

# FORCED STERILIZATION OF NATIVE AMERICANS: LATER TWENTIETH CENTURY PHYSICIAN COOPERATION WITH NATIONAL EUGENIC POLICIES?

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Many consider their plight an “archetypal” genocide. Others posit, however, that every essential characteristic of genocide has already been realized throughout their tragic history. A short summary of activities qualifying for genocide, each directed against disparate Native American tribes, may lend historical clarity. Centuries ago, the British suggested that they should be exterminated.<sup>1</sup> Their soldiers proceeded to decimate them with smallpox—a virus to which native populations had no immunity. Additional efforts, literally over centuries, to eradicate their race would follow. There would be a “Trail of Tears,” lethal attacks on Nez Perce men, women, and children to acquire their ancestral homeland, and the infamous massacre at Wounded Knee—to name only a few. The protracted policy directed against the United States of America’s indigenous peoples represented misguided governments, widespread avarice, and enforcement by an at times ruthless, undisciplined military. When naïve efforts with smallpox and crude annihilations with bullets were eclipsed by scientifically sterilized technique, two twentieth century neologisms—genocide and eugenics—would be added to contemporary reflection. When the United Nations approved Resolution 96, five activities would serve as the definition for Genocide under International Law. They were: killing members of a specific group; causing serious bodily or mental harm to other members of that same group; deliberately inflicting conditions aimed directly at those persons’ destruction; imposing measures to prevent births of the group’s progeny; and, last, forcibly transferring children for rearing from the individuals in question to ethnically-dissimilar families.<sup>2</sup> In this regard, the second Twentieth Century phenomenon mentioned—eugenics—has imposed measures to prevent births within many groups undergoing similar persecutions. A book by Edwin Black, *War Against the Weak: Eugenics and America’s Campaign to Create a Master Race*, exhaustively studied the evolution of America’s eugenics policy, which, in various guises, was exported to Germany as a template for the Third Reich’s Final Solution. These immoral activities, verified by many since, should have ended after Nuremberg’s deliberations. A recent, albeit weakly publicized, continuation of eugenic policy in the context of genocide has been well-documented. It has again been specifically directed towards Native Americans. The arena in question has been inhabited by the old evils of forced abortions and sterilizations. That two-pronged approach to knowingly limiting births in a targeted population had been emblematic of eugenic policy in the early to mid-Twentieth Century. Unfortunately, eugenic “birth control” had been resuscitated, or simply continued, as recently as the 1970s with voluntary physician complicity. That will be the issue before us.

## Investigation into Allegations of Forced Abortions and Sterilizations in the 1970s

When she was twenty years old, a Native American woman underwent a total hysterectomy by an Indian Health Service (I.H.S.) physician for unconvincing indications.<sup>3</sup> Her experience came to light in the 1970s when she visited Dr. Connie Pinkerton-Uri herself a physician of Native American heritage. About the same time, two other young Native American women in Montana underwent appendectomies and also received “incidental” tubal ligations. Were these merely aberrations or the first publicized examples of a disturbing pattern? The three individuals represented, unfortunately, the “tip of an iceberg.” Documentation of physician complicity in the forced sterilization of Native American women will be pursued hereafter as a serious bioethical issue that has been virtually ignored in the U.S.A., where each and every part of it took place. Mere description of the events, however, cannot stand alone. Prescriptive discourse can only proceed if those events in question are placed in the specific context of prior eugenic policy in America. A critical question must then be posed. Was physician complicity in the forced abortions and sterilizations of Native Americans purely a result of eugenic designs, or was it fueled by other precipitants?

