NOTE


Vanessa Volz*

"I know I am not expected to have children. I don’t know how I know, I just do. Nobody ever said anything; it’s probably what they didn’t say that made the difference."1

I. INTRODUCTION

In February of 2005, Carrie Ashe, a thirty-four-year-old Atlanta woman suffering from postpartum depression,2 pleaded guilty to killing her five-week-old daughter.3 The Fulton County District Attorney’s Office conceded to a plea bargain that allowed the woman to avoid a murder trial and possible prison sentence if she agreed to undergo surgical sterilization.4

"We're always concerned when an unusual condition is the price to stay out of jail because of the fear it isn't truly voluntary," said Jack Martin, legislative committee chair of the Georgia Association of Criminal Defense Attorneys.5 However, Ashe's attorney reported that it was her client's "choice to go forward."6 "We just looked at the circumstances and said there's got to be an end to this," Fulton County District Attorney Paul Howard explained. "She's still at an age where she could continue to have children. We thought this might be the right thing to do."7

Ashe's plea bargain, which is purportedly the first criminal case in the state of Georgia in which a woman has agreed to undergo sterilization in order to avoid prison time,8 raises innumerable questions about a woman's autonomy over her body. Specifically, it brings into focus

*J.D., University of Georgia School of Law. B.A., Bard College. The author is a staff attorney at the Rhode Island Disability Law Center in Providence. She would like to thank Bill Boling, Ann Puckett, Gregg DeMaria, and Gregory Volz for their helpful comments in reviewing earlier drafts of this article.


2. Postpartum depression has been classified as a mental health issue that affects ten to fifteen percent of women who have children. Michael L. Perlin, "She Breaks Just Like a Little Girl": Neoniocide, the Insanity Defense, and the Irrelevance of "Ordinary Common Sense", 10 WM. & MARY J. WOMEN & L. 1, 14 (2003) (discussing postpartum depression, psychosis, and criminal defense theories of law).


4. Id.

5. Id.

6. Id.

7. Id.

8. Id. Such sentencing arrangements, however, are not uncommon in other states. See, e.g., Erika T. Blum, When Terminating Parental Rights is Not Enough: A New Look at Compulsory Sterilization, 28 GA. L. REV. 977 (1994) (for an explanation about alternative sentences, including the use of "voluntary" sterilization, in other states).
a woman’s decision whether or not to bear a child, whether the state should play a role in making this choice for a woman, and what rights should be provided to women with disabilities who may or may not want to have children. While Ashe’s decision to undergo surgical sterilization has been regarded as a voluntary “choice,” her story invokes a reminder of a chilling period in United States history. During the first half of the twentieth century over 64,000 involuntary sterilizations were performed throughout the country, most on women who were determined to have cognitive disabilities.

This paper examines the reproductive rights of women with disabilities, focusing on decisions related to child-bearing that have been made on behalf of women without their consent. While there are many types of disabilities, the focus here is primarily on women with cognitive disabilities, as opposed to those with physical impairments. This note first examines the history of the sterilization movement, which rapidly spread during the early 1900s due to the popular eugenics movement. Second, this note discusses current sterilization reform statutes that allow sterilization with judicial authorization. Third, this note considers the competency standard of women with disabilities to raise children. Next, it reflects upon how the pro-choice and feminist movements have unintentionally, although hazardous, excluded women with disabilities from their consideration. Despite this treatment, women with disabilities have unique concerns that deserve attention, including the fact that the issue of “choice” to them is as much about the choice to bear a child as it is to have the choice to terminate a pregnancy. Finally, this note investigates how recent advancements in genetic and reproductive technologies have facilitated a woman’s understanding about her pregnancy. Unfortunately, this information has inadvertently fueled a backlash against individuals with disabilities. This phenomenon has consequently rendered a disabled woman’s quest for reproductive autonomy and privacy more difficult, as life with a disability continues to be looked upon as undesirable and tragic.

Reproductive technologies now provide women with information about potential impairments to their fetus. Since laws continue to limit access to abortion generally while supporting a woman’s decision to abort a fetus that has a disability, this reinforces the discriminatory notion that life with a disability is somehow less valuable or not as fulfilling as a life unaffected by a disability. However, as the disability rights movement has shown, life with a disability practices at the turn of the century were particularly prevalent in certain states; in California, for example, the state Supreme Court noted that the state led the nation in sterilizations. See Conservatorship of Valerie N., 40 Cal. 3d. 143, 152 (1985).

12. Individuals with disabilities, whether male or female, physically impaired or mentally impaired, have long been the subject of both pity and spite by the American public. Only when the disability movement became a disability civil rights movement, with an emphasis on civil rights and opportunity for individuals with disabilities, did this shift in perception begin to occur. See generally Samuel R. Bagenstos, The Future of Disability Law, 114 Yale L. J. 1, 10-23 (2004); Samuel R. Bagenstos, Subordination, Sigma, and “Disability,” 86 Va. L. Rev. 397 (2000) (offering a greater discussion on the shift in the disability movement from an issue of charity to an issue of civil rights).

13. Laws in recent years that have limited a woman’s access to abortion include parental consent laws, mandatory counseling, and 24 hour waiting periods. See The Guttmacher Institute, State Policies in Brief: An Overview of Abortion Laws, http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf.

bility can be rewarding and worthwhile with the proper accommodations, support, and unbiased attitudes from other members of society.

