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NONCONSENSUAL STERILIZATION OF THE MENTALLY DISABLED IN NORTH CAROLINA: AN ETHICS CRITIQUE OF THE STATUTORY STANDARD AND ITS JUDICIAL INTERPRETATION

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In North Carolina, the mentally disabled remain subject to nonconsensual sterilization pursuant to statutory authority. The primary goal of this article is to provide an ethics critique of both the North Carolina statute and its application by the courts. Four arguments support the position that the statute and the relevant case law unethically infringe upon the sexual autonomy of the mentally disabled. First, eugenic provisions

1. The North Carolina statute, N.C. GEN. STAT. §§ 35-36 to 35-50 (1995), is often referred to as an “involuntary” or “nonconsensual” sterilization statute because the state can pursue sterilization when the individual is either unable to consent or when the procedure goes against the individual’s consent. Although the statute uses the specific term “mentally retarded,” this article employs the term “mentally disabled” as some may find the former to be derogatory.

2. See Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics 68 (1989) (“[T]he core idea of personal autonomy is . . . personal rule of the self while remaining free from both controlling interferences by others and personal limitations, such as inadequate understanding, that prevent meaningful choice”). The definition of sexual autonomy for the purposes of this article will be a subcategory of the “core idea of personal autonomy” as defined by Beauchamp and Childress. Id. Thus, paralleling the Beauchamp and Childress definition, sexual autonomy is personal rule of the self that remains free from the controlling interferences and the personal limitations that prevent meaningful choices regarding sexual intercourse and subjects associated with the sexual act. The sexual act is a vehicle for procreation, and thus the first step in parenting one’s genetic child. In addition, it is a fundamental component of the marriage relationship. Thus, procreation (for the parenting of one’s genetic child) and marriage are subjects encompassed by the term “sexual autonomy.”

It is important to note, when discussing constitutional issues, that the term “sexual autonomy” as defined in this article is encompassed by the terms “right of privacy” or “liberty.” The terms “right of privacy” and “liberty” on the constitutional level, as with the term “sexual autonomy” on the ethical level, include procreation, Skinner v. Oklahoma, 316 U.S. 535 (1942); parenting, Pierce v. Society of Sisters, 268 U.S. 510 (1925); and marriage, Loving v. Virginia, 388 U.S. 1 (1967). This article is an ethics critique, rather than a
of the statute constitute ethically inappropriate grounds for sacrificing sexual autonomy "for the public good." Second, the statute's procedures for protecting the sexual autonomy of the mentally disabled individual are inadequate. Third, the statute disproportionately infringes upon the autonomy of the mentally disabled poor. Fourth, the statute and corresponding case law have the effect of "objectifying" the mentally disabled woman and allowing cultural attitudes toward women to play a large role in the sterilization decision.

The secondary goal of this work is to provide an ethical model for non-consensual sterilization of the mentally disabled in North Carolina. This model serves only to address the ethical issues raised by the North Carolina statute; it is not intended to serve as a model for nonconsensual sterilization in other jurisdictions.

I. AUTONOMY AS A CONTROLLING PRINCIPLE

When analyzing the ethical issues involved in sterilization of the mentally disabled, the autonomy interests of the mentally disabled individual should receive primary consideration. Subordination of sexual autonomy, of the North Carolina statute and case law. Thus, it uses the term "sexual autonomy" rather than "right of privacy" or "liberty."

3. See Gerard S. Letterie & William F. Fox, Legal Aspects of Involuntary Sterilization, 53 FERTILITY & STERILITY 391, 392 (1990). In 1883, Sir Francis Galton was the first to introduce the term "eugenics" in the literature. Galton defined the concept as: "(1) encouraging the propagation of useful, productive members of society (positive eugenics) and (2) reducing the numbers of unfit persons in society (negative eugenics)." Id. at 392. Letterie and Fox assert that the current use of the term "eugenics" is usually limited to the second prong of Galton's definition. Id.

4. In order to give primary consideration to the autonomy interests of the mentally disabled, one must first determine what autonomy interests a mentally disabled individual holds. Tom L. Beauchamp and LeRoy Walters write that:

"Autonomy . . . has been analyzed in terms of freedom from external constraint and the presence of critical internal capacities to self-governance. . . . To respect an autonomous agent is to recognize with due appreciation that person's capacities and perspective, including his or her right to hold certain views, to make certain choices, and to take certain actions based on personal values and beliefs."

CONTEMPORARY ISSUES IN BIOETHICS 28 (Tom L. Beauchamp & LeRoy Walters eds., 3rd ed. 1989). Beauchamp and Childress consider the mentally disabled to be persons with "diminished autonomy." BEAUCHAMP & CHILDRESS, supra note 2, at 68. Beauchamp and Walters define a person with "diminished autonomy" as one who is "highly dependent on others, less than self-reliant, and, in at least some respect, incapable of choosing a plan on the basis of controlled deliberations." Beauchamp & Walters, supra, at 29. The words "diminished autonomy" imply that the mentally disabled may have a certain degree of autonomy.

Two inquiries must be made, when interpreting the language in the above statements, in order to determine whether the "diminished autonomy" of the mentally disabled individ-
omy to alleged social interests is incompatible with educational efforts providing the mentally disabled with an environment that stresses autonomy. Current educational programs pursue "normalization," a process by which mentally disabled individuals learn to develop skills that enable them to live independent and self-sufficient lives. "Normalization" programs have placed an emphasis on sexual autonomy because sexual activity is viewed as an integral part of an independent and self-sufficient life.

Philosophical approaches toward sterilization that subordinate sexual autonomy to society's alleged interests run counter to the process of "normalization" nonetheless sufficient to encompass a given issue facing her. First, there must be an assessment of whether an individual has the "capacities ... to hold certain views and make certain choices." CONTEMPORARY ISSUES IN BIOETHICS 28 (Tom L. Beauchamp & LeRoy Walters eds., 3rd ed. 1989). Second, there must be an assessment of whether these "capacities" are sufficient for making an autonomous decision regarding the given issue.

In making the second assessment, Ruth Faden asserts that mental disability is a matter of degree, and therefore the capacities of the mentally disabled individuals will fall on a "continuum." Interview with Ruth Faden, Senior Research Scholar, Kennedy Institute of Ethics at Georgetown University, Washington, D.C. (Apr. 15, 1994). Faden states that some of the mentally disabled on this "continuum" may not have any capacity to make choices; therefore they may not have any autonomy interest in the given issue facing them. Id. She adds that at a given threshold, some of mentally disabled may have capacities further along the "continuum" and thus will be able to understand the issues facing them and to express a preference. Id. Finally, at another threshold further along the continuum, some mentally disabled individuals will have the ability to understand the issues facing them and will be able to express a preference that considers their greater life view or plan. Id. Faden asserts that policy-makers draw lines that place "competency" to make an autonomous choice with regard to different medical procedures on different points along on the continuum. Id. In applying this analytical framework to sexual autonomy, this article espouses the position that an autonomy interest regarding procreation and parenting of one's genetic child is present if the capacities described infra note 80 are met. An autonomy interest in marriage is present if the capacities described infra note 93, are met.

5. The words "independence" and "autonomy" have been used interchangeably. For example, Beauchamp and Childress have stated: "A person's autonomy is his or her independence, self-reliance, and self-contained ability to decide." TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 56 (1979).


7. Id. at 815-16. According to some commentators, "[s]ignificant advances continue to be made in normalizing the quality and style of life of the mentally retarded. These changes in societal attitude have provided new opportunities for mentally retarded individuals to enjoy more normal and satisfying sexual experiences." Allan Chamberlain et al., Issues in Fertility Control for Mentally Retarded Female Adolescents: I. Sexual Activity, Sexual Abuse, and Contraception, 73 PEDIATRICS 445, 445 (1984).

Science has documented that the mentally disabled are capable of enjoying "normal and satisfying sexual experiences." Id. at 445. One study revealed that there were no significant differences between the sexual experiences of mildly mentally disabled children and their non-disabled counterparts in the 15 to 19 year old age group. Id. at 450.
malization." These approaches constitute an unacceptable return to the distancing and isolation from "mainstream" society previously experienced by the mentally disabled.9

Two approaches that often subordinate the sexual autonomy of the mentally disabled to society's alleged interests include the eugenics based rationales and the "best interests" rationales. A eugenics approach to sterilization of the mentally disabled would subordinate sexual autonomy for the sake of preventing genetic transmission of mental deficiencies.10

8. Normalization attempts to "mainstream" the mentally disabled individual by "making available...patterns or conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society." Scott, supra note 6, at 815 n.28 (citing Nirje, Symposium on Normalization: The Normalization Principle - Implications and Comments, 16 Brit. J. Mental Subnormality 62, 62 (1970)). An emphasis on sexual autonomy contributes to the "mainstreaming" sought through normalization because "freedom and privacy in social and sexual relationships may be as important to mentally disabled persons as to others." Id. at 816. In contrast, subordinating sexual autonomy to alleged societal interests does not bring the mentally disabled "as close as possible to the norms and patterns of mainstream society," but instead isolates the individual from society by removing one of the "patterns or conditions of everyday life" that normalization seeks to introduce. Id. at 815-16 n.28.

9. Elizabeth Scott asserts that "[t]he notion that mentally disabled persons are sexual beings is only recently gaining acceptance.... In the past, dealing with sexual behavior was viewed as a problem: usually, preventing sexual contact among residents or participants in programs...for mentally retarded persons was standard policy." Scott, supra note 6, at 816 n.29.

