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Selected Montana laws discrepancies and possible effects on population growth

Charlotte Kilburn Easter

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SELECTED MONTANA LAWS, DISCREPANCIES, AND
POSSIBLE EFFECTS ON POPULATION GROWTH

By

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ABSTRACT

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The purpose of the study was threefold: to establish that there is a population problem, to scrutinize the primary group of Montana laws that affects population growth in order to determine whether there were any discrepancies when compared with the United States Supreme Court decisions, and to ascertain the possible effects of these laws on population growth in Montana.

In order to accomplish these goals, a thorough perusal of the Montana laws that deal with abortion, sterilization and family planning was essential. Also essential were interviews with the directors of pertinent agencies and library research that uncovered illuminating background material.

Certain conclusions were unavoidable. Every community has a population problem when quality of life, pollution problems and urban sprawl are considered. If one accepts the premise that population is a problem, then the Montana laws need changing. There have been five U.S. Supreme Court decisions that negate parts of the very restrictive Montana Abortion Control Act. The Voluntary Sterilization Act is in keeping with the national sentiment but could be improved. The law that affects availability of contraceptives has been superseded by a Supreme Court decision, and the law that delineates the consent of minors to medical and surgical services is not as all-inclusive as it should be.

The directors of the agencies that deal with family planning and abortion, report a recent doubling of caseloads for the State Family Planning Program. This trend indicates a need for these services that must not be neglected.
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I also appreciate very much the ready cooperation of Steven S. Tokarski, Deputy Director of the Law and Population Programme at Tufts University, who sent invaluable material, and the generosity of Ann German, a 1976 graduate of the Law School at the University of Montana, who let me use her researched data.
PREFACE

Because population is considered by many to be the focal point of environmental problems and because law directly affects people's lives, even in as personal an area as procreation, it seemed that a study of Montana laws that are related to population growth would be productive.

According to Luke T. Lee, an authority on the study of law and population growth, there has been little research done in the area. In 1965, there was only one lawyer at the United Nations World Population Conference in Belgrade. In a recent communication, the Deputy Director of the Law and Population Programme at Tufts University noted that to date very few people are involved in the research.

In order to facilitate a uniform consideration of the laws, Morris L. Cohen, Librarian and Professor of Law at Harvard Law School and Consultant to the Law and Population Programme, devised a classification plan to code all the laws that affected population growth. Since it seemed more productive to gear my research to a larger program, I decided to use this code for the Montana laws that I considered.

When Luke T. Lee did his research on the international situation, he found that certain laws had a very
marked effect on population. Three of these groups of laws were those concerned with abortion, sterilization, family planning and the use of contraceptives, which necessarily included human rights. I have considered these laws in the Montana setting.

Each section will include some background material, a consideration of the Montana law and its discrepancies, the possible effects on population, and the law coded according to the Programme code.
CHAPTER I

INTRODUCTION: POPULATION CONTROL IS THE PRIMARY ENVIRONMENTAL PROBLEM

A Delineation of Some of the Concerns About Population

"Man is now, whether he likes it or not, and, indeed, whether he knows it or not... the sole agent for the evolutionary process on earth. He is responsible for the future of this planet."¹ He has to make choices that involve the use of atomic power, the fertility of man and the possibility of the rape of the earth's resources.

Kenneth Boulding, the renowned economist, likens the earth to a spaceship that does not have unlimited reservoirs for anything, either for resources or for pollution.² Fossil fuels, which so sustain us, are definitely exhaustible in a few centuries, and will be used even more rapidly if the developing countries emulate the developed countries successfully and soon. He reminds us that the Second Law of Thermodynamics is inescapable, that some energy is always lost in

transfer. This idea that production and consumption are possible evils is a new and radical one for economists, as is the idea for the layman that it is necessary to conserve for posterity. There is a great deal of sentiment for "living today and letting tomorrow take care of itself," although Boulding points out that it is a healthier society that identifies itself with posterity and takes care of the present for the sake of the future. He has a presentiment that the "shadow of the future spaceship, indeed, is already falling over our spendthrift merriment."

Garrett Hardin's philosophy of the tragedy of the commons is well-known but should be reiterated because of his theory about population.

A fair defense can be put forward for the view that the world is infinite; or that we do not know that it is not. But in terms of the practical problems that we must face in the next few generations with the foreseeable technology, it is clear that we will greatly increase human misery if we do not, during the immediate future, assume that the world available to the terrestrial human population is finite. "Space" is no escape. A finite world can support only a finite population; therefore population growth must eventually equal zero.

In the basic commons theory each man keeps adding

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3 Ibid., p. 4.
4 Ibid., p. 7.
5 Ibid., p. 8.
6 Hardin, "The Tragedy of the Commons," in Hanks et al., Law and Policy, p. 75.
to his herd because that is a personal gain for him; the loss from overgrazing is shared by all, and so the individual profit accrues until a time when there is so much overgrazing that the whole arrangement falls apart. We can understand the same principle as it applies to pollution; it is cheaper for a man to pollute than it is to install pollution-control equipment. We can understand it as it applies to national parks, where numbers of people may destroy our heritage; as it is applied to the freedom of the seas where it is already apparent that there can be too much harvesting of fish.  

Garrett Hardin also takes exception to the United Nation's Declaration of Human Rights in 1967, to the affirmation that each family should have the right to decide its own size. He does not believe that this freedom of choice will reduce the population by the necessary number. He maintains that every time there is an infringement on the commons, people cry "Rights" and "Freedom." "Individuals locked into the logic of the commons are free only to bring on universal ruin; once they see the necessity of mutual coercion, they become free to pursue other goals." The Ehrlichs define population growth as a "crisis."

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7 Ibid., p. 77.
8 Ibid., p. 79.
9 Ibid., p. 82.
Through the years they have not held out much hope for improved worldwide conditions. The Ehrlichs paint a grim picture of worsening conditions in the undeveloped countries of Biafra, Colombia, in the city of Calcutta, and of worsening conditions in the developed countries, due to famine, due to the pollution that changes the earth's atmosphere, and due to the stockpiling of deadly weapons.10

There has been a constant and continuing debate about whether the production of food will keep up with the growth of population. Some believe that there actually is no problem at all. For example, the British economist, Colin Clark believes that increases in population cause agricultural revolutions, more land being put into use, more effective herbicides, better seeds. He estimates that there are 10.7 billion hectares of "standard land equivalent." The United Nations Food and Agriculture Organization figures that there are 3.4 billion acres in use today.11 (There are 2.471 acres in a hectare.) However, fertilizer is credited for the greatly increased harvest in the United States, not the acquisition of new arable lands. Optimists point to other beneficial developments for agriculture such as improved seeds, herbicides, cloud-seeding, and so forth.


11Hanks et al., Law and Policy, p. 104.
Despite the optimists, the UN Food and Agriculture Organization predicted in 1974 a shortage of 83 million tons of grain for the developed countries in 1985. If the 1972 crop failures recur there is a predicted shortage of 100 million tons. Actually, according to the Population Council Factbook, in 36 of 67 developing countries, with data for periods 1970 to 1972 and from 1972 to 1974, per capita food production was less from 1972 to 1974 than it had been two years earlier. "These findings indicate an increasing dependence on imports, or a deterioration in diets in affected countries." So, because of droughts and floods in 1973 and energy-caused price increases, the anticipated harvest from the "miracle" seeds of rice, corn, and wheat have not developed. The Ehrlichs predict nothing but trouble from these supposedly improved conditions, because of ecological considerations of farmers, the unwise use of herbicides, and of irrigation.

There are other hidden problems such as the need for people in the U.S. to use their land for something besides agriculture. There are conflicts in the dependency relationships that develop between countries when it is necessary to import food and fertilizers. Then there is the problem of

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12 Ibid., p. 105.
14 Ibid.
having to import a great amount of fertilizer. China was agriculturally independent in the 1950s, but in the 1970s the grain output will have to be increased by 50 to 60 million tons and, consequently, 20 to 30 million tons of chemical fertilizer will be needed.\footnote{Hanks et al., Law and Policy, p. 107.}

Paul Ehrlich, ever the pessimist, recommended that no food aid be given to countries where the population situation is hopeless or to those countries who are not trying desperately to balance population and food. He also suggested that we should give massive aid for birth control and that we should supply not only fertilizer but technicians trained in ecology and sociology as well as agronomy. "Extreme political and economic pressure should be brought to bear on any country impeding a solution to the world's most pressing problem."\footnote{Ibid., p. 108; Ehrlich and Ehrlich, Population.}

Dr. N. E. Borlaug, agronomist and recipient of the Nobel Peace Prize in 1970, predicted that the "growth of population will outstrip man's best efforts to continue to increase the food supply." He joined with 21 Nobel prize winners and five presidential advisers to encourage the implementation of more birth control research.\footnote{Hanks et al., Law and Policy, p. 109.}

One of the recent most informative debates, in 1976,
was between Bread for the World and the Environmental Fund and was occasioned by the Fund's paper on "The Real Crisis Behind the Food Crisis." Information from the debate was used by the Subcommittee on International Resources, Food and Energy, of the U.S. House of Representatives.

Bread for the World accused the Environmental Fund of being unethical, non-Christian, and lacking in moral responsibility and realism. Bread for the World maintained that poor countries have lagged behind in food production because of "lack of fertilizer, improved seeds, irrigation, pesticides, storage facilities and transportation--or to lack of basic services, such as credit on fair terms, and other extensive services such as health care." Bread also maintains that our aid is only one-tenth of what it was for Europe during the Marshall Plan, and that we have not committed ourselves to a true global effort. Bread accused the Fund of a very basic selfishness on the part of the "haves" and in not adjusting so as to give the "have-nots" ways to alleviate their hunger situations.