II. HISTORY OF THE TWENTIETH CENTURY STERILIZATION MOVEMENT

The substantial number of sterilizations that occurred in the first half of the twentieth century spawned out of the controversial eugenics movement, which asserted that the "human race [could] be gradually improved and social ills simultaneously eliminated through a program of selective procreation."\(^{15}\) Beginning in 1900, state legislatures passed almost one hundred statutes that validated eugenic practices.\(^{16}\) Eugenicists prevailed in disseminating the message that "the breeding habits of [inferior] populations were an important matter of public policy."\(^{17}\) The onset of the twentieth century brought with it a "belief that the transfer of ‘bad genes’ . . . had to be contained," and that it was the government’s job to enforce it.\(^{18}\)

In 1907, Indiana became the first state to enact a compulsory eugenic sterilization statute,\(^{19}\) within the next two decades, over twenty-three states had passed eugenic laws.\(^{20}\) In 1925, the Supreme Court of the United States intervened in what had previously been state domain, and handed down Buck v. Bell,\(^{21}\) which held Virginia’s state compulsory sterilization statute to be constitutional. Although many decisions have followed Buck, the case still has not been explicitly overruled almost a century later. Buck concerned eighteen-year-old Carrie Buck, who was committed to the State Colony for Epileptics.\(^{22}\) Buck, described by the United States Supreme Court as “feeble-minded,” gave birth out of wedlock to a child who was also described as “feeble-minded.”\(^{23}\) The Supreme Court of Virginia was willing to allow Buck to be released from the colony to secure a good home; however, the Justices would not do so unless they could ensure, through sterilization, that she would not bear any additional children.\(^{24}\) Buck appealed the Virginia decision to the United States Supreme Court on the grounds that the statute which authorized her sterilization violated her due process and equal protection rights under the Fourteenth Amendment.\(^{25}\) The Supreme Court, however, upheld the sterilization statute as constitutional, and Justice Holmes, writing for the majority, explained that “[i]t is better for all the world if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles are enough.”\(^{26}\) With this constitutional analysis, Holmes gave more weight to the rights of society as a whole than he accorded to Carrie’s individual rights derived from the Fourteenth Amendment. He elaborated, “[t]he principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.”\(^{27}\) Further, while he acknowledged that this principle might work if applied to the general population rather than to the small number of individuals confined to institutions, “the answer is that the law does all that is needed when it does all that it can.”\(^{28}\)

Ironically, approximately fifty years after the Supreme Court heard her case, Buck was found to be of perfectly average intelligence; moreover, she eventually married and lamented her inability to bear additional children.\(^{29}\) Expert testimony at the trial earlier in her life, however, purported that Buck had engaged in “immorality, prostitution, and untruthfulness; ha[d] never been self-sustaining . . . [and] had a record of prostitution and syphilis.”\(^{30}\) Therefore, Buck’s status as an uneducated, poor woman from the South appeared to factor into the

16. Id.
17. See Leslie-Miller, supra note 9, at 125.
18. Id.
22. Id. at 205.
23. Id.
24. Id. at 205-06.
25. Id. at 205.
26. Id. at 207.
27. Buck, 274 U.S. at 207.
28. Id. at 207-08.
29. See Leslie-Miller, supra note 9, at 129 n.39.
30. Trial Transcript at 40-42, Buck, 274 U.S. at 200 (testimony of Dr. Albert Priddy).
Court’s analysis of her competency to bear and raise children as strongly as any identifiable mental disability. Indeed, during this time period, as Buck’s case exemplifies, poor, uneducated women often were regarded as unfit for procreation or motherhood merely because of their socioeconomic status, regardless of whether they actually had a disability.\(^\text{31}\) Often, an individual’s impoverishment would hastily be equated to having a mental disability.\(^\text{32}\) Poor women, as will be discussed later in this note, have often been targets of government programs to restrict their reproductive capabilities. In a sense, the reality of poverty can equate to a social disability that is as debilitating as a diagnosable disability.\(^\text{33}\)

The United States Supreme Court revisited Buck, albeit on different terms, in the 1942 decision, Skinner v. Oklahoma.\(^\text{34}\) In this case, the Court affirmed the proposition that the Due Process Clause and the right to privacy derived from the Fourteenth Amendment guarantees all adults the right to make their own decisions regarding procreation.\(^\text{35}\) In Skinner, Justice Douglas stated that the right to procreate is “fundamental to the very existence and survival of the [human] race,”\(^\text{36}\) but the Court declined to explicitly overrule Buck. In Skinner, the Court found that the Oklahoma statute in question, which sterilized habitual criminals for crimes of moral turpitude, was a violation of the Equal Protection Clause.\(^\text{37}\) The Court distinguished Skinner from Buck because there was no violation of equal protection in Buck, as all so-called “feeble-minded individuals” released from institutions were to undergo sterilization.\(^\text{38}\) The Court discussed in Skinner that scientists believed at the time of Buck that cognitive disabilities could pass from one generation to another.\(^\text{39}\) In Skinner, only individuals who committed crimes of moral turpitude were to be sterilized.\(^\text{40}\) A special section of the law excluded persons convicted of several kinds of felonies, including income tax evasion, embezzlement, and political offenses, from the reach of a sterilization petition.\(^\text{41}\) The Court could find no scientific evidence that criminal behavior is inherited, and therefore the statute was overturned.\(^\text{42}\) The majority opinion, written by Justice Douglas, recognized that “the power to sterilize, if exercised, may have subtle, far-reaching and devastating effects. In evil or reckless hands it can cause races or types which are inimical to the dominant group to wither and disappear.”\(^\text{43}\)

Since the Skinner case, the United States Supreme Court has not revisited the issue of whether involuntary sterilization is unconstitutional,\(^\text{44}\) thereby leaving these decisions in the hands of state courts. Even as late as the mid-1970s, some courts adjudicating the constitutionality of sterilization laws took an approach similar to that of Justice Holmes in Buck. For example, in 1975 the North Carolina Supreme Court decided in In re Moore\(^\text{45}\) that a statute providing for the sterilization of mentally ill or mentally retarded persons was a valid exercise of the state’s police power.\(^\text{46}\) According to the court, North Carolina had a “compelling state interest” in “prevent[ing] the procreation of children who will become a burden on the State.”\(^\text{47}\)

Such decisions slowly became less common, however, and by the 1970s, women’s re-

---


\(^{32}\) See generally Leslie-Miller, supra note 9.

