
Chapter 5

DIFFICULTIES IMPEDING WIDER
ACCEPTANCE OF STERILIZATION

4 No PROGRAM, however comprehensive on paper or conscientiously administered, can leave the human factor out of reckoning. In its everyday application, proposals which appear self-evident to those on one level of education and culture may run counter to the beliefs and values of those on another, or the individual may react in a manner which is emotionally not rationally determined. We need not be surprised to find that such an innovation as eugenic sterilization, calling for changed ways of thought and impinging on deep-seated instinctive feelings, arouses misunderstanding and antagonism and is specially difficult to promote among those illiterate and backward groups where its benefits would be most obvious. This would be true of any area; but in the particular setting of a rural southern State with its high fertility and relatively low educational levels, its depressed economic conditions and fundamentalist traditions, and a Negro sub-culture within the larger culture, paradoxically both the need and the obstacles are intensified.

We have already indicated a few of the difficulties which North Carolina social workers encounter in their attempt to carry out the sterilization program. The time has now come to undertake a more detailed analysis, since only by understanding the nature of these difficulties—some of them with universal significance—can we discover what lies behind the bare statistics and their meaning for those who plan the strategy of social change.

IGNORANCE, PREJUDICE, AND SUPERSTITION

Under North Carolina law, eugenic sterilization is not offered to normal individuals but applies exclusively to the feeble-minded and mentally afflicted. The understanding of these people is limited, many of them are illiterate, and lacking any consistent sense of purpose, they can be easily influenced. Their relatives, drawn from similar social groups, if not themselves defective (as often happens) are unlikely to be more than dull normal in intelligence, slow to accept new ideas, and incapable of viewing a situation except in immediate personal terms.

It is extremely difficult for case workers to explain eugenic sterilization to such clients, allay their fears, and convince them of its value; and we note that of the 85 county welfare departments who had handled sterilization cases, 71 of them check "Resistance of client and relatives" as a major problem. (See Appendix C, analysis of questionnaire returns.) Ignorance and superstition were mentioned again and again by workers with practical experience of interpreting the program; and the mental limitations of their clients apart, we must remember that such characteristics are common to uneducated country people all over the world. One public health nurse who had undertaken a special sterilization project in a rural county described her difficulties as follows: Ignorance and lack of education were the biggest obstacles, not only where sterilization was concerned but in relation to all sorts of things such as child welfare and personal health. Men and women will agree to the operation, then back out later. "They believe you when you are talking to them" but then they get confused through talking to friends and relatives. This occurs especially in the case of men, who don't seem to be able to grasp the difference between vasectomy and castration even though they may apparently be convinced after you have explained it to them. Women are more receptive to the idea, but dislike going to the hospital and put off making arrangements; or their husbands may object on religious or selfish grounds. (Some notes on a visit made with this worker to the home of one of her clients will be found in Appendix D.)

Confusion exists as to the exact nature of the operation, and analogies are drawn with familiar veterinary procedures on farm animals or with the effects of hysterectomy. Men are fearful that their sexual capacities may be impaired, women give heed to old wives' tales about the dire results of interference with nature, and many of them are understandably reluctant to submit to a surgical operation which they cannot regard as urgent. The following extract from a social agency case record shows how firmly ingrained an irrational idea may become:

Mrs. J., a white woman, wife of a butcher, has seven living and five dead children. One child was born with a deformed foot, another has a speech defect and is feeble-minded (I.Q. 60). Mrs. J. has been attending a psychiatric clinic for treatment of anxiety and depression and is considered of borderline intelligence. She also suffers from kidney trouble, backache, and hemorrhoids.

The agency is trying to get her sterilized either on mental or physical grounds, but she will not agree to the operation because of what it may do to her. She has a sister who has been in the State mental hospital for about ten years. When this sister was 25 she had an operation and soon thereafter "lost her mind." The doctor denied that he had removed the sister's womb and the doctors at the State hospital say that the operation could not have affected her sister's mind, but Mrs. J. and her relatives know better. They have asked "plenty of doctors" and they all say that the womb must have been removed. Mrs. J. is obviously convinced that this caused her sister's mental condition.

The case of Ada T. reported at length in the appendix, provides another example of ignorance, fear, and confused thinking on the part of a mentally defective unmarried mother, and the attempt to interpret sterilization to such people is indeed a discouraging and disappointing task. One welfare superintendent says: "There is still so much ignorance and superstition and fear among feeble-minded clients and relatives where any mention is made of sterilization that it is next to impossible to help them dispel these reactions." Another, less pessimistic, says: "Clients and relatives require understanding, persuasion and encouragement. It takes plenty of time."

THE PATTERN OF HIGH FERTILITY

The North Carolina birth rate of 27.5 per 1,000 population in 1946⁸⁴ is among the highest of any State in the Union. Unparalleled outside the rural South, it represents a survival of earlier frontier tradition and the patriarchal folkways long since discarded by urbanized American culture. Many factors have contributed to this situation in the past: an agricultural economy, the isolation of rural life, little schooling for whites and less for Negroes, fundamentalist religious beliefs and the Biblical sanction of many children. Children too were needed as helpers on the farms, and a continual northward migration to industrial cities drained off those surplus adult workers who could not be supported on the land. Although two world wars and the depression have wrought increasing social and economic change in the southern scene, old ways of thinking linger on especially among those classes who have little formal education and are least affected by the spread of urban ideas.

To the observer from another culture and a different continent, no aspect of the study has been of greater interest than the attitudes and practices relating to fertility. In keeping with rural tradition, here we have early marriage, some families of considerable size, indifference to contraception (if not complete ignorance of its techniques), and a fatalistic acceptance of childbearing as woman's inevitable state. Many girls marry when in their teens, giving them a much longer reproductive span over a period when fertility is greater than those who marry at the urban mode of 6 or 8 years later. The law accords with custom, since until recently (1947) the legal age for marriage was 14.⁸⁵ It has now been raised to 16.

Of the 48 mentally normal women who were interviewed in the follow-up study, half had been married before they were 20; and of these, one was married at 13, three at 14, four at 15 and five at 16. (See Table XI, Appendix B). Selective factors apart, it can safely be said that this feature would not be found among any group of women in England, of a comparable social level, nor would it be probable among groups from the more urbanized areas of the United States. In the same sample, 16 of its members still under

30, we had two women who had had 8 pregnancies, five who had 9, one each who had 10, 11, 12, and 13, and one who had 20, including three sets of twins. Such cases of high fertility are familiar to social workers since every agency could provide matching examples; and, even above the relief level, those in rural areas who produced large families did not incur the comment or social disapproval that would be visited upon them elsewhere.

Another surprising feature of the sample was the absence of contraceptive effort disclosed and the lack of interest in such possibility. Although some women said they would have preferred fewer children or posited an ideal of three or four, it was plain that conscious planning of family size appeared to their minds as a pleasant dream but not an attainable reality. Twelve had never attempted any birth control whatever, not even *coitus interruptus* (the usual resort of the uneducated low-income couple), and 20 had made such sporadic or insufficient effort that for all practical purposes they were within the same category. "I never did hear of it," said one 26-year old white woman, with seventh grade education, who had been married at 16 and had five children. These findings accord with those of a study of rural mothers (unselected by fertility) made by Hagood⁴⁵ in North Carolina and four other southern States, where it was found that the mean age at marriage was 18, the mean number of children 6.4, and only 8 out of 69 women had ever practiced contraception, mostly by unscientific means.