The Fund had several definitive responses to Bread's position:

1. During the peak grain years, 1973 to 1974, the world population could not be fed and since then it has increased by 270 million people. Food production has not kept

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pace with population growth. World per capita consumption of grains fell from 311 kilograms to 274 kilograms from 1974 to 1975. This was a decrease in food consumption even though the total population increased.\(^{19}\) From 1948 to 1952, the poorer countries were exporting cereal grain products. Presently, they are importing 55 million metric tons of cereal grains. The UN's Food and Agricultural Organization predicts that needs will triple by 1985 and that there will be famine.\(^{20}\)

2. Climate is a major factor in food production, and climatologists have warned that the North Atlantic area has experienced the warmest weather for centuries, but that the warm period has ended.\(^{21}\)

3. Another major fallacy is the idea of exporting capital-intensive-energy agricultural methods, methods that are based on petroleum products, into labor-intensive countries. Because the population is six times larger than it was in 1900, and because of the importance of capital-intensive methods, the Sahara Desert is not only expanding southward but also northward, due to overgrazing, extension of grain farming, firewood gathering. "Populations are outgrowing the biological systems that sustain their life styles."\(^{22}\)

\(^{19}\)Ibid., p. 3.
\(^{20}\)Ibid., p. 4.
\(^{21}\)Ibid.
\(^{22}\)Ibid.
In the Sudan there is a gradual shifting of vegetational zones toward the south, with an ever increasing loss of forest and widening the desert. Desert creeps into the steppe, while steppe loses ground to desert; it creeps into the neighboring savannah, which in turn creeps into the forest.\textsuperscript{23}

The rise in human numbers is the immediate catalyst of deteriorating food production systems.\textsuperscript{24}

Irrigation can cause increased salinity in the soil. Pakistan lost two million hectares of fertile land because of salinity. Dams are built without regard to the amount of siltation from forestry and agricultural practices upstream. Wells are drilled for an increased water supply, which increases herd sizes, which means more pasture is needed than can be supplied. Peasants cut down and pull up newly planted trees for food for their herds. Pesticides and fertilizers kill fish and poison waterways. Miracle seeds need water, pesticides and fertilizer to do well.\textsuperscript{25} Despite these problems, farmers in the developing countries have increased food production in Asia by 350 percent, in Africa by 250 percent, in Latin America by 250 percent, but hunger is still rampant.\textsuperscript{26}

The Bread advocates believe that it is the responsibility of the developed countries to help the developing

\textsuperscript{23} Ibid., p. 5.
\textsuperscript{24} Ibid.
\textsuperscript{25} Ibid.
\textsuperscript{26} Ibid.
countries no matter what their population policy is. The Fund believes that it is really a particular country's responsibility to feed its people and, consequently, to take an interest in limiting the number of its people. The Fund maintains that mankind has a duty to limit its numbers, so that finite resources can be used wisely.

The total possible food assistance from the U.S. is only 6 percent of the total grain production of the world. This amount would be used by the projected increase in population in less than three years.  

With finite resources, an exponentially increasing population means an exponentially decreasing amount of resources per person. It is not logically possible to reconcile this mathematical fact with the current wave of worldwide "rising expectations" and clamor for a "new economic order" which will bring affluence to all. Put in a different way this can be extended to the statement that there are no "have not" nations, only overpopulated nations. We often think of India as a poor nation, but if the resources of India were divided among 100 million instead of 600 million people, would not Indians be six times as affluent on the average? As the world population grows exponentially, will we rapidly become a "have-not" world?  

In 1972, the Commission on Population Growth and the American Future issued its report. One of the Commission's prime points was that every country has a population problem, trying to balance "size, growth, and distribution of the quality of life to which all aspire."  

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27Ibid., p. 6.
28Ibid.
29Hanks et al., Law and Policy, p. 94.
defined the population problem in several ways: lack of fulfillment of dreams, spreading out of population and consequent deterioration of the environment, concentration in metropolitan areas, irreversible inroads on natural resources by increasing numbers of people who always expect a better way of life and pro-natalist pressures from outmoded traditions.\(^{30}\)

Statistically, the Commission pointed out that one extra child per family would equal 51 million more people during the next three decades.\(^{31}\)

Some Attempts to Alleviate the Pressures by Legal and Other Means

Edgar Chasteen believes that the only way to control runaway population growth is to establish compulsory birth control, to allow people to have only the number of children that society establishes as an acceptable number. He castigates Planned Parenthood by calling it a "service-program designed to provide contraceptive assistance to individuals in order to further whatever personal goals they have."\(^{32}\)

Harriet Pilpel, International Advisory Committee on Population and Law, disagrees with Chasteen and argues that if all pro-natalist laws were removed from the United States national and state codes, there would be absolutely no need

\(^{30}\)Ibid.

\(^{31}\)Ibid., p. 96.

to consider involuntary population control. The pronatalist laws that she stresses are those that restrict abortion, prohibit mailing or shipment in interstate commerce of unsolicited advertisements for contraceptives and of unsolicited contraceptives, laws that prohibit display and advertisement of contraceptives, the unavailability of Medicaid for sterilization, and practices that restrict voluntary sterilization. She believes that these pronatalist laws should be presented to the people in referendum form and that, if the people were informed and knew of these laws, they would want them repealed. The State of Washington repealed its anti-abortion law by a vote of 56 percent.

If we identify the laws, publicize them, show that we don't want them, and show that their repeal has a substantial downward impact on our population growth rate, we will most probably end up with exhortations to get rid of them--It is to me incredible that, at a time when some are talking about compelling and coercing people not to have children, they are not mentioning the fact that many people in this country are being compelled and coerced to have children they don't want.

Pilpel cites the fact that in New York 169,000 abortions were

34 Ibid., p. 80.
35 Ibid.
36 Ibid.
performed in the year after the repeal of the law and that in Japan the population growth was halved in the decade after the practice of abortion was adopted.\textsuperscript{37}

There have been other suggestions for controlling population growth and these are known as "Beyond Family Planning." Some of these suggestions include involuntary controls, such as putting some contraceptive device into the water system, or requiring each girl to have a time capsule implanted that could be removed only with governmental permission. These controls would be difficult to activate because many developing countries are without any central systems, either technical (such as water), or administrative. Again, involuntary controls would run counter to religious and ethnic standards.\textsuperscript{38}

Beyond Family Planning suggestions often include educational campaigns by schools and television. There are incentive programs, both "positive" and "negative." Payments for the use of contraceptives and for periods of not having children are "positive." "Negative" incentives are forms of punishment, such as taxes on births or withdrawal of family allowances.

There are suggested broad changes in fundamental institutional arrangements that could have the effect of

\textsuperscript{37}Ibid.

lowering fertility, such as the minimum age of marriage, bonuses for delayed marriages, the encouragement or requirement of females in the labor force.

There are approaches through political channels. The U. S. could withhold food unless population is controlled. A new international agency could be formed for the extension of family planning throughout the world.

Many factors make the adoption of widespread population control difficult. Many theories and ideas sound good but are impractical. Developing countries have many programs and problems to consider—agriculture, industry, education, military, health, communication. There also has to be widespread public acceptance of the need for population control. This realization has been developing slowly and, slowly, more is being attempted. Family planning is being tried by many countries. Government is unlikely to push something that is politically unpopular, unwanted, and unattractive. 39 No single effort is feasible; there has to be a combination of efforts—medical, economic, legal, and social. 40

However, the Population Council Factbook of 1976 reported that governmental anti-natalist policies were adopted in the Singapore and Taiwan programs. In Taiwan,  

39Ibid., p. 4.  
40Ibid., p. 12.
the government decreased the subsistence allowance if govern­mental employees had more than two children, and thereby helped establish the promotion of the two-child family as the norm. The government also publicized the advantages of sterilization.\textsuperscript{41}

Singapore managed to reach its goal of 2.1 total fertility rate in 1975 and in order to maintain this rate it has instituted the following measures:

Social policies related to family and population planning include the following: income tax relief for the first three children only; reduction in paid maternity leave from three to two deliveries; an increase in delivery charges with increasing birth order (the fee is waived if either spouse accepts sterilization within one month of delivery); no priority to large families in subsidized housing; and lower priority in admission to primary school for children of fourth or higher birth order, unless one parent is sterilized with the birth of the fourth child and no fifth is born. Sterilization and abortion are available upon request if performed by a registered physician.\textsuperscript{42}

In 1968, the United Nations Conference on Human Rights in the Teheran Proclamation adopted the resolution that family planning is a basic human right, as is, also, the availability of the knowledge of contraceptives. The term, human right, means that the states are legally responsible and should consider the possible elimination of some old laws and the adoption of new ones. There are many laws

\textsuperscript{41}Population Council Factbook, p. 27.
\textsuperscript{42}Ibid.
that negate each other or that offer pro-natalist inducements, or that are difficult or impossible to enforce. Some laws have "hidden" effects on fertility. The whole area of individual's rights versus society's rights should be considered. It would seem to be essential that those people who are interested in family planning would have to study the laws with the intention of revamping them. 43

CHAPTER II

ABORTION: A CONSIDERATION OF SOME
OF THE LEGAL ASPECTS

Background Material

According to the Ehrlichs, abortion, the explosion of a fetus from the womb before it is viable, is the commonest form of birth control in the world. One million women per year in the United States and millions in the rest of the world have chosen abortion in spite of the often grave danger, the disapproval, and the illegality.\(^1\) In the United States, 45 percent of maternal deaths have been due to botched abortions.\(^2\) Nearly all of the United States, Latin America, Asia, and southern and western Europe have had very restrictive laws. Often abortion was allowed only when the mother's life was in danger. Even in the most liberal countries, such as Japan and Hungary, where, in 1970, abortions exceeded births, women have had to apply for and receive permission to have the operations.\(^3\)

Abortion was not disapproved until the Judeo-

\(^2\)Ibid., p. 222.
\(^3\)Ibid.
Christian ethic became established; it was not made illegal until the nineteenth century when so many women were dying from the butchery. 4

The Roman Catholic belief is simple, straightforward and unrelenting. Each human, including the embryo right after the union of the egg and the sperm, has received its right to life from God. 5 Any direct interference is a crime against God and nature. Any human being, including the embryo, which dies unbaptized is incapable of being rescued from sin. The life of the baby is more important than the life of the mother. It is all for the sake of the higher spiritual order. 6

Many of the Protestants believe that the birth of an unwanted child is a worse crime than abortion. They believe that the mother is a complete human being with responsibilities and that the embryo is human only in a biological sense, not in an intellectual or ethical sense. 7

The biological concept is that the fetus is only a potential human being, that it will not develop fully even after birth unless it has the proper care. 8

4 Ibid.
5 Ibid., p. 224.
7 Ehrlich and Ehrlich, Population, p. 224.
8 Ibid.
Gradually, the philosophy developed that families should be able to make their own decisions for a particular family's welfare, and laws with new concepts were passed. The British Abortion Act of 1967 held that abortion was acceptable if "immediately necessary to save the life of or prevent grave permanent injury to the physical health or mental well being of the pregnant woman." The American Model Penal Code recommended abortion by a licensed physician if,

... he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave mental or physical defect, or that the pregnancy resulted from rape, incest, or other felonious intercourse. All illicit intercourse with a girl below the age of sixteen shall be deemed felonious for purposes of this subsection.  