A sterilization decision that subordinates sexual autonomy in favor of an alleged societal interest indicates that the decision maker necessarily views sexual behavior between mentally disabled individuals as a "problem." The "problem" would be the "harm" caused to society by the exercise of sexual autonomy. Use of sterilization to solve the "problem" parallels the isolation imposed on the mentally disabled in the past to prevent their sexual activity. One point of interest arises with John P. Radford's assertion that until the 1920's, even eugenicists viewed sterilization as a more extreme option than isolation for solving the "problem" of genetic transmission of mental disability: "Many eugenicists feared that advocacy of sterilization would gain for the movement an image of extremism, which might prevent the widespread acceptance of its viewpoint." John P. Radford, Sterilization Versus Segregation: Control of the "Feebleminded," 1900-1938, 33 Soc. Sci. Med. 449, 453 (1991).

10. Throughout the 19th century, eugenic theory was the basis for most state legislation. Jeff Goldhar, The Sterilization of Women with an Intellectual Disability, 10 Tasmania L. Rev. 157, 161-165 (1990). Goldhar states that in 1931, 24 states in the union had laws with eugenic purposes. Id. at 163. The subordination of "sexual autonomy" to the state interest under the eugenics rationale is best captured by Justice Holme's infamous declaration in Buck v. Bell: "It is better for all the world if instead of waiting to execute degenerative offspring for crime, or let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind...Three generations of imbeciles is enough." Buck v. Bell, 274 U.S. 200, 207 (1927).

Though Buck has been limited by later Supreme Court decisions such as Skinner v. Oklahoma, 316 U.S. 535 (1942), the eugenic state interest elucidated by Holmes above has not been ruled unconstitutional and continues to underlie the North Carolina statute and
The first reason for rejecting eugenics based rationales for sterilization of the mentally disabled is that the underlying scientific basis for such rationales has been discredited. The following excerpt explains: "Most of the profoundly retarded are incapable of reproduction because of physical or genetic disabilities, and others remain in protected environments that make sterilization unnecessary. Thus, the number of retarded who lack the ability to consent and who may need involuntary sterilization is small." In addition, data shows that in most instances children born to mentally retarded individuals will not have genetic defects. Science has established that less than five percent of mental retardation is hereditary. Thus, one can conclude that the decision to allow sterilization of the mentally disabled, when made without precise knowledge that a defective gene will be transmitted, sacrifices autonomy and, in the majority of cases provides no "benefit" to society's gene pool.

A second reason for rejecting the eugenics rationale is that the decision to allow sterilization in the small number of cases where transmission of a genetic defect is scientifically predictable is ethically flawed. Ninety percent of the mentally disabled are born to non-mentally disabled parents. To target the mentally disabled solely on eugenic grounds, without targeting normal parents who will genetically transmit mental disability, would constitute groundless discrimination. Because society places the "sexual autonomy" of non-mentally disabled parents above eugenics concerns, such concerns should not infringe upon the sexual autonomy of the mentally disabled.

Although eugenic principles underlie provisions in some state statutes, most states have adopted statutes and judicial standards espousing a "best interests" analysis. This approach generally professes to consider the "best interests" of the patient, but also usually considers the best in-

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13. Coleman, supra note 11, at 60.
14. Id.
terests of society.\textsuperscript{16} The "best interests" approach, as the eugenics approach, often subordinates the sexual autonomy of the mentally disabled to the interests of society.\textsuperscript{17} In so doing, the "best interests" approach provides a return to the unacceptable distancing and isolation of the mentally disabled from "mainstream" society, which they experienced prior to the "normalization" trend.

II. NORTH CAROLINA'S INVASION OF SEXUAL AUTONOMY

A. The North Carolina Statute and Eugenics

North Carolina is the only state that requires public officials, specifically directors of state institutions and county directors of social services, to petition a court for the sterilization of the mentally disabled. Two provisions describing this duty are eugenic. First, the statute requires the public official to petition for sterilization when she believes that sterilization would be for the "public good."\textsuperscript{18} Second, the statute requires the public official to petition for sterilization when she believes that the mentally disabled individual is likely to procreate a child with a physical, mental, or nervous system disease.\textsuperscript{19} Case law has interpreted these two provisions as providing a compelling state interest that allows the state to infringe upon the sexual autonomy of the mentally disabled. In one case, the court indicated that in

[a]cting for the public good, the state, in the exercise of its police\textsuperscript{16}

\textsuperscript{16} \textit{Id.}

\textsuperscript{17} Richard Estacio asserts: "Unfortunately, those statutes which exhibit a concern for societal interests tend to subordinate the rights of the mentally disabled individual whenever the interests of the person and the interests of society appears to be at odds." \textit{Id.} Estacio supports his claim by citing \textsc{Idaho} Code §§ 39-3901 - 39-3910 (1977) (providing for sterilization of patients unfit to raise children), Miss. Code Ann. §§ 41-45-1 to 19 (1972) (balancing the best interests of society and the patient), and N.C. Gen. Stat. §§ 35-36 to 35-50 (1995) (allowing sterilization for the "public good"). \textit{Id.} at 420 n.63.

\textsuperscript{18} See N.C. Gen. Stat. § 35-39(2)(1995). The statute provides that "[i]t shall be the duty of such petitioner to institute proceedings . . . [w]hen in his opinion it is for the public good that such patient, resident, . . . or noninstitutional individual be sterilized." \textit{Id.} The "petitioner" mentioned in this provision refers to directors of state institutions, county directors of social services, or other public officials acting as such directors. \textit{Id.} §§ 35-36, 35-37.

\textsuperscript{19} The statute provides:

\textit{It shall be the duty of such petitioner promptly to institute such proceedings as provided by this article . . . [w]hen in his opinion such patient, resident of an institution, or noninstitutional individual would be likely, unless sterilized, to procreate a child or children would have a tendency to serious physical, mental or nervous disease.} \textit{Id.} § 35-39(3) (1995).
power, may impose reasonable restrictions upon the natural and constitutional rights of its citizens. . . . It is the function of the legislature, and its duty as well, to enact appropriate legislation to protect the public and preserve the race from the known effects of the procreation of mentally deficient children by the mentally deficient.\textsuperscript{20}

The court followed this comment with a direct quote of the statement of Supreme Court Justice Oliver Wendell Holmes in \textit{Buck v. Bell} that supports eugenics.\textsuperscript{21} Therefore, the state’s “compelling” interest was grounded firmly in eugenic theory.\textsuperscript{22}

The court in \textit{In re Truesdell} tried to ameliorate eugenic based infringement upon sexual autonomy by stating that “minimal best interests standards are constitutionally required” before sterilization can be ordered.\textsuperscript{23} Yet, as Fischman asserts, such a stance cannot be reconciled with the language of the statute. The statute specifically requires a district judge to authorize sterilization when the respondent would procreate a child likely to have a serious deficiency.\textsuperscript{24} After \textit{In re Truesdell}, North Carolina courts may face a situation where the eugenic statutory provision upheld in \textit{In re Truesdell} conflicts directly with the “best interest” of a mentally disabled patient.\textsuperscript{25} Thus, by upholding eugenics as a basis for steriliza-

\textsuperscript{20} In \textit{re Moore}, 221 S.E.2d 307, 312 (N.C. 1976)(citing \textit{In re Cavitt}, 157 N.W.2d 171 (Neb. 1968)). The “compelling interest” of the state to prevent the birth of children with inheritable mental deficiency has been cited in later North Carolina cases. See \textit{e.g.} \textit{In re Truesdell}, 304 S.E.2d 793, 805 (N.C. 1983).

\textsuperscript{21} “It is better for all the world if instead of waiting to execute degenerative offspring for crime, or let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles is enough.” \textit{Buck v. Bell}, 274 U.S. 200, 207 (1927).


\textsuperscript{24} \textit{Id.} at 1208 (citing N.C. GEN. STAT. § 35-43 (1995)).

\textsuperscript{25} \textit{Id.} at 1212. Fischman describes the possible conflict as follows: These questions will arise most notably in cases in which a court finds that the statutory test is satisfied, but that sterilization is not in the respondent's best interests, or that sterilization is in the respondent's best interests, but that the statutory test is not satisfied. \textit{In re Truesdell} provides little guidance as to which set of standards should take precedence in such cases.

\textit{Id.} at 1209.
tion, *In re Truesdell* has provided an opportunity for the North Carolina legislature to rethink its position by requiring some consideration of a minimal "best interest" standard.\(^{26}\)

Eugenic principles in the statute and case law should be abandoned in favor of the sexual autonomy interest of the mentally disabled. As was argued in the preceding section, the science underlying eugenic based sterilization of the mentally disabled has been discredited. In addition, there is no ethically acceptable basis for targeting the mentally disabled for sterilization solely on eugenic grounds. In contrast, a decision by a third party to sterilize a mentally disabled individual may forever deny that person the opportunity for any expression of "sexual autonomy" such as procreation and parenting one's own genetic child.

**B. Inadequacy of Procedures Safeguarding Autonomy**

Three factors render inadequate the statute's procedures for protecting the autonomy of the mentally disabled individual. First, even if the individual is found able to consent, the statute does not consider her consent or objection to be controlling. Second, the sterilization petition fails to adequately protect autonomy. Finally, the statute fails to guarantee full exploration of the individual's capacity to enjoy expressions of sexual autonomy before sterilization is ordered.