On November 6, 1976, the Government Accounting Office (G.A.O.) released the results of its investigation (HRD-77-3) into allegations of forced abortions and sterilizations specifically targeting Native American women. Similar events at four of twelve I.H.S. areas (Albuquerque, New Mexico, Aberdeen, South Dakota, Oklahoma City, Oklahoma and Phoenix, Arizona) were included in the tabulations. Records verified that the I.H.S. performed 3,406 sterilizations between 1973 and 1976.<sup>4</sup> “Tip of the iceberg” would be an appropriate metaphor. Per capita, the figure was equivalent to sterilizing 452,000 non-Native American women within the same time frame.<sup>5</sup> One location in Albuquerque “contracted out” sterilizations to local, but non-I.H.S. physicians; therefore, their region did not add any procedures to the Fed’s final count, contributing to the underestimate. Independent research demonstrated that as many as 25-50% of the Native American women of that era were sterilized between 1970 and 1976.<sup>6</sup> Independent verifications thus were critical. The G.A.O. did not interview a single woman subjected to sterilization. That task would be left to others. The G.A.O. also admitted that “contract” physicians were not required to comply with federal regulations (including informed consent) in the context of the surgical procedures. Further study of consent forms utilized revealed that three substantively different ones proliferated. Verbal and written consent information, in some instances, neither apprised women that they could refuse nor informed them that the procedure was irreversible. It also appeared that “consent,” in many instances, was obtained only with coercion.

What may be the most disturbing aspect of the investigations also surfaced: *it had been physicians and healthcare professionals in the I.H.S. and contracted by the I.H.S. who coerced these women and performed the procedures.* It was they who abandoned professional responsibilities to protect the vulnerable. Substantive judicial investigations did not follow. In most instances, reparations would not be forthcoming. That the timing of events transpired a generation after similar atrocities during World War II—these precedents already adjudicated, proscribed, and punished—made the events all the more disturbing.

Further perspective on the magnitude of the travesty emanated from selected independent statistics. On a single Navaho Reservation, from 1972-1978, there was a 130% increase in the number of abortions (a ratio of abortions per 1000 deliveries increasing from 34 to 77).<sup>7</sup> The same study also demonstrated that in the interval between 1972 and 1978, sterilization procedures increased from 15.1% to 30.7% of the total female surgeries performed.

When a more thorough investigation of the consent process followed, resultant data only added to professional embarrassment. Healthcare professionals' coercive tactics to obtain consent included threats of withdrawing future healthcare provisions or even custody of Native American children already born.<sup>8</sup> The scandal of what had in all particulars become a replay of earlier twentieth century eugenic policies led to a Congressional hearing. Senator James Abourezk, Democrat, South Dakota, who was the individual who had been the moral instigator for the GAO investigation, chaired the hearing. Little else in terms of publicity, justice, or public outcry would eventuate. The results of the investigation have not been evaluated, only if even retrospectively, solely from a bioethical perspective. The inherent behaviors that led to forced abortions and sterilizations are obviously disconcerting in many ways, but particularly as a result of two characteristics. First, although shocking, they were completely consonant with federal and state policies from the early to mid-twentieth century regarding the treatment of vulnerable populations marginalized under descriptors such as "feeble-minded, criminal," as well as a host of other equally demeaning epitaphs. Did history merely recycle or continue to enforce the prejudices of preceding generations? Or, alternatively, was another sinister dynamic in place to manipulate a new generation of physicians? Second, how could the activities transpire in America after the corpus of the Holocaust, Nuremberg, and Geneva was made public? Furthermore, as a contemporary contingent, could the presently dormant activities resurface today if eugenics is repackaged by the Spirit of the Age as genetic engineering? Answers to these and other seminal queries require historical context as a foundation to further study. Efforts must begin with an overview of eugenic policy and practice in the America of the early to mid-twentieth century.

### **Background: Physician Complicity with Twentieth Century Eugenic Policy**

The early to mid-twentieth century not only witnessed the cruel enforcement of eugenic philosophy throughout America, but also was followed by genocide writ large on an international stage. It goes almost without saying that the world-at-large concurrently experienced a progressive and dramatic deterioration in a Hippocratic ethos. The decline of Hippocratic ideals preceded the disappearance of the Oath from medical school graduation ceremonies by decades. Participation by physicians would become critical to the success of both eugenics and genocide. The next generation of physicians to follow these notorious pioneers would continue the misguided activities—targeting Native Americans. Although Native Americans were not the only marginalized group of this era to suffer at the hands of governmental policies implemented by physician technique, their experiences would catch up to some of the others (African Americans and Latinos, especially).