In 1970, the state of New York passed a very liberal law requiring only the agreement between the woman and her physician. Abortion on demand was legalized for women who were less than twenty-four weeks pregnant.

In the USSR, abortion was legalized at the time of the Revolution and remained legal until 1936. It was then allowed only for eugenic reasons (a defective fetus). Abortion was legalized again in 1955, but with the qualification

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9 Friedman, Changing Society, p. 265.
10 Hanks et al., Law and Policy, p. 146.
11 Ibid., p. 123.
that the operation be performed in a hospital by a knowledgeable person.\textsuperscript{12}

In Japan, abortion was legalized as early as 1948 for medical, economic and eugenic reasons. In 1954, there were one million abortions. Japan's population problems are obvious because of the limited size of the country and because the leaders no longer consider conquest as a means of spreading out.\textsuperscript{13}

In between the restrictive Roman Catholic position and the very liberal positions of New York, Japan and Russia, there are varying degrees of legalization of abortion for several different reasons: medical, eugenic and social. Professor Friedman believes that there are several areas of concern where there should be no question of performing abortions: a defective fetus (no reason to add to the social burden), for humanitarian reasons (such as a result of rape), or when several qualified people decide that a birth will endanger the particular family welfare. He believes that the "social reality of illegal abortion must be eliminated."\textsuperscript{14}

The Supreme Court Decision and Some Results of the Decision

On January 22, 1973, by a 7 to 2 vote, the U. S.

\textsuperscript{12} Friedman, Changing Society, p. 267.

\textsuperscript{13} Ibid.

\textsuperscript{14} Ibid.
Supreme Court struck down the abortion laws in Texas and Georgia and also limited any state's right to prohibit abortion. The decision was based on the right to privacy as protected by the 14th Amendment and also established that the "due process clause does not include the unborn." In short, the decision covered the following points:

1. During the first three months of pregnancy, the decision to abort rests solely with the woman and her doctor.

2. During the second three months, the State can regulate abortion procedures to protect maternal health.

3. During the third three months, when the fetus is viable, the State can regulate or even prohibit abortion except when it is necessary for the mother's mental or physical health.

Thus, the Court decided that if a state wanted to protect its interest in the potentiality of human life and wanted to pass an abortion law, it could do so only to apply to the last three months of a pregnancy and then only if the mother's mental and physical health were not endangered.

Legalized abortion has some obviously positive results. In the first place, there is a marked decrease in the

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16 Ibid., p. 44.

17 Ibid.

18 Ibid.
number of deaths that are caused by botched illegal operations. In the second place, there is a termination of unwanted pregnancies that would not have been possible otherwise. Some of these latter may have been simply timing failures, but even in these cases the birthrate may be lowered because a woman's desire for a larger family decreases with postponement and with age, as does fertility.19

After the Supreme Court decision of 1973, legal abortions reached an estimated figure of 700,000 in 1973.20 In 1968, the figure was about 25,000.21 The figures indicate that legal abortions are decreasing the birthrate.22 In California, in 1964, the number of live births was 374,000; in 1973, it was 300,000.23 In New York City, after abortion was legalized in July of 1970, 402,000 legal abortions were performed in two years.24 Two-thirds of these were nonresidents, but of the residents, approximately one out of three pregnancies were aborted. Many people who have legal abortions would not consider having illegal abortions. As a result, the illegitimate birthrate declined. There was also

20 "Supreme Court on Abortion Laws," pp. 43-44.
21 Ibid.
22 Ibid.
23 Ibid.
24 Hanks et al., Law and Policy, p. 124.
a marked effect on the birthrate in New York City. It declined 23 percent, which was three times the national average. One of the authorities estimated that 50 percent of this decline was due to legalized abortion.\textsuperscript{25}

As a result of a very strong, vocal minority group, there have been many constitutional amendments proposed to prohibit abortions or to return the legal authority to the states. One law that was passed by Congress forbids Legal Services to help women obtain abortions.\textsuperscript{26} By the end of 1973, many states had passed abortion laws tightening the procedures. Twenty-eight states have passed "conscience clauses," which establish that no person or institution can be compelled to perform an abortion. For example, the directors of a hospital can disallow abortions on their premises for moral or religious reasons. Originally, this "conscience clause" amendment was introduced by Senator Church and passed by Congress. Pressure has been brought to bear by several state legislatures that have delivered petitions to Congress urging passage of anti-abortion laws.

In Louisiana, North Dakota and Mississippi, the anti-abortionists have been successful in restricting abortions to less than 5 per 1000 women. Some state laws require the father's consent for the operation. It is often impossible

\textsuperscript{25}Ibid.

\textsuperscript{26}Peter Strenfels, "Ethics and Fetal Research," Commonweal, May 6, 1976, p. 112.
to obtain.27 (In July 1976, the Supreme Court ruled that it was unconstitutional to require that a woman's husband consent to the abortion.)28 "Conscience clauses" have made abortions unobtainable for many. These "conscience clauses" can be challenged in the courts, especially where the hospitals are supported by public money, but each case has to be decided separately, which is a long and costly process.29

The Montana Abortion Control Act Compared with the Supreme Court Decision

It should be noted that a state law, even though contradictory to a U. S. Supreme Court decision, stands until challenged in the courts. The laws of each state have to be considered state by state. However, an attorney general with integrity will not allow a state's laws to stand which are contradictory to the Supreme Court's ruling.

In the Roe v. Wade decision [93 S. Ct. 705 (1973)], the Court ruled that:

A state criminal abortion statute of the current Texas type that excepts from criminality only a life-saving procedure on behalf of the mother, without regard to pregnancy state and without recognition of the other interests involved, is violative of the Due Process Clause of the Fourteenth Amendment.30

28Ibid., July 12, 1976, p. 15.
Montana State Attorney General Robert Woodahl apparently overlooked this ruling.31 "Woodahl's opinion implies that the Court found a right of privacy broad enough to encompass the abortion decision, but not broad enough to prevent the state from punishing a woman who acted on the decision."32 He submitted a bill of his own to the Legislature which was added as amendments to a House bill that had been passed. The House bill had been "substantially in conformity with Roe v. Wade guidelines."33 The whole bill passed the Senate with further amendments, but was never able to gain conference committee acceptance. In his bill, Woodahl had emphasized the state interest in preserving potential life which was contradictory to the spirit of Roe v. Wade. He had included a "conscience clause," and also a severability clause which held valid all those parts not specifically invalid.34

In April 1973, Mary Doe, who was six or seven weeks pregnant, filed suit alleging that the Revised Codes of Montana, 1947, Sections 94-101 and 94-402, governing abortions, were federally unconstitutional and sought an injunction against their enforcement by Woodahl and Missoula County

31 Ibid., p. 109.
32 Ibid., p. 110.
33 Ibid., pp. 111-112.
34 Ibid., p. 110.
Attorney Robert Deschamps. On May 2, 1973, the United States District Court for the District of Montana found them unconstitutional as applying to any abortions that may be performed during the first trimester of pregnancy and issued a restraining order to prevent the defendants from enforcing the statutes against Mary Doe or her physician. On May 29, 1973, the Court declared the Montana criminal abortion statutes unconstitutional and gave the following message to the Montana Legislature:

I have considered whether this Federal Court should abstain from granting relief beyond that given in the temporary restraining order and have concluded that in the public interest any doubt about the invalidity of the Montana abortion law should be removed. The official position of the State of Montana is that the laws will be presumed to be constitutional until a court of competent jurisdiction rules to the contrary. This position shadows the constitutional rights of women as delineated in Roe v. Wade, supra, and confuses the members of the medical profession who may be called upon to perform abortions. By this order, the Montana Legislature is advised that the interests of the state in the unborn may be asserted only in a law tailored to conform to the guidelines established in Roe v. Wade, supra.35

Intent and Purpose

Consequently, the Legislature passed a law called the Montana Abortion Control Act, that seems to be fairly limiting in several ways.36 The very intent and purpose

36See the Montana Abortion Control Act reproduced at the end of this chapter.
of the Act seem contradictory to the scope of the Supreme Court's position in *Roe v. Wade*. The Act itself is in the Criminal Code under Offenses Against the Family. The intent of the Act is to restrict abortion to the extent permissible. The purpose of the Act is to protect every human life, whether unborn, aged, healthy, or sick. This purpose is not restricted to the last trimester, which was so designated by the Supreme Court.