In such a social pattern, proposals for sterilization fall if not on deaf at least on unprepared ears. Women are psychologically conditioned to a reproductive role, men to unrestricted exercise of marital rights, and the incentive to control fertility which would be present in a more sophisticated urban environment is almost entirely lacking. Hence much of the failure to persist with contraception, even when instruction has been given; the unco-operative attitude of husbands; and the oft-expressed opinion that interference with nature is morally wrong.

We may gain some picture of the life and outlook of one North Carolina country woman from this account of a visit to her home:

Mrs. F. and her family live in an unscreened four-room shack which is perched on the side of a mountain valley. They own 23 acres of rough hilly land, planted where possible in corn, tobacco, and vegetables, and they have a cow and some fowl. \$200 of taxes are owing on the land. Their sole cash income is an A.D.C. grant.

Mrs. F., an epileptic white woman of 43, was married at 15, has six boys and five girls, and has also had a 5-months' miscarriage. She is now eight months pregnant and is feeling very wretched and ill. Her face reddened from exposure in the fields, she looks healthy enough but her legs are swollen and discolored and many of her teeth are missing. In manner she is friendly and straightforward and can still laugh and joke in spite of her troubles.

Mr. F. has been ill for a long time with hemorrhage and vomiting and can only work odd days. Mrs. F. thinks it may be cancer, but her husband won't go to a doctor and says he'd rather die at home. He left school in the fourth grade and "can't read nor write nor nuthin." Mrs. F. herself reached the sixth grade.

She says that none of her children are affected with epilepsy, but adds that her elder boy was rejected for Army service on account of fits. The 15-year old boy "can't learn" and is only in the fourth grade at school. She has never been in a hospital for any of her confinements nor for treatment for fits, which come on more often during pregnancy. At one time she was paralyzed for six weeks following an attack, but refused to let them take her to a hospital.

Before every child was born she was working on the farm till the last minute, as well as having all the household work to do. Her life has been hard. "I've done every kind of work a woman could do except ploughing." She was told about birth control on several occasions but "I never did go till it was too late. I kept puttin' it off." Sterilization was suggested for her husband but "he won't even talk about it." She fervently hopes this pregnancy will be the last.

MEN AND STERILIZATION

In view of the comparative simplicity of a vasectomy procedure it might be thought that men would readily agree to have it performed, especially in those cases where the alternative was a major operation for their wives. This however is not the case. There was overwhelming evidence from social workers and physicians that sterilization of men was unpopular, difficult to put across and

unlikely to be accepted except in rare instances. Of the 74 county welfare departments who answered a question on this point, 54 stated that the resistance of men was greater than women, a situation which is reflected in the small number of non-institutional male sterilizations recorded (only 73 in 18 years); and the explanatory comments made by welfare superintendents are full of such negative expressions as "resent," "fear," "unwilling," "opposed," "averse to," etc., which show clearly enough the tone of their clients' reactions. "Very few will submit to operations," says one superintendent. And another: "Women don't mind it as badly as men."

A senior gynaecologist who held that the husbands of his patients should come forward for sterilization and was accustomed to urge this course upon them admitted that in his 17 years at the hospital he had only got four men to agree. Another gynaecologist who tried to do the same in his private practice, with similar lack of success, said that his patients invariably come back with the reply: "My husband isn't in favor." A New York surgeon,¹²¹ reporting on a series of 172 sterilizations which he had performed on women, commented that in the whole of his professional experience only one husband, and he a medical man, had chosen to be operated on instead of his wife. Figures from Sweden⁸⁰ tell the same story: in the 5-year period 1935-40 male sterilizations made up only five percent of the total. Leaving aside those selective factors, already discussed, which bring a greater proportion of women to the notice of the eugenic authorities, it is clear that there must be some deep-seated reason for this universal fear and antagonism shown by men to proposals for sterilization.

Advocates of the measure, themselves familiar with reproductive anatomy and methods of operation, tend to underestimate the ignorance of the average person in such matters. Detailed instruction on human sex processes is rarely a part of the school curriculum and people acquire information—often inaccurately—by hearsay or haphazard reading. We should not expect the dull and mentally defective to be any clearer about distinctions between sterilization and castration than they are about other half-understood scientific facts, but the same confusion is found among

normal and even well-educated persons. In a recent questionnaire answered by 229 men and women students in a southern State university,* all of whom had 14 or more years continuous education and were presumably selected from the upper intelligence levels of the community, 38 percent thought that sterilization meant loss of sexual potency in the male and 52 percent thought it caused absence of menstruation in the female. Several physicians who were interviewed referred to similar misconceptions among their male patients.

This expectation of eunuchoid effects is difficult to reverse, nor does intellectual comprehension of its fallacy suffice to overcome doubts and fears which may be largely unconscious. To man, any operation involving the genitalia appears as a threat to his physical integrity and his capacity to perform (and enjoy) what is after all his basic biological function. Psychoanalytic research has demonstrated the strength of these castration fears and the many anxieties to which they give rise; and it was pointed out by two surgeons that performance of vasectomy on a neurotically-disposed individual might well result in functional impotence. This is not the place to embark on extended discussion of the concepts of male sexual psychology, but it is being increasingly recognized that psychic factors, little considered in earlier studies of vasectomy, are of very great importance when an operation is being contemplated.

Then, too, we must remember that the regular release of sex tension is a normal and expected part of married life and is likely to assume a greater relative value in the eyes of those who have few alternative outlets for interest or self-expression. Kinsey's study⁵⁷ has shown the extensive and imperative nature of human sex activity even when surrounded by cultural taboo, and it is unrealistic to think that married individuals of low or defective intelligence will be restrained by appeals to continence or eugenic forethought, or welcome a proposal which they fear will endanger their satisfaction. As one welfare superintendent said: "Men feel it [i.e., sterilization] is robbing them of some inherent right."

Hence we have not only objections from men with regard to

*University of North Carolina, 1947 (unpublished).

themselves but objections to the sterilization of their wives. Again the same emotions are aroused: fear that wives will be less responsive or entirely uninterested in sex relations. "He was afraid she wouldn't be any good," a public health nurse reported of an unsuccessful interview with a patient's husband. (Such beliefs are not confined to the uneducated: in the questionnaire already referred to, 17.9 percent of the University students replying thought that frigidity would result from sterilization.) One of the Negro gynaecologists, accustomed to talk with husbands for permission to operate on their wives, said he thought an important factor in refusal was the pride a man had in his ability to make his wife pregnant. You saw this more frequently with older men: there was much less difficulty in getting the younger ones to consent.

It is probable that some similar half-conscious motivation was operative in the following situation, taken from a case record of one of the teaching hospitals:

A white woman of 34 with seven children and again pregnant. Spitting blood and run down. Several children under clinic care; post-partum therapeutic sterilization recommended by the obstetrical department. The woman agreed, husband (a cab driver earning about \$30 a week) refused. He couldn't or wouldn't give his reasons, though talked to by both doctor and social worker.

We may stigmatize such attitudes as "selfish"; but having done so, we are still faced with the fact of their existence and the need for understanding if any constructive approach is to be made.

