleviate the problems of giving birth during their busiest seasons. Some Indian tribes recognized that a woman's menstrual cycle related to fertility, and the women in these tribes did not have intercourse during their fertile period. Other tribes used the dried and crushed roots of the red cedar and juniper plants in a tea to prevent

births. Henry de Laszlo and Paul Henshaw reported in 1954 that Indians used oral contraceptives, including the boiled roots of dogbane or wild ginger; beverages made from milkweed, arum, Indian paint brush, or rosemary; and the dried roots of thistle, squaw root, and the Mexican wild yam. The basic material that pharmaceutical companies use in birth control pills is diosgenin from the Mexican wild yam. Native Americans used a variety of birth control methods, and they understood how to use the methods that were available in their homeland. Even in the late 1970s, in the Southwest and other regions, Indian women used teas and herbs for brews to prevent pregnancies.³⁴

Sterilization affected not only the tribal communities and the women's roles within those communities, but it also affected the families of the women who the IHS sterilized. Mary Crow Dog wrote about her sister's, Barbara, sterilization in her book, *Lakota Woman*. Barbara also belonged to AIM and went to an IHS hospital to deliver her baby. The doctors told her she needed a Cesarean section. When she became conscious after the surgery, she discovered that the doctor had sterilized her against her will. "In their opinion, at that time, there were already too many little red bastards for the taxpayers to take care of. No use to mollycoddle those happy-go-lucky, irresponsible, oversexed AIM women."³⁵ Barbara's child died two hours after the delivery, and her husband left her. Barbara's confidence in herself as a woman disappeared, and she became involved with several different men who beat her and abused her mentally. It was not until the late 1980s that Barbara finally realized that

the sterilization was not her fault. Crow Dog explained how Barbara's experience with the IHS made Crow Dog decide to deliver her own child naturally. It also affected Crow Dog because Barbara often brought the men with whom she was involved to Crow Dog's home. One of the men punched holes in a wall, while another one broke a lamp and a chair. They disturbed the peace in Crow Dog's home, and caused the relationship between the sisters to become distanced.³⁶

Allen, one of twelve Native Americans the author interviewed, knew two women who the IHS sterilized: his wife and his sister. His wife became very depressed after the sterilization and started drinking heavily. He took over full responsibility for the care of the two children they already had. He remained married to his wife, but since 1978 she has been institutionalized in a "psychological hospital in the city. She never got over it." He related how his wife refused to talk to him after the surgery and that "it was like she stared right through me." She did go home from the hospital for a few months, but she refused to take her medication and "tried to kill herself three times." Allen also recounted that the "doctors say she'll need to be on this medication for the rest of her life. And they say it was brought on by the sterilization."³⁷

The sterilization of Allen's sister did not affect him as directly as his wife's did. Her husband left her and she became very protective of her children. Allen and his parents had to intervene on several occasions when his sister would not allow

the children to participate in normal childhood activities such as Little League and bicycling. He wrote that "my sister didn't really affect me personally very much. But I saw what she did to her family and it took a lot of time to get things right again." Allen no longer uses the services that the IHS provides to Native Americans. "I still have problems going to the doctor we use now. The actions of the IHS made me realize that you can't just blindly trust people to help you when they're supposed to. They're just as likely to hurt you."³⁸

An IHS hospital in South Dakota sterilized Tammy's mother when Tammy was ten-years-old. Tammy related how her mother repeatedly told the family that the IHS did not have her approval for the sterilization. Her mother became very possessive of Tammy and her brother and was easily riled following the surgery despite taking prescribed hormonal supplements. "She never used to get very angry with us. I mean, she was always concerned about us, but she always talked to us when we got in trouble. After this she would just yell and yell. It was a big change." The actions of Tammy's mother caused Tammy to start skipping school to have some freedom from her mother's possessiveness. "So I almost flunked out of high school. But I made it - barely. Actually what happened was that a counselor got a hold of me and figured out what was going on She talked me into doing something about what happened somehow." Tammy became a nurse and went to work for the IHS. She claims she works there to keep "an eye on things." One of her duties is to explain birth control and sterilization

to the women who ask for information. She learned the Lakota language and is able to explain the different methods of birth control and sterilization in both Lakota and English to the women. Tammy states that the women are more comfortable with her than they are with the white medical staff.³⁹

Betty's experience with sterilization occurred because the IHS sterilized a friend of her family. The woman was the sister of some friends of Betty's husband. The IHS sterilized the woman in 1973. Following the sterilization, the woman moved to Chicago, where she lived on the streets and became an alcoholic. She returned to the reservation in the summer of 1977. On a November night in 1977, Betty's husband saw the woman roaming around the reservation and asked her if she had a place to stay. She had nowhere to go, and he offered her a room in his home. The woman accepted his offer and went home with him. Betty conveyed that the woman left in the middle of the night and took Betty's infant son with her. Betty and her husband reported the baby missing to the police, who later found the woman and the baby; but within an hour after they were found, the baby died. His body was covered with bruises. Betty said, "She either beat him or dropped him or something." The sterilization of the family friend profoundly affected Betty and her family. "My son died. How do you get over something like that? . . . She couldn't have any children so she took ours. And he died because of it."⁴⁰