1. **Consent not Controlling**

The statute requires that the district court judge disregard the mentally disabled individual's lack of consent or objection to sterilization and authorize the procedure if she finds evidence that the individual would probably be unable to care for a child or is likely to procreate a child with serious physical, mental, or nervous system disease.\(^{27}\) Ninety percent of all mentally retarded persons are only "mildly" retarded and accordingly are capable of withholding or granting consent to sterilization.\(^{28}\) In light of this statistic, the state is left with a great deal of room to infringe upon the autonomy of mentally disabled individuals.

Unlike North Carolina, other jurisdictions will uphold the decision of a mentally disabled individual who has been found competent to consent or object. In Oregon, for example, if an individual has the capacity to consent, but instead objects to the sterilization, then the court will deny the

\(^{26}\) *Id.* at 1212.


\(^{28}\) *Coleman,* *supra* note 11, at 67.
petition for sterilization. Other states will not even proceed with a “best interests” analysis unless it is first shown that the mentally disabled individual lacks the capacity to consent.

2. Petition Procedures

The first flaw in the petition procedures is that the statute fails to require expert analysis of the individual’s capacity to consent. Although the mentally disabled individual’s consent is not controlling, courts may find it relevant. Thus, in order to protect the autonomy of the mentally disabled individual, the court must properly assess capacity to consent.

Autonomy is best protected by involving experts who accurately can assess the individual’s capacity in the process. The statute assumes by not requiring such expert analysis that the public official petitioning for sterilization is either qualified or will choose qualified personnel to assess the individual’s capacity to consent. Public officials without special training erroneously may decide that a patient lacks capacity to consent. If the petitioner recognizes her own lack of expertise, then she may consult a physician or psychologist to assess capacity to consent. As Elizabeth Scott asserts, however, “most physicians, including psychiatrists, have very limited expertise in mental retardation; most psychologists have only marginally more. A specific designation of expertise and training in mental retardation would promote more accurate assessments of competency . . . .”

Several states protect the autonomy of the individual by requiring expert participation in assessing capacity to consent. Connecticut courts require evidence regarding incapacity to consent from at least three court

29. Roberta Cepko, Involuntary Sterilization of Women, 8 BERKELEY WOMEN’S L.J. 122, 152 n.206 (1993). In addition to Oregon, Cepko lists several states, including Maine and Connecticut, in which the patient’s ability to consent is the central issue in a sterilization hearing. Id. at 152 n.204-207.
30. Id. at 153.
31. The statute requires that the petition include a statement of consent or objection from the individual as well as her parents or guardians. If the individual is incapable of consent, then the statute requires a certification by the petitioner that the procedure has been explained to the person upon whom the operation is to be performed. N.C. GEN. STAT. § 35-40 (1995).
32. Scott, supra note 6, at 849.
33. Id. The American Academy of Pediatrics advocates this view, stating: “Obtaining the assistance of professionals trained in communicating with persons who are mentally handicapped is essential in seeking to assess capacity.” AMERICAN ACADEMY OF PEDIATRICS COMMITTEE ON BIOETHICS, Sterilization of Women Who are Mentally Handicapped, 85 PEDIATRICS 868, 869 (1990).
appointed impartial experts who have personally observed the individual within the last twelve months before they will find that an individual lacks capacity to consent. 34 Maine requires a court to appoint at least two impartial experts in either the development disability or mental health sciences, and at least one psychologist who has evaluated the patient to assess the individual’s capacity. 35 In contrast, courts in North Carolina have held that the mentally disabled individual has no constitutional right that would require the court to appoint and to pay a medical expert to examine and testify on behalf of the mentally disabled individual. 36

The second flaw in the petition procedures is the failure to safeguard sexual autonomy from possible conflicts of interest between the petitioning public official and the parents or guardian of the mentally disabled individual. 37 As a petitioner, the public official’s conflict of interest is three-fold. If the petitioner is a director of an institution for the mentally disabled, then pregnancy and menstrual cycles may place an increased burden of care on her institution and its staff: “Pregnancy or preserving reproductive function may significantly increase the difficulty of caring for the patient; an infant would make further demands on the same caretaker or necessitate the shift of that responsibility to other individuals or institutions.” 38

The literature reflects concerns that public officials may seek sterilization to prevent or alleviate an increased burden of care. 39 The American College of Obstetricians and Gynecologists states that “the primary or

34. Cepko, supra note 29, at 152 n.204.
35. Id. at 152.
37. For purposes of this article the term “conflict of interest” refers to a situation in which a public official, parent, or guardian has a personal interest that potentially conflicts with the sexual autonomy interests of the mentally disabled individual.

It is important to note that this subsection of the paper does not suggest that people who are incapable of making autonomous choices should be treated as capable of making those choices without the interference of a third party. Instead, this subsection posits that when determining whether an individual is capable of making autonomous choices, an assessment of capacity to consent must be free from the conflicts of interest held by such third parties. If exploration, free from these conflicts of interests, reveals that the individual is not capable of consent or objection, then there may exist a role for a third party in the decisionmaking process. This role should be limited, however, by the principles in Part II B.3. of this article.

38. AMERICAN ACADEMY OF PEDIATRICS COMMITTEE ON BIOETHICS, supra note 33, at 871.
39. This concern is not exclusive to the United States. Other western countries have voiced similar concerns. For example, two British authors write: “The issues relating to both community care and parental wishes lead to another widely voiced criticism: that such sterilizations are a matter of convenience for those who care for women . . . rather than in
contributing indications for sterilization based on presumed or anticipated hardships to others should be viewed with great reservation ...."\(^{40}\)

Roberta Cepko expresses skepticism toward sterilization by hysterectomy because it provides an "immediate, tangible relief to the [mentally disabled] woman's caretaker, by relieving the caretaker of personal hygiene burdens."\(^{41}\) Upon analyzing several cases, Cepko concludes that "courts are too willing to rest hysterectomy authorizations on the ground of medical need, overlooking the incidental benefits that may have motivated parents and institutional staffs to seek authorization of hysterectomies."\(^{42}\)

As a director of an institution or social services program, the petitioner also may encounter budgetary and political pressure to prevent pregnancies of the mentally disabled through the use of sterilization. Political pressure may stem from the state's interest in protecting its purse from increased costs of care and other costs associated with children who may become future wards of the state.

Both the North Carolina case law and statute place a high premium on protecting the state's purse from the procreation of children who may become wards of the state. The North Carolina statute requires a public official to petition for sterilization when the petitioner is of the opinion that the mentally disabled individual will have a child for whom she is unable to care.\(^{43}\) One commentator has stated that a basic purpose of this provision is the prevention of "an increased number of charges to the welfare roles."\(^{44}\)

The North Carolina judiciary has held that "[t]he people of North Carolina . . . have a right to prevent the procreation of children who will become a burden on the State."\(^{45}\) Another commentator states that, by deduction, one must assume that the interest protected here is financial.\(^{46}\) Political pressure to reduce costs of care and budgetary constraints have been implicated in the compromising of sexual autonomy for the men-

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40. American Academy of Pediatrics Committee on Bioethics, supra note 33, at 868.
41. Cepko, supra note 29, at 162.
42. Id. at 163.
44. Estacio, supra note 15, at 421.
45. In re Moore, 221 S.E.2d at 312.
46. Shaw, supra note 22, at 1072 n.52.
tally disabled in Great Britain. Coupled with the large discretion bestowed upon public officials in bringing sterilization petitions, budgetary constraints and political pressure make it possible that the same compromising of the rights of the mentally disabled will occur in North Carolina.

Yet another conflict of interest that may lead institutional directors to petition for sterilization is fear of liability for offspring resulting from rape in their institution. Directors may seek sterilization, in lieu of spending resources to prevent rape in the institutions, as an easy way to avoid liability for future offspring. Cepko argues that use of sterilization to avoid rape related pregnancy is often not in the best interest of the mentally disabled individual because pregnancy may be the only evidence that the mentally disabled individual is being raped. Thus, court ordered sterilization could facilitate undetected rape, and thus would run against the interests of the mentally disabled. Cepko cites several cases where institutional authorities "encourage[d] parents to sterilize their [institutionalized] daughters for the convenience of the staff and to prevent

47. Robert Lee and Derek Morgan wrote about the case of the British woman who was sterilized to avoid pregnancy. The following excerpt summarizes that article:

The location of mentally handicapped people in the community was always likely to prove especially costly, and it is beyond argument that the whole process has been massively under resourced. Jeanette's [the individual who was sterilized] vulnerability is a consequence of this; she is but one victim, one hostage to fortunes which are redirected away from mental health care.

Lee & Morgan, supra note 39, at 242.

48. Robert Shaw has been especially critical of the large discretion bestowed upon petitioners by the statute, and the statute's lack of adequate safeguards:

Under the new statutory scheme an individual may be recommended for sterilization and the operation carried out under court order without any positive finding by a qualified individual or group that such an operation is in fact justifiable. The initial decision to sterilize is not based on scientific evidence that a defect is inheritable, or alternatively, on positive facts supporting a finding of parental unfitness, but on the opinion of the petitioning county social services director or director of a state institution. The statute does not articulate how these officials, individuals who might not possess any medical or scientific expertise, are qualified to determine effectively the inheritability of a particular defect.

Shaw, supra note 22, at 1076.