Despite the continued “swearing” of the Hippocratic Oath in both the U.S.A. and Germany, eugenic sterilizations and euthanasia, targeting the weakest, were explicitly practiced in both countries.<sup>9</sup> As prime examples of breeches against the mandate to “Do no Harm,” these were not the only proscribed, but nonetheless lethal, physician misadventures surfacing elsewhere, for the first time, within that same time frame. Bacteriological warfare began under direct physician aegis. It had been initiated on a small scale during WWI by Turkish physicians (not soldiers) and later expanded by Japanese physicians as early as 1927.<sup>10,11</sup> These same Japanese physicians had sworn a Shinto-Buddhist Oath that, exactly like the Hippocratic Oath, explicitly proscribed patient harm at the hand of physicians.<sup>12</sup>

The earliest examples of eugenically-directed harm to individuals in America, albeit not generalizable to a majority of physicians, have included a physician in Kansas, F. Hoyt Pilcher, who surgically sterilized fifty-eight “feeble-minded” children as early as the 1890s.<sup>13</sup> Another, Harry Clay Sharp, graduated medical school in 1893 and explicitly practiced medical castrations on individuals who masturbated.<sup>14</sup> Albert John Ochsner advocated the compulsory sterilization of criminals before the turn of the twentieth century and his philosophy was enthusiastically published in the *Journal of the American Medical Association*.<sup>15</sup> The late nineteenth century would be a harbinger of worse things to come.

W. Duncan McKim, in 1899, was one of the first American Physicians to suggest professional complicity in the execution of undesirables, and he provided a pragmatic way to accomplish his end. He observed, consistent with an eugenic “frame”, “heredity is the fundamental cause of human wretchedness...the surest, and most humane means for preventing reproduction among those we deem unworthy of the high privilege of reproduction is a gentle painless death...In *carbonic acid gas* we have an agent...”<sup>16</sup>

The eugenic activities herein superficially chronicled from the early to mid-twentieth century—forced sterilizations, euthanasia of sick newborns, the proposed “gassing” of a wide variety of “undesirables”—openly inhabited mainstream America. The nefarious behaviors were supported at the highest seats of government and disseminated by the intelligentsia and wealthy (Woodrow Wilson, Teddy Roosevelt, Oliver Wendell Holmes, both the Rockefeller and Carnegie Foundations). The activities were so imbedded into the cultural psyche that they may have persisted.<sup>17</sup> They were an indelible stain of blood on America and its medical practitioners. They are chronicled in this manuscript only in a selective and abbreviated fashion in order to illustrate a critical point. The sterilization practices of the physicians targeting Native American women in the 1970s were very similar to the “typical” legalized behavior of physicians in the eugenics movement only a single generation removed. They were similar in philosophy as well as in technique. Unlike the physicians described above, the physicians of the 1970s were protected from publicity and were thus rendered “anonymous.” Only a single legal recourse to identify a culpable practitioner would be pursued.<sup>18</sup> Three Northern Cheyenne women filed suit against the hospital at which they were sterilized. Defendants’ attorneys convinced the women to settle for a cash settlement prior to a Supreme Court hearing. The women complied, and names of physicians who participated in theirs and others’ sterilizations and abortions would be forever lost.