According to evidence from surgeons and health workers, when a man has agreed to vasectomy and been successfully operated on, it seems that he is likely to be pleased and satisfied. A report from the rural health department which had arranged the comparatively large number of 30 male sterilizations may be quoted at length since it throws light on procedure and reactions. When a woman comes to the department with serious medical indications against pregnancy, the staff nurse visits the husband and "tries to sell him the idea" of vasectomy. Of course, "they all think that what we want is castration but when they find out it doesn't interfere with their pleasure, it's all right." This particular staff nurse has been

in the department for a number of years, is well-known round about, and this helps to give people confidence in her advice. During her stay, no ill effects of male sterilization have been reported, so "men sell other men on the idea." "The news gets around."

There is no attempt to push people into sterilization against their will. The nurse gives them a clear simple explanation of what it means, in language they can understand, and shows them that the operation does not involve removal of any sexual organ. They are unlikely to consent at once, but over a period of time—maybe a year or longer in some instances—with subsequent interviews they eventually come round. Some men don't want anyone told that they have had the operation; others advertise their satisfaction in the community.

Unsuccessful vasectomy can give rise to obvious marital problems, especially if the husband is of a jealous or suspicious nature. Two such cases were reported (from different areas) where the man's wife had become pregnant following his operation and he had accordingly accused her of infidelity, a situation calling for much skill and tact in handling by doctor and social worker. In the above mentioned health department the doctor instructs the patient to wear a condom for several months after the vasectomy has been done, since there is always a possibility of some active sperm remaining. We have no evidence to show that any stigma of mental or social inefficiency attaches to the operation.

LEGAL AND PROCEDURAL DIFFICULTIES

The preparation of a petition for the Eugenics Board involves a great deal of preliminary work. Assuming the client has agreed to sterilization, consent must be obtained from his next of kin or legal guardian, and in a few cases a guardian ad litem may have to be specially appointed. A medical examination by the certifying physician has to be arranged, and a further psychological test if the client is feeble-minded. A surgeon must be found who is willing to perform the operation, and provisional arrangements made for hospitalization. Then all these papers must be assembled, together with a social history on the client, and sent to the Eugenics

Board. Compared to the informality of therapeutic sterilization, this is not a simple procedure but makes considerable demands on busy case workers; and at any stage some obstacle may crop up, or delay be such that the client loses interest. It is therefore understandable that these requirements, necessary though they are for safeguarding individual rights, should be regarded by the social workers as bothersome, over-elaborate, and often superfluous in low-grade mental cases.

Thirty-eight county welfare departments checked the item "legal and procedural" as one of their principal difficulties, and there were frequent comments criticizing the formality of the law which prevented its being more successfully applied. "Getting sterilizations through is complicated," said one Health Officer. "It takes two or three of us, many interviews, bringing pressure to bear, to get this one thing done." "The machinery is too clumsy," was the opinion of a Board of Health official, concerned that so few cases were going through in view of the extent of mental deficiency in the State. "Red tape and a cumbersome procedure," said another of his colleagues. While the Eugenics Board is properly concerned to supervise all petitions in strict accordance with the statute, this care appears in a different light to many of those on the case-work level, who sometimes describe it impatiently in terms of "red tape." "The Board are purists and sticklers for detail," says a welfare superintendent, experienced in handling sterilization cases. A hospital social worker thinks "the Board are leaning over backwards to be right legally" and cites her difficulty in tracing long-lost next-of-kin; "the procedure will have to be loosened up a bit if it's to be commensurate with the need" (a senior health officer); "the law is straightlaced and stiff. It isn't flexible enough," says a gynaecologist, favorable to therapeutic sterilization. At his hospital "we've by-passed the Board on several occasions. There's so much red tape in getting petitions approved." A Judge of the Juvenile Court thinks that sterilization is "a fine thing, if you can get it done." But "that Eugenics Board—" there are so many difficulties, and the legal procedure would need to be speeded up.

There were two chief criticisms made. One referred to the

necessity of obtaining consent from relatives who, although not legally determined as feeble-minded, might themselves be of low mentality; and the further difficulty of obtaining—as is customary—informal consent from the client. The other criticism was the necessity which sometimes arose of tracing remote and uninterested next-of-kin, also for purposes of consent. We have already mentioned the problem faced by social workers when they try to interpret sterilization to uneducated and maybe illiterate people, and many feel it is inconsistent to require both that the client give consent and be feeble-minded. One county specifically asks: "Could some of the 'red tape' be cut in regard to the consent of the feeble-minded adult? We are thinking of a mother of four children, born out of wedlock, who is definitely feeble-minded and who will not give consent for sterilization. With her mother's consent, we think we should have the operation." Another county instances the following: "Husband, due to low mentality, refused to sign necessary papers for his or his wife's operations—just does not like signing papers."* Several counties suggested that the requirement of consent from next-of-kin be eliminated in cases where they were known to be mentally incompetent or defective; many thought that compulsory powers should be available.

Although the statute appears to sanction compulsion (sterilization may be authorized after special hearing when consent is withheld) in practice this never takes place, except in mental institutions; nor can an individual be made to go through with the operation if he changes his mind after the petition has been approved (a disappointment to the social workers, who may have put much time and effort into the case). If compulsion were exercised, a great deal of hostility might be stirred up which could jeopardize the whole existence of the law; and rather than incur this risk, it is thought better to let some few resisters go unsterilized.

In a program of voluntary sterilization, procedural safeguards are to some extent balanced against successful functioning. While the formalities undoubtedly have a deterrent effect, from a strictly

*Eugenics Board states that these two cases could legally be handled without the feeble-minded persons' consent but that it is improbable that any doctor or hospital would co-operate in the first one cited.

legal point of view the law has been pared to the minimum consistent with individual safety, and its wider use may rest on the guidance given to administrators and case workers and the simplification of detail wherever possible. What happens at present in many cases is that the inevitable delays of petition procedure make it difficult to sustain a client's resolve and interest, especially when they are likely to be swayed by uninformed relatives or lose a sense of urgency.

This difficulty was specifically mentioned by eight county superintendents, one of whom remarks: "When subject and relatives signing consent find that after 'papers' are signed and so much time elapses until hospital and operation," very often they decide at that point not to go through with it." We have here one explanation of the discrepancy between the number of sterilizations authorized and those actually performed (Table I, Appendix B), though other accidental circumstances such as the discovery of a serious heart condition, rendering operation unsafe; removal of the family to another state; pregnancy found to exist after the petition had been approved, may also be responsible.* Then too there is the problem of obtaining co-operation for a mental test, no easy task in view of the general low educational background of clients and their suspicion and distrust of such proposals. Another superintendent writes: "We have one situation here in which we feel the woman should be sterilized but we have not been able to get her to accept the necessary preliminary psychological examination. In this instance if we get both the woman and man to agree it would be necessary to proceed at once before they had time to change their minds." An experienced case worker summed up the difficulties of arranging sterilization for feeble-minded women as follows: getting them convinced of the need and value of the operation, gaining their consent, their willingness to submit to a mental test and face a surgical operation. They are easily put off by remarks and gossip of others. "If you knew what we social workers are up against—" Parenthetically, we may point out that

*An analysis of the reasons for non-performance of authorized operations during the 12-month period July 1947 to June 1948, supplied by the Eugenics Board, is given in Table XII, Appendix B.

despite the difficulty of getting tests done, they are still the only valid way of determining feeble-mindedness.