\(^{33}\) See generally Pokempner & Roberts, supra note 31.

\(^{34}\) 316 U.S. 535 (1942).


\(^{37}\) Skinner, 316 U.S. at 542-43.

\(^{38}\) Id. at 542.

\(^{39}\) Id. at 546.

\(^{40}\) Id.


\(^{42}\) See Alward, supra note 19, at 194-95.

\(^{43}\) Skinner, 316 U.S. at 541.


\(^{45}\) In re Moore, 221 S.E.2d 307, 313 (N.C. 1976).

\(^{46}\) Id. at 312-13.

\(^{47}\) Id.
productive rights had achieved constitutional protection. After deciding *Roe v. Wade* in 1973, the United States Supreme Court reaffirmed the constitutional status of reproductive rights in numerous subsequent cases. This included the 1977 decision, *Carey v. Population Services,* where the Court explained that the “decision whether or not to beget or bear a child is at the very heart of [the] cluster of constitutionality protected choices,” and the more recently decided *Planned Parenthood v. Casey* in 1994. “[I]t is settled now, as it was when the Court heard arguments in *Roe v. Wade,* that the Constitution places limits on a State’s right to interfere with a person’s most basic decisions about family and parenthood, as well as bodily integrity,” the Court explained in *Casey,* the decision that reaffirmed the central holding of *Roe.*

The right to decide whether or not to reproduce extends to a broad range of people, but women with disabilities, particularly those with cognitive disabilities, continue to be excluded from this group. While many involuntary sterilization state statutes have been struck down since the *Buck* days of eugenic ideology, a handful of states still keep the law on the books, including Arkansas, Delaware, Georgia, Idaho, Mississippi, North Carolina, Vermont, and Virginia. However, by the 1980s and 1990s, most state courts were taking a more sympathetic view towards individuals affected by sterilization laws. For example, in 1995, the Colorado Supreme Court reversed a lower court order to sterilize an incapacitated adult woman. The court explained that “[a]n individual’s right to procreate is fundamental.” The court did not find clear and convincing evidence that the woman was “incompetent to grant or withhold consent to sterilization.”

*Buck,* however, supported this argument that the government could place limitations on a woman’s reproductive decisions, which is an important foundation behind the *Roe* formula that allows states to regulate abortions in later stages of fetal development. The *Roe* court did not declare an “unlimited right” to abortion and, in reaching this decision, drew on cases, such as *Buck,* which adhered to the idea of regulating such conduct. Justice Blackmun wrote for the majority in *Roe* that the privacy right involved in deciding whether to terminate or continue a pregnancy “cannot be said to be absolute.”

Generally, while the right to abortion has been protected under *Roe,* subsequent decisions such as *Planned Parenthood v. Casey* have slowly chipped away at that right by recognizing the established constitutional limitations on the right to abortion, such as parental consent forms and twenty-four hour waiting periods before the procedure can take place. However, the privacy right to reproductive autonomy in *Roe* appears to be more restrictive for women with disabilities than for women without disabilities. While involuntary sterilization statutes are not used with the regularity with which they were used during the early part of the twentieth century, they can still be invoked with the proper judicial consent procedure. Moreover, in some states women with disabilities can be prevented from retaining legal custody of their children on the basis of their disability. These restrictions on full reproductive rights for women with disabilities suggest discriminatory treatment, which arguably violates both the Equal Protection Clause and the due process right to privacy of the Fourteenth Amendment.

### III. THE STATUS OF INVOLUNTARY STERILIZATION METHODS TODAY

Although involuntary sterilization procedures have predominantly subsided in modern day, opinions still differ as to whether individuals with disabilities should be afforded equal protection with other persons regarding deci-

The sterilization issue of the late twentieth and early twenty-first century primarily has turned on the sterilization of women who are not confined to institutions. Specifically, the issue revolves around who the decision maker should be in situations where a woman with a disability lives with her family or on her own; should it be the parents or guardians of a disabled woman, the courts, or the woman herself? A few jurisdictions, such as Colorado, have banned the sterilization of incompetent individuals altogether. However, in most states sterilization is still an option as long as appropriate judicial approval is obtained first. The requirements for judicial approval may be considered the most fundamental procedural protection prerequisite for forced sterilization today. Arguably, there are reasons to require judicial involvement in sterilization decisions; judges are usually without direct interest in the particular controversy, and therefore they can provide an objective perspective. Opponents to this procedure, however, question a judge's role in making such an important decision, since judges have their own prejudices and shortcomings, and judicial discretion can be abused. Moreover, often a judge is unfamiliar with the woman's reproductive capacities, thereby rendering an important decision highly impersonal.