49. Cepko, supra note 29, at 142.

50. Id.

51. Id. This viewpoint is supported by stories in the public media. In one case, "the alleged attack went unnoticed until the woman showed signs of pregnancy several months later." Terry Wilson, Jury Clears Rape Suspect in Nursing Home Attack, CHI. TRIB., Dec. 15, 1993, at 3. See also Kate Stone Lombardi, Rape and the Mentally Retarded, N.Y. TIMES, July 25, 1993, at WC1.
liability for offspring resulting from rape."\(^{52}\) *In re M.K.R.* involved a sterilization petition for a thirteen year old girl.\(^{53}\) The authorities at her school suggested that parents allow her to be sterilized in order to avoid pregnancy because she was in constant danger of being "assaulted and ravished."\(^{54}\)

In allowing parents to petition for sterilization of their children, the statute fails to consider that parents and guardians face a conflict of interest.\(^{55}\) Parents of noninstitutionalized individuals may view sterilization as the answer to an increased burden of care. Most jurisdictions presume that the parent's interest in preventing the inconvenience associated with menstrual hygiene and unwanted pregnancy conflicts with their child's interests.\(^{56}\)

One study surveying parents of severely mentally disabled individuals revealed that fourteen percent found that the difficulties in managing menstruation constitute a proper basis for authorizing sterilization.\(^{57}\) A federal court recognized this conflicting interest when it declared unconstitutional a former provision of the North Carolina statute requiring public officials to file sterilization petitions upon a parent's request: "We think such confidence in all next of kin and all legal guardians is misplaced, and that the unstated premises of competency to decide to force initiation of the proceeding and never failing fidelity to the interest of the retarded person are invalid."\(^{58}\) North Carolina case law, however, reflects a different attitude. Earlier in 1976, in *In re Moore*, the North Carolina Supreme Court upheld then current provisions of the statute and stated that "[the mentally disabled child's] mother unquestionably is in a

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53. *Id.* at 142 n.134 (citing *In re M.K.R.*, 515 S.W.2d. 467 (Mo. 1974)).
54. *In re M.K.R.*, 515 S.W.2d. at 468.
56. Scott, *supra* note 6, at 821-22, 845, 847. Although Scott's autonomy model provides a greater role for parents than do most state models, Scott clearly states that this presumption is valid when the mentally disabled individual has an autonomy interest in procreation. *Id.* at 847.
position to know what is best for the future of her child."\(^{59}\) Later cases, relying on the authority of In re Moore, have failed to address the role of parents petitioning and consenting for sterilization of their mentally disabled children.\(^{60}\)

As in the case of the public petitioner, parents may view sterilization as a means of preventing increased costs of care due to pregnancy or menstrual cycles. Lucille Wolf and Donald Zarfas revealed that parents' attitudes toward sterilization are "pragmatic" and affected by the practical considerations of rearing children.\(^{61}\) The authors acknowledged parents' concerns regarding the results of heterosexual contacts by their mentally disabled children and concluded that "[p]arents of retarded persons have the right to an old age free from the care, supervision, and financial responsibility of caring for grandchildren."\(^{62}\) The authors' statement regarding parental interests, however, is colored by the study's revelation that seventy-one percent of parents favored involuntary sterilization of their mentally disabled children.\(^{63}\) This figure takes on added significance when coupled with the study's conclusion that sixty-four percent of parents felt no need for involving a legally authorized third party in the decision to sterilize if their physician already concurred with their sterilization decision.\(^{64}\) Together, these figures represent attitudes that reflect a disregard for patient autonomy.

Coupled with the large procedural discretion\(^{65}\) remaining in the statute, the above mentioned conflicts of interest create several ethical concerns. The conflicts of interest may constitute the underlying purpose of a petition for sterilization by a public official or a parent.\(^{66}\) By allowing a petition based solely on the discretionary concerns of public officials and

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59. In re Moore, 221 S.E.2d at 316.
62. Id.
63. Though the Wolf-Zarfas study was conducted in Southwest Ontario, the study corroborated the results of a prior study conducted in the United States. Wolf and Zarfas specifically mention the corroboration of the Whitecraft-Jones (1974) study that found 85% of parents approving sterilization and the Bass (1967) study revealing that 60% of parents approved sterilization. Id.
64. Id. at 127.
65. See Shaw, supra note 22, at 1076.
66. See N.C. GEN STAT. §§ 35-36, 35-37 (1995). It is important to note that while the statute places an affirmative duty on public officials to petition for sterilization in some circumstances, parents are authorized to petition without restrictions. Id.
parents, their conflicts of interests can be couched in terms of "the public good," the inheritability of the disease, inability to raise children, or the "best interest" of the mentally disabled person.

The conflicts of interest may also lead to violations of autonomy during the gathering of evidence to support the petition. Fischman asserts that in order to meet evidentiary standards, mental health staff and parents may "commit egregious invasions of the privacy of the mentally retarded persons while attempting to gather enough evidence to support a sterilization petition." Fischman's concern is warranted because the statute fails to provide the mentally disabled individual with notice of the right to counsel until after the evidence has been gathered and the petition has been filed.

The United States Supreme Court seems unconcerned. In 1984, the Court let stand a 1968 decision upholding the legality of the state's decision to sterilize a mentally disabled individual. Elaine Riddick was raped at the age of thirteen and became pregnant. North Carolina's proffer of evidence asserted that Riddick was "mentally retarded, did poor work in school, (and) was promiscuous." Two major facts warrant questioning the state's efforts in gathering evidence. First, the state ordered her sterilization based on consent obtained from Riddick's father, who the petitioners knew was mentally disabled and was not her legal guardian. Second, Elaine Riddick attended and graduated from community college as a young woman in her twenties.

3. Exploring the Capacity to Enjoy Sexual Autonomy

If an individual is truly incapable of consent or objection, then sterilization will not violate her sexual autonomy as long as there has been a full examination of her mental and emotional abilities and she is found to lack capacity to enjoy or understand expressions of sexual autonomy. It is error to assume that a mentally disabled individual will not be capable of enjoying other expressions of sexual autonomy just because she is

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67. Fischman, supra note 23, at 1208.
68. N.C. GEN. STAT. § 35-45 (1995). It is also likely that the mentally disabled individual will not receive the benefit of an impartial guardian ad litem because the statute only provides for one when there is no next of kin or legal guardian. N.C. GEN. STAT. § 35-40 (1995).
70. Id.
71. Id.
72. Id.
73. See Interview with Ruth Faden, supra note 4; Scott, supra note 6, at 831.
found legally incompetent to make a medical decision regarding sterilization.IG Sexual autonomy interests that must be fully explored include in-

74. See Scott, supra note 6, at 837. Scott asserts that:

The ability to make an informed medical decision involves a level of cognitive functioning that many mentally retarded persons lack. However, a person who is unable to make this implementing decision might nonetheless be capable of making the underlying decision to have or to forgo having a child. This decision is fundamentally different from the medical sterilization decision and requires different capabilities.

Id. In addition, Scott states that a mildly disabled individual may have the ability to fulfill basic parental responsibilities regardless of whether she is legally competent to make a decision regarding sterilization. Id. As an example, Scott cites the case of a 35 year old mentally disabled mother who visited the Forensic Psychiatry Unit at the University of Virginia. This woman had experienced problems with contraceptives and was requesting sterilization. Her competency was in question because of her inability to think abstractly about the permanency of sterilization. Id. at 839. For a discussion of criteria used for determining when a mentally disabled parent is capable of fulfilling "basic parental responsibilities," see infra notes 125-29 and accompanying text.

Professor John Grassi of Cambridge College backs Scott's opinion. He states that many individuals may not be capable of formal "operational thought" involved in medical decisions, but they may still be capable of exercising sufficient "practical intelligence" to provide basic parental care. Telephone Interview with John Grassi, Ph.D., Chair of Graduate Program in Urban Education at Cambridge College, Cambridge, Mass. (Mar. 19, 1994) (citing ROBERT J. STERNBERG PH.D., THE TRIARCHIC MIND (1988)).

Harvard Psychiatrist Mick Burglass supports Grassi and Scott:

Basic parenting most often involves issues of "single link proximal causation" (or to use Grassi's words: "practical intelligence"). In "single link proximal causation," an "effect" is close in time to the "event" that caused it. Medical decision making involves "multiple link proximal causation;' this requires thought (what Grassi terms: "operational thought") in situations involving large time spans between the actual "event" (such as providing consent) and the final "effect" (such as a medical complication). In addition, "multiple link proximal causation" involves added variables such as probabilities that given "effects" will occur after a given "event." Therefore, when we consider "multiple link proximal causation," some Supreme Court Justices may not meet some doctor's standards regarding competency over certain medical decisions.

Telephone Interview with Mick Burglass, M.D. (Psychiatry), M.P.H., M.S. (Neuropsychology), M. Div., Professor at the Harvard Medical School Clinical and Research Faculty at the Zinberg Center for Addiction Studies and former Professor at Harvard Divinity School, Cambridge, Mass. (Apr. 10, 1994).