Consents

When Justice Blackmun delivered the Court's opinion in *Roe v. Wade*, he indicated that the trimesters have different types of importance. During the first trimester, it is less dangerous to the pregnant woman to have an abortion than to deliver in normal childbirth, and the decision should rest solely with the woman and her doctor. In the Montana Act, the consents to abortion and the detailed recordkeeping that is required are more restrictive than Justice Blackmun intended. In his opinion, concerning the first trimester,

\[\ldots\] the attending physician, in consultation with his patient without regulation by the State, can determine whether the pregnancy should be terminated. The judgment may be effectuated by an abortion free of interference by the state.\[37\]

Second Trimester Health Regulation

decision established that the state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of this type of state regulation are requirements as to the qualification of the person who is to perform the operation, as to the licensing of that person, as to the facility—whether it is a hospital or clinic—and the licensing of that facility.  \(^{38}\)

Concurrent Opinions of Additional Physicians

After viability, usually the third trimester, the state has the right, established by *Roe v. Wade*, to protect the life of the fetus and may prohibit abortion except when necessary to save the life and health of the mother; but it should not have the right to require written opinions from two doctors other than the woman's doctor. According to the decision of the U.S. Supreme Court *Doe v. Bolton*, \(^{39}\) any doctor is licensed by the state to perform according to the best of his ability and in no other case of surgery is a doctor required to have other opinions. He may have them if he deems them to be necessary, but they are not required in the profession. \(^{40}\) The Montana Act requires written concurrent opinions from two licensed physicians, after viability. \(^{41}\)

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\(^{38}\)Ibid.

\(^{39}\)Ibid., p. 132.

\(^{40}\)Ibid., p. 136.

\(^{41}\)Montana Abortion Control Act, Sec. 131.5.
Conscience Clause

In the case of Hathaway v. Worcester City Hospital, the decision of the U.S. Court of Appeals, First Circuit 1973, found that after a state had undertaken to provide general short-term hospital care, it could not be selective about the particular cases that, in procedure, were no different from other surgeries that were routinely performed. Such selectivity infringed on individual rights. The Montana Act establishes that a hospital does not have to perform an abortion on religious or moral grounds and that all persons shall have the right to refuse to take part. Subsequent to the Worcester decision, can the Montana Act apply to public hospitals?

Notice to Husband

In November of 1976, in Montana, a three-judge federal district court (in the case of Doe v. Deschamps), declared unconstitutional the part of the Act that required a written notification be sent to the husband. However, it was struck down because of its wording and not because of its purpose; it does not specify a conclusive and incontrovertible method of giving notice. Nevertheless, in July

42Hanks et al., Law and Policy, p. 141.
43Ibid.
44Montana Abortion Control Act, Sec. 131.6.
1976, the Supreme Court had ruled that it was unconstitutional to require that a woman's husband consent to the abortion. The ruling was based on the philosophy that the woman should have the right to terminate the pregnancy because she was more immediately and directly affected, that the husband could not have that right since the state did not have the right.

"Mature Minors"

At this time, the Supreme Court also decided that a state could not impose a "blanket" restriction requiring women under 18 to obtain parental permission for an abortion. The Court stipulated that the states might be able to enact laws requiring parental consent if the laws exempted "mature minors." It would seem that this decision would apply to Montana's requirement that minors notify parents concerning abortions.

Prohibition of Advertising for Abortions

The same district court ruled that it was unconstitutional to prohibit communication or advertising for the purpose of soliciting or inducing a person to have an abortion. This law would have had the adverse effect of crippling the Family Planning Program and some physicians' policies.

47 Newsweek, July 12, 1976, p. 15.
District Court Decision re Concurrent Medical Advice

These decisions of the same district court on concurrent medical opinions and criminal homicide seem to be questionable and possibly could be appealed. This court ruled that it was constitutional to require the opinions of two additional physicians before performing an abortion not necessary to save the woman's life in cases where the woman may be carrying a viable fetus. The Missoulian quoted from the decision:

... the will of the woman and her physician are no longer of primary consideration. Medical judgments may vary in this complex area, and the state may properly require more than the opinion of the woman's attending physician to insure that the potentiality of life is not destroyed. 49

The reasoning in the Doe v. Bolton case would seem to negate this judgment. The U.S. Supreme Court ruled in this case that in no other surgical procedure is a doctor required to have other medical opinions.

District Court Ruling on Criminal Homicide

The district court found no objection to the part of the Act that ruled that a person negligently or intentionally causing the death of a viable fetus delivered during an abortion would be criminally liable. "Viable" as defined by the court means the ability of the fetus to live outside of the mother's womb even though with artificial aid. 50 "Negligently"

49 Ibid.
50 Ibid.
as defined by the state criminal code means that a person acts negligently with respect to a result or to a circumstance, described by a statute defining an offense, when he consciously disregards a risk that the result will occur or that the circumstance exists; or if he disregards a risk, of which he should be aware, that the result will occur or that the circumstance exists. The risk must be of such a nature and degree that to disregard it involves a gross deviation from the standard of conduct that a reasonable person would observe in the actor's situation. Gross deviation means a deviation that is considerably greater than lack of ordinary care.

The above provision of the Act, combined with the Edelin conviction of manslaughter in Massachusetts, must have the consequential effect of making physicians very leary of performing late abortions. Dr. Edelin had been convicted of manslaughter in the death of a fetus during a legal abortion. In December of 1976, according to the Missoulian, the Massachusetts Supreme Court found that he had had "no evil frame of mind, was actuated by no criminal purpose, and committed no wanton or reckless act in carrying out the medical procedures on October 3, 1973." Dr. Edelin said, "This decision will relieve physicians in general who worry about sound medical judgments ending up as a criminal case."\(^{51}\)

\(^{51}\)Ibid., December 18, 1976, p. 1.
In July 1976, the U.S. Supreme Court had delivered a decision that might have bearing on this district court opinion. This decision, by a vote of 6 to 3, struck down a State of Missouri ruling that required physicians to use as much care to preserve the life of an aborted fetus as of a fetus intended to be born alive.\textsuperscript{52} This ruling would appear to relieve the physicians of some of the pressure.

The Impact of Abortion

At the present time the abortion situation nationally is in a state of flux. This situation emphasizes the importance of the legal aspects of population policy. Immediately after the Supreme Court decision of 1973, an organization called "The Right To Lifers" was formed. Their goal is to overturn the decision of the U.S. Supreme Court by the adoption of a constitutional amendment that would make abortion illegal. This year seven states passed a resolution calling for a constitutional convention in order to pass an anti-abortion amendment. The total number of states concurring is eleven, including Louisiana, Missouri, Indiana, Minnesota, Massachusetts, Arkansas, Rhode Island, North Dakota, South Dakota, Utah, and New Jersey. Anti-abortion measures are pending in six more states. The only exemption from the ruling that is to be allowed by these states is the abortion that

\textsuperscript{52}Newsweek, July 12, 1976, p. 15.
is necessary to save the life of the mother.\textsuperscript{53}

On June 17, 1977, the House of Representatives passed an affirmative vote that no federal funds could be used to pay for or promote abortions, even to save the life of the mother. The opponents argued that this ruling would cause discrimination against the poor and would involve cases of victims of rape and incest who would be eligible for Medicaid.\textsuperscript{54}

On June 21, 1977, the Supreme Court handed down a ruling that Justice Blackmun, who wrote the 1973 \textit{Roe v. Wade} decision, called "punitive and tragic" for "financially helpless women." This June ruling stipulated that the states have no legal duty to pay for abortions when mothers' lives are not endangered. Also, it ruled that public hospitals cannot be forced to do an operation when mothers are not able to pay for it.\textsuperscript{55}

Said Justice Blackmun, "Implicit in the court's holdings is the condescension that she may go elsewhere for her abortion. I find that disingenuous and alarming, almost reminiscent of 'let them eat cake'."

"This is a sad day for those who regard the Constitution as a force that would serve justice to all evenhandedly

\textsuperscript{53}\textit{The Missoulian}, June 17, 1977, p. 2.
\textsuperscript{54}\textit{Ibid.}, June 18, 1977, p. 1.
and, in so doing, would better the lot for the poorest among us."

There are 300,000 women on welfare who request abortions during the first trimester. Because of this ruling, these women will have to locate free clinics or give birth to unwanted babies. Welfare recipients total almost one-third of the total 1.1 million legal abortions in the United States annually.

This most recent ruling does not prohibit funding by the states, but the future for state funding is not bright. 56

When the impact of the practice of abortion on world population is considered, the Supreme Court does seem to have taken a step backward. The success of the practice of legal abortion in safely reducing the number of births, generally unwanted births, should be sufficient argument for supplying aid where needed.

To quote directly from Kingsley Davis, Department of Demography, University of California at Berkeley:

Induced abortion, for example, is one of the surest means of controlling reproduction, and one that has been proved capable of reducing birth rates rapidly. It seems peculiarly suited to the threshold stage of a population-control program, the stage when conditions of life first made large families disadvantageous. It was the principal factor in the halving of the Japanese birth rate, a major factor in the declines in birth rate of East-European satellite countries after legalization of abortions in the early 1950's, and an

56 Ibid.
important factor in the reduction of fertility in industrializing nations from 1870 to the 1930's. Today, according to Studies in Family Planning, "abortion is probably the foremost method of birth control throughout Latin America."57

(In fact, Japan had such phenomenal success in decreasing the population when abortion was legalized, that that country, in 1971, was considering deemphasizing abortion and switching to contraception. They were concerned about a prospective labor shortage.)58

The Supreme Court decision will probably have an effect on abortion in the state of Montana, although the results would not be known immediately. There were 700 welfare abortions in Montana last year. This is an increase of 10 percent per year. The total number of abortions, according to the Department of Health and Environmental Sciences, was 1803 in 1977.

W. F. Ikard, Chief of the Medical Assistance Bureau of the Department of Social and Rehabilitative Services, said that Montana would continue to pay for its part, which has been 40 percent of the cost of each operation. Federal Medicaid has paid for 60 percent. The officials figure that each abortion costs about $300.00. However, if federal funds were cut off completely, the state officials would have to decide whether to spend this share on this one part of the medical


program. One aspect to be considered would be the consequential decrease of state monies to attract federal matching funds for other purposes.  

Studies in 1975 showed that Montana's abortion rate was about one-half the national average. Nationally, one abortion is performed for every four live births. The Montana figures were 120 abortions for every 1000 live births. It is thought that one reason for the lower figures in Montana is the high cost of abortions, most of which are performed in hospitals. In Missoula, the price is about $225.00. Another reason may be the Montana law that requires notification of parents by the minors. In the state of Washington, no parental consent is required, and the ratio there of abortions to live births is one to three. Many minors may leave Montana and go to Washington for the operation.