The IHS procedures had serious consequences in the personal lives of the American Indian women that physicians

sterilized. Dr. Pinkerton-Uri stated that many of the Indian women did not understand that the sterilizations could not be reversed, and "when they do realize they can't create life, they feel castrated and psychological problems result."⁴¹ She continued by relating how the women "often have a total nervous breakdown, try to commit suicide, go into prostitution, or become alcoholics . . . Families are torn apart by the woman's distress, and husbands often resent the operations done without their consent."⁴² Studies have revealed that the major factors that cause regret following a sterilization are the woman "being very young (most of the women sterilized at Claremore [Oklahoma IHS Hospital] are in their teens and twenties), deciding under duress, and the procedure [being] suggested by the physician rather than the patient." The experiences of the following women reflect these factors of regret and Pinkerton-Uri's after-effects.⁴³

Fee Podgarski interviewed Barbara Moore, a member of the Rosebud Reservation in South Dakota in 1979, when she was in Germany as a representative of the Pan-Indian delegation at the Society for Threatened Peoples Conference. Moore entered the IHS hospital on the reservation to deliver her child in 1975. The doctors informed her that she had to have a Cesarean delivery. "When I woke up the next day after the operation I was told that my child was born dead . . . Besides this, they told me that I could not have any more children because they have had to sterilize me."⁴⁴ She continued by saying, "I was sterilized during the operation without my knowledge and without

my agreement. What could I say and do? It was already too late."⁴⁵ Moore did not discuss the affects of sterilization on her life, but she did berate the IHS for performing sterilizations.⁴⁶ Moore became a spokesperson for the women who had been abused with the IHS sterilization practices.

In March 1978 two Native American women testified before the Human Rights and Opportunities Committee of the Senate. Patricia Buck Wolf underwent a hysterectomy in 1971. She believes that she was sterilized because she was a welfare mother and a Native American. She testified that her physician told her that a routine Pap smear exposed cancerous cells and that "she was led to believe her life was in danger if she did not have the hysterectomy."⁴⁷ While the doctors told her that she would not be able to have children following the operation, they did not explain the risks or offer her any alternatives. During her testimony, Wolf was nervous and uncomfortable. She related that she had just recently discussed her sterilization with other women and that she had never testified before. Despite her nervousness, Wolf continued with her testimony and revealed that she only had one follow-up visit to the hospital's women's clinic and that the doctors did not discuss the absence or presence of cancer with her. Nor did she receive radiation therapy for the alleged cancer. She also revealed that "her inability to have children contributed to the breakup of her second marriage."⁴⁸

Sheila Michaud testified not only for herself but also for eleven other women whose names she read from a petition to the

hearing officials. The letter claimed that doctors sterilized Michaud and the other women without their consent. Michaud's testimony revealed that the women who signed the petition were all welfare recipients at the time of their sterilizations and that they underwent similar experiences to that of Wolf because their physicians also convinced the women to have sterilization procedures performed. The reasons the doctors gave them included ovarian cysts (for which surgery is not required), cervical infections, and tubal pregnancies. Doctors convinced five of the women to undergo sterilization because they already had two or more children.⁴⁹

On a cold, blustery November day in 1971, Cheryl went into labor. Her husband immediately took her to the Claremore Indian Hospital in Oklahoma for the delivery. While she was in labor, the nurses asked her several times if she wanted to be sterilized following the birth. She told them she did not. Cheryl's labor was hard; after eighteen hours she agreed to have a Cesarean section and signed some forms authorizing the procedure; within an hour she gave birth to a healthy son. While she was under the affects of the anesthesia, the doctor also performed a hysterectomy. Cheryl remembers signing "a couple" of forms when she agreed to the Cesarean, but she does not recall signing a consent form for a sterilization procedure. At the time she signed the papers, she was in a great deal of pain and extremely tired from the prolonged labor.⁵⁰

Two months later, at her postpartum checkup, Cheryl asked the doctor why she had not had a menstrual cycle since she had

given birth. She said, "The doctor told me that I had signed a consent form to be sterilized, and that a hysterectomy had been done following the Cesarean section." Cheryl was twenty-one at the time of her hysterectomy, and Jeremy was her first child. Jeremy died at the age of four months from sudden infant death syndrome. Cheryl could have no more children. "My husband and I tried to find out if I could have a transplant of a uterus, but it wasn't possible. Why did he do this to me? What gave him the right to cut out a part of me that I wanted left alone? I had told them [the nurses] several times that I didn't want to be sterilized." Cheryl's husband left her a year after Jeremy's death because he wanted to have children. Cheryl remarried in 1985, and now she and her new husband are foster parents of Cherokee children.⁵¹

Employees of the family planning office from a nearby IHS hospital approached Janet regarding sterilization in 1973. Janet was twenty-nine and had three children. The social workers came to Janet's home six times when her husband was at work. "They told me that I should be sterilized because I didn't want any more babies right then, so I said yes and signed a consent form. My tubes were tied the next day They didn't tell me I couldn't ever have any children after they did it." Janet found out that the sterilization was irreversible during an American Indian Movement demonstration against IHS sterilizations at Clãremore in 1974. For fifteen years following this discovery, a psychiatrist treated Janet for severe depression. Her youngest daughter still refuses to

utilize the IHS for any type of medical care.⁵²

In the spring of 1974, Alice went to the IHS hospital in Pawnee to obtain information on birth control. She was an unwed mother with two children. The hospital employee explained the different types of birth control, but they stressed sterilization as the best method for Alice because she was an unwed mother. Alice said, "She told me that I'd lose my federal benefits if I had anymore kids without being married. I couldn't do that. We depended on that to survive. I had to sign that form I don't remember anything being said about it [the surgery] being irreversible."⁵³