Robert Canto M.D. reveals exactly why consent to a medical operation like sterilization involves "operational thought" (Burglass's "multiple link causation" thinking) far above the level of thought required for basic parental care:

In assessing an individuals ability to consent, I give the individual a list of pros and cons regarding the particular form of sterilization at issue. Most patients have the pros in mind when they come to me. But most of the time they are not fully aware of the cons. The cons associated with the procedure include: possibility of infection such as an abscess, chronic pain, fistula (abnormal communications between two organs), inadvertent tying of the ureters etc. I proceed to explain what these cons are medically. Many "normal" patients are not able to
terests in procreation, parenting one's own genetic child, and marriage.\textsuperscript{75}

The North Carolina statute fails to guarantee full exploration of the individual's capacity to enjoy expressions of sexual autonomy for three reasons. First, the statute provides for an evidentiary hearing only if requested by the mentally disabled individual, a petitioner, or another interested party.\textsuperscript{76} If an evidentiary hearing is never requested, then a district court judge can order sterilization without a witness or evidence additional to that which was presented with the petition.\textsuperscript{77} When a judge assesses evidence in a nonconsensual sterilization petition without considering the relevant conflicts of interest, the autonomy of the individual may be compromised. A full evidentiary hearing, requiring both a proffer of evidence against sterilization, in conjunction with testimony by court appointed impartial experts, could reveal the conflicts of interest and would provide a greater safeguard for the sexual autonomy interest of the individual. Maine employs this approach in its nonconsensual sterilization cases.\textsuperscript{78}

By not requiring a hearing in which an attorney must proffer evidence against sterilization, North Carolina provides an opportunity for the mentally disabled individual's attorney to side with public officials or parents and advocate that sterilization is in the individual's "best interest."\textsuperscript{79}

\textsuperscript{75} See Beauchamp \& Childress, supra note 2, at 68 (definition of sexual autonomy).
\textsuperscript{76} N.C. GEN. STAT. § 35-43 (1995).
\textsuperscript{77} Id.
\textsuperscript{78} See Cepko, supra note 29, at 152. Roberta Cepko asserts: "Reflecting a concern for balance, [Maine] requires the respondent's attorney to ensure that 'information and evidence in opposition to sterilization without informed consent is fully represented' at the best interest hearing.” Id. at 152 (emphasis omitted).
\textsuperscript{79} See id. at 152 n.201. Cepko recognizes this danger stating that "the absence of [opposition to sterilization] in many of the cases is striking.” Id. See also C.D.M. v. State,
Under the North Carolina statute, this could result in no one requesting an evidentiary hearing. Alternatively, if a court requires an evidentiary hearing, then the only evidence proffered might be that which advocates sterilization for the mentally disabled individual's "best interest." Under both scenarios, the judge's decision would be based on the meager and possibly biased evidence provided by the petitioning public officials and parents.

Second, the statute permits sterilization without a full exploration of the individual's capacity to adequately parent children as an expression of their autonomy. Instead of requiring findings of fact that ensure that an individual has the capacity to care for children, the statute allows vast judicial discretion. "No standards are provided to aid in the judicial determination of what degree of probability of unfitness . . . is appropriate. In other words, the statute permits limitless discretion by the pet-

627 P.2d 607, 609 n.4 (Alaska 1981) (At hearing, the guardian ad litem had "reluctantly argued that jurisdiction [to order sterilization] did not exist. On appeal, he . . . now joins C.D.M's parents in urging us to find that the jurisdiction does exist").

80. See Scott, supra note 6, at 837. On an ethical level, the position herein espoused agrees with the claim that "competency to make a meaningful choice to procreate rests on the individual's ability to fulfill the basic responsibilities of parenthood." Id. Thus, an individual who is capable of caring for a child has a legally protectable interest in procreation, and [an] individual who lacks this capability does not. Id. at 838. This standard asserts that an autonomy interest in parenting and procreation exists only if the individual is capable of performing "basic parental responsibilities." This standard does not contemplate that the individual must fulfill the "basic responsibilities of parenthood" alone, as long as assistance is available. See infra notes 88-92 and accompanying text. See also infra notes 125-129 and accompanying text (discussing the criteria for assessing what constitutes adequate parenting).

At this point, one could argue that the potential child's interests must be considered. A response to this argument is that the standard of competency to make a meaningful choice, elucidated by Scott above, already considers the potential child's interests. Under Scott's standard, a potential child's interests carries enough weight that exercise of the potential parent's autonomy interest in parenting and procreation is conditioned on the ability to perform adequately basic parental responsibilities. This standard is very far along the capacity "continuum" elucidated by Ruth Faden. See Interview with Faden, supra note 4. The standard requires more than a capacity to understand the given issue and to make a preferential decision that considers her life view or plan. Id.

Yet, one could counter that ethical analysis should consider the potential child's prospective view on being born and possibly raised by mentally disabled parents. This argument would have to assume that once a parent has shown that they can fulfill the "basic responsibilities" of parenthood, a child may still have preferred not to have been raised, nor ever conceived, by the mentally disabled parent. Until a study has been made, however, that demonstrates that children of the mentally disabled actually hold these preferences, basing sterilization on the potential child's perspective would constitute an infringement of sexual autonomy on the basis of groundless speculation.

tioner and the district court judge."\textsuperscript{82} North Carolina case law reflects the district court's "limitless discretion"\textsuperscript{83} in applying the varying subjective criteria that courts have used to determine an individual's capacity to care for a child. In the case of \textit{In re Johnson}, the court allowed the sterilization of a mildly mentally disabled woman because she "exhibited emotional immaturity, the absence of a sense of responsibility, a lack of patience with children, and continuous nightly adventures with boyfriends followed by daily sleep and bedrest."\textsuperscript{84} In contrast, the court in \textit{In re Truesdell} focused primarily on the mentally disabled individual's inability to provide for the basic physical needs of the child.\textsuperscript{85}

While a judge's subjective criteria for sterilization may vary, the relevant cases share a common focus on the capacity of the mentally disabled individual to raise a child absent outside help. North Carolina cases applying two "compelling state interests" have authorized sterilization of individuals based on inability to care for a child. First, the state has an interest in preventing the birth of children who will become burdens to the state.\textsuperscript{86} Second, the state has a compelling interest in the welfare of the unborn child.\textsuperscript{87} Although the first asserted interest may be sufficient to preclude judicial inquiry into possible sources of public assistance, there is no valid policy reason for lack of judicial inquiry into possible private sources of assistance.

Private sources of assistance could include spouses and family members willing to make a commitment to help raise the child, protect its welfare, and prevent any burden to the state.\textsuperscript{88} Thus, by performing such an inquiry the court could preserve both state interests and the sexual autonomy of the mentally disabled individual.\textsuperscript{89}

\textsuperscript{82} Shaw, \textit{supra} note 22, at 1077.

\textsuperscript{83} Id.

\textsuperscript{84} \textit{In re Johnson}, 263 S.E.2d at 809. When this evidence was challenged as irrelevant to proper parenting, the court claimed broad discretion: "[t]he standard of admissibility based on relevancy and materiality is of necessity elastic, and the evidence need not bear directly on the issue as long as there is a reasonable, open and visible connection with the subject of the lawsuit." \textit{Id.} (emphasis omitted).

\textsuperscript{85} \textit{In re Truesdell}, 304 S.E.2d at 808.

\textsuperscript{86} \textit{In re Moore}, 221 S.E.2d at 312.

\textsuperscript{87} Id.

\textsuperscript{88} See generally \textit{In re Montgomery}, 303 S.E.2d 324 (N.C. App. 1983), rev'd, 316 S.E.2d 246 (N.C. 1984) (vacating an order terminating the rights of two mentally disabled parents when the petitioners failed to show that the parents as a couple provided inadequate physical and emotional care).

\textsuperscript{89} One could argue that as a matter of policy, when family members petition the court for sterilization, or join the sterilization petition, courts should not waste time and effort inquiring into the possibility of family members providing assistance. This position,
This position is consistent with New Jersey’s requirement that a trial court assess whether an individual, together with a spouse, would be able to care for a child. Inquiry into private sources of assistance could also include private sector institutions who may teach and oversee the mentally disabled individual. Scott asserts that there has been a growing recognition that some mentally disabled individuals can function as parents, and that there is a new focus being placed on supportive services and training in parenting skills. Another commentator states that “research indicates that mentally retarded persons can learn to overcome virtually any deficiency in parenting abilities.” Courts presently may not demand inquiries into available private sources of assistance. Nevertheless, such inquiries are required based on constitutional grounds and ethical concerns for sexual autonomy.

Third, the statute and corresponding case law prescribe sterilization without providing for any exploration of the mentally disabled individual’s sexual autonomy interest in marriage. Cepko asserts that “evidence, however, relies on the speculation that family members act or believe similarly regarding the issue of sterilization. Research has not unveiled a study on individual family members agreeing or dissenting regarding sterilization of another family member. Thus, inquiry into possible aid from nuclear and extended family members is warranted even when certain family members petition for sterilization.

90. See In re Grady, 426 A.2d 476, 483 (N.J. 1981). The Hastings Center, Institute of Society, Ethics and Life Sciences Behavior Control Research Group asserts:

Another factor that must be taken into consideration is that parental functions are often shared by a couple. If one parent lacks the competence to perform certain parental tasks, the other parent may be capable of carrying them out. Consequently, in considering competence to be a parent, it may be inappropriate to focus exclusively on the capabilities of the mentally incompetent person while ignoring the possible competence of the partner.


91. Scott, supra note 6, at 816 (citing Rosenberg & McTate, Intellectually Handicapped Mothers: Problems and Perspectives, CHILDREN TODAY, Jan.-Feb. 1982, at 24; Madsen, Parenting Classes for the Mentally Retarded, 17 MENTAL RETARDATION 195 (1979)).


93. In applying the analytical framework elucidated by Ruth Faden, this article takes the position that an autonomy interest in marriage should be found when an individual is capable of understanding the issue of marriage and can express a preference regarding the present or future marital status. See Interview with Ruth Faden, supra note 4. This standard requires “capacities” on a much lower threshold on the “continuum,” see Interview with Ruth Faden, supra note 4, than the “capacities” required to find an autonomy interest in procreation and parenting of one’s genetic child. See supra note 80. The higher “capacities” requirements for an autonomy interest in procreation and parenting of one’s genetic child are rooted in protecting the potential child’s interest. Id. The capacity of the mentally
dence indicates that men and women with mental disabilities do in fact marry." She argues that "[s]ome individuals would not consider marriage to an infertile person, so eliminating this potentially critical aspect of desirability in a mate results in a potentially smaller pool of partners for [the sterilized]." Cepko concludes that to "the extent that sterility restricts the marital possibilities of a mentally disabled woman," it invades that person's constitutional right to marry. Although the constitutional issue is beyond the scope of this article, sterilization without a full investigation of the individual's interest in marriage unethically invades sexual autonomy.