An interesting new development, for those concerned with abortion in Montana, was the opening, in February 1977, of a private women's clinic in Missoula. This Blue Mountain Women's Clinic is the only abortion clinic in Montana. It provides the following services: abortion (for the first trimester); contraception (counseling, examination, selection, and prescription); detection of pregnancy (urine testing,

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pelvic examination, counseling); detection of breast or cervical cancer (breast examination, pap smear, and cervical exam). Counseling and referral services are provided. The fee for abortion services is $150.00. The Clinic asks for the written consent of the parents if the patient is under eighteen. If it is not forthcoming, the operation is performed and the notification is sent to the parents to satisfy the legal requirements. The staff has qualified personnel—two doctors and trained nurses.63

Two of the legal requirements that are a real expense to the Clinic are the informational report and the pathology report that have to be sent to the Department of Health and Environmental Sciences. These reports cost the Clinic $12.00 each.64

When Jennifer Thompson, Director of the Clinic, was asked about the repercussions of the recent U.S. Supreme Court decision, she said, "We do about 50 abortions per month, and 10 percent of them are paid for by federal funds. The decision has dealt a severe blow to the reproductive freedom of poor women. If Montana denies funds to poor women for abortions, Montana women will be forced to turn to dangerous self-induced abortions or face unwanted childbearing."

63Blue Mountain Women's Clinic (brochure), Missoula, Montana, 1977.

64Telephone interview with Pat Tucker, Compiler of Statistics, Blue Mountain Women's Clinic, June 27, 1977.
However, in Montana, the decision will probably have no immediate effect because the Legislature will not decide the dispensation of federal funds until the next session in 1979.65

And so in Montana, as elsewhere in the world, abortion is a thorny issue. Although it can be credited with the successful reduction of population, as in Japan, the acceptance of the idea of women being allowed "abortion on request" is met with continual resistance. In Montana, the practice of abortion would probably become more common if the Abortion Control Act were less restrictive in the consents required, in the detailed recordkeeping, in the concurrence of the two physicians, in the "conscience clause" (that has real significance because of the great distance between hospitals), and in the criminal homicide threat.

The Law Coded by the Fletcher Plan

Title 94, Revised Codes of Montana, The Criminal Code of 1973, As Amended through the 44th Legislature in 1975 (94-5-613 to 94-5-624). (The following sequence of Sections was rearranged to comply with the Fletcher Code, as indicated in the Preface).

130. Abortion

The Montana Abortion Control Act

130.2 Restrictions and Prohibitions Generally (94-5-614)

Statement of purpose. The Legislature reaffirms the tradition of the state of Montana to protect every human life, whether unborn or aged, healthy or sick. In keeping with this tradition and in the spirit of our constitution, we reaffirm the intent to extend the protection of the laws of Montana in favor of all human life.

Regulation

131.3 Consent Requirements (94-5-615 and 94-5-616)

"Informed" consent, written statement signed by physician and woman. (Termed "voluntary consent"). Statement to include the following information supplied to woman by physician: (a) stage of development of fetus, methods to be used, and effects of abortion on fetus, (b) physical and psychological effects of abortion, (c) available alternatives to abortion, including childbirth and adoption.

"Consent to abortion": no abortion can be performed without "informed" consent and without a written notice to the husband (unless voluntarily separated from her) or a written notice to parent or guardian if the woman is under 18 and unmarried. The above consents are not required if the licensed physician certifies that the abortion is necessary to preserve the life of the mother. There will be no coercion to have the abortion from any person, executive officer, administrative agency of the State of Montana or any local governmental authority.
131.5 Requirements as to Length of Pregnancy (94-5-618)

No abortion may be performed within the state of Montana after viability of fetus unless necessary to preserve the life or health of the mother. Physician must set forth in detail the medical facts in writing plus written concurrent opinions from two other licensed physicians after an examination. This latter is not necessary if licensed physician certifies that abortion necessary to preserve the life of the mother. Failure to follow this regulation will be considered a felony.

131.6 Regulation of Individuals or Agencies Performing Act (94-5-618)

No abortion may be performed within the state of Montana except by a licensed physician. Felony otherwise.

(94-5-620) Refusal of a facility to participate due to religious or moral tenets or beliefs shall not give rise to liability or any recriminatory action. All persons shall have the right to refuse any participation in abortion.

131.7 Regulation of Place or Circumstance of Performance (94-5-618)

No abortion, after the first three months of pregnancy, shall be performed except in a hospital licensed by the Department of Health and Environmental Sciences. Felony otherwise.

131.8 Procedural Requirements (94-5-619)

Every facility in which an abortion is performed shall keep on file upon a form prescribed by the department a statement dated and certified by the physician including but not limited to prior pregnancies, medical procedure used for abortion, gestational age of fetus, vital signs of fetus after abortion, medical procedure used to protect and preserve life of fetus.

The physician performing the abortion shall cause such pathology studies to be made in connection as the department shall require by regulation and the facility shall keep such reports on file.

Also to be kept on file are the original of all documents: the informed consent, the consent to abortion, the certification of necessity of abortion to preserve the life of the mother.
or health of the mother and certification of necessity of abortion to preserve life of the mother.

The facility to file report within 30 days upon dept. (Department of Health and Environmental Sciences) form with information from the above requirements but not to identify individuals.

The names and identities to be protected but the statistics to be made public annually.

(94-5-621) The Department is to make regulations for comprehensive system of reporting maternal deaths and complications within the state of Montana due to abortions (directly or indirectly).

131.9 Malpractice (94-5-617)

The timing and procedure of abortion must be such that the viability of the fetus is not intentionally or negligently endangered except if necessary to preserve the life or health of the mother. Felony otherwise.

A person commits criminal homicide if he purposely or knowingly or negligently causes the death of a premature infant born alive, if such infant is viable (ability of a fetus to live outside the mother's womb, albeit with artificial aid). A premature infant born alive and viable becomes a dependent and neglected child subject to provisions of state law unless the termination of the pregnancy is necessary to preserve the life of the mother or the mother and/or spouse agree in writing either before or within seventy-two hours of the abortion to accept parental responsibility.

132 Advertising (94-5-618)

It shall be a misdemeanor for any person, physician, facility or agency to engage in solicitation, advertising or other form of communication having the purpose of writing, inducing or attracting any person to come to a facility, physician, or other person or agency to have an abortion or to purchase abortifacients.

133 Official Services

Abortion Counselors and Counseling Services (69-6901 to 69-6908)

This Act to make available to women desiring abortion at least two counseling sessions with qualified counselor:
a. The purpose is to aid the patient in recognizing all alternatives open to her.

b. To encourage patient to express deep feelings.

c. To enhance the mental stability of patient.

d. To encourage the responsible facing of any decision in regard to abortion at the earliest possible stage of pregnancy.

The Division with the mental health Division of the Board of Institutions shall develop criteria and standards of counselors.

The physician or medical facility shall inform the patient and refer the patient to an approved counselor for priority appointment. In case of an unmarried minor a priority appointment shall be made.

Minimum counseling services shall be provided to any pregnant woman interested in terminating pregnancy. The minimum to be one session before the abortion and one after termination.

No abortion is to be contingent on the counseling.

134 Control of Fees and Costs

Division's responsibility to find accessible counselor who will provide services at no cost when patient cannot pay fee.
CHAPTER III

STERILIZATION

Background Material

Opinions about sterilization are changing and have changed in many places throughout the world in order to keep pace with the growth of the human rights philosophy.\(^1\) At the turn of the century in the United States it was thought wicked to use sterilization to avoid childbearing and it was considered exemplary to have large families.\(^2\) The eugenic use of sterilization was much in vogue.\(^3\) Today, in our country, these ideas are reversed.

In 1968, the International Conference on Human Rights adopted the Proclamation of Teheran which stipulates, in paragraph sixteen, that "Parents have a basic human right to determine freely and responsibly the number and spacing of their children."\(^4\) Therefore, not only do

\(^2\)Ibid., p. 353.
parents have a basic right to family planning, but any law which imposes compulsory sterilization on any individual is inconsistent with the principles of the Proclamation. It is interesting to note that the recent political defeat of Indira Gandhi in India was blamed, in part, on her compulsory sterilization program.

There was no doubt about the extent of Mrs. Gandhi's defeat. Much of southern India remained loyal, partly because it had not felt the excesses of her aggressive birth-control program, which often led to forced sterilization.\(^5\)

In February of 1973, the Association for Voluntary Sterilization held an international conference in Geneva and in their legal workshop formulated a model of recommendations that would guarantee people's freedom of choice. The following outline is from that workshop:

I. Generally Applicable

Every individual of either sex has the right to obtain a procedure that will establish voluntary permanent or temporary infertility and the government has an obligation to make available appropriate service, subject to the following:

1. The individual is over the age of local consent and furnishes evidence of his or her voluntary consent.

2. The individual is fully informed by an appropriate person of the immediate and possible and probable long-term consequences of the procedure, and informed of the various methods of family planning. When appropriate, the individual shall also be encouraged to consider carefully over an interval of time the consequences of the different courses of action available.

\(^5\)Newsweek, April 4, 1977, p. 42.
3. If an individual is a member of a particular ethnic, religious, or philosophical group, he or she shall be offered the option of receiving such information as set out in Section Two, above, jointly from the person giving the information and a representative of the group concerned, unless the person giving the information belongs to that group.

II. Applicable to Incompetents

The following shall apply with respect to any person who does not have legal capacity to consent: if the parents or guardian of such a person, and a physician, have decided that temporary measures will be ineffective, they may apply for a procedure to render that person permanently infertile to a Board, duly appointed by the appropriate authority, which may, after full consideration, grant their application.

The Board shall consist of at least five persons, both lay and professional, of both sexes, which shall act by vote.

The Board shall also include a person or persons, representative of the particular ethnic, religious or philosophical group of which the person who is the subject of the application is a member.