An IHS facility in southern Minnesota sterilized Julie in the summer of 1974 when she was twenty-eight. While she was in labor, she signed a form that she thought was for a painkiller. The nurses did give her a painkiller, but the physician also sterilized her. Julie stated that she doesn't remember exactly what she signed because she "was in pain at the time and wasn't paying too much attention to them [the forms]." She related that the nurses told her about sterilization throughout her pregnancy and while she was in labor, but they did not tell her that she was signing a consent form for sterilization. While Julie had a second healthy daughter in the hospital, she revealed that she and her husband wanted three children. Her husband left her shortly after he found out about the sterilization because he "wanted a real woman. He didn't think I was a woman anymore without my uterus. What was I? An 'it?'" Julie no longer trusts the IHS and goes there only for routine

health problems such as the flu or strep throat.⁵⁴

Debra is from Montana, and an IHS physician sterilized her in the spring of 1975. At the age of twenty-six, she underwent a hysterectomy immediately following a Cesarean section. She related that "they came in the next day and said they needed me to sign some forms that hadn't been signed before the c-section. And they wanted me to date it the day before, but I put the right date on it." The nurses tried to convince her to put the previous day's date on the forms, but although she "was in a lot of pain still and under the influence of the meds, I understood enough to know they were trying to get me to put the wrong date on it to protect their butts." Debra asserted that the medical staff did not tell her that they had sterilized her until the day she left the hospital. IHS personnel did not grant a seventy-two hour waiting period, and the form Debra signed did not have the required statement at the top saying that she would not lose any benefits if she refused to be sterilized. Debra believes that hospital personnel did not inform her about the sterilization, or about other methods of birth control, because she had already completed three years of college and was better informed than the majority of Indian women. She stated that the sterilization "made me change my life in important ways. I didn't become an alcoholic or go berserk like some women did. I changed my major at college and went on to become a lawyer. I specialize in medical cases and family law." Debra claimed that the sterilization made her more aware of the problems that Native Americans face, especially in the breakup of Indian

families. "I try to keep families together. Not so much from divorce, but from the social services trying to separate children from their parents. I know I've made a difference in some lives, but I wish I could do that for more of them."⁵⁵

Debra managed to turn a bad experience into something that helped others.

In June of 1974, Ann signed a consent form to be sterilized and her physician tied her tubes the next day. Family planning personnel convinced her to have the procedure, but they did not explain any other methods of birth control to her. Ann was an alcoholic with three children at the time of the sterilization, and the family planning staff told her that she would lose her federal benefits if she did not have her tubes tied. She stated that "it was like they were in this big rush to get it [the sterilization] all done. Now I know the rules had changed and they were screwing with what they were supposed to do. So I can't have any more kids." Right after she had her tubes tied, Ann went on a "drinking binge" that lasted for almost six months. Her extended family took care of her three children during her "illness," as she refers to it. She finally stopped drinking a year after the sterilization when employees of the social service department started proceedings to take her children away from her. When describing the sterilization, Ann related that she "was really ashamed of it for a long time. It's real important in our tribe to have children and they took that right away from me. I still haven't told anyone outside of my family about what happened." Ann

continues to use the IHS services, but she never goes to her appointments there alone. She related that "I feel like I can stand up to them more if it isn't just me there. They're really pushy. I don't trust them, but I can't afford to go anywhere else."⁵⁶

Helen lives in Tulsa, Oklahoma, and a doctor at the IHS hospital in Claremore, Oklahoma sterilized her with a tubal ligation in 1973. She did sign a consent form, but stated that "I'm not proud of that fact, but I did. They told me I'd lose the medical benefits I got if I refused to do this." Helen contended that the hospital staff did not tell her that the surgery could not be reversed, and that they did not offer her any other methods of birth control. "I had just lost a baby - I miscarried - and they told me that my body wasn't ready to have other kids tight then so it would be best if I got my tubes tied right away." Helen, like the other women, did not ask to be sterilized. "They brought it up after I lost the baby. I bled a lot and had to have a transfusion. They said it would be best for me, and when I asked about the pill they just told me the bad stuff about it. They didn't tell me about anything else at all." After learning of Helen's sterilization, her husband left her. Three years after they divorced, he apologized to Helen for his actions, and they remarried six months later. "I've always felt that if my tubes hadn't been tied that I wouldn't have taken him back. You see, I didn't think any other man would want me because I couldn't have any more kids, so I remarried him. Things are better between us, but they've never

been the same as they were before." Helen moved to Tulsa because she wanted to get away from the IHS and receive medicaid. She recently started going back to the IHS because of "this new business with the government cutting funding for welfare." Helen started saving money "so I can afford to go to a real doctor when I need to. They lost my trust. They didn't like Indians even though they were supposed to help us."⁵⁷