Inquiry into potential assistance from a spouse or other private source of assistance in child rearing can serve to protect the mentally disabled individual's sexual autonomy interests of procreation and parenting one's own genetic child, as well as marriage. If such an inquiry revealed the ability to care for a child with the aid of a spouse, then North Carolina's "compelling interest" in child care would be met. Such an inquiry would thus provide protection against the impact of sterilization on marriage (cited by Cepko above).

C. Autonomy and the Poor

Nonconsensual sterilization may infringe not only upon sexual autonomy, but may also invade a mentally disabled individual's autonomy on a psychological level. Events affecting bodily integrity have reciprocal psychological effects. Before sterilization surgery is performed, the sterilized individual to understand the issue of marriage and to express a preference regarding their present or future marital status has been well established.

94. Cepko, supra note 29, at 144.
95. Id.
96. Id. Summarizing a previous survey of mentally disabled individuals who had been sterilized, Cepko states: "The most common ground for disapproval of the sterilization was that the surgery would 'prevent [them] . . . from passing as normal, particularly if she or he is contemplating marriage to a normal person, and' infertility was viewed as 'preventing the . . . [person] from assuming the normal roles of motherhood and fatherhood.'" Id. (quoting G. Sabagh & R.B. Edgerton, Sterilized Mental Defectives Look at Eugenic Sterilization, 9 Eugenics Q. 213 (1962)).
97. See Beauchamp & Childress, supra note 2, at 68 (acknowledging that autonomy can be compromised on the psychological level: "autonomous persons sometimes make nonautonomous choices imposed by illness or depression"). This section of the article asserts that by denying a choice of physician to the mentally disabled who cannot afford their own physician, these individuals are not afforded the opportunity to minimize restraints on autonomy from fear, anxiety, panic, depression, or other reactions to the sterilization procedure.
98. Telephone Interview with Eduard Azcarate, Ph.D., Clinical Psychologist and for-
mentally disabled individual may be burdened psychologically by fear, anxiety, and may even show signs of panic. After the surgery has been performed, the individual may feel a deep sense of loss, depression, and even trauma. Modern psychology categorizes these postoperative effects as "somatopsychic." Invasions of the body through sterilization

99. Interview with Eduard Azcarate, supra note 98. See also Blumenfield & Thompson, supra note 98, at 48-59 (providing an in-depth discussion on psychological burdens experienced by patients before surgery).

100. Interview with Eduard Azcarate, supra note 98. See also Ronald D. Franks, M.D., The Difficult Patient, in UNDERSTANDING HUMAN BEHAVIOR IN HEALTH AND ILLNESS, supra note 98, at 101, 111-112. The writings of Franks corroborate Azcarate's statement. Regarding the psychological effects of sterilization by hysterectomy, Franks writes:

A woman's psychological response to the loss of the uterus is quite varied and depends on many factors, including the reason for the operation, the woman's acceptance of its necessity, her age, her psychological maturity, and the stability of her sense of her femininity. Her husband's attitude is also extremely important. Some men reject the woman as no longer truly feminine because of their own unconscious fears as well as their desires for children. Even under the best of circumstances, complete psychological recovery following a hysterectomy may take many months. This is because much psychological response is based upon an unconscious thinking which does not have a logical basis. For example, any operation may be viewed unconsciously, as the punishment. This is especially true of operations on the sexual apparatus. The person views the organic pathology as a punishment for sexual behavior. Great guilt is still attached to sexual thoughts and sexual activity by many people. Physicians must be aware of this, and should take steps to prevent a depressed patient's sexual behavior from being severely inhibited.

Id.

Regarding sterilization through vasectomy, Franks writes that "[t]here are more frequent adverse psychological reactions to vasectomy than is generally recognized." Id. at 110. Robert Dickes and John L. Fleming add:

The use of surgical methods [such as vasectomy] requires a permanent shift in the person's self image, which normally induces an awareness of sexuality and the ability to be fertile. This ability to be fertile is lost in the operative procedure. Some individuals cannot tolerate this even though they may consciously seek the operation. Careful presurgical evaluation of the patient is needed.

Jonathan Dickes, M.D. & John L. Fleming, M.D., Sexuality in General Medical Practice, in UNDERSTANDING HUMAN BEHAVIOR IN HEALTH AND ILLNESS, supra note 98, at 349, 353.

101. Stedman's Medical Dictionary defines the "somatopsychic" as: "Relating to the body-mind relationship; the study of the effects of the body upon the mind, as opposed to psychosomatic." STEDMAN'S MEDICAL DICTIONARY 1435 (25th ed. 1990). Eduard Azcarate explains the term somatopsychic: "The term 'soma' means body, and the term 'psyche' refers to the mind. The term describes how changes in the body affect the mind. As an example, people who have diabetes experience mood changes when blood sugar
have had well documented negative psychological effects on mentally disabled individuals.\textsuperscript{102}

If, after a full exploration, an individual is found incapable of consent and having no interests in sexual autonomy (e.g. the individual cannot have children, is incapable of a marriage relationship, etc.), then the individual should be granted a full opportunity to minimize psychological effects that will compromise her autonomy. In order to minimize this invasion, patients should be allowed to choose the physician who will perform the sterilization operation.\textsuperscript{103} If a patient is unable to make such a choice, then parents or guardians should choose the physician because

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\textsuperscript{102} Psychological effects stemming from sterilization include "great anxiety about being considered different," or "an intense feeling of deprivation at the thought of not being able to bear children," and "a degraded status of the self." Cepko, supra note 29, at 152 (citing Sabagh & Edgerton, supra note 96).

\textsuperscript{103} The word “minimize” recognizes that once the state imposes sterilization, there will be an invasion of the body, and thus a reciprocal psychological effect. The choice of physician, however, may allow the mentally disabled individual to minimize the psychological impact of sterilization by providing a sense of comfort or trust in a physician. Interview with Eduard Azcarate, supra note 98.

A good rapport between patient and physician is especially important as regards the mentally disabled. There are two psychological benefits in providing a choice of physician. First, there will be a sense of “continuity” of support, of remaining somewhat in control of the situation, that the individual is given from the time before the operation to the recovery period that follows. This “continuity” may reduce psychological trauma that may follow the invasion of the body by the surgeon. Second, it is an enormous psychological benefit to allow the mentally disabled to choose a physician with whom they feel “comfortable.” Feelings of “comfort” or “discomfort” are magnified in the mentally disabled individual and they often react violently to people they dislike. A “comfort” relationship with a physician will allow the mentally disabled individual to feel less invaded, less fear and less anxiety before the operation. This will preserve more of their psychological autonomy.

\textit{Id.} See Michael Blumenfield, M.D., \textit{The Participants in the Doctor Patient Relationship, in The Basic Models of the Doctor-Patient Relationship, supra note 98, at 19.} Dr. Blumenfield provides an in-depth discussion on the psychological effects of physician characteristics upon patients, as well as an example of how a physician imposed upon a patient who does not feel “comfortable” with that physician can cause adverse psychological effects.

Sometimes a single characteristic of the doctor can have a tremendous emotional significance to the patient . . . For example, a black patient living in a ghetto may have very distinct emotional reaction to a white physician based on previous experiences involving white authority figures. Such feelings could include fear, hopelessness, and anger and they will hinder the medical treatment and the ability of the patient to cooperate with the physician.

\textit{Id.} at 23.
they have an interest in the psychological well-being of their child.\textsuperscript{104}

The North Carolina statute provides such a choice for those who can afford a private physician, but not for those unable to afford a physician.\textsuperscript{105} Mentally disabled individuals whose families can’t afford a private physician will undergo sterilization from a physician chosen by the public official who petitioned for the sterilization.\textsuperscript{106} The effect of this scheme is to allow the state to impose sterilization without giving individuals from lesser means a chance to minimize the psychological invasion of autonomy that can be caused by the procedure.

In order to maximize autonomy, the state should not only provide a choice of physician to all mentally disabled individuals that it orders sterilized, but it should also pay for those sterilizations.\textsuperscript{107} If the state orders a sterilization and parents are forced to pay, then a financial conflict of interest may lead parents to “shop around” and base their choice of phy-

\textsuperscript{104} The court must order sterilization by the least drastic or burdensome means. See \textit{In re Truesdell}, 304 S.E.2d 793, 811 (N.C. 1976). Once the judge prescribes the least intrusive sterilization method, the court eliminates possible conflicts of interest that may otherwise lead parents to choose selectively only physicians who will perform the method of sterilization they request.

\textsuperscript{105} N.C. GEN. STAT. § 35-38 (1995). This paper does not question the constitutionality of treating the mentally disabled poor differently from those with sufficient wealth to afford a physician. The courts have turned away from earlier intimations that wealth-based classifications should receive strict constitutional scrutiny. \textsc{Geoffrey R. Stone et al.}, \textsc{Constitutional Law} 743 (1991). Instead, this paper raises the ethical issue surrounding the greater invasion of autonomy faced by those mentally disabled individuals who are not afforded a choice of physician.

\textsuperscript{106} N.C. GEN. STAT. § 35-38.