Another historical question that should be confronted follows naturally: did eugenically-driven policies and practice in America disappear after WWII? Or since

“old habits die hard,” was it more likely that the events propagated against Native American women represented a continuation of said policies, oblivious to both Nuremberg and United Nations directives? There has been substantial evidence brought to bear to support the proposition that eugenic practice survived the decades consequent to WWII in the U.S.A. and was “alive and well” in a protected environment during the 1970s. In Edwin Black’s book, he observed through many examples that the scientific transition from eugenics to “genetics” merely repackaged the same, sinister techniques under an old but durable philosophical umbrella.<sup>19</sup> Another peer review source named both the individuals and foundations that continued to engineer minority populations’ futures through eugenic birth control techniques—each similar to the preceding generation.<sup>20</sup> In fact, in 1952, of the ten members of John D. Rockefeller’s Population Council, six had been openly active in the enforcement of U.S. eugenic policies during the preceding era.<sup>21</sup>

Since it seems that eugenic technique in the U.S.A. continued to prosper after WWII, there is still something else left to consider in this context: were these anonymous physicians who sterilized and performed abortions on Native American women solely motivated by the same animus as their recent and contemporary colleagues? Were they knowingly participating in a policy of eugenic birth control through abortions and sterilizations? Or, alternatively, might there still be additional rationale for their unethical professional behavior?

### **What was it that motivated certain physicians to sterilize and abort Native American Women during the 1970s?**

From the outset, it may be prudent to separate the physicians under study into two groups. There are those who were members of the I.H.S. and those who were in private practice and were contracted solely for technique (in this instance sterilizations and abortions in Albuquerque, N.M.). The salaried physicians of the I.H.S. possessed certain characteristics that may help explain their ethical behavior. First, they were not well paid. New recruits were salaried at \$17,000 to \$20,000 per year.<sup>22</sup> Their average workload could be exhausting and approximated 60 hours per week.<sup>23</sup> Applications for vacant I.H.S. positions dwindled from a peak of 700 in 1971 down to 100 in 1974. These are mundane statistics, possibly, but in total they are suggestive that I.H.S. physicians of the early 1970s were not looking to increase their workload. There would have been no incentive to do so. Additional surgical procedures would not increase income. But what else were they like culturally and what may have motivated them since it does not appear to be money? One 1972 study demonstrated that 6% of their contemporary physician colleagues would have recommended sterilization as an option for birth control to “white” women, but as many as 14% would have recommended sterilization if the woman was from a minority group or on welfare.<sup>24</sup> In the specific scenario of a welfare mother with three or more children, 97% preferred the sterilization option. One year later, another study suggested that physicians of that era believed that they were performing society a service when they limited the growth of poor populations by whatever means available.<sup>25</sup>

A quote from that time, by the President of the Association for Voluntary (sic) Sterilization, Dr. Curtis Wood, illuminates the issue further:

After 30 years of delivering babies, I've found that if the doctor does a proper job of offering sterilization to these women on welfare, a high percentage of them would accept it. I have found after 3 to 4 minutes of talking with them they will accept it.<sup>26</sup>

In fact, in the same article as Dr. Woods' quotation, the primary author, Barbara Caress, summarized prevailing cultural attitudes thus,

Sterilization abuse is both systematic and wide-spread...it stems from a combination of factors... teaching and research...*fee for service systems*...it is the most widespread example of *medicine as an instrument of social control*... Since 1970, the figures show an almost 3-fold increase in the incidence of female sterilization, from 192,000 in 1970 to 548,000 in 1974...Many young Gynecologists in training have united their professional needs for training and *their political ideas*...Another reason for an increase in operations is *greed*... Between 1967 and 1973, federal support for family planning services increased more than 1300%...the line between voluntary and involuntary sterilization becomes thinner all the time.

The cultural evidence supports, at least for I.H.S. physicians exempt from greed, a push towards sterilizations and abortions within Native American communities consistent with the predominant medico-cultural zeitgeist—responsive to eugenic aims. That particular tendency again betrayed a critical fact alluded to before: eugenic philosophy and practice persisted in the U.S.A. despite the Nuremberg Trials. It was still a problem for medical ethics, but it was barely ever spoken of. The author attended medical school at the same time and was never apprised of the issue in any educational venue. Laws after Abourezk's investigations stopped the forced sterilizations on reservations as well as activities aimed at removing children from their birth families (see also *Relf v. Weinberger* and the Indian Child Welfare act of 1978 for additional information). Repeat surveys are not available, however, to attest to whether physicians would have surrendered their eugenic dogmas if legal punishment did not follow. One may conjecture that the answer would resonate loudly—probably not. Since there has been a paucity of evidence to draw firm conclusions regarding equivalent eugenic bias of the private practice physicians, who themselves were not salaried government employees, but rather, were paid for additional procedures, were there other plausible dynamics adding to their motivation?