In February 1974, physicians at Claremore Indian hospital in Oklahoma performed a hysterectomy on Diane right after she gave birth to her son by Cesarean section. Diane does not remember signing a consent form, but believes she must have signed one since they performed the surgery on her. When she found out three days later that the doctors had sterilized her, Diane "told them they had to fix it. They told me they couldn't, that they'd done a hysterectomy." Diane saw a psychologist for ten years following the sterilization because she had problems with depression. "I still get really depressed about it when I think about it. But now I get angry, too." The sterilization caused Diane to fear that something "deadly" would happen to her two sons. Mike was a nine-year-old when Diane had her baby, and that summer she refused to take his bicycle out of the garage because she "was afraid he'd get hit by a car or something." She described how she "was really protective of the baby and now he's having problems adjusting to being an adult. I didn't let him learn to make decisions on his own. And it's all my fault. I was never like that before they did this to me." Diane never took her children back to the IHS facility in

Claremore. The entire family sees a physician in Tulsa who is part Cherokee.⁵⁸

In 1976, when she was twenty-four, the Indian Health Service sterilized Linda. While Linda did sign a consent form, clinic personnel did not inform her of the permanence of the procedure, nor of any alternative methods of birth control. The county where Linda lived had filed charges against her for possession of drugs. Her attorney suggested that she undergo a complete physical, including blood tests, to show that she was not under the influence of drugs; the tests did not show any drugs in her system. A social worker at the clinic talked Linda into having a tubal ligation because "with all the problems I was having in my life, I didn't think it was a good idea to have kids right then." The worker did tell Linda that she would not lose any federal benefits if she refused to sign the consent form, but the woman did not explain the birth control or diaphragm methods of birth control to Linda. "They did tell me about the IUD [intrauterine device], but they made it sound so awful that I didn't want to do that. Then they suggested getting my tubes tied. The physician did it the next day. They tied my tubes." Linda had originally approached the subject of birth control with the medical staff by asking for information on the intrauterine device. Linda did not have any children at the time of the tubal ligation. "I will never be a mother. And with my background, I will never be able to adopt a baby either. So they took a part of me away that can never be filled."

Later that year, after Linda discovered that the

sterilization was irreversible, she did become involved in the "drug scene." The district attorney had dropped the previous charges against her because Linda disclosed information to the court that her boyfriend had owned the drugs. Because police had found the drugs in the boyfriend's belongings, the county dropped the charges against Linda. After her court appearance, Linda stopped seeing the man, but only until she found out that she would never be able to have children. She started dating the man again "because I didn't see what it mattered when I would never get the things [children] I really wanted." Linda began using drugs and selling them. The police eventually caught her, and in September 1979 the courts sent her to a woman's prison. "I just got out three years ago [1995], and I have a real hard time getting a job and keeping one when they're always looking at me funny." While Linda realized that her involvement with drugs is her fault, she stated that "I don't think I would have gone that way if it hadn't been for them tying my tubes. I think that pushed me over the edge." Linda still does not trust the IHS or other government programs that are supposed to assist Indian tribes. "I think Indians ought to take over all the IHS places and make then tribal clinics and hospitals or whatever. The government should just give tribes the money for the services and then let the Indians run things."⁶⁰

Native American tribes, communities, families, and women all suffered from the sterilizations that occurred during the 1970s, and the effects are still being felt. Physicians

sterilized 25 percent or more of Native American women compared to 15 percent of white women during this decade. Tribes lost part of their ability to reproduce and assure the continued survival of their people. For tribal communities that had a high number of women sterilized, the esteem they received from other tribal entities lessened, and their political power also abated because their population did not increase as much as quickly as other tribal communities. Sterilization tore Indian families apart, and the number of divorces attributed to sterilization was very high. Friends of the women suffered with them over the sterilizations, but the friendships could not always withstand the burdens the sterilized women placed on them.

The women sterilized at the IHS hospitals and clinics faced the most traumatic effects of the sterilizations. Many women required psychological care with counseling and/or drugs for many years following their sterilization. When a woman chooses sterilization as her method of birth control after receiving the required information, psychological problems still occur but not as frequently and not to the degree that Native American women encountered.⁶¹ A large number of the women's marriages disintegrated because the husband had not been consulted regarding the procedure, because he no longer believed his wife was a "total woman," or because the wife's grief and anxiety over the sterilization strained the marital relationship beyond the point of repair. Sterilized women often became more protective and possessive of their children because the mothers

feared for their children's safety to a greater degree than they had before. Alcohol and drug abuse became a major factor in the lives of many of the sterilized Indian women. For some of them, their abuse of alcohol and drugs led to social service workers either taking their children away from them or threatening to do so. It also took the women a long time to realize that they were not at fault for the sterilization. Many of the Native American women lived with feelings of shame and guilt, and some have just started talking with other Native American women about their experience. While some of the sterilized women continued to utilize IHS services for their health care needs, they only did so because of economic reasons. The women did not trust the IHS for their health care treatment, and the majority of them refused to return to IHS facilities for many years following their discovery that the sterilization could not be reversed. The small number of women who had attended college or who been involved in some form of political activism became angry with the IHS medical practices and directed their anger over their sterilization experience into becoming involved in correcting the problem or into becoming advocates for other Native Americans. The IHS sterilization practices profoundly affected the Native American people.