A 1981 decision, In re Grady, was one of the first cases to establish that a judge is the appropriate decision maker in determining the sterilization of a disabled woman who is not living in an institution. This case concerned a young woman, Lee Ann Grady, who was born with Down's syndrome and raised at home by her parents with younger siblings. When Grady was eighteen, her parents tried to have her surgically sterilized, but the hospital refused, claiming that it "could not legally permit the operation without judicially authorized consent for [Grady]." After the trial court ruled in favor of the operation and imposed standard procedural safeguards and substantive requirements that Grady be found incompetent, the Attorney General appealed to the New Jersey Supreme Court. In the controversial In re Quinlan case, the New Jersey Supreme Court authorized that the decision to terminate extraordinary life support measures for incompetent comatose persons should be left to the family and physicians. Unlike Quinlan, the Grady court held that the extraordinary medical procedure here, the sterilization of a retarded person, would always require judicial approval. In commenting upon its departure from Quinlan, the court noted that the sterilization of the mentally impaired had a "sordid history" of abuse. Judicial authorization therefore was regarded as a safety mechanism to protect individuals from unnecessary sterilization.

Under most current sterilization reform laws, "the state may authorize sterilization" under its authority "if certain conditions are met." Many of these state laws follow a model derived from In re Guardianship of Hayes, a Washington Supreme Court decision. In this case, a mother petitioned the court to have her sixteen-year-old daughter, Edith Hayes, sterilized. However, the court found that sterilization was not in Hayes's best interests, and it established a two-part inquiry in reaching this decision. First, the court must determine whether the individual is competent to make an informed medical decision about sterilization. To achieve this determination, the judge must find by clear and convincing evidence both that the individual is incapable of making his or her own decision about sterilization, and is also unlikely to develop sufficiently to make an informed judgment in the foreseeable future. This examination "seeks to protect the autonomy interest of the competent.

65. Id. at 80.
66. COLO. REV. STAT. §27-10.5-128(2)(4)(2005) (stating "no person with developmental disabilities who has not given consent shall be sterilized").
67. Scott, supra note 62 at 817.
68. Id.
69. FIELD & SANCHEZ, supra note 36, at 90.
70. Id.
71. Id.
72. Id.
73. Id. at 88.
75. See REILLY, supra note 41, at 155.
77. Id.
78. See Scott, supra note 62, at 817.
79. 608 P.2d 635, 641 (Wash. 1980).
80. Id. at 637.
81. Id. at 638.
82. Id.
83. Id.
84. Id. at 641.
person who has no need for a surrogate [decision maker].”

"If the court determines the person is incompetent [however] . . . it must then consider specific factors and decide whether sterilization is in the person's 'best interests'."

Courts rely on varying factors to determine what qualifies as a woman's "best interest". One analysis inquires whether the individual is "able to reproduce and whether she is 'imminently' likely to engage in sexual activity." The petitioner may also be asked to "demonstrate that less drastic forms of contraception have been tried and are not feasible." Moreover, the court must assess the woman's "capacity to care for a child," and in some states the court must also determine if a woman understands her reproductive functions and the "relationship between sexual intercourse, pregnancy, and childbirth." The Hayes decision went further than other similar cases in that the court also presumed that sterilization would have detrimental effects on the physical or emotional health of the patient, which is a consideration most other courts have ignored. In Hayes, the court found that the evidence failed to illustrate that sterilization was in the patient's best interest; further, it said that the "best interests" requirement will be satisfied only in a "rare and unusual case." It also stated that "[t]here is a heavy presumption against sterilization of an individual incapable of informed consent."

Many states now have laws that resemble the Hayes decision by embodying strict procedural and substantive requirements that create a strong presumption against sterilization. Generally, a court can order sterilization only upon findings based upon clear and convincing evidence, but "state rules vary on whether and how sterilization can be approved," and they will most likely "continue to vary" until the United States Supreme Court articulates a "constitutional rule that must be followed."

IV. COMPETENCY OF WOMEN WITH DISABILITIES TO HAVE CHILDREN

Current sterilization statutes bring into question the competency of a woman as a parent in determining whether sterilization is appropriate. Today, it is generally conceded that the interests or desires of the medical patient reign supreme, but this presumption is often disregarded or dismissed as insignificant when considering the desires of a woman with a disability. Should the patient be the sole determinant of sterilization decisions, or should the interests of others weigh into the balance as well? Other interests to consider may include those of parents, the state, and the child. In the sterilization context, the main question turns on whether a woman with a disability would be a competent parent if she were to become pregnant and bear a child. Such questions of competency depend upon the type and severity of the disability, which may vary greatly in degree.

Women with cognitive disabilities have historically been stereotyped as unable to occupy the sphere of motherhood. Such stereotypes have prevailed into modern day, although this stigma has been in tension with increased examples of parents with mild mental disabilities who successfully raise their children. "Competenc[y] doctrine presumes that the individual is capable of making a rational decision, and competence is [generally] equated with rationality." Competency doctrine is most frequently used to describe the mentally ill or mentally retarded; the latter group in particular

86. Id. at 818.
87. Id. at 819.
88. Id. at 820.
89. Id. at 819-20.
90. See id. at 820.
91. See Field & Sanchez, supra note 36, at 91.
92. See Hayes, 608 P.2d at 637.
93. Id. at 642.
94. See, e.g., Grady, 85 N.J. at 235 (holding that those who are incompetent to make decisions for themselves are best protected by judicial decisions); Wentzel v. Montgomery Gen. Hosp., 293 Md. 685, 695 (1982) (holding that a guardian's decision to approve sterilization is valid only if it is medically necessary).
95. See Scott, supra note 62, at 818.
96. See Field & Sanchez, supra note 36, at 91.
97. Id. at 100.
98. Id.
100. Id. Many child protection statutes, for example, "list mental retardation as a factor supporting a finding of unfitness to be a proper parent." Id.
101. Id. at 830-31.
endures strict state regulation in termination of parental rights proceedings. Legal history dictates a long line of cases which protect the fundamental rights of parenting and procreation through the Due Process Clause of the Fourteenth Amendment. However, although parental rights may be considered fundamental, these rights are not absolute, and they can be regulated by legislation that withstands strict scrutiny analysis. Specifically, a conflict arises when the right to bear and raise children comes into tension with the state’s interest in protecting those children against incompetent parenting.