These private physicians would become the first generation reimbursed dollar for dollar by the U.S. taxpayers and solely for technique. These physicians had been "contracted" only to perform surgeries on Native American women that could not be provided by the resources of the I.H.S. They inhabited an environment that rewarded eugenic-minded procedures whether or not the physicians in question deemed them appropriate or ethical. In fact, for them, the ethical dilemma could be totally avoided. They would be reimbursed for every sterilization and abortion, neither audited nor "capitated" in any manner. They were free from ethical restraints—including stricter informed consent practices. Could the characterization of their practice style, that is, a contract model, have contributed in any way to what eventuated?

William May has conceptualized potential descriptive models for medical practice. In essence, such practices may philosophically emanate from the perspectives of a Code,

a Covenant, a Contract, or as Philanthropy.<sup>27</sup> It may be reasonable to proceed and place the private practices in question, that is, those contracted for abortions and sterilizations, in one or more of these categories. Would categorization determine what impact, if any, the practice “frame” might have on physician behavior? This line of reasoning may be buttressed by excluding conceptual models that are thoroughly inconsistent with the behaviors under scrutiny.

First, the activities studied to this juncture were definitely not philanthropic. Government monies reimbursed the physicians *quid pro quo*. Second, covenantal practice assumes respect for patient dignity no matter the patient’s ethnicity, and in this narrative that means neither harming nor coercing, as well as actively advocating for the vulnerable. Therefore, Covenantal behavior was lacking. Code for our purposes will refer to Hippocratism, solely for reasons that it represented medicine’s longest-lived and most internationally apprehended Code. Since harm is implicit in the activities of coerced sterilization or abortion, traditional “codified” professional behavior was also lacking. Others may argue that the physicians acted by the tenets of other “codes,” but May would classify those particular codes as variants of Hemingway’s “code-hero” model. That model merely represented a passing, fictional fad best represented in *A Farewell to Arms*. That leaves what has appeared “prima facie” to fit best, a contract model with reimbursement in full for an unlimited number of sterilizations and abortions.

The ethical dangers lurking behind a contract model for medical practice may be probed through the behaviors leading to the bioethical dilemma under study. Technique is all that was rendered by the contracted physicians, and expenditure of that technique equalled exactly what was reimbursed. The contract model can completely divorce the surgical activities from any and all ethical deliberation. Contract medicine rewards technique. It has no room in its ontology for right or wrong. Although his deliberations regarding a Technological Society preceded much of what would become contemporary medicine as technique, Ellul has something to say about contracted physicians trapped in the ethical vacuum of technique. In his own words, “Technique becomes autonomous; it has fashioned an omnivorous world which obeys its own laws and which has renounced all tradition. Technique no longer rests on tradition, but rather on previous technical procedures; and its evolution is too rapid, too upsetting, to integrate the older traditions.”<sup>28</sup> If “poetic license” is allowed, tradition in this instance may be interpreted as Hippocratism or at least some acceptable ethical structure conjoined to medical technique. Ellul described technique further for our age, “In fact, technique is nothing more than means and the ensemble of means. This of course does not lessen the importance of the problem. Our civilization is first and foremost a civilization of means; in the reality of modern life, the means, it would seem, are more important than the ends.”<sup>29</sup> Contracts have the inherent potential to reward physicians for technique as means devoid of an ethic to elevate technique towards the ends of medicine. Physicians can be rewarded for “means” to the exclusion of the laudable, traditional “ends.”

Whether money for technique superseded or merely contributed to the loud, persistent sirens of eugenic philosophy in the decade of the 1970s cannot be addressed with any greater certainty. However, if reimbursement without consideration of right and wrong was a catalyst, the present generation had better take heed. That criticism follows.