The hearts of American Indian women are not yet on the ground, but the lives of the women the IHS sterilized are badly damaged. They are slowly recovering from their experiences, but it will be a long time before they are completely healed. The women refuse to let sterilization conquer them.

CONCLUSION

The sterilization of minority women, especially those of American Indian heritage, obviously affected the women's self-esteem, how men viewed them, and the conditions under which they lived after sterilization. In 1976, Congress passed the Indian Health Care Improvement Act. This measure gave tribes the right to manage or control Indian Health Service programs. Native American tribes have taken over many Indian Health Service facilities, have become involved in the administration and care provided by other facilities, and have started their own health services. Tribes are now involved in gaining grants to support their health services; in contracting with outside physicians for Indian health care; in planning, designing, monitoring, and influencing the programs that the Indian Health Service continues to provide; and in providing oversight of federal personnel at Indian Health Service facilities.²

While the sterilizations that occurred in the 1960s and 1970s harmed Native Americans, Indian participation in their own health care since the Indian Health Care Improvement Act has strengthened their tribal communities. Sterilization abuse has not been reported recently on the scale that occurred during the 1970s, but the possibility still exists for it to occur. The Department of Health, Education, and Welfare regulations and

Indian involvement in health care are not enough to eradicate abuse. The Department of Health, Education, and Welfare does not audit the family planning or Indian Health Service programs; it only audits the computer records on reported sterilizations that do not meet the guideline's requirements. Until the department conducts full audits on all sterilizations that the federal government funds, sterilization abuse will continue to concern Native Americans.

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CONCLUSION

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- "Alice." Interview by author. 10 January 1999. Oklahoma City, OK. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Allen." Letter received by author. 26 November 1998. Letter in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Ann." Telephone interview by author. 13 March 1999. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Betty." Telephone interview by author. 19 November 1998. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Cheryl." Interview by author. 23 February 1999. Tahlequah, OK. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Debra." Telephone interview by author. 23 November 1998. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Diane." Telephone interview by author. 30 December 1998. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Helen." Interview by author. 14 November 1998. Tulsa, OK. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Janet." Telephone interview by author. 3 January 1999. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Julie." Interview by author. 27 December 1998. Duluth, MN. Tape recording in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Linda." Letter received by author. 12 December 1998. Letter in possession of author. A pseudonym is used to protect the identity of the interviewee.
- "Tammy." Letter received by author. 12 December 1998. Letter in possession of author. A pseudonym is used to protect the identity of the interviewee.

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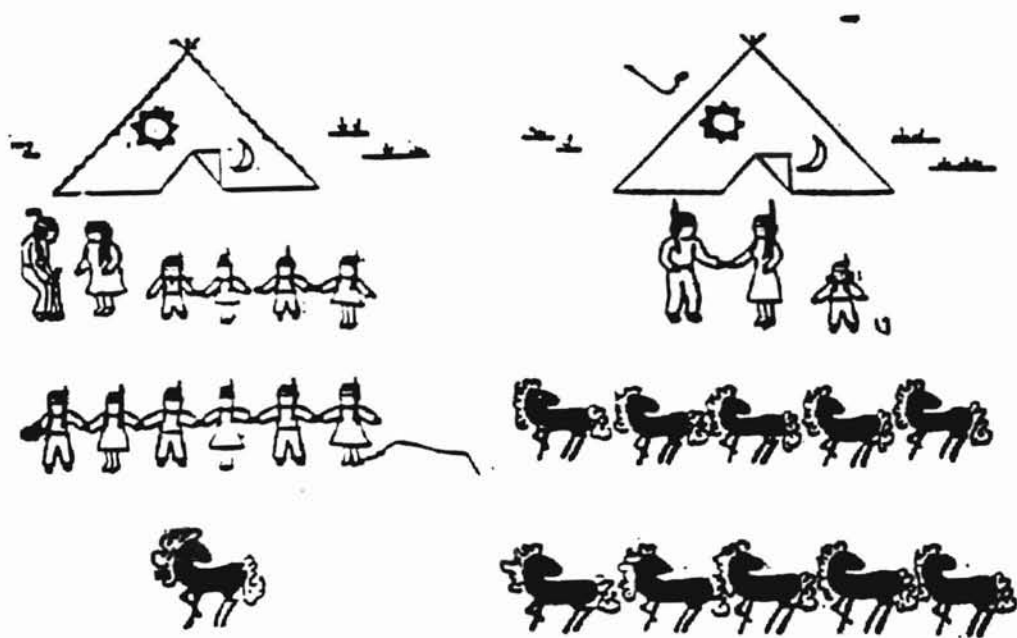
APPENDIX I

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PAMPHLET

Kathy Schwerin, Pippa Franks, and the
San Francisco Women's Health Center
"San Francisco Women's Health Center"
Off Our Backs, Inc. (Washington),
October 1976

and

"Oklahoma: Sterilization of Native Women Charged to I.H.S."
Akwesasne Notes 6
Early Winter 1974



These illustrations are part of a pamphlet produced by the HEW Dept to induce native people to have less children so that they will become wealthy. The net result seems that parents end up with neither children, riches, nor future instead. "Women who are poor don't get rich by having their tubes tied," says Dr. Constance W., a Native American physician.