Individuals with cognitive disabilities or mental retardation often have their parental rights terminated. Mental retardation, as defined by the United States Supreme Court in City of Cleburne v. Cleburne Living Center, “refers to significantly sub-average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the development period.” The use of the term “mental retardation,” however, often “constitutes an ambiguous ... and potentially discriminatory classification system.” This single term references a large population of individuals, including those who are severely impaired to those who are quite high-functioning.

Indubitably, the competence of a parent is a matter of grave significance. Child abuse and neglect have reached staggering proportions in the United States, and as a consequence, the safety of children in the care of their parents is a serious matter. Child protection statutes often point to an array of factors when considering the termination of parental rights. Some common factors include “abandon[ment], [physical abuse], failure to provide a child’s material needs, and inability to provide the child with an education or necessary discipline.”

In some child protection statutes, mental retardation or other developmental disabilities can be a reason to remove a child in cases of incompetence. Moreover, historically, statutes have described the presence of retardation “as sufficient for [the] removal of children and ultimate termination of parental rights, without any requirement that [parental incompetence] be independently shown.” Furthermore, there is great ambiguity in determining what constitutes inadequate child rearing, and therefore great discretion is left to judges who may not be well-trained in issues related to mental retardation or other mental impairments. As a result, parents may be found guilty of neglect in one community but not in another.

The state must show a compelling reason why the parent is unfit and unable to raise her own child. Courts used the “better alternative” test to determine whether a mentally retarded individual was deficient or unfit simply because there existed a better alternative environment in which the child could live. Even though this test is no longer used, case history suggests that courts at times are too hasty to terminate parental rights without more closely examining the individual situation. While a child’s safety and care should be of principal importance, parents who have cognitive or developmental disabilities often can still provide the necessary support for their children. In other words, a mother’s right to parent should

103. Alward, supra note 19, at 191.
105. Id. at 985-86.
106. Alward, supra note 19, at 188.
108. SARAH F. HAAVIK & KARL A. MENNINGER II, SEXUALITY, LAW AND THE DEVELOPMENTALLY DISABLED PERSON 2 (1981). Note also that the term “mental retardation” is often increasingly replaced by more respectful words such as “developmental disability,” “intellectual disability,” or “cognitive disability.”
109. Based upon their IQs, people who are mentally retarded are typically grouped into four categories: mild, moderate, severe, and profound. See Morgan Cloud et al., Words Without Meaning: The Constitution, Confessions, and Mentally Retarded Suspects, 69 U. Chi. L. Rev. 495, 510 (2002).
111. See FIELD & SANCHEZ, supra note 36, at 243.
112. Id.
113. Id.
114. Id. at 244.
116. See, e.g., Orangeburg County Dep’t of Soc. Servs. v. Harley, 393 S.E.2d 597 (S.C. Ct. App. 1990) (wherein a mother who was classified as mentally retarded could not manage her finances, follow simple instructions, or take care of herself).
117. See FIELD & SANCHEZ, supra note 36, at 19.
118. Id.
not be terminated merely because her IQ is below a certain level if she is still able to provide for the child. Courts, however, often determine parental competence solely on the basis of an existence of a disability; or, as previously discussed, they approve sterilization methods that ensure that pregnancy will never occur in the first place.\footnote{119}{Id.}

\section{V. REDEFINING REPRODUCTIVE CHOICE FOR WOMEN WITH DISABILITIES}

The issue of whether or not to have a child is an extremely personal decision that each woman hopes to make for herself. Women with disabilities, however, often are not allowed to make such choices independently. In spite of a growing awareness and acceptance of a woman’s autonomy to make decisions about her own body, the reproductive rights issues of women with disabilities have received scant attention from scholars, legislators, or even the feminist movement in recent years. The typical public perception of women with disabilities is that they are not expected to have romantic or intimate relationships; rather, they “are perceived as asexual . . . not desiring love or sex,” and rarely involved in committed relationships.\footnote{120}{Patricia E. Erwin, Intimate and Caregiver Violence Against Women with Disabilities, Battered Women’s Justice Project-Criminal Justice Office (July 2000), http://www.bwjp.org/documents/Erwin-diswomenformatted1.htm.} Disability-rights advocates Michelle Fine and Adrienne Asch explain that “[w]omen with disabilities traditionally have been ignored not only by those concerned about disability but also by those examining women’s experiences.”\footnote{121}{Adrienne Asch & Michelle Fine, Introduction: Beyond Pedestals, in Women with Disabilities: Essays in Psychology, Culture, and Politics 1, 3 (Adrienne Asch & Michelle Fine, eds., 1988).} As one feminist scholar said, “Why study women with disabilities? They reinforce traditional stereotypes of women being dependent, passive, and needy.”\footnote{122}{Id. at 4.}