The attitude of relatives varies, and consent may be withheld for many reasons. Some of these, such as ignorance and superstition, have already been discussed, or the feeble-mindedness of the relatives themselves. Objections may be made on religious grounds, or, in institutional cases, there may be the fear that the patient or inmate might later hold the signing of consent against the responsible relative. As we have seen from the review of practice at Caswell and Samarcand, parents are sometimes reluctant to authorize the sterilization of their children even when presented with uncontrovertible evidence as to their unsuitability for parenthood, and the same difficulty is manifest in cases of unmarried feeble-minded girls at large in the community. "So many times the place where we completely fail on these sterilization cases—parents just up and say 'nothing doing'," commented a welfare superintendent in conversation. Another writes: "One [feeble-minded] Negro girl has not been sterilized because of resistance from relatives. They do not think it fair to take away the right to have children."

Where the client is married, the requirement of the husband's or wife's consent presents the spouse with a right of veto which may be—and in practice often is—unfairly exercised. It happened that of the 48 sterilized women who were interviewed, 9 of them reported that their husbands had at first completely refused to agree to the operation or had required a great deal of persuasion and pleading before they would give consent. Many people feel that such control by one individual over another is hardly to be thought desirable, however orthodox it may appear to the legal mind;* and it is frequently criticized by health and social workers who are thus prevented from giving a constructive service to mentally or physically handicapped clients.

The change in Eugenics Board procedures most often called for by administrators was in the direction of quicker action on petitions and provision to deal with emergency cases, as, for instance,

*A view taken, among others, by the Brock Committee. C. E. p. 47. 108

when the client is already in the hospital for confinement, agrees to sterilization, but is unlikely to be of the same mind if she has to be discharged and return at some later date for operation when the petition has been approved. One superintendent who writes a thoughtful letter on the matter, suggesting that procedure be simplified and the Board meet more often, goes on to say: "I know that it is necessary to move with proper care in this serious matter of sterilization, but it happens often that the most serious accidents are due to too much slothful caution." Up till recently the Board has met once a month, but at a meeting in February 1948, in response to the opinions expressed in the questionnaire, it was decided that emergency cases could be handled between meetings by a special session with at least three members of the Board present. But even in an emergency, there is constant emphasis that the rights of every individual, including the mentally backward, must be protected.

Another step towards encouraging greater activity is the publication of a sterilization manual, drawn up by the Eugenics Board secretary. This manual is intended for heads of institutions, public health officers, welfare superintendents and case workers, explaining in clear and simple manner exactly what must be done to arrange a eugenic sterilization and the type of case which is covered. With such a guide at hand, it seems probable that in the future some of those difficulties and perplexities which arise from misunderstanding of an admittedly complicated procedure may be considerably lessened.

RELIGIOUS OPPOSITION

In our earlier survey of the religious background of North Carolina we saw that of the State's total population of $3\frac{1}{2}$ million, over a million belonged to the Baptist and Methodist Church and only ten thousand to the Catholic. Such religious opposition to sterilization as is found tends therefore to be based on Biblical sanctions and individual beliefs about sin, rather than on edicts laid down by a priestly hierarchy; and is chiefly evident among the less-educated or the fervent adherents of fundamentalist tradi-

tion. We must not forget that southern attitudes have a strong religious coloring and the outlook of some rural people in many ways is still akin to that of the nineteenth century.

At first sight it seems paradoxical that in this culture, and among individuals of the same social class, sterilization should be both widely accepted and yet condemned; but this is a clear sign of the social ferment which is taking place and the conflict of old and new ideas, eventually to be resolved in new modes of adaptation. Furthermore, the study revealed a great gulf between moral-religious reasoning and actuality; between abstract theorizing and the life experience of those who had been sterilized. It thereby underlined the importance of tolerance and the avoidance of any attempt to enforce particular religious dogma among the community at large.

The time limitation of the study prevented any direct approach to religious leaders for their views (with one exception) and such evidence as we have is largely incidental, being obtained from welfare departments, social workers and doctors, and from sterilized persons themselves. However, it was clear that from a practical point of view, organized Roman Catholic opposition, the greatest hindrance to sterilization in many other States, was negligible. Whatever Catholics individually may believe, in North Carolina their numbers are too small for them to have serious influence on the Legislature, nor can they impede the sterilization program except by individual refusals to co-operate—as for instance in the case of surgeons or certifying physicians—or by denying hospital facilities to sterilization cases. Three county superintendents mentioned this difficulty about getting sterilization done in their area, where no other hospital was available.

From what has already been said, it is plain that the sterilization program in North Carolina is genuinely voluntary and no one is or can be operated on against his or her will. Persuasion and argument are legitimately used, but compulsion never. If only those persons are sterilized who wish to be sterilized, this fact should of itself—if logic and tolerance prevailed—eliminate the organized opposition of religious bodies.

FUNDAMENTALIST BELIEFS

In the South, the Bible is regarded literally by large sections of the community as an accepted guide to life. The fundamentalist religious beliefs, so derived, are productive of considerable opposition to sterilization since anything that appears to be contrary to nature or to Divine law is held morally wrong and against "the Lord's will." Indeed, what might be called "the Lord's will" point of view, with an associated fatalism and clear-cut notions of "right" and "wrong" is common to a large part of the rural population and is especially marked among Negroes for whom religion assumes an intensely personal and emotional character.

The Bible was prominently displayed in many white and Negro homes which were visited, and women who had been sterilized often reported prolonged heart-searchings before they agreed to the operation.

(Mrs. A., age 40, white, former cotton mill operative): At first she wondered if it was right. The Bible doesn't say anything definite about sterilization, but there is the text: "Suffer little children to come unto me and forbid them not." However, she thought the welfare of the children she already had should come first. "I did it for the best."

(Mrs. B., age 38, white, former welfare worker): When sterilization was first proposed, she wondered "if it was right in God's sight. The Bible teaches some things about divorce and sex" and after all, women were put on earth to have children. But she trusted Dr. X., and thought her health and the existing children came first. Her grandmother was "horrified" when she had it done. The old lady (then 86) had had 13 children herself and thought her granddaughter could do the same.

(Mrs. C., age 37, Negro, hosiery mill worker): She says of her operation, necessitated by some uterine damage: "I feel like the Lord was in it." Her destiny was in His hands and everything that happened to her was His will. She prayed all night long before the operation and decided that the Lord meant her to have it. But sterilization is only right under certain conditions, when "it's to save lives. . . . I didn't go in for mine to gain material things of the

world"—like some women she knows. They have it "to get from under havin' children" and have more money and clothes for themselves.

A gynaecologist reports that husbands sometimes object to the sterilization of their wives because "it's not what God intended"; a public health nurse tells of another obstructive husband who quoted her the Biblical injunction "Be fruitful and multiply" adding "the Bible didn't say anything about sterilization." In this case the entire family was "low-grade" mentally and the wife had had five children in four years.

Similar attitudes are reported from the county welfare departments:

Clients needing sterilization are largely of ——— religious faith and are blocked by their beliefs.

Operation resisted because of belief on part of client or her relatives that sterilization is sinful.

Mountain people are very fundamental in their religion and fear they are committing a sin if nature is interfered with.

A certain religious sect that has its following among the less educated and poor offers a very stiff resistance.

The father of a patient released from a mental institution refused to permit sterilization because of religious scruples. She later gave birth to an illegitimate child.

In the case of Ada T. (Appendix D) we have already seen something of the difficulty which such religious convictions present to social workers endeavoring to promote sterilization. The even more curious case of Mary Lou J. gives insight on local color and the social world of the uneducated Negro. (See Appendix D.)