APPENDIX II

INDIAN HEALTH SERVICE ADMINISTRATIVE OFFICES, HOSPITALS, AND HEALTH
CENTERS

U.S. Department of Health, Education, and Welfare
Public Health Service
The Indian Health Program of the Public Health Service
Washington, D.C.
1978

INDIAN HEALTH SERVICE ADMINISTRATIVE OFFICES

Headquarters

Indian Health Service (301) 443-1083
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Areas

Aberdeen Area (605) 225-7581
Indian Health Service
115 4th Avenue, S.E.
Federal Building
Aberdeen, South Dakota 57401

Albuquerque Area (505) 766-2151
Indian Health Service
Room 4005, Federal Building and
U.S. Courthouse
500 Gold Avenue, S.W.
Albuquerque, New Mexico 87101

Alaska Area (907) 265-3153
Native Health Service
P. O. Box 7-741
Anchorage, Alaska 99510

Billings Area (406) 657-6403
Indian Health Service
2727 Central Avenue
Billings, Montana 59103

Oklahoma City Area (405) 231-4796
Indian Health Service
388 Old Post Office and
Courthouse Building
Oklahoma City, Oklahoma 73102

Phoenix Area (602) 261-3143
Indian Health Service
801 East Indian School Road
Phoenix, Arizona 85014

Portland Area (503) 221-2020
Indian Health Service
Federal Building, Room 476
1220 S.W. 3rd Avenue
Portland, Oregon 97205

Navajo Area (602) 871-4811
Indian Health Service
P. O. Box G
Window Rock, Arizona 86515

Programs

Bemidji Indian Health (218) 751-1210
Program Office
203 Federal Building
Box 768
Bemidji, Minnesota 56601

Office of Research
and Development (602) 792-6600
Indian Health Service
P. O. Box 11340
Tucson, Arizona 85734

United Southeastern Tribes (615) 251-5104
Indian Health Service
Corks Tower Building, Suite 810
1101 Kermit Drive
Nashville, Tennessee 37217

California Indian Health (916) 484-4836
Program Office
Federal Building
2800 Cottage Way, Room E-1823
Sacramento, California 95825

INDIAN HEALTH SERVICE FACILITIES

Hospitals

Location	No. of Beds	Outpatient Visits, 1977	Location	No. of Beds	Outpatient Visits, 1977
Alaska			Nevada		
Anchorage	170	88,699	Owhee	15	11,225
Barrow	13	17,661	Schurz	26	7,357
Bethel	42	43,371	New Mexico		
Kanakanak	29	13,688	Albuquerque	54	34,305
Kotzebue	40	20,838	Crownpoint	46	26,497
Mt. Edgecumbe	82	17,710	Gallup	181	102,115
St. George	6	2,217	Mescalero	15	16,862
St. Paul	4	4,478	Santa Fe	35	20,413
Tanana	20	6,677	Shiprock	69	45,589
Arizona			Zuni	35	30,846
Ft. Defiance	76	77,144	North Carolina		
Kearns Canyon	38	37,043	Cherokee	26	39,828
Parker	20	17,031	North Dakota		
Phoenix	168	111,928	Belcourt	50	39,720
Sacaton	30	26,016	Ft. Yates	32	19,217
San Carlos	36	33,855	Oklahoma		
Sells	40	31,382	Claremore	50	50,523
Tuba City	108	85,391	Clinton	14	15,570
Whitewater	38	45,873	Lawton	52	54,721
Winslow*	40	20,283	Pawnee	14	21,544
California			Tahlequah	40	67,528
Winterraven	19	16,372	Talihina	52	30,671
Minnesota			South Dakota		
Cass Lake	22	23,487	Eagle Butte	33	34,572
Red Lake	30	30,613	Pine Ridge	58	40,696
Mississippi			Rapid City	54	25,747
Philadelphia	40	23,082	Rosebud	41	38,700
Montana			Sisseton	32	17,879
Browning	34	42,399	Wagner	26	16,653
Crow Agency	34	31,088	Totals:		
Hartem	18	16,366	No. of Hospitals		51
Nebraska			No. of Beds Available		2,286
Winnebago	39	22,444	No. of Outpatient Visits, 1977		1,715,114

*Winslow hospital closed 7/1/77. Two new hospitals will open in fiscal year 1978 in Acoma Laguna Cañonito, New Mexico and in Ada, Oklahoma.

APPENDIX III

RECOMMENDED CONSENT FORM

Comptroller of the United States
Investigations of the Allegations Concerning Indian Health Services
Washington, D.C.
Government Accounting Office
November 6, 1976

ENCLOSURE IV PUBLIC HEALTH AND SOCIAL SERVICES DEPARTMENTS ENCLOSURE IV
VOLUNTARY STERILIZATION
PATIENT CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS.

A non-therapeutic sterilization may not be performed until at least 72 hours have elapsed after the execution of the consent document.