## Conclusions

Although the travesty of forced sterilization and abortions targeting Native Americans occurred a generation ago and has ended, a revisit in 2010 is appropriate for a number of reasons. At this juncture, the irrefutable facts should be summarized. There has been ample evidence, gleaned from both governmental as well as private investigations, that Native American women underwent an excess of forced sterilizations and abortions at the hands of the I.H.S. and privately contracted physicians during the decade of the 1970s. Furthermore, the data retrieved were also consistent with coerced and otherwise flawed informed consent procedures. The foundational breach in ethics animating the procedures occurred in America. The United States of America already possessed a twentieth century historical record that had actively fostered eugenic sterilizations. Multiple state and federal laws protected each perpetrator throughout the overlapping eras. The activities heretofore summarized have continued even after they ended on Indian reservations. A prime example was the state of California, whose record for forced sterilization prevailed from 1909 through 1979, subsidized through federal funding.<sup>30</sup> Approximately 20,000 operations similar to those studied herein were performed in that state (mostly on the institutionalized, African-Americans, and Latinos), some of these occurring nearly thirty years after the Nuremberg Trials.

It also seems reasonable to presume that it was the power of eugenic philosophy—rather than other motives such as money—that drove those physicians employed by the I.H.S. Their generation's responses to confidential questionnaires betrayed a commitment to eugenics that seemed barely effected by events consequent to WWII. The private practice physicians' behavior under government contract may be more difficult to completely explicate. Despite a similar influence of eugenic philosophy for them as members of the same medical culture and generation as I.H.S. employees, obvious from the time they were educated and practiced, their example as a first generation of contracted U.S. physicians may bode poorly for a continued reliance on rich monetary awards dedicated solely to technique.

Might imitation of a similar contract model, that is, one protected by law, be viable today? With increased attention paid to declining physician reimbursement concurrent with debate on healthcare reform, there may be enough evidence to sustain the proposition that "quid pro quo" payment for technique could result in increased physician consumption of resources. The Dartmouth Atlas has demonstrated that Medicare beneficiaries in "higher spending" regions undergo a greater volume of procedures than comparably matched individuals in "lower spending" regions.<sup>31, 32</sup> The procedures involved correlate with less quality and greater mortality. Much like the movie "Field of Dreams," if the Government (i.e. Medicare/Medicaid) pays for it, they (i.e. certain physicians) will come and perform specific procedures for the requisite reimbursement.<sup>33</sup> The ethical issues inherent in whether the procedures in question are in the best interests of the patient are being broached in Congress now, but only in an effort to save money—not right wrongs. If indeed quality, morbidity, and mortality are paramount, as human dignity demands that they are, then reimbursements for some or all of these procedural disparities are unethical.

In fairness, one must also comment that the negativity in this manuscript towards some physicians caring for Native Americans during a particular historical era should not be construed as a blanket condemnation of all or even a majority of physicians

who serve the Native American community. In fact, the subjects for ethical scrutiny in this report probably represented a minority of physicians. Recent publications have demonstrated the high scientific and professional integrity evidenced by physicians in this area.<sup>34</sup>

Finally, the addition of physicians to the armamentarium of both eugenics and genocide, especially during this and the last century, is an ominous observation. Physicians in the I.H.S. during the time in question were young, often “fresh” out of training. Since their generation, additional medical graduates have moved even further from the tenets of “Do No Harm” along with many other critical yet disregarded traditions of Hippocratism. Furthermore, the ever-increasing shift away from any semblance of a covenantal model for medical practice—replacing that paradigm with a pure contract model—is in itself foreboding. Payment for any medical technique removed from the brackets of ethical consideration may tempt physicians in an era of decreasing reimbursement. In fact, recent economic realities suggest that today’s plethora of temptations will probably exceed those of the 1970s. Erosion of Hippocratism seems to inhabit every aspect of these tragedies and many others like them.

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