III. Performance by Individuals

Nothing in these provisions of law shall compel any individual to participate in a voluntary infertility procedure, but any individual declining to participate shall have the obligation to inform the individual requesting the procedure, of another person or facility which offers such procedures. However, every government-supported facility shall be obliged to make such procedures available.

IV. No Effect on Marriage and Divorce Laws

Nothing in these provisions of law shall be interpreted to modify the laws on marriage or divorce.

V. No Liability for Non-negligent Voluntary Infertility Procedure

No physician or other person or health facility shall be held civilly or criminally liable for proceeding in accordance with the foregoing provisions.  

Those who were at that workshop felt that there were several areas that governments should especially consider when devising their regulations. They should be wary of "informed consent" as it may or may not be correlated with inducements or incentives. Also, a minimum age requirement cannot guarantee "informed consent." There should be adequate counseling. The waiting period, spouse's consent, standards for the operation, and liability of persons involved cannot be overlooked. There was so much disagreement about the "spouse's consent" because of culture and traditions that it was agreed only that governments "should adopt such legislation as may be required to make voluntary sterilization available for contraceptive purposes." Family planning has a connotation of both parents planning the spacing of the children. Some of the representatives believed that if consent was required, one or the other parent would be kept more or less in bondage, probably the woman. Others felt that marital bonds could be dissolved because of lack of consent. Still others maintained that this would only result in destroying the family.  

Although many governments allow voluntary sterilizations, they often have restrictive covenants. The state of Virginia, the city of Singapore, and the country of Denmark have waiting periods after declaration of intent: Virginia  

of thirty days, Singapore of seven days, and Denmark of no more than six months.  

Denmark has a minimum age requirement of eighteen years, Singapore of twenty-one years, and Austria of twenty-five years. Denmark, Singapore and Japan require the spouse's consent on the grounds that family planning is of concern to both parents. Japan even requires consent from "one who, not legally married, possesses marital status with the applicant." Czechoslovakia, Denmark, Singapore, and some U.S. states stipulate that voluntary sterilization operations must take place in government hospitals. A 1941 Panama law allows the operation to be performed on women only. Some countries require a minimum number of children before sterilization; Panama requires five, Czechoslovakia, four (or three if the woman is over thirty-five), three in India, one in Singapore. Denmark and Sweden recognize social and economic hardship as a valid reason. Some countries require an official board to decide on all voluntary sterilizations. In some places, the board decides only on specific cases, e.g., requests from those who are under age.

Some countries--Turkey, Italy, South Vietnam--prohibit voluntary sterilizations and both the person performing

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9 Ibid., p. 108.
10 Ibid.
the operation and the client may be punished by imprisonment or fines or both. In Turkey, sterilization is allowed for eugenic or preventive medical reasons but not for family planning purposes. In Nicaragua, only the person performing the operation is punished, but the punishment is reduced if voluntary consent is given by the patient. There is a similar law in Guatemala.  

In many countries there is confusion about voluntary sterilization because it is not addressed specifically by law. "The laws ostensibly applicable to sterilization are the criminal laws on assault and serious bodily injury, which equate the benign work of a skilled physician on a willing patient under clinical conditions with a brutal criminal assault."  

In France and Belgium, those performing the operation are criminally responsible. The patients "could not authorize anybody to violate on their persons the rules governing the public order."  

As late as 1974, in Austria, non-therapeutic sterilization with consent was a crime. In South Korea, Uruguay, Ethiopia, Greece, and Pakistan consent negates the blame for "bodily injury" or "infringement of legal interest." In Ghana, Nigeria, Tanzania and Zambia, the physician is absolved of blame if

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11 Ibid., p. 109.
12 Ibid., p. 111.
13 Ibid.
he intends benefit to the patient. In other countries, such as the Philippines, Iran and Lebanon, where there is no specific statute, sterilization is not considered a crime.\textsuperscript{14}

Of interest to almost everybody, in connection with sterilization, is the study of eugenics, the improvement of the quality of the race. Around the turn of the century, the genetically-oriented ideas of Sir Francis Galton were well accepted; according to Dunn, his "positive eugenics" was to encourage the procreation of the biologically and socially desirable elements of the population; "negative eugenics" was to rid society of the undesirable elements. Galton's theories correlated well with the laws of heredity propounded by Gregor Mendel. The conclusions substantiated each other.\textsuperscript{15}

In 1922, Harry Laughlin wrote \textit{Eugenical Sterilization in the United States}. This book became the bible for the pro-sterilization advocates. Harry Laughlin was Assistant Director of the Eugenics Record Office of the Carnegie Institution of Washington and of the Eugenics Association of the Court's Psychopathic Laboratory. This latter institution promulgated the belief that "hereditary mental defects lie at the bottom of most fundamental crimes."\textsuperscript{16} Laughlin was also

\textsuperscript{14}Ibid.

\textsuperscript{15}Dunn, "Eugenic Sterilization Statutes," p. 281

expert eugenics agent for the House Committee on Immigration and Naturalization. According to Brown, his book cited the following types as unable to conduct themselves normally in the social order:

... feeble-minded; the insane (psychopaths); criminalistic (to include the delinquent and wayward); epileptic; inebriate (drug habitues); diseased--T.B., syphilitic, leprous, chronic and infectious diseases; blind (seriously impaired vision); deaf (seriously impaired hearing); deformed (also crippled); dependent (orphans, ne'er-do-wells, homeless, tramps, and paupers)... 17

Because of this same reasoning, according to Pitts, Justice Holmes in 1927 rendered the famous, or infamous, decision in the Buck v. Bell case, saying, "Three generations of imbeciles are enough." Buck v. Bell was a case brought by the Superintendent of the State Colony for Epilepsy and the Feeble-Minded, to test Virginia's statute to sterilize mental defectives. Holmes' argument was:

It is the usual last resort of constitution arguments to point out shortcomings of this sort (re: due process of law). But the answer is that the law does all that is needed when it does all that it can, indicates a policy, applies it to all within the lines, and seeks to bring within the lines all similarly situated so far and so fast as its means allow. Of course, as far as these operations enable those who otherwise must be kept confined to be returned to the world, and thus open the asylum to others, the equality aimed at will be more nearly reached. 18

_17_ Ibid.


We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for the lesser sacrifice, often not felt to be such by those concerned, in order to prevent our being swamped by incompetence. It 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 own kind.20

The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. The Supreme Court could not say, as a matter of law, that grounds did not exist to justify the sterilization order.21

A fallacy of Carrie Buck's case is that her daughter was classified as very bright by the staff of the hospital where she died of measles at the age of nine.22

Today, many of the theories of the geneticists are considered fallacious. "Studies indicate that approximately 89% of all feeble-minded children are born to normal parents and often two feeble-minded persons produce a normal child."23 The certainty of finding and eradicating a recessive trait is very questionable.

However, the problem of overpopulation and the burgeoning welfare rolls may encourage the state to realize a

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20Ibid., p. 1067.
21Ibid., p. 1068.
22Ibid., p. 1048.
"compelling state interest." The health and welfare of its citizens and the fact that some children are born to those who are unable to care for them are legitimate state concerns. Many authorities believe that environment as well as heredity affects mental competency and that children should be removed from the home of incompetents.

Improved standards of medical care allow the genetically less fit to survive and to procreate children whose own genetic endowment and potential are socially disfunctional. The social cost of seeking and of achieving the propagation of the unfit will become an increasingly sizeable component of the terrible calculus of economic health care and effort to preserve individual life.

However, since the individual human rights philosophy has precedence worldwide, the following arguments against involuntary sterilization for eugenic or environmental reasons are widely recognized. Involuntary sterilization is an unreasonable deprivation of liberty; it violates substantive and procedural due process of law. It is doubtful that anyone is really qualified to decide who should be sterilized. There is also the fear that involuntary sterilization would be used prematurely and the belief that it is immoral.

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26 Ibid., p. 357.
In 1963, the last year that reports were available, the total compulsory cases (twenty-eight state statutes) equaled only 488.\textsuperscript{29}

Two very recent involuntary cases have been Wyatt \textit{v.} Adherholt in 1973 and Relf \textit{v.} Weinberger, in 1974. In the Wyatt case, the federal district court of three judges overturned an Alabama statute allowing the superintendent of the State institution to sterilize at will. The reason given was "no procedural safeguards," such as advance notice of hearing, recommendation by a board, etc. The Relf case involved the sterilization of two minor sisters without parents' consent. The charge was filed against the Department of Health, Education and Welfare that federal funds had been used for sterilization of minors and other incompetents and that poor people had been coerced into accepting sterilization under threat of losing federal aid.\textsuperscript{30} It was felt that patients receiving Medicaid for childbirth were often victimized. Consequently, the regulations of HEW were rewritten to specify that no federal funds would be withheld for non-sterilization of a legally competent person and that no funds of the Family Planning Program of the Public Health Act or of the Social Security Act would be used for those who were not legally competent, either because of age or lack of

\textsuperscript{29}Brown, "Mr. Justice Holmes," p. 1052.

\textsuperscript{30}Ibid., p. 1056.
An interesting aspect of involuntary sterilization concerns criminals. Thirteen states have passed laws favoring sterilization of certain criminals. The Skinner v. Oklahoma decision casts doubt on the validity of these laws because Chief Justice Stone, even though he agreed with the decision, questioned whether a state could base its sterilization laws solely on eugenic grounds. However, some recent court decisions have upheld the sterilizations if a compelling state interest can be shown.