I, _____
have been counseled by _____
of _____
on the below mentioned items in regard to my request for a voluntary sterilization:

I. PROCEDURES FOR VASECTOMY

I understand that sterilization for men is the surgical procedure called the vasectomy. In a vasectomy a doctor cuts and ties off the vas tube so that the sperm, produced by the testicle, cannot mix with the semen. What the doctor does is very simple. Usually it is done in his office and only takes about a half hour and he usually uses a local anesthesia. The vasectomy is a permanent method of contraception. A doctor will not usually perform a vasectomy unless he is sure that the man who wants it understands that it is permanent. There are some temporary inconveniences following vasectomy, normal routine may have to be limited in the following 2-3 days and an additional contraception is necessary for the next 3 months, or until the physician is able to determine that there are no sperm present in the ejaculate. Sexual relations are usually not hampered. Also, with the male vasectomy, as with any other surgical procedure, there are potential-side effects. Any time one makes an incision in the human body, there is a possibility of immediate or delayed bleeding and/or infection. With vasectomy, these side effects are very rare and much less frequent than similar side effects of the sterilization procedure for women. From the physiological point of view, there is no difference in the sexual relationship of a man and a woman before and after vasectomy has been performed. Sexual excitement, sexual intercourse, and orgasm remain totally unaffected. The nature of the ejaculate is thinner and less opaque. The amount is fractionally reduced.

II. PROCEDURE FOR TUBAL LIGATION

I understand this operation is performed to block the path of the reproductive cells so they cannot reach the uterus where fertilization

occurs. This operation does not affect either menstrual periods or the age at which the change of life occurs. The ovaries and uterus are unchanged by the operation, the ovary continues to release an egg each month and tying the tubes merely prevent the egg from being fertilized by the sperm. Production of female hormones by the ovaries that determine femininity is not interrupted by cutting and tying the tubes. As with male vasectomy, no reduction of sex drive or function occurs. Also as with male vasectomy and with any other surgical procedure, there are potential side effects. Any time one makes an incision in the human body, there is a possibility of immediate or delayed bleeding and/or infection.

A. TUBAL LAPAROSCOPY

The physician makes two small incisions about a half inch long in the abdomen. Through one incision is inserted a laparoscope, an instrument that combines a high intensity light and magnifying lenses. Carbon dioxide gas is then pumped in to distend the abdomen, this allowing the physician to see the Fallopian tubes more clearly. A second instrument, combining a tiny forceps and a cauterizing device, is inserted into the other incision. Grasping the Fallopian tube with the forceps, the physician fuses the tube shut with brief bursts of electricity. This procedure is done on both tubes. Laparoscopy is ordinarily performed under general anesthesia. In many cases the woman is able to leave the hospital the same day, although an overnight stay may be necessary. As with any surgical procedure, there are some potential side effects; however, with this operation, they are minimal. Recovery only takes a few days with some slight discomfort in the abdominal area.

B. ABDOMINAL TUBAL LIGATION

The physician makes an incision just above the pubic hair line about 4-5 inches long. The physician will expose the Fallopian tubes and cut a small piece out of both tubes, tying and cauterizing the ends of the tubes. The abdominal tubal ligation is usually performed under general anesthesia and frequently in conjunction with other abdomen surgery. The woman usually remains in the hospital for 2-3 days. The abdominal muscles will feel sore, and it may take a few days to walk easily. Normal activity may be resumes after 10 days, or whenever the physician advises.

C. VAGINAL TUBAL LIGATION

This procedure is performed through an incision about one inch long in the vaginal wall. The patient is in the same position as when having a pap smear, and generally has had a general or spinal anesthesia. The physician inserts an instrument called a culdoscope through the incision to locate the tubes. The

culdoscope has a tiny forcep attachment and cauterizing device which cuts and cauterizes both Fallopian tubes. After he has cut and cauterized the tubes, the physician closes the incision with sutures which dissolve in about 10 days. The procedure usually lasts about a half hour, but the woman usually remains in the hospital overnight. This procedure has a slightly higher risk of infection, and the patient may resume normal activities, but the physician should be consulted as to when she may resume intercourse. Tampons must not be used for at least 4 weeks after surgery.

III. I UNDERSTAND THAT THE INTENT OF THIS PROCEDURE is to make me sterile and unable to have additional children. I have been informed that this procedure is non-reversible and that it must be considered as such prior to my consent. I am aware that on occasion some people have psychological depression after tubal ligation or vasectomy. It was pointed out that the intense counseling performed prior to surgery is an effort to minimize this depression. I understand that this procedure will in no way interfere with my normal sex habits after recovery and may decrease sexual tensions caused by the fear of unplanned pregnancy.

IV. METHODS OF FAMILY PLANNING

During the counseling session(s) prior to my surgery I have been instructed in other methods of family planning:

1. PILLS. I was told how the pill works and that the effective rate was the highest available among non-surgical methods. I was informed that many pills were available, some more acceptable than others depending upon the needs of the individual.
2. IUD. The intrauterine device was explained and demonstrated including appropriate effective rates and the fact that this method requires no daily pills or other function to be remembered daily. The discomforts which sometimes accompany insertion were explained as were the numerous types of IUD's.
3. DIAPHRAGM. This method was explained to me starting with the method of measurement. I was instructed on how to insert the device properly and the absolute requirement to use proper lubricants. I was informed that the diaphragm must be used each time intercourse occurs.
4. CONDOM. Condoms were explained as an effective method, especially when used in conjunction with spermicidal foam. I was told that when used according to directions, these two methods in combination should be considered as effective as the birth control pill with fewer side effects. I was also informed that some

pregnancies occur when only one of these methods is used, and that an interruption in the love making process is necessary to insure proper contraceptive protection which some individuals deem undesirable.