The religious climate of the rural South is a survival of earlier tradition, less common now in other areas of the United States or in contemporary Western Europe. In these circumstances, we should be surprised not so much at the opposition to sterilization but the comparative success which the program has achieved, sug-

gesting that other social forces are coming to have increased influence and new values being substituted for the old.

ETHICAL OBJECTIONS

Objections to sterilization on ethical grounds, as distinct from religious or personal-emotional, were more commonly found among the educated who were never themselves likely to come within the purview of the law. They often appeared to be founded on emotion or on inaccurate knowledge of the actual situation and envisaged dangers to individual or community which—while theoretically possible—have not arisen in North Carolina experience. Arguments center on three main points: that sterilization was used by the Nazis as a measure of race extermination; that sterilization encourages promiscuity and immoral behavior; and as a corollary that venereal disease is more widely spread. A subsidiary argument, though scarcely to be classed as "ethical," is that people of low intelligence will always be needed to perform the unskilled work of society, and total reduction of their numbers is accordingly unwise.

The misuse of sterilization in Hitler Germany to serve Nazi doctrines of "race hygiene," and the later inhuman experiments in castration carried out on victims of concentration camps have done much to set back people's thinking all over the world towards any measure of negative eugenics which involves compulsion or surgical intervention. Those who do not understand the difference between such wholesale and unwarranted application and the conservative safeguards of a democratic law tend to regard voluntary sterilization as the thin end of a wedge, undermining individual rights and eventually perhaps lending itself as an instrument of class or racial persecution. An example of this sort of thinking appears in a speech made in England by Cardinal Griffin, Archbishop of Westminster, in 1947, when he warned doctors against co-operating in the sterilization of the unfit. "I have visited concentration camps in Germany and Poland," he said, "and have seen very clearly where wrong principles can lead. The state has no right whatever even to legalize voluntary sterilization."

It is understandable that Jewish physicians should have strong

feelings on the subject, and one social work administrator reported three such among her acquaintance who would never sign a sterilization petition, however commendable the case. Negroes, another minority group, might conceivably fear that sterilization would be used in the South as an adjunct to doctrines of "white supremacy," but there is no evidence to indicate that North Carolina practice is in any way influenced by racial prejudice. This fear of abuse, however unfounded, is a very real matter, and must be taken into account in all efforts to change people's attitude.

PROMISCUITY AND VENEREAL DISEASE

Due to the lack of follow-up service and general shortage of case workers, none of the institutions or welfare departments could provide any definite information on the subsequent sexual behavior of their discharged sterilized inmates or clients. Opinions were offered, or reference made to an isolated case, but no over-all picture was obtained. At Caswell Training School, for instance, the psychologist said of girls who had left the institution after operation: "I believe they are pretty moral," adding that several had got married; while on the other hand the Superintendent of Dix Hill mental hospital cited a psychotic patient who attempted to become promiscuous at an Army camp after her discharge, having previously remarked to an attendant that since sterilization she had "nothing to worry her." This patient had a promiscuous history before her admission and was sterilized at the insistence of her parents.

A fairly common view on the social results of sterilization of such persons was expressed by the social worker at the State Hospital for Negroes. He said he did not believe that sterilization of patients who have been promiscuous would solve many problems or enable more to be discharged. If they are well enough to leave and can make an adjustment in the community, they can be let go, but the hospital is reluctant to release in such cases unless there is someone to look after them. Furthermore, if you sterilize this type of girl and she knows she can't become pregnant, it is likely to spread V. D. "The men who come in contact with her—it's just what they'd like to hear." Similar apprehensions are voiced in a

letter from a psychiatrist to one of the social agencies about a proposed sterilization for their client, Louise H.

Louise, a white feeble-minded married woman of 17, has two children, one born before marriage, the other not her husband's. She has been involved in prostitution and the children are neglected. The family and relatives are known to relief and welfare agencies and to the Juvenile Court; the husband's family likewise. Louise agreed to sterilization and was sent by the agency to a psychiatric clinic for the necessary examination when she was found to have an I.Q. of 67 and a M.A.* of 10.1. The psychiatrist (a woman) gave the following opinion:

"I do not feel that sterilization on the basis of feeble-mindedness could be recommended in this case. To sterilize her because of the social difficulty she represents in the community does not seem to me the proper solution to the problem because I feel that it would only open the door wide to promiscuity and the spread of venereal diseases. . . . Some program which is more adequate and which will put people such as Louise to work possibly on farms in a close organization might possibly prove to be a more productive solution as far as responsibilities of welfare agencies are concerned and would be more constructive in its relation to war and post-war conditions." (The letter was written in 1942.)

Despite these views, it seems very doubtful that sterilization in itself would act as incitement to promiscuity in the absence of previous unstable tendencies, or that feeble-minded persons of either sex are likely to be restrained by prudential considerations. On this point, Dr. Butler, Superintendent of the Sonoma State Home for the feeble-minded in California, who has had several thousands of sterilizations performed in the institution, writes:¹⁸ "The fear of contracting a venereal disease or bearing children, legitimately or otherwise, has no deterring effect on the mentally deficient." And an investigation made by Popenoe (1927)³¹ on the adjustment of 423 sterilized paroled girls from this same institution found that while one in twelve became sexually delinquent, nine in twelve of the girls had already been sex offenders before commitment. Sterilization is no substitute for the supervision of unstable and defective persons in the community, nor

*Mental age.

is it intended to solve the problems which their behavior may present except insofar as it prevents the birth of children who would be handicapped by heredity and an unfavorable social environment. One welfare superintendent makes a nice comment on its advantages in this respect: "We have had some feeble-minded girls, unmarried, who have been greatly benefitted for the fact that they realize they are very weak sexually and this operation has given them some security in knowing that if they do fall they will not become pregnant."

As moralists view the world, punishment, present or hereafter, should follow a lapse from approved conduct, and, in the sphere of sex, fear of consequences is held important in restraining people from the indulgence of their illicit desires. Whatever we may think of this philosophy, enough evidence has been given to show its inappropriateness where the feeble-minded and psychopathic are concerned and the unlikelihood that either promiscuity or venereal infection can be controlled by fear and ethical admonitions. As a senior health officer said, commenting on V.D. as a public health problem: "You can't locate a disease on moral lines" and this realistic attitude was generally current among health and social workers who had first hand experience of social facts.

An administrator long connected with correctional schools gave his opinion of sterilization as follows: He looks at it in a practical way. There is a lot of theoretical argument against it—infringement of liberty, eugenic grounds never really justified, little large-scale effect and so on; but he feels it is better to make one mistake in sterilization (i.e., selecting an unsuitable individual, whose subsequent behavior might conceivably become more anti-social) than to do nothing at all. "You need to work with problems at their source"—there's no use spending time and effort treating symptoms when you don't try to do something about the underlying cause. "Otherwise people just keep coming along"—the defective and delinquents reappear with every generation. In the training schools he has seen sons, grandsons, and other relatives going through, all of the same family. He realizes of course that many people have been "put off" sterilization by what Hitler did in Germany; but again, you have to be practical. If psychiatrists and

others had the daily experience of social workers in dealing with certain types of cases, they would see sterilization more in perspective.

We can see, however, that the existence of such objections as we have discussed lends support to the Eugenics Board policy in its avoidance of direct propaganda and court proceedings. If much publicity were encountered and sterilization made to seem a compulsory measure, it would be easy for some contentious demagogue to play upon people's emotion with irrelevant and irrational argument and thereby endanger the entire program in the State.