\textsuperscript{107} The ethical questions presented by imposing a physician upon a patient whom the state has ordered sterilized is much different from the recent abortion cases where the court held that the state was not required to pay for the abortion procedures. See \textit{Rust v. Sullivan}, 500 U.S. 173 (1990); \textit{Harris v. McRae}, 440 U.S. 297 (1980), and \textit{Maher v. Roe}, 432 U.S. 464 (1977). Those cases involved questions of subsidies for rights that were constitutionally protected. In contrast, these cases involve questions of a state’s ethical obligation to pay for a physician, chosen by the patient, once the state has imposed a procedure upon the individual.

On a legal level, however, some may argue that the state fulfills its obligation to the mentally disabled individuals of lesser means by providing a qualified physician to perform the operation. Providing a qualified physician, however, is not an adequate solution to the ethical issue raised by denying certain mentally disabled patients an opportunity to minimize psychological effects associated with sterilization. In order to minimize psychological effects associated with sterilization, a patient requires something in addition to a medically qualified individual provided by the state. The mentally disabled individual requires a qualified physician with whom she feels “comfortable.” See Interview with Eduard Azcarate, \textit{supra} note 98. Arguing on an ethical level, once the state imposes the psychological burden associated with sterilization, it should pay for the choice of physician that will minimize the invasion of psychological autonomy.
sician on expense rather than on psychological compatibility with their child.

D. Invasions of Female Autonomy

1. Objectification

The statutory language and its corresponding judicial interpretations objectify the mentally disabled woman. The root of this objectification lies in the language of the statute requiring a judge to order sterilization when the individual would be likely to procreate a child with genetic "deficiencies" or one that she may not be able to care for. The court has stated that the individual is unable or unwilling to control procreation by alternative birth control or contraceptive methods.\(^{109}\)

Although this judicial interpretation attempts to safeguard autonomy interests by requiring certain evidence, it makes clear that avoiding societal burdens associated with "pregnancy" is the primary purpose of the statutory provision.\(^{110}\) Thus, although a straightforward reading of the statute suggests that it applies to both men and women, the judicial focus on "pregnancy" imposes the greatest burdens on mentally disabled women. One possible burden is that mentally disabled women will be the subject of most sterilization petitions.\(^{111}\) This burden might be summed

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110. As case law has previously stated, these burdens on society include the procreation of genetically "defective" children or future wards of the state. See supra text accompanying notes 20 and 45-46.

One could counter that the judicial interpretation is primarily aimed at preventing sexual activity and pregnancy for the moral and mental health of the individual, rather than to prevent societal burdens. There exists a separate statutory provision, however, that authorizes sterilization for the mental or moral best interests of the patient. N.C. Gen. Stat. §§ 35-39 (1995). Furthermore, in In re Truesdell, the court stated that it was specifically addressing the state interest in "the prevention of the birth of a child to a person who would be incapable of discharging the responsibilities of parenthood." 304 S.E.2d at 805.

The court stated in North Carolina Association for Retarded Persons v. State that it was applying the judicial interpretation to the provision found in N.C. Gen. Stat. §§ 35-43 because: the person "would be likely, unless sterilized to procreate a child, or children which probably would have serious physical, mental or nervous disease[s]." 420 F. Supp. at 455.

111. Although the actual statistics on the gender of the nonconsensually sterilized in North Carolina are not available, it is apparent that the majority of sterilization cases na-
up by the following message sent to mentally disabled women by this judicial interpretation of the statute: one aspect of your biology has no worth, burdens society, and must be removed. This message objectifies the mentally disabled woman.

Objectification involves ascribing the features of an object to a living being. Shapiro states that one feature of being an object is that “its full value can be exhaustively captured by specifying the uses to which it can be put.” Shapiro asserts that because the full value can be captured, the object is then not viewed as autonomous or worthy of corresponding duties. Thus, one could argue that the court ascribes the mentally disabled woman a “full value” less than what is worthy of reproduction by denying her the use of her body for procreation. As an object, the woman’s “full value” is deemed insufficient to warrant preservation of her sexual autonomy. Under the current statutory scheme, her “full value” is also deemed unworthy of a duty to inquire into possible sources of private assistance or training to help her properly raise children.

Shapiro adds that one method of objectification involves the manipulation of physical and mental functions without a “disorder-based justification.” Sterilization of the mentally disabled woman could be seen as a manipulation of the physical and mental functions associated with pregnancy and menstruation. Although the state’s interests may meet legal “compelling interest” standards, they do not meet a “disorder-based justification” standard. As was mentioned, the scientific basis underlying a state’s eugenic interest in preventing the birth of “defective” children has largely been discredited. In addition, the state’s interest in protecting its purse from future wards of the state is groundless without inquiry into possible private sources of assistance from spouses, family, or institutions.

2. Negative Cultural Views of Women

Lack of evidentiary standards in the statute and case law may allow cultural stereotypes held by parents, public officials, and judges to play a role in the sterilization decision; thus, it potentially infringes upon the

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113. Id.
114. See supra text accompanying notes 88-92.
115. Shapiro, supra note 112, at 351.
sexual autonomy of the mentally disabled. Cepko asserts that there is a history of cultural preoccupation with sterilization of women deemed unfit to raise children, but that there is no such preoccupation with male parenting. She asserts that of several dozen modern sterilization cases, only two involved sterilization of men. The results from the Wolf and Zarfas study mentioned above corroborate this view. The study revealed that parents of mentally disabled males viewed their abilities in the area of marriage and child rearing more positively than did parents of mentally disabled females.

The case of In re Johnson exemplifies the infusion of a cultural stereotype into the sterilization decision. In assessing Tempie Johnson’s capacity to parent, the court relied on evidence of her “morals [and] sexual activity,” specifically “focusing on nightly adventures with boyfriends.” The court also considered evidence that Tempie “was able to help clean the house but that she did not have the patience to cook.” Finally, the court stated that in past years Tempie had shown signs of impatience with children, immaturity, and irresponsibility. In considering the evidence, the court did not inquire into the possibility that Tempie’s mate may prefer to cook or clean. The court’s opinion resounds of stereotypical and antiquated views regarding the role of women in society by applying cooking, cleaning, and sexual morality standards to Tempie. Furthermore, immaturity and irresponsibility provide little if any aid in predicting Tempie’s parental skills given the fact that the petition to sterilize was brought when she was barely twenty years old.

Comparing the court’s standards, with the gender-neutral standards developed by the Hastings Center Behavioral Control Research Group, further exposes the gender bias in In re Johnson. In determining parental

118. Id. at 140.
120. In re Johnson, 263 S.E.2d at 809.
121. Id. at 807.
122. Id. at 809.
123. Id. at 807. At the time of the case Tempie had a mate who had expressed a desire to marry her. Id.
124. Though Tempie Johnson was 23 at the time of this case, two years prior she had already exercised an appeal after a district court had ordered her sterilization. See In re Johnson, 243 S.E.2d 386 (N.C. App. 1978).
125. See Interview with Mick Burglass, supra note 74. Although the Hastings Center standards were developed in 1981, Harvard Psychiatrist Mick Burglass asserts that: “The Hastings Center’s standards are fundamentally correct and still hold today.” Id. See also infra note 127 (Professor Burglass suggesting that one of the standards leaves room for
unfitness, two of the six factors considered by the Hastings Center include "inconsistency in value system" and an "inability to establish interpersonal relationships." The words "inconsistency in value system" has two proper interpretations. The words may indicate a concern for contradiction between values within the system, or a concern for the inconsistent application of values to the child. Under either interpretation, this standard leaves little discretion for moral judgments upon the actual values and norms within the given system. In the case of *In re Johnson*, however, the court focused only upon the propriety of Tempie's values, rather than focusing on "inconsistencies" in either the content or application of Tempie's value system. In doing so the court imposed the above mentioned sexual morality and housekeeping norms that it found to be consistent with the role of women in society.

The words "inability to establish interpersonal relationships" do not call for moral judgments regarding the nature of relationships. Rather, courts to apply them in such a manner as to label mentally disabled parents unfit, although they may be adequate parents).

126. See Macklin & Gaylin, *supra* note 90, at 95-96. Several members of the group oppose employing these criteria until there is sufficient effort to teach the mildly retarded, like Tempie, to function in each of these six areas. *Id.* at 96.

Three of the remaining factors considered by the Hastings Center are lack of language skills, pervasive reality distortion, and inability to communicate essential survival information. *Id.* at 95. The text of the case did not mention the consideration of any evidence remotely similar to these factors. It is likely, however, that Tempie surpassed these standards given the fact that the text suggests that her disability was mild.

Persistent malevolence toward a child is the remaining factor indicating parental unfitness. *Id.* One might argue that Tempie's lack of patience could constitute "malevolence" during a moment of lost patience; however, it would have been difficult to argue that the evidence offered met a "persistent malevolence" standard. Evidence in the case only mentions a former statement by Tempie that in her youth she had lost patience with children, and a statement by her former foster mother that Tempie "was not interested in children and paid no attention to them." *In re Johnson*, 263 S.E.2d at 807. The importance of this statement is limited, however, given Tempie's other statement that she "would like to have children." *Id.* In addition, it should be noted that her foster mother's statements were made from observation of Tempie's behavior as a youth. *Id.*

127. See Interview with Mick Burglass, *supra* note 74. Burglass asserts:

The words "inconsistency in value system" can be misapplied by courts to mean an inconsistency between the mentally disabled person's values and the values held by the "mainstream." Such an interpretation is reminiscent of the eugenic programs of Nazi Germany where individuals were sterilized because their values were not consistent with that of the state. Sterilization based on an inconsistency between an individual's values and those of the state raises a freedom of religion question.