5. FOAM. Foam and other chemical spermicides such as jellies and creams were explained as an effective method of birth control, especially when used with a condom. I was told that when used according to directions, these two methods in combination should be considered as effective as the birth control pill with fewer side effects. I was also told that pregnancies may result when foam, cream, or jelly is used by itself. I understand that to use foam there may an interruption in the lovemaking process which some people find undesirable.

6. NATURAL. Natural family planning was explained as a method involving abstinence. I was told that only on certain days could I get pregnant and was told how to predict when these days were. I was informed that this was a highly participatory method and cooperation (from sex partner) was an absolute necessity before any contraceptive protection was available.

7. STERILIZATION. This surgical procedure as explained to me as a method to make my body incapable of becoming pregnant/or making a woman pregnant. I was informed that some individuals accidentally become pregnant/impregnate after this procedure because the canal that was cut during the operation grows back. I was told that this is rare. I was also informed that some individuals have periods of depression following this procedure. I am fully aware that I may, at any time before surgery, retract my consent to have this procedure performed. I am also aware that my decision will not in any way affect any other federal benefits or privileges which are available to me or my family from this or any other organization.

I have received counseling as described above and have been given an opportunity to ask additional questions about any and all methods, procedures, risks, benefits, or other concerns which I may have.

I understand that there must be a 72 hour waiting period between the time I receive counseling and sign this consent form, and the time my sterilization surgery is actually performed.

I now hereby voluntarily consent to a _____
_____ surgical sterilization procedure.

(SIGNATURE OF PATIENT)

(SIGNATURE OF PERSON OBTAINING THE CONSENT)

(SIGNATURE OF SPOUSE) - (IF MARRIED)

(TIME)

(DATE)

I, _____,

was designated by _____
as her/his auditor-witness, and was present when she/he received her/his
counseling and information on sterilization discussed and there were
opportunities for additional questions.

(SIGNATURE OF DESIGNATED AUDITOR-WITNESS)

(DATE)

(TIME)

APPENDIX IV
INTERVIEW QUESTIONS

Interview: Sterilized Women

Pseudonym:

Location:

Date:

INTERVIEW QUESTIONS:

When were you sterilized?

Did you sign a consent form?

Was sterilization fully explained to you: permanence of procedure, side affects, alternatives?

Were you under any type of stress when you signed the consent form? (In labor, under anesthesia, had just delivered a child.)

If so, was the consent form explained to you in detail?

Did the consent form contain a statement at the top of the form explaining that you would not lose your federal benefits if you refused to be sterilized?

Was there a 72 hour waiting period between the time you signed the consent form and the time of the sterilization procedure?

Were you informed of other methods of birth control? If so, why did you choose sterilization?

Did you initially bring up the subject of sterilization, or did medical personnel bring up the subject?

Did you have any children at the time you were sterilized?

How has sterilization affected your life?

Has the sterilization affected your opinion of the Indian Health Service?

Is there anything else you would like to add?

**Interview: Those who were indirectly affected by
sterilization of friend or family member.**

Pseudonym:

Location:

Date:

QUESTIONS:

Do you believe the sterilization of the friend or family member was involuntary? If so, why or why not?

If the person sterilized was a family member. Did the sterilization cause any changes in your family's life?

For example, did your family split up over the issue?

Was there a change in the manner in which the sterilized individual treated you personally?

Were you caused any personal stress by the sterilization of the woman and, if so, how and why?

Did the sterilization of the family member or friend affect your views or attitudes toward the Indian Health Service and, if so, how and why?

What were the direct effects on your personal life as a result of the sterilization of the family member or friend?

APPENDIX V
INSTITUTIONAL REVIEW BOARD REVIEW FORM

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

DATE: 10-07-98

IRB #: AS-99-008

Proposal Title: STERILIZATION OF NATIVE AMERICAN WOMEN: 1960s
AND 1970s


Principal Investigator(s): Michael Logan, Jane Lawrence

Reviewed and Processed as: Full Board

Approval Status Recommended by Reviewer(s): Approved

Please see attached letter.

Signature:



Date: November 4, 1998

Carol Olson, Director of University Research Compliance
cc: Jane Lawrence

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modification to the research project approved by the IRB must be submitted for approval. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

VITA

Jane A. Lawrence

Candidate for the Degree of
Master of Arts

Thesis: INDIAN HEALTH SERVICE: STERILIZATION OF NATIVE
AMERICAN WOMEN, 1960s-1970s

Major Field: History

Biographical:

Education: Graduated from Two Harbors High School, Two Harbors, Minnesota in May 1977. Attended Winona State University, Winona, Minnesota for the 1977-1978 year. Received Bachelor of Arts degree in History from the College of St. Scholastica, Duluth, Minnesota in May, 1996. Completed the requirements for the Master of Arts degree with a major in history at Oklahoma State University in Stillwater, Oklahoma in July, 1999.

Experience: Employed in various office positions, including receptionist, secretarial, and office manager positions, in Duluth, Minnesota from 1978 through 1997. Employed by Oklahoma State University, Department of History, as a graduate teacher's assistant from 1997 to present and as a senior secretary, Oklahoma State University, Department of Agricultural Economics from 1998 to present.

Professional Memberships: Phi Alpha Theta, Minnesota Historical Association.