NEGROES AND STERILIZATION: PLANTATION HERITAGE AND PRESENT ATTITUDES

The most distinguishing feature of any southern State is the existence of a large Negro population and the legal and social barriers which maintain it in segregation. Negroes are not assimilated: they live side by side with whites but in a separate social world of their own; and the strength of southern tradition is such that it is very difficult for members of either race, however well-intentioned, to bridge the gulf and gain real understanding of the other's attitude. Divergence is accentuated by an over-all contrast in economic status, educational attainment and general health, factors which in themselves would impede close social contact between groups even where color was not involved. We have already noted (Chapter 1, p. 4) that the North Carolina Negro birth and infant mortality rates, a good index of relative social advancement, are much higher than for whites; the maternal death rate (per 1,000 live births, 1946) is 4.0 as against 1.3 for whites (U. S. average 1.6);⁸⁴ venereal disease is six to seven times more common;* there is almost four times the amount of illiteracy (Chapter 1, p. 6); and the median income of Negro families averages just over one-half of that for whites.¹²⁴ Of the total North Carolina Negro population of 981,298 (1940) only a relatively small

* In North Carolina in 1946, 1,018 cases of primary and secondary syphilis were reported among the white population and 3,556 among the Negro. This gives a rate of .37 per 1,000 for whites and 3.45 for Negroes. See also Spencer B. King, Jr., *Selective Service in North Carolina*, pp. 262-69.⁵⁶

proportion are of middle and upper class status, and the mass of Negro people live under conditions of poverty, neglect, and rural isolation. It is with these farmers and laborers, whose ways of thinking are characteristic of a simpler "folk" society, that this section of our study is concerned.

"The stabled torpor of black sleepers, all the illicit loves, the casual and innumerable adulteries of Niggertown." So Thomas Wolfe, one of North Carolina's greatest writers, saw one aspect of the alien life of Negroes. The sociologist, however, must look for an explanation of deviant marital behavior in other than moral terms and refrain from judgments which are based on the standards of white groups whose historical and cultural environment has been entirely different. It is not so long since Negroes were white men's slaves, subject to direction in almost every detail of their lives, and considered by their masters as inferior beings to whom the ordinary human rights did not apply. Under slavery, family life was disorganized, attachments broken up at a slave-owners' whim or by the husband deserting to seek freedom and work elsewhere. Formal marriages were not customary, illegitimacy carried no social stigma, and the sexual restraints of a Puritan theology were either unknown or meaningless.

Although the plantation system has almost disappeared and Negroes have gradually been accorded a varying measure of education and equality, tradition and custom of former days still influence the behavior of the more ignorant people in the South. We see this in the frequency of common law marriages, whereby the parties declare without legal formality their intention of living together, the casual desertions and separations, the large numbers of illegitimate births, and a general freedom in regard to sex which is psychological as much as social. While this undoubtedly leads to the greater incidence of venereal disease (though we must remember the difficulty of educating such people about the importance of medical treatment), on the credit side it means that sex is more naturally accepted without conflict or repression, and the Negro child is usually welcomed whatever his parentage. Nor are numbers of children a matter for concern since this type of Negro, lacking incentive and opportunity for the achievement

of a higher standard of living, rarely envisages long-term goals and is content to live from day to day, taking whatever comes. "I wished all 14 was living. I enjoy all of them," says a Negro mother of nine, whose other five babies were stillborn or died in infancy. Her husband was crippled, and the entire family existed in four rooms in half of a tumble-down wooden tenement. "The average lower-class Negro always has his doors open for a child or an aged person," says a welfare executive, himself a Negro, commenting on the relative ease with which child placement could be carried out among the colored population. In Appendix D, we cite the account of a Court case brought against an elderly man for the support of his five illegitimate children, and the following story of Cora G., although by no means typical, throws further light on deviant Negro attitudes toward conventional marriage.

Cora, age 23, is a nice-looking Negro girl with four children, only the first being legitimate, and that by her subsequent marriage to the father. Her education ceased at the fourth grade—"I started company early and got in the family way and had to leave"—and she was 14 when the child was born. She married the following year but only lived with her husband for two months as he was very unsatisfactory and later got into trouble for shooting another woman. She is now divorced, lives alone in a poor but spotlessly-kept home, and has various "boy friends" who visit her.

Her present "boy friend" is the father of the two younger children, both boys. The local Health Department arranged for her sterilization (to quote their case record) "because of economic condition and moral reasons," and Cora's only regret with regard to the operation is that her "boy friend" says he wanted a girl and "he might be upset" if he knew she couldn't have any more children. (She had not told him of the nature of the operation.) He sometimes talks about marriage and she thinks "we might in the long run." He too was married before, but had no children of the first union.

Cora answered questions about her sex life in a perfectly natural manner and did not seem in the least embarrassed to discuss her extra-marital relationships or her pre-marital pregnancy. Apparently such a situation in no way outraged the mores of her own group.

Then too there are problems of ignorance, of superstition, belief even in witchcraft, "hexing" and "voodoo." Although these

latter are becoming rare, it was reported by several psychiatrists that such fears occasionally entered into the hallucinations of psychotic Negro patients and must therefore have played some part in their previous normal thinking. Predilection for revivalistic and emotional types of religion is another feature of Negro sub-culture, again historically determined; and makes for uncritical acceptance of existing conditions together with firmly-held ideas about the personal revelation of Divine will. Some of this has already been illustrated in the cases of Ada T. and Mary Lou J. in the Appendix, and the attitude of another fundamentalist preacher and his feminine followers towards sterilization and certain health measures shows the same mixture of ignorance, resistance and religious conviction (Reverend X case, Appendix D).

REACTION TO EUGENIC ENDEAVOR

Since Negroes make up more than a quarter of North Carolina's people, the proponent of social action is here faced with a very different situation to that prevailing in other regions of the United States or in countries such as Britain and Scandinavia where the population is largely homogeneous and levels of education approximate. Among such backward and isolated groups as we have described, no great response can be expected to proposals of a scientific nature which run counter to folkways and experience; nor can individuals easily be brought to see their necessity. This difficulty was stressed many times by the health and social workers whose best efforts with Negro clients were often unavailing, but it was realized that race alone was not the sole determinant. In answer to the question on differing attitudes, one welfare superintendent writes: "Tendency to find more resistance among the uneducated, and more of the Negro clients are uneducated, proportionately. Believe any difference found is basically a matter of educational level rather than one of race." This view was corroborated by other workers ("the Negroes tend to resist more than the whites which may be due to ignorance and superstition which is more prevalent among the Negroes than the whites." "The very ignorant of both races are very suspicious of this type of operation.") and although there were some dissentient

opinions ("Negroes more fearful of surgery and 'doing wrong'." "Negroes think it will ruin their health." "Colored people are more opposed to sterilization than white people."), we note that of the 67 county welfare departments who answered this question, 50 said they had found no difference between the races. But this still leaves unexplained the relatively small number of operations, by population ratio, on Negro women (Table VI, Appendix B).