However, sex is a subject fraught with many questions and apprehensions for women with disabilities.\footnote{123}{Virginia Kallianes & Phyllis Rubenfeld, Disabled Women and Reproductive Rights, Disability & Society 203, 207 (1997).} One disability-rights writer points out that “after ‘Will I walk again?’ the most common questions asked by newly disabled people are, ‘Can I have sex?’ and ‘Will I be able to have children?’”\footnote{124}{Id.} Given the existing discomfort and confusion concerning the sexuality of non-disabled individuals,\footnote{125}{See Kallianes & Rubenfeld, supra note 124, at 205.} it is not surprising that the sexuality of those with disabilities has been overlooked. However, the fact remains that women with disabilities have concerns about their sexuality and their reproductive rights in general. While the feminist movement, led primarily by non-disabled women, has struggled for women to have the choice not to bear children by advocating for abortion rights, women with disabilities view reproductive rights as more than the right not to have a child. The concept for them also “encompasses the right to be recognized as sexual, to bear children – even a disabled child – to be seen as ‘fit’ to mother.”\footnote{126}{Id.} Reproductive freedom for women with disabilities, therefore, parallels abortion rights in this sense; if all women have the right to choose not to bear a child, then all women must also have the right to bear children.\footnote{127}{Id.}

Current laws on reproductive autonomy profess to worship the autonomy of an individual’s right to choose, but this ideology often results in a limited, unbalanced perception; that is, this belief is primarily based on protecting the “right not to procreate”, rather than working to protect the right to procreate.\footnote{128}{Id.} The right to bear children has received little attention because it has seldom been challenged; in fact, the only Supreme Court case to affirm the right to procreate is \emph{Skinner v. Oklahoma}.\footnote{129}{Id.} For women with disabilities, however, this issue is very real and salient. The “right to procreate” translates into a need for women with disabilities to have access to all kinds of reproductive services, ranging from sexual health education, which is rarely offered in special ed-

\footnotesize{\textsuperscript{119}Id.\textsuperscript{120}Patricia E. Erwin, Intimate and Caregiver Violence Against Women with Disabilities, Battered Women’s Justice Project-Criminal Justice Office (July 2000), http://www.bwjp.org/documents/Erwin-diswomenformatted1.htm.\textsuperscript{121}Adrienne Asch & Michelle Fine, Introduction: Beyond Pedestals, in Women with Disabilities: Essays in Psychology, Culture, and Politics 1, 3 (Adrienne Asch & Michelle Fine, eds., 1988).\textsuperscript{122}Id. at 4.\textsuperscript{123}Virginia Kallianes & Phyllis Rubenfeld, Disabled Women and Reproductive Rights, Disability & Society 203, 207 (1997).\textsuperscript{124}Id.\textsuperscript{125}HAAVIK & MENNINGER, supra note 109, at 8.\textsuperscript{126}See Kallianes & Rubenfeld, supra note 124, at 205.\textsuperscript{127}Id.\textsuperscript{128}See Scott, supra note 62, at 807.\textsuperscript{129}Id. at 814.}
ucation classrooms, to access to contraceptives. Medical professionals often respond with surprise when women with disabilities seek information about birth control or pregnancy, and they often may be ill-prepared to provide appropriate care. Medical providers frequently treat disabled women as incapable of making their own choices, especially when those choices involve sexuality and pregnancy.

This lack of access to sexual health information can prove dangerous. Due to inadequate information, women with disabilities may not receive necessary reproductive and obstetrical care, or appropriate information on protecting themselves from sexually transmitted diseases. Women with disabilities may also miss out on crucial information about domestic violence and sexual assault, which affect the population with disabilities at a greater percentage than the general population. Though statistics vary, estimates reveal that more than half of women with physical disabilities suffer from intimate abuse in their lifetime. Moreover, women with disabilities are reportedly more vulnerable to abuse than non-disabled women. These women suffer from greater injuries for longer periods of time, and when they seek justice or protection through the legal process, they encounter myriad obstacles in a system that is not accessible to individuals with their special needs.

Courts of justice have repeatedly acknowledged that women with severe mental disabilities are often subject to sexual abuse or rape, especially in institutionalized settings. For example, in one Maryland case, the court found that “[t]here was evidence showing that the guardianship petition [to sterilize a thirteen-year-old girl] was motivated by a sincere desire to free [the girl] of the pain and other consequences suffered by her during menstruation and because of genuine concern that [she] was an easy subject for rape and resulting pregnancy.” In other words, courts that justify sterilization because a woman is incompetent to understand the meaning of sex assume that the mentally retarded woman will be raped. Therefore, the law establishes a system which assumes that women who cannot understand sex will be raped, and then authorizes involuntary sterilization to prevent pregnancy.

Women with disabilities have claimed that the denial of their mothering rights through forced sterilization or general discouragement by doctors, professionals, and family members not to have children, is an experience of oppression. “Given society’s insistence that disabled women are asexual and ‘unfit’ mothers . . . [a disabled woman may wish to bear a child to disprove the stereotype of asexuality, to prove] that she is indeed like other women, or to regain some semblance of [an] ordinary life.” Moreover, it cannot be disputed that the triumvirate of “marriage, childbearing, and parenting” may be the most rewarding of activities in which a woman with a disability, and indeed, any woman or parent, ever engages. Giving birth and raising children can bring that individual a sense of security, an increase in self-esteem, a sense of belonging, and