It should be noted that even in the Skinner case, the decision was not concerned with the constitutionality of punitive sterilization, although the statute held that three convictions by an Oklahoma court or a court in any state of a felony or a crime involving moral turpitude would define the person as an "habitual criminal" and subject the felon to sterilization under the statute. The decision was concerned with discrimination in the statute because the crime of embezzlement was excluded. Justice Douglas said that, "the state may not punish . . . those who have committed intrinsically the same quality of offense. . . . Sterilization of those who have thrice committed grand

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33 Brown, "Mr. Justice Holmes," p. 1058.
larceny, with immunity for those who are embezzlers, is a clear pointed unmistakable discrimination.\textsuperscript{34}

In 1965, in the case of "In re Andrade," the U.S. Supreme Court upheld the decision of the trial court that the petitioner had to be sterilized because he could not support his minor children. Involuntary sterilization was allowed because of a compelling state interest, the necessity for the state to assume care of the children. It is possible to envision that this argument could be applied to anyone receiving welfare for the care of children, such as Aid to Dependent Children.\textsuperscript{35}

In 1973, the American Bar Association recommended to all the states that they remove any legal restrictions that they might have against voluntary sterilization.\textsuperscript{36} Some of the states still have some restrictive covenants, such as spouse's consent, a waiting period, or required place for the operation. Since low-income groups cannot afford an expensive operation, it is thought by some authorities that the public facilities should be made accessible to them, if there are gynecological procedures available at the facilities. This recommendation was not meant to apply to anyone who was mentally or legally incompetent because of age or capacity, to give "informed and

\textsuperscript{34}Ibid., p. 1059.
\textsuperscript{35}Pitts, "Sexual Sterilization," p. 362.
\textsuperscript{36}Pilpel, "Voluntary Sterilization," p. 105.
binding consent" for the operation.\textsuperscript{37}

Most states do not have either statutory or case laws regulating voluntary sterilization, so what regulations there are have been drawn up by such non-governmental agencies as hospitals.

Most hospitals require the written consent of the spouse, plus, in the case of the woman, that she have either conceived or delivered a certain number of children and that they be of a certain age. The operations are also usually not allowed if the couple is experiencing temporary economic difficulties, or where the couple feels they are not yet ready to assume the responsibilities of parenthood; or where the couple anticipates a reversal of the operation in case of remarriage, death of children, or other change of circumstances; or where the potential parents desire sterilization as a convenient and effective method of shirking the responsibilities of parenthood.\textsuperscript{38}

At a time when even religious authorities have changed opinions about sterilization because of the problems of overpopulation and the increasing expense of raising the children, it would seem that the hospitals have so much authority that they make the decisions for the individuals.

\textsuperscript{37}Ibid.

\textsuperscript{38}Pitts, "Sexual Sterilization," p. 363.
As a whole, though, society has come a long way toward accepting sterilization as a tool of family planning. In the future it may be included in the minimum health care of families.\textsuperscript{39} A step in that direction was the decision in the case of Jessin v. the County of Shasta, where the California court found that the county could provide sterilizations for indigents but did not stipulate who should pay for the operation.\textsuperscript{40}

Another important case was that of Clink v. Lavine when the New York Supreme Court, in 1974, decided that the state legislature had intended that sterilization be used as a Family Planning tool.\textsuperscript{41} The health of the wife had become endangered by the birth of numerous children, and the Department of Social Services had refused Medicaid for a vasectomy on the grounds that the husband was not the one whose health had been damaged. The couple was economically eligible for Medicaid. The court declared that if that reasoning was accepted there would be no kidney transplants, skin grafts, etc. This was not the purpose of the law. The law itself stated that medical assistance should include Family Planning Services.\textsuperscript{42}

\begin{flushleft}
\textsuperscript{39}Ibid.  \\
\textsuperscript{40}Ibid., p. 362.  \\
\textsuperscript{41}"M.K.R., In Interest Of," p. 309.  \\
\textsuperscript{42}Ibid., p. 310.
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The Montana Law and Some of Its Discrepancies

With a case like the previous one and with a possible conflict between individual rights and the "compelling state interest," and with the question of that gray area of involuntary sterilization, everything seems to be in a state of flux. Montana, however, is riding high on the crest of individual rights, with no provision for anything but voluntary sterilization.

Up until 1969, when it was repealed, Montana had an Eugenical Sterilization Law, the purpose of which was to "better the physical, mental, neural, or psychic condition of said inmate" or to protect society from the menace of procreation by said inmate. Certificates for sterilization were submitted to the Board of Eugenics by the chief physicians of each institution. The Board had the power of final approval, which could be appealed to the district court of the district where the institution was located. The Board consisted of the chief physician of each custodial unit, the president of the state medical association, a female member named by the medical association and the secretary of the State Board of Health.

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43 Inmate was defined as an idiot, feeble-minded, insane or epileptic person who is treated, trained, or cared for within a custodial institution.

44 Act, Revised Codes of Montana 1947, 38-601 to 38-608.

45 Ibid.
In 1974, the Legislature made only minor changes in the Voluntary Sterilization Act that was adopted in 1969 and that safeguarded the rights of the mentally incompetent. According to one authority, it is the only one in the nation that provides an avenue for the non-institutionalized incompetent to petition for sterilization.\textsuperscript{46}

The Montana statute is unique among the state laws in mandating the personal and voluntary consent of mentally disabled persons to their sterilization.\textsuperscript{47} The method is for the prospective patient to file an application with the Department of Institutions and then meet with the Board of Eugenics. At that meeting it is decided whether the person is able to understand the consequences of the operation. If the person is not capable of understanding, it will be unlawful thereafter to perform the operation.\textsuperscript{48}

According to Mr. Nick Rotering, the Attorney for the Department of Institutions, the last operation for sterilization of a mentally incompetent person was performed in 1972. Last January, the terms of those people on the Board of Eugenics expired, and the Governor has not reappointed anybody. The Board of Eugenics would seem to be in a state of


\textsuperscript{47}Ibid., p. 463.

\textsuperscript{48}The Missoulian, November 28, 1975, p. 3.
limbo. It can be assumed that if someone wanted to be sterilized they could apply to the Department of Institutions and that then a Board would be convened.

There is no Montana law that is concerned with the voluntary sterilizations of competent persons. Vasectomies are performed in doctors' offices; women's operations are performed in the hospitals. However, hospitals' regulations often govern whether or not sterilizations are available. In a decision in the latter part of 1975, Judge Lessley of Bozeman, Montana, decided that a wife could opt, without her husband's consent, for an operation that would make her sterile. The husband's consent was required by the Deaconess Hospital in Bozeman, as it is in many hospitals in Montana. In another case, Taylor v. St. Vincent's Hospital, the right of the hospital to withhold treatment because of religious or moral reasons was upheld. The result of this decision, which is also a part of the federal legislation, is to restrict treatment from the ones who need it most—the poor and needy. This is especially true in Montana where hospitals are so far apart.

Montana might do better to adopt a law that would affect both voluntary and involuntary sterilizations and that would be in keeping with the Model Outline that was a

result of the International Meeting of the Voluntary Sterilization Association in 1973. That plan insured that the individual had the freedom to opt for permanent infertility, but that this decision was safeguarded by dissemination of appropriate information about consequences of the operation and about various family planning methods. There was also a provision for those who were incompetent and did not have the legal capacity to consent. Application could be made by parent or guardian and a physician to a board of lay and professional people who would decide by voting. This provision would satisfy a "compelling state interest" in solving the problem of children born to those who are unable to care for them. The problem of inaction of hospitals and doctors due to religious and moral reasons was solved by making them responsible for informing the individual of other persons or facilities that would provide the services. The overall philosophy of the plan was that it was the government's obligation to see that the service was made available.

The Possible Effect on Population Growth

Although the total number of sterilizations is ever increasing throughout the nation, it is very difficult to ascertain how they have affected a birthrate that has already been decreased by other methods. Since it is the most popular method for couples in which the wife is aged
30 to 44, there is a distinct possibility that couples turn to sterilization after having used other methods and after their families are complete. The only way to discern the full impact of sterilization would be to know how much unwanted fertility was prevented by its use, but in our country, unwanted fertility has already been decreased by the pill and the IUD and, where they fail, by the backup measure of abortion. All of this speculation is not to diminish the importance of sterilization as a permanent and effective means of birth control.

In Montana, there are no public records kept of sterilizations. As has been mentioned, vasectomies are done in doctors' offices and salpingectomyomies are performed in hospitals and the records are kept in these respective places. Dr. John Wilson of the Department of Health and Environmental Sciences said that it would be possible but extremely difficult to get the statistics. However, it is logical to assume that Montana would be following a national trend of the increasing use of sterilization as a means of birth control.

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51 Ibid., p. 125.
The Law Coded by the Fletcher Plan

Title 69, Revised Codes of Montana, As Amended through the 44th Legislature in 1975 (69-6401-6406; 69-5222-23-24). (The sequence of Sections has been rearranged to correspond with the Fletcher Code.)

110. Sterilization

Voluntary Sterilization--State Board of Eugenics

110.1 Inducement and Assistance Generally

No inducement at all.

110.2 Restrictions and Prohibitions Generally (69-6406)

If, upon the hearing, the Board of Eugenics finds that the applicant does not possess the capacity for voluntary consent to sterilization, the Board shall make a certificate setting forth that finding. The original certificate shall be sent to designated physician, a copy shall be sent to applicant or parent or guardian, and one copy to remain in permanent files of the Department of Institutions. After the certificate is filed, it is unlawful, and punishable as a misdemeanor, for any person to perform or assist in the performance of a sterilization of the applicant or to produce or assist directly or indirectly in the procurement of such sterilization on the applicant, and any such person shall be civilly liable for damages for the performance or the procuring directly or indirectly of the performance of eugenical sterilization upon the applicant. However, nothing in this Act shall prohibit a physician, at the request of the applicant, his or her parent, guardian or custodian, from performing a sterilization procedure on the applicant for purely medical as distinguished from eugenical reasons.

111. Regulation of Act

111.3 Regulation of Individuals or Agencies Performing Act (69-5223)

Refusal to participate in sterilization operation
(1) No private hospital or health care facility shall be required contrary to the religious or moral tenets or the stated religious beliefs or moral convictions of such hospital or facility as stated by its governing body or board to admit any person for the purpose of sterilization or to permit the use of its facilities for such purpose. Such refusal shall not give rise to liability of such hospital or health care facility, or any personnel or agent or governing board thereof, to any person for damages allegedly arising from such refusal, nor be the basis for any discriminatory, disciplinary, or other recriminatory action against such hospital or health care facility, or any personnel, agent, or governing board thereof.