The eugenic connotations of illegitimacy take on other than the usual meanings in this cultural scene. Where there is widespread disregard among certain classes of Negroes for the sex and marriage conventions of white society, upsetting though this may be to the community, it does not necessarily indicate the same positive association with feeble-mindedness as would be found elsewhere. (We discuss this at greater length in Chapter 6.) The problem here—apart from that of care of children of such unions—is rather that the eugenic effectiveness of the pre-marital health examination is undermined and early discovery of syphilis or other morbid condition made less likely. It was reported from a health department in one city which has a Negro population of approximately 24,000 that 24 percent of all Negro births during 1946 were illegitimate.* At the Negro pre-natal clinic of another city's health department the social worker (a white woman) said that the majority of patients were young unmarried girls and the difficulty was to get them to come soon enough since they tended to hide their pregnancy till the sixth or seventh month. The girls' attitude, according to this informant, is "very matter-of-fact, nonchalant."

So far as could be ascertained, Negroes—educated or otherwise—do not have any feeling that the sterilization program is intended to reduce the numbers of their race or that such motives are present in the minds of white social workers and administrators. Race tension is less acute in the Upper South to which North Carolina belongs where race relations approximate a borderline between North and South. In the Deep South, it is conceivable that the attitude of Negroes to the program there might contain

* See *Annual Report*, Bureau of Vital Statistics, North Carolina State Board of Health, 1946.⁸⁴

more of distrust and hostility. The fifteen sterilized Negro women who were interviewed had all welcomed the operation though in the majority of cases it had been arranged for them by white people; and three Negro social workers stated independently that such resistance as was encountered among clients of their own race could be attributed to ignorance and inertia, present also in relation to many other health measures. The tempo of social change in the South, always leisurely, is even slower in these Negro rural groups.

INDIFFERENCE OF THE MEDICAL PROFESSION

In a previous chapter we surveyed the position of gynaecologists in respect to sterilization, and our concern is now with the general practitioner in the community. Leaving aside those who have religious or ethical scruples against the operation, there is no doubt that doctors generally could do more to promote sterilization than they do. Not only are they better equipped than social workers to explain the physiological side of the procedure, but their personal contact with patients in a family setting enables them to see more of illness in relation to the life situation than is possible to the clinical specialist. Thus strategically placed, one would expect that in cases where further pregnancies were undesirable on mental or physical grounds and successful contraception unlikely, the doctor would advocate sterilization to his patient for her own protection and co-operate where necessary with welfare departments in the legal and financial arrangements. But with a few exceptions, the evidence at our disposal suggests that doctors do not interest themselves in the possibility, and rarely trouble to bring cases of feeble-mindedness among their patients to the notice of the Eugenics Board.

As many of our illustrations have shown, sterilization, if performed at all, is frequently undertaken much too late in a woman's reproductive career to protect either society or her own health, yet the unfavorable condition must often have been known to a doctor at some earlier point. For example, among the series of sterilized women interviewed, Mrs. S., Negro, age 30, in addition to six living children, a seventh dead in infancy, and a miscarriage, had

a record of six stillbirths, five of them in succession. During a number of pregnancies she took sick and had to stay in bed for the final three months, affected with some sort of paralysis. "The doctors didn't know what was wrong"; nevertheless, birth control was not suggested nor was she sterilized until after her fourteenth confinement.

Medical indifference towards sterilization was mentioned not only by social workers but by doctors in the public health service who criticized their colleagues as lacking in social-mindedness. "They aren't interested in a woman's general welfare—they don't see the home conditions" (woman medical officer in charge of contraceptive clinic). "We have difficulties with the doctors—they're hard to move" (senior health officer of city department). "The doctor only sees the patient's disease or clinical condition: he's not much interested in prevention" (public health nursing executive). Complaints from welfare departments about inadequacy of co-operation from local physicians have already been cited (Chapters 3 and 4), and the general impression obtained is that sterilization—and to some extent, contraception—is regarded as a social rather than a medical concern. This refers, of course, to attitudes: the operation itself and assessment of clinical indications are the obvious province of the gynaecologist.

The situation is one which raises the whole question of concepts of medical function. Is the doctor strictly to confine himself to curative aspects, emphasizing diagnosis and treatment, illness and remedy; or is he to look further afield and sponsor preventive action which will provide future benefit both to the individual and to society of which he himself is a part? In the past it has certainly been held that the amelioration of social and economic evil was not the doctor's concern, that patients and their diseases as they appear in clinic or consulting room were the proper object of his energy. This limited view is slowly giving way to one which sees the patient in terms of his total environment, psychological no less than physical or material, and treatment on all three planes as therefore complementary. When doctors are trained in this philosophy of social and preventive medicine, they will be ready to accept wider responsibilities and be less apathetic towards measures for reform.

CURRENT PRACTICAL PROBLEMS

Shortage of Hospital Accommodation and of Surgeons. Operations cannot be performed if hospital beds are not available and surgeons lacking to do the work. This simple statement of fact is sometimes forgotten by disappointed advocates of sterilization, who would blame insufficient use of the measure on the disinterest of the public or of social workers, but it may be more important in affecting statistics than any other circumstance. We have seen that one North Carolina mental institution has been unable to carry out any sterilizations whatever for a period of 18 months since no surgeon could be obtained, and another has been forced to curtail seriously the numbers done owing to an all-over shortage of staff and accommodation. Thirteen county welfare departments specifically mentioned this difficulty as impeding the sterilization program in their area, some of their comments being as follows: "Occasionally we have had to wait a month or two to get a client admitted to the hospital after authorization has been received for sterilization operation." "There is a definite shortage of hospital accommodations—the lack of available beds and the high costs of hospitalization are severe handicaps."

In common with other rural southern States, medical care and hospital facilities in North Carolina are far from adequate for people's need. A State Commission^{73,74} which investigated the situation in 1944 reported that there were 128 general hospitals with 8,745 beds (for a total population of 3½ million), and that an additional 6,000 beds would be required to meet the minimum recommended standard of 4 per 1,000 population. Thirty-four of the counties had no hospital beds whatever. In ratio of physicians to population, North Carolina ranked forty-fifth of all States in the Nation with a pre-war total number (1940) of 2,298, and it was estimated that 1,300 more doctors were needed, most of them in rural areas.^{73,74} When these statistics are further examined by race it will be seen that Negroes suffer even more than whites since in 1944 there were only 1,665 general hospital beds available for a colored population approaching a million; and 129 practicing Negro physicians, or 7,783 people per doctor. Negro patients are

not accepted in the majority of white institutions; and in the few where they are, it is on a segregated and very limited basis. Of the additional 6,000 beds recommended by the Commission, more than a third of them were required for Negroes. White doctors are often used by Negro patients, and in many cases preferred to those of their own race.

In its report the Commission also noted the declining proportion of general physicians practicing in rural areas, and the concentration of specialists, including surgeons, in larger towns and cities where modern hospitals were available. This tendency towards centralization is a general development, by no means peculiar to North Carolina; but in a State where almost three-quarters of the people live in rural areas, its implications are particularly serious. As things are at present, the few surgeons in local hospitals are fully occupied in dealing with emergencies and urgent cases and cannot devote time, or bed space, to sterilizations which are not an imperative procedure. Wartime call-up of doctors accentuated the difficulties of medical care and even now, three years after the war's ending, the shortage thus occasioned has not been made good. It is likely to be one explanation of the decreased number of sterilizations performed under Eugenics Board authority since 1938 (Table V, Appendix B).