*Id.* Considering Professor Burglass's view, one could argue that the court in *In re Johnson* made the same inappropriate comparison between the values of Tempie Johnson and societal values (as viewed by the court).
this standard focuses on the actual "ability" or "capacity" to establish a relationship. Tempie Johnson had several established relationships at the time of her case. Indicators of her capacity to establish relationships include "two boyfriends, one of which wanted to marry her, [and Tempie's indication that] she would like to have children." Instead of considering her "ability" to establish relationships, the court judged the moral propriety of her relationships. As stated above, the court held that evidence concerning Tempie's "morals," "nightly adventures with boyfriends," and "attitudes about birth control" were relevant and material considerations regarding parental fitness. Such considerations, however, speak less of the individual's capacity to care for a child and more of the judge's beliefs regarding the role of women in relationships.

III. A Proposed Model

The North Carolina statute should be rewritten. The eugenics-based provisions of the statute should be removed. The new statute should focus on protecting the autonomy of the mentally disabled individual.

In order to fully protect autonomy, the current system should be replaced by a system employing an independent ethics committee and mandatory full evidentiary hearings. Ethics committees are designed to assist physicians, families, and the mentally disabled in the sterilization process. Committee members are chosen as independent professionals who are experts in topics such as advocacy for the mentally disabled, disability law, sexuality of the disabled, reproductive health, and special education.

The new statute should provide that all requests for nonconsensual sterilization of a mentally disabled individual must be made to an ethics committee. The committee would then research the request and decide whether to petition a court for sterilization. One advantage of using an independent ethics committee is the elimination of the current conflicts of interests that may underlie petitions for sterilization in North Carolina.

By eliminating conflicts of interest, an ethics committee can also provide protection against violations of autonomy when evidence is gathered.

128. *In re Johnson*, 263 S.E.2d at 807.
129. *Id.* at 809.
130. See Thomas E. Elkins, M.D., *The Use of Societally Based Ethics Advisory Committee to Aid in Decisions to Sterilize Mentally Handicapped Patients*, 1 *Adolescent & Pediatric Gynecology* 190 (1988). The University of Michigan has a committee whose primary goal is to maximize patient autonomy. *Id.* at 191.
131. *Id.*
for the sterilization decision. The ethics committee should be limited to making certain findings of fact during the research process. First, the committee must explore the mentally disabled individual’s capacity to consent or object to sterilization. The use of an ethics committee would guarantee that capacity to consent is fully explored by qualified expert members of the committee.\textsuperscript{132} If the individual were found to be competent to make the sterilization decision, then the individual’s consent or objection would control.

Second, if an individual were found incapable of consent or objection, then the committee would fully explore her sexual autonomy interests in procreation, parenting her own genetic child, and marriage. If the individual were found to have an autonomy interest in any one of these expressions, then the committee should reject the nonconsensual sterilization request.\textsuperscript{133} An autonomy interest in procreation or parenting one’s own child must be acknowledged, if the individual together with a spouse will be able to provide the minimum requirements necessary for adequate child care.\textsuperscript{134} The interest should also be acknowledged if the individual is capable of learning the fundamentals of parenting. This standard attempts to remove some of the subjective input and accompanying biases mentioned above that are present when gauging autonomy interests.

Opinions of public officials, family members, and physicians may be solicited during the exploration of these autonomy interests. These opinions should be viewed, however, as secondary to the findings made by the

\begin{itemize}
\item \textsuperscript{132} Currently, the North Carolina statute does not require an assessment by a qualified expert of the capacity to consent. Instead, the task is left to the public official petitioning for sterilization. \textit{See supra} text accompanying notes 20-26.

\item \textsuperscript{133} One could argue that even though an individual has an interest in reproductive autonomy, nonconsensual sterilization may preserve a greater autonomy interest in freedom from psychological or physical burdens associated with procreation and menstruation. This argument, however, involves a subjective weighing of the burdens of reproduction or menstruation on the individual versus the benefits of procreation, parenting, or marriage. Thus, the argument is a “best interests” argument in disguise, rather than an autonomy argument. The autonomy model presented here, however, differs from autonomy models that ban all nonconsensual sterilization. \textit{See Coleman, supra} note 11, at 67. The autonomy model presented acknowledges that an individual may have no autonomy interest in procreation, parenting, or marriage. For example, an individual will have no autonomy interest in parenting or procreation if these activities have no meaning to her. \textit{See Scott, supra} note 6, at 831. In such a situation, sterilization may be consistent with autonomy.

\item \textsuperscript{134} This standard melds the mandated inquiry into spousal support for raising a child in \textit{In re Grady} with the position that “the individual who is capable of caring for a child has a legally protectable interest in procreation, and that the individual who lacks this capability does not.” \textit{Scott, supra} note 6, at 831.
\end{itemize}
committee. In this manner, the role of conflicts of interest will be limited.

If the committee finds that the individual does not have any of the aforementioned interests in sexual autonomy, then it must explore the full medical and psychological ramifications of pregnancy or menstruation. The committee must then explore whether less drastic contraceptive means of preventing pregnancy or menstruation exist. If the committee of experts finds these means to be inadequate, then it should explore the least drastic form of sterilization. If the committee finds that the least drastic means of sterilization would prevent physical and psychological disease associated with pregnancy, then it might petition a court for sterilization.

Once a petition is filed with a court, the statute should provide for a

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135. See Elkins, supra note 130, at 191. Under the University of Michigan model, the opinions of family and physicians are of secondary concern to patient well-being in the decision making process. Id. Note that the autonomy model presented here diverges from Scott's model at this point. Scott asserts that when an individual is unable to consent and has no reproductive autonomy interest, the sterilization decision should be left to parents. See Scott, supra note 6, at 853-54. Under the model presented here, however, sterilization can only be recommended to a court by the ethics committee.

136. See Planned Parenthood of Greater Northern New Jersey, The Norplant Subdermal Contraceptive Implant 1 (November 1992). One alternative to sterilization that should be considered is the Norplant Subdermal Contraceptive Implant. Planned Parenthood of Greater Northern New Jersey describes the contraceptive as follows:

Norplant is a long-acting, highly effective, reversible contraceptive method. Six thin, flexible capsules are inserted through a large needle just under the skin of the woman's upper inner arm. The capsules of silicone rubber tubing contain a synthetic progestin, levonorgestrel, and deliver adequate hormones for five years of contraception. The pregnancy rate for Norplant is less than 1 per 100 women per year, which is lower than for the pill and comparable to surgical sterilization. . . . The method is reversed when the implants are removed. Id.

The Norplant Subdermal Contraceptive Implant, however, may not be suitable for some mentally disabled patients. Contraindications such as thromboembolic disorders, abnormal genital bleeding, liver disease, breast cancer, migraines, abnormal liver functioning, bleeding disorders, hypertension, diabetes, depression, epilepsy, gall bladder disease, and renal disease may preclude the use of the contraceptive. Id. at 2-3. An interview with Planned Parenthood gynecologist Majin Faxas revealed that one of the major disadvantages to Norplant is that it may cause heavy vaginal bleeding and severe migraine headaches. Interview with Majin Mediano Faxas, M.D., Planned Parenthood Participating Physician, New Jersey (Mar. 28, 1993). Dr. Faxas revealed that such symptoms may necessitate removal of the implants. Id.

137. Note that this decision does not involve a subjective weighing of the competing interests described in the “disguised best interest” approach. See discussion, supra note 133. The decision to sterilize will be based on medical and psychological prognosis of disease associated with pregnancy and menstruation.
full evidentiary hearing. The court should then appoint an attorney who would have access to court appointed experts, and who would present evidence against the sterilization petition. Such a hearing should protect sexual autonomy in two ways. First, because the composition of an ethics committee would be a controversial subject, and concerns such as gender bias might stem from an unbalanced composition, an opposing attorney might reveal bias in the decisionmaking process by presenting her own "gender neutral" experts. Second, an opposing attorney might object to evidence gathered outside of the prescribed research limitations. This could expose improper committee conclusions regarding the client's ability to consent or object, or her reproductive autonomy interests.

If the court determines that nonconsensual sterilization is appropriate, then the individual should be given a choice of physicians who would perform the procedure. In order to maximize autonomy, the state should provide a choice of physician to all mentally disabled individuals it orders to be sterilized pursuant to the new statute. The ability to choose a physician would provide an opportunity for the mentally disabled to minimize the psychological invasion of autonomy that can result from the procedure. If the individual is incapable of making such a choice, then her parents or guardians should choose the physician. Parents or guardians are most likely to be aware of the individual's preferences, and to have an interest in her psychological well-being. The state should pay for sterilizations authorized under the statute in order to prevent parents or guardians from "shopping around" for physicians based on price instead of the psychological needs of the mentally disabled individual.

IV. CONCLUSION

The North Carolina statute, and the manner in which it has been applied through case law, fails to protect adequately the sexual autonomy of the mentally disabled individual. North Carolina continues to cling to the past with statutory provisions based on eugenic theory that fail to provide adequate procedures for safeguarding the sexual autonomy of the mentally disabled. The results are violations of mentally disabled individual's sexual autonomy interests in procreation, parenting one's own genetic child, and in marriage. In addition, the statute has a disproportionate impact on the autonomy of the mentally disabled poor and mentally disabled women. One solution would be the combined use of ethics com-

138. Elkins, supra note 130, at 190.
mittees and full evidentiary hearings to provide adequate protection for the autonomy interests of the mentally disabled.