130. Many special education students are removed from “mainstream classrooms” into self-contained settings. Although laws have developed over the past thirty years that provide for more integrated educational settings, prior to the 1970s it is estimated that over seventy percent of students with disabilities were taught in separate classrooms from their non-disabled peers. See Robert L. Hughes & Michael A. Rebell, Special Educational Inclusion and the Courts: A Proposal for a New Remedial Approach, 25 J.L. & Educ. 523, 524 (1996) (citing Mary Ellen Guzman, Success for Each Child: A Research-Based Report on Eliminating Tracking on New York City Public Schools, 42 (1992)).
131. See Kallianes & Rubenfeld, supra note 124, at 208.
132. Id.
133. Id.
136. Margaret A. Nosek et al., Vulnerabilities for Abuse Among Women with Disabilities, 19 Sexuality and Disability 177, 177 (2001).
137. Id. at 178.
138. See Stefan, supra note 103, at 811.
139. Wentzel, 447 A.2d at 1246.
140. See Stefan, supra note 103, at 812.
141. Id.
142. See Kallianes & Rubenfeld, supra note 124, at 210.
143. Id. at 210-11.
144. See Field and Sanchez, supra note 36, at 18.
a reason to continue living. These concerns and interests, however, too often seem lost in the mainstream reproductive rights movement that focuses on “choice” as the choice whether or not to abort a fetus. The pro-choice movement, it seems, would benefit by adapting a more comprehensive definition of the term to include the concerns of women who may want to have a child, but have systematically been denied that right.

VI. “IMPERFECTION” AS A REASON NOT TO REPRODUCE

The focus of the pro-choice movement, however, has remained relatively unchanged in spite of new issues that have developed in recent years. While “discussions of new reproductive technologies should have pushed disability issues to the forefront of abortion and feminist discussions,” these concerns have scarcely been addressed. The pro-choice movement has existed alongside remarkable developments in genetic technologies that now make the scope of the medical profession wider than humans ever imagined possible. Although abortion once meant that a woman would have the absolute right to decide not to have a child at a particular time, technical genetic information is now available that enables a woman to decide whether to give birth to this particular child. Women who are able to access “prenatal testing through ultrasound, amniocentesis, or chorionic villi sampling” may, as Ruth Hubbard observes, be in a situation where “the more privileged of us can control not only whether and when to have children, but the kind and quality of children we ‘choose’ to have.”

Indeed, many expectant parents face pressures to have “perfect” children, or those free of disabilities or any other perceived impairment. Just a few years ago, Peter Singer, a professor of Bioethics at Princeton University, explained that “[i]t does not seem quite wise to increase any further draining of limited resources by increasing the number of children with impairments.” Some states have taken this ideology and developed official policies to prevent the birth of babies with disabilities. For example, Alabama has a policy to identify families who have members with genetic disorders “that cause birth defects and mental retardation”; the state then encourages the “prevention of birth defects . . . through education, genetic counseling and amniocentesis” when applicable.”

While Alabama “encourages” the identification of birth defects and even implicitly condones the termination of such pregnancies discovered to be characterized as genetically impaired, the State otherwise renders a woman’s choice to terminate a pregnancy much more difficult. For example, ninety-three percent of the counties in Alabama have no abortion provider, and the State has imposed numerous obstacles that must be satisfied before an abortion can be obtained. Ironically, states such as Alabama encourage the identification and even termination of pregnancies that may result in genetic disorders, yet it makes accessible abortions for all women increasingly difficult to procure. The bias against individuals with disabilities is startlingly clear: if a fetus is not “perfect” or free from genetic disorders, then society, or at least our elected government, are willing to pay the price of not having such a child.
encourages such pregnancies to be terminated.\footnote{153}

Further, even international abortion laws take an inconsistent approach to fetuses with and without disabilities. In Britain, for example, abortion is legal under certain circumstances for the first twenty-four weeks of pregnancy; however, if the fetus is impaired by a severe disability, then abortion is legal up until the end of the term.\footnote{154} As recently as April of 2005, the country of Iran passed a new abortion law that allows for abortion under two circumstances: (1) if the life of the mother is endangered; or (2) if the fetus is “damaged.”\footnote{155} Pregnancies resulting from rape, however, must still be carried to full term.\footnote{156}

These policies inevitably beg the question: Why, as a culture, do we still seem to value a life free from disability as somehow more worthy than a life of an individual with a disability? After all, it can be argued that disability is a social construct, and that disadvantages that arise for individuals in our society because of a physical or mental impairment are due to our society’s construction of what is acceptable.\footnote{157}

This is not to say that women with disabilities are not pro-abortion advocates; on the contrary, many are among the most vocal supporters of reproductive freedom. “We should know better than anyone why the government should not be allowed to restrict what one can and cannot do with one’s body,” one woman with a disability has explained.\footnote{158} “However, when the discussion turns to abortions chosen because prenatal screening has detected fetal impairment, [there is concern] that social prejudices and negative stereotypes about disabled people lead to assumptions that women should not bear children who might be disabled.”\footnote{159} Therefore, there is implicit discrimination against individuals with disabilities underlying procedures that allow for abortions if a fetus is impaired.

While some disability advocates challenge such selective abortions, others do not advocate prohibiting these procedures, but instead argue that pro-choice advocates “should not prescribe any specific reason—such as fetal disability—to justify a woman’s right to [an] abortion.”\footnote{160} It seems that such a “no justification required” policy would most accurately reflect a woman’s right to personal privacy that is articulated in Roe v. Wade.\footnote{161} The Supreme Court, as previously mentioned, did not declare the privacy right in Roe as absolute, noting that past decisions such as Buck v. Bell have clarified that there is not “an unlimited right to do with one’s body as one pleases.”\footnote{162} However, the court did not stipulate that a reason must be given as a condition precedent for a woman to choose to have an abortion. Following this Roe privacy standard, a woman should be able to make a decision about whether to continue or terminate a pregnancy without having to justify why she has made her choice. Otherwise, by allowing abortions based upon specified criteria, whether by fetal impairment or pregnancies resulting from rape or incest, some potential lives are consequently weighed as more valuable than others. Devaluing lives that may be impaired due to a disability implies that a life with a disability is not worth living. These individuals can lead fulfilling and satisfying existences, especially with the proper accommodations and support provided by other members of society.