Shortage of Case Workers. The understaffing of welfare departments in North Carolina has already been referred to at several points (see especially Chapter 3, pp. 41 and 43). Here too the war depleted the number of trained workers, and in recent years there has been a high turnover of personnel, both circumstances affecting the efficiency of service rendered. Since the preparation of a sterilization petition calls for much time and trouble and a skilled approach to each individual client, it is not surprising that the departments should sometimes have to neglect this activity in favor of others more urgent and quickly completed. "Everyone has so much to do," explained the director of the Public Assistance service. Overwork, insufficient staff, and a harassing array of different duties did seem to be the characteristic situation. In one city the welfare superintendent stated that his regular staff members were attempting to handle a total case load of about 250 each; in another

smaller town (population 17,000) the department only had three case workers to administer every type of program including care of children, the aged, and the blind.

We saw that shortage of staff was cited by 35 counties as the main difficulty in arranging sterilization; and the detailed remarks made by some superintendents show that they realize the procedure needs to be undertaken by trained people if it is to achieve maximum success. "Since August 1945 there have been many changes in our case-work staff. Much of the time we have had no case worker or only a part-time untrained worker" (one petition filed in the year June 1946-47). "Because of shortage of staff we have been unable to arrange for psychiatric examinations and to use persuasive methods of convincing client" (no petitions filed, same period). "This has been a serious problem for several years and still continues. New staff members are being given instructions on the handling of sterilization cases" (two petitions filed). "If we had more staff we would be able to do more intensive case work with our families and perhaps have more clients requesting sterilization" (no petitions). "This [i.e., staff shortage] has been and will continue to be a difficulty in working with sterilization cases because such cases do require so much time for interpretative measures that a case worker seldom feels that she has sufficient time to give to the case when she has so many other pressing jobs to be performed" (two petitions filed). "More time to work with clients and relatives should result in more people willing to be sterilized" (one petition filed).

These comments have been quoted at some length because they reveal what perhaps has hitherto been unconsidered, that the success of voluntary eugenic sterilization depends on a tremendous amount of good case work. Convincing a person of low intelligence and usually little education to have this operation requires endless patience and an understanding from the social worker of feeling as well as fact, of emotional reactions as well as statutory formality. It is not a process which can be carried out routinely, in haste, or by those unskilled in the handling of human relationships.

Allocation of Costs. "The lack of sufficient funds to provide hospitalization and other types of medical care for public assistance

recipients and other needy persons constitutes one of the greatest problems in North Carolina at this time. Most of the counties are unable financially to provide sufficient money for this purpose . . . and several make practically no provision except for emergency situations." Thus we read in the 1944-46 Biennial Report of the State Board of Public Welfare.⁸⁶ Even if increased appropriations have since been authorized, the rising cost of all services leaves the position substantially the same. The North Carolina eugenic sterilization statute in placing the onus of payment for non-institutional operations on the boards of county commissioners (N. C. Public Laws, Chap. 224, Sec. 2) did not direct that any additional State funds be allocated for such purpose, and in consequence each county welfare department must make what arrangements it can in relation to budget and local hospital facilities available.

As the summary of replies (See Appendix C) of the questionnaire analysis shows, there is no general pattern either of costs or the ways in which they are met. Fifty-one counties pay no surgeon's fee, operations being done on a charity basis or by full-time staff in county hospitals; 18 counties reported fees varying from \$15 to \$100, the average figure being \$42.22. Total hospital costs, which might or might not include a surgical fee, averaged \$47.42 among the 31 counties which gave information on this point, but the expense could be as high as \$150, or the entire operation might be obtained free under some special local arrangement. (See Question 5, B 1 in Appendix C.) We may remember that these findings refer only to 85 of the 100 counties in the State since five did not return the questionnaire and 10 had no experience with sterilization cases.

It is plain that a county unfortunately situated in respect to cost of operation would find this a considerable hindrance in carrying out the program. Local commissioners might not view with favor any proposed expenditure for this purpose, or the department's entire funds might be so limited as to prohibit it altogether. Nor could contributions from clients be expected since the majority are indigent; and even if they had an employment record, there is no general compulsory health insurance or State health service (as in Britain) which would cover a worker's hos-

pital and medical care. One superintendent of a city department, enthusiastic about sterilization, told how the expense of operations was a heavy item on his already inadequate budget since the surgeon must be paid a fee of \$50 every time. In an attempt to get more cases put through, he had approached the local medical association who discussed and approved a recommendation that no fee be charged for the sterilization of welfare clients; and since then, five surgeons had agreed to do one operation a month each without charge.

Similar complaints about expense appear among the comments made by 25 other superintendents who found that finance was a principal problem. "Unable to get surgery paid for," says one of them tersely. "Funds inadequate to do as much of this work as is needed," says another. "No money is provided by our county commissioners to take care of the operation." "Our general relief fund is \$10,000 for the year. This does not leave much for sterilization." "County is unwilling to pay costs of operations; usually the people concerned are indigents." "Our chief difficulty is getting the bill paid." "Very small hospitalization fund—usually needed for emergency cases." This impasse presumably was not envisaged when the statute was drafted, but at the present time it is proving an effective brake on eugenic intention. We noted in Chapter 3 that three State institutions, Caswell, Samarcand, and Dobbs Farms, are also limited in the number of sterilizations they can undertake because of difficulty over financial arrangements. Could more men be encouraged to come forward for sterilization, the situation regarding cost would be greatly altered. In the rural health department where many vasectomies had been performed, it was pointed out that this procedure avoided the economic problem of paying for 10 to 14 days hospital care for women and was further approved by the medical staff who needed the beds for more urgent cases.

Even though eugenic sterilization be considered a measure of social welfare and extended largely to those in low-income groups, it is not justifiable to exploit surgeons by expecting them therefore to operate for charity nor to demand of hospitals that they take patients at uneconomic rates. If the State is convinced of the value

of sterilization and concerned to have the program succeed, it should make some provision for meeting legitimate costs which cannot be shouldered by the impoverished local authorities. As we shall suggest in a later chapter, the eventual saving to public funds is likely to be greater than that brought about by immediate economy.

A SUMMING UP

The advocate of sterilization is necessarily interested to discover which of all the many difficulties we have surveyed are products of a specific cultural situation and which are universal. As we have stressed throughout, in a rural area where incomes are low, people scattered and isolated from educational influences, and public services comparatively undeveloped, the application of this or indeed any social reform labors under greater handicap than would be the case elsewhere. With respect to sterilization, in North Carolina the main problems arise from certain features characteristic of the rural South as a whole: the relatively poor economic condition of its people, their ignorance and conservatism, the survival of high fertility, Negro masses with different standards, and the discarded folkways of earlier America still powerful in religion and morality. Then too, the insufficiency of medical services is a problem less acute in wealthier and more urbanized areas.

But other factors appear inherent whatever the social setting. Since the democratic tradition requires the guarding of individual rights and avoidance of compulsion wherever possible, it is inevitable that petition procedure should remain a complex and well-considered matter, though minor improvements can be made without the sacrifice of principle. Men everywhere are going to take the same resistant attitude to proposals for operation on themselves. (We saw that psychic fears were general, not related to education, residence or social class.) Religious and ethical opposition may also be expected, varying according to predominance of particular beliefs and to some extent of education (by which is meant an understanding of social facts and their influence on behavior). Doctors have usually tended to conservatism in such borderline medico-sociological matters as contraception and

therapeutic abortion, and their stand in relation to sterilization is likely to be similar. (That there will be individual exceptions we do not doubt.)

One general conclusion to be drawn from this survey of North Carolina experience is that the successful application of a voluntary sterilization program, in any area, requires a skilled case-work service and satisfactory medical and financial arrangements. However excellent a law and well-intentioned its administrators, it cannot function effectively if such practical foundation is neglected.