However, with the development of genetic and reproductive technologies, a societal belief has evolved that babies must be perfect, and expectant parents consequently experience the pressure to give birth to children without disabilities. “Soon it will be a sin for parents to have a child that carries the heavy burden of disease. We are entering a world where we have to consider the quality of our children,”\footnote{163} according to embryologist Bob Edwards. Women who discover that their fetus may or will be...
disabled consequently face many pressures to abort. The concept of “pro-choice” in the process becomes reduced to choosing between having a “healthy baby” or a “defective child.” This inevitably leads to a discussion as to what is considered to be “defective.”

It becomes difficult, however, to define “defective,” except to note that such a “non-defective” child suggests the concept of a human without impairments or disabilities. This attitude reflects a fear and ignorance about disabled individuals, which fosters a dismissive attitude towards the value of the life of a disabled individual. As the British Council of Disabled People explains, “[t]here can be no informed choice [about reproductive options] as long as genetic counseling is directive and continues to misinform women about the experience of disability. There can be no free choice as long as prejudice against and fear of disabled people continues.” This double standard that allows abortions due to fetal impairment needs to be addressed, and pro-choice advocates need to explain that if allowing abortion in such circumstances is acceptable, then abortion under all circumstances must be allowed and accepted. Otherwise, the potential life of an impaired fetus acquires less value than the potential life of another fetus.

VII. CONCLUSION: ELIMINATING DISCRIMINATION AND GUARANTEEING REPRODUCTIVE AUTONOMY

Almost two generations before the publication of The Bell Curve, Justice Holmes said in Buck v. Bell that “[i]t is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.”

This quotation accepts as a premise the idea that it is acceptable for some human beings to make fundamental life decisions for others of an alleged “imbecility,” thus depriving them of their sacred autonomy. Moreover, Justice Holmes’s comment suggests that some individuals are less valuable to society than others.

Such a biased attitude against the poor and disadvantaged continued well into the twentieth century and beyond. During the 1960s, for example, a number of state legislatures considered bills that were designed to discourage the birth of illegitimate children. Mississippi and Louisiana adopted laws that made parenthood out of wedlock a crime punishable by thirty to ninety days in jail. In 1967, an Ohio judge ruled that a woman with two illegitimate children had violated the state’s child neglect law by failing to provide a “stable moral environment” because she was not married. In several states in recent years, legislatures considered offering child support subsidies only to those welfare mothers who agreed to be sterilized. As late as the 1980s, the chairman of the Board of Resources in Texas suggested that welfare recipients should have mandatory sterilizations.

Targeting low-income women’s reproductive capabilities has persisted even today. A new type of contraception, Norplant, was approved at the end of 1990, and it quickly became popular among public policy makers because of its simplicity: to induce infertility for five years, a woman only has to allow a health care practitioner to surgically implant the device in her arm. After Norplant’s arrival, states introduced more than twenty-five bills to impose various reproductive regulations, including a 1993 South Carolina House Bill that mandated the use of Norplant if a woman received welfare benefits and already had two or

164. See Tait, supra note 147, at 452.
165. See Sayce & Perkins, supra note 132, at 23.
166. Richard J. Herrnstein & Charles Murray, The Bell Curve: Intelligence and Class Structure in American Life (Simon & Shuster, 1994). The Bell Curve was a controversial best seller that posited a thesis (though not original) that reinforced the belief that there is a scientifically verifiable link between race, genes, and intelligence. The authors concluded that our intelligence as a nation is in decline, and they speculated as to what types of public policies might be implemented to curtail this phenomenon.
167. See Buck, 274 U.S. at 207.
168. Id.
169. See Alward, supra note 19, at 175.
170. See Reilly, supra note 41, at 160.
172. See Reilly, supra note 41, at 161.
175. Id. at 45.
more children. Another proposed bill in the state of Washington provided monetary compensation for welfare recipients who used Norplant. Moreover, Norplant has been imposed as a condition of probation. In People v. Johnson, a California court convicted Darlene Johnson, a pregnant twenty-seven-year-old mother of four, of physically abusing her children. Her prison sentence was suspended, but the court imposed the use of Norplant as a condition of her probation.

The fact that governments were attempting to regulate the reproductive capacities of the poor in American society is not surprising. At the beginning of the twentieth century, after all, the Supreme Court was led to believe that a single, young, poor, and uneducated woman named Carrie Buck was cognitively disabled and consequently unable to care for children. Individuals who are in positions that do not allow for adequate self-advocacy soon discover that people in authority are only too eager and willing to make these important life-changing decisions for them. Study after study indicates that "there are significant differences in incidence of sterilization along income and welfare lines [. . .] the poor are sterilized at disproportionately higher rates." Individuals with disabilities often occup any other children in Buck v. Bell. Consequently, this woman was sterilized against her will and unable to further experience the joys of motherhood. Such decisions, unfortunately, have occurred too often in this country's history, and they have predominantly resulted from ignorance and fear about women with disabilities who merely desire to be treated with equality and respect.

176. Id.
177. H.R. 5335, 59th Leg., Reg. Sess. (Wa. 2005) (providing women $500 initially and $50 for each year the contraceptive was used thereafter).
179. Johnson, No. 29390, slip op. at 13-14.
181. See Asch & Fine, supra note 122, at 11.