(2) All persons shall have the right to refuse to advise concerning, perform, assist, or participate in sterilization operations because of religious beliefs or moral convictions. If requested by any hospital or health care facility, or person desiring sterilization, such refusal shall be in writing signed by the person refusing, but may refer generally to the grounds of "religious and moral convictions." The refusal of any person to advise concerning, perform, assist or participate in sterilization, shall not be a consideration in respect of staff privileges of any hospital or health care facility, nor a basis for any discriminatory, disciplinary, or other recriminatory action against such person, nor shall such person be liable to any person for damages allegedly arising from refusal.

(3) It shall be unlawful to interfere or attempt to interfere with the right of refusal authorized by this section, whether by duress, coercion, or any other means. The person injured thereby shall be entitled to injunctive relief, when appropriate, and shall further be entitled to monetary damages for injuries suffered.

(4) Such refusal by any hospital or health care facility or person shall not be grounds for loss of any privileges or immunities to which the granting of consent may otherwise be a condition precedent, or for the loss of any public benefits.
111.1 **Consent Requirements** (e.g., spouse, parent, outside agency).

**Board of Eugenics:** composition, qualifications, allocation, designation. (82A805)

(1) There is a Board of Eugenics, appointed by the governor and subject to confirmation by the Senate.

(2) The Board consists of seven members and one ex-officio member. The members are:

(a) Two physicians licensed to practice medicine and surgery in this state to be appointed after considering the recommendation of the Montana Medical Association.

(b) One lawyer licensed to practice law in this state to be appointed after considering the recommendation of the Montana Bar Association.

(c) Three lay members.

(d) One psychologist.

(e) The Director of Institutions, who is an ex-officio member of the Board.

(3) The Board is allocated to the Department of Institutions for administrative purposes only.

(4) The Board is designated as a quasi-judicial board, so that it is subject to state qualifications for quasi-judicial boards.

113. **Official Eugenic Program**

113.1 **Mental Incompetents** (69-6401)

The purpose of the Voluntary Sterilization Act is to provide a method through proper hearing whereby certain persons whose sterilization would benefit themselves and the state may voluntarily consent to such sterilization under adequate safeguards protecting them against involuntary or unnecessary sterilization.

The persons to whom this act is applicable are those who under appropriate standards would be diagnosed as capable of consenting to sterilization but whose capacity to consent
has been questioned by a licensed physician, and who, if they should procreate offspring, might be expected either,

(1) to transmit mental deficiencies to such offspring, or

(2) be unable to adequately care for or rear such offspring without the likelihood of adverse effects on such offspring caused by such environment.

Further, the group to which this set applies are those who have the capacity to appreciate and understand the nature of the medical treatment they are to undergo and the consequences thereof and to consent voluntarily to such treatment.

113.1-5 Procedural Requirements (69-6403)

(1) The Department of Institutions shall receive applications by or on behalf of persons covered by this act to be sterilized. Upon receipt of the application, the Board of Eugenics shall conduct a hearing at which the applicant must be present in person for examination by the Board and evidence must be presented to establish:

(a) Whether the applicant is one of the group covered by this Act;

(b) Whether it would be in the best interest of the applicant and the state for the applicant to be sterilized;

(c) Whether evidence by a qualified clinical geneticist or by someone recognized by the Board of Eugenics as having expertise in clinical genetics indicates that sterilization is desirable and beneficial to the applicant;

(d) Whether the applicant, whether or not a minor, is capable of understanding and does understand the nature and consequences of the medical treatment he or she will undergo and with this understanding voluntarily consents thereto;

(e) Whether the medical treatment can be carried out without unreasonable risk to the life and health of the applicant;

(f) The method and manner in which the sterilization is to be accomplished.
has been questioned by a licensed physician, and who, if they should procreate offspring, might be expected either,

(1) to transmit mental deficiencies to such offspring, or

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(c) Whether evidence by a qualified clinical geneticist or by someone recognized by the Board of Eugenics as having expertise in clinical genetics indicates that sterilization is desirable and beneficial to the applicant;

(d) Whether the applicant, whether or not a minor, is capable of understanding and does understand the nature and consequences of the medical treatment he or she will undergo and with this understanding voluntarily consents thereto;

(e) Whether the medical treatment can be carried out without unreasonable risk to the life and health of the applicant;

(f) The method and manner in which the sterilization is to be accomplished.
(2) At the hearing the applicant shall designate the person to perform the sterilization who may be any physician and surgeon licensed to practice medicine in the state. The applicant at the hearing shall sign a written voluntary consent to the sterilization in the form to be provided by the Department of Institutions.

When the Board of Eugenics has established all of the above, a certificate shall be made reciting the findings and signed by all members of the Board. Copies to be sent to the physician, to the permanent files of the Department of Institutions and to the applicant or parent or guardian. Arrangements for the medical treatment shall be made between the physician designated in the certificate and the applicant or parent, guardian or custodian.

113.1-6 Malpractice (69-6405)

Neither the members of the Board of Eugenics, nor any physician and surgeon or assistant concerned, nor any other person participating in the execution of the provisions of this Act in conformity with the Board's certificate is thereafter civilly or criminally liable to anyone for having performed or authorizing the performance of the sterilization. The physician or surgeon or assistant concerned is liable for any damage caused by the negligent performance of the sterilization in accordance with the general law of the state covering such negligence.
CHAPTER IV
FAMILY PLANNING

Background Material

For many years there have been well-known people associated with family planning, people who were not necessarily acting under the auspices of the law. In fact, most of their efforts were directed at changing laws that restricted the free choices of people toward planning the number and spacing of their children.¹ Margaret Sanger, who was born in 1883, was one of these. She was repeatedly arrested, but she continued to disseminate birth control information and, eventually, she founded the American Birth Control League.² Years later, in 1968, her efforts came to some fruition during the Conference on Human Rights in Teheran, when Resolution XVIII, the Human Rights Aspects of Family Planning, the right to adequate education and information on family planning, was adopted.³

The policy of family planning should not be confused with the policy of population planning. Family planning provides for the free choice of couples to decide the size of their families, the spacing of their children. Population planning would be a governmental policy. "It would entail deliberate influence over all attributes of a population, including its age-sex structure, geographical distribution, racial composition, genetic quality, and total size."\(^4\) It could be hoped that family planning, as such, would eventually be for the best welfare of the state and that the "best kind of national population policy would be one that serves the general welfare by promoting informed individual choice."\(^5\)

It has been difficult to gain acceptance of the idea that people should have family planning information and free choice concerning the birth of their children. It was only ten years ago that the Griswold case in Connecticut gained national prominence and cleared the way for new freedoms. On November 2, 1961, the Planned Parenthood Federation Chapter in Connecticut opened a clinic in New Haven. Within a matter of hours, a complaint about obscene literature and consequent breakage of the law was made by a citizen. The police


\(^5\)Ibid., p. 453.
investigated. Estelle T. Griswold, the executive director of the Planned Parenthood Federation in Connecticut and the director of the clinic, and C. Lee Buxton, the medical director of the clinic were arrested, freed on bond, and trial was held on December 8, 1961. The verdict was "guilty of violation of the Connecticut Comstock Law," which was an act passed by the Connecticut Legislature in 1879 to "suppress the trade in and circulation of obscene literature and articles of immoral uses." Both the Appellate Division of the State Courts and the Supreme Court of Errors "affirmed the convictions and held that the law was not an invasion of the right of privacy."

The court adhered to the principle that courts may not interfere with the exercise by a state of the police powers to conserve the public safety and welfare, including health and morals, if the law has a real and substantial relation to the accomplishment of those objects. The legislature is primarily the judge of the regulations required to that end, and its police statutes may be declared unconstitutional only when they are arbitrary or unreasonable attempts to exercise its authority in the public interest.

The Supreme Court of Errors based its decision on the fact that the legislature had not changed the law. In so

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7 Ibid., p. 221.

8 Ibid., p. 239.

9 Ibid., pp. 239-40.
doing, the court abrogated its responsibility. According to Henry Abraham and Leo Hazlewood, Professors of Political Science at the University of Pennsylvania, the Court "passed the buck" by not recognizing a "prolonged deadlock over human rights. The courts have an obligation to resort to interstitial legislation or direct activism and to strike the law." It should have heeded the fact that the legislature was deadlocked over the Comstock Law and that any proposed legislative change in the law had always been stalemated in the State Senate by a very strong Catholic minority. The Court should have recognized a case of basic human rights and should have written exceptions into the law for medical personnel, social workers and for "the prevention of disease."

The case was appealed to the U.S. Supreme Court and the convictions were reversed. The majority opinion was that the Comstock Law invaded the "penumbral" rights of privacy and repose guaranteed under the first, third, fourth, fifth, ninth, and fourteenth amendments and, therefore, it was unenforceable.

It was not until 1972 that the most important case concerning the distribution of contraceptives was heard by the U.S. Supreme Court. This was the case of Eisenstadt v.

\[^{10}\text{Ibid.}, p. 242.\]
\[^{11}\text{Ibid.}, p. 240.\]
Baird. 12 Baird had given a woman a package of vaginal foam at the close of his lecture on contraception. He was subsequently convicted and faced a sentence of five-years imprisonment.

Under the Massachusetts law, only registered physicians and pharmacists, authorized by prescriptions, could disperse contraceptives and then only to certain people. Contraceptives could go to married persons; they were unavailable to single persons to prevent pregnancies; they were available to anyone from anyone to prevent the spread of disease. The Court of Appeals determined that the intent of the statute was not to protect the morals of single persons and the health of everyone, but to limit the use of contraceptives. This limitation was denounced as an unconstitutional infringement on the rights of single persons under the Equal Protection Clause of the Fourteenth Amendment. 13

The U.S. Supreme Court delivered the following opinion:

If under Griswold the distribution of contraceptives to married persons cannot be prohibited, a ban on distribution to unmarried persons would be equally impermissible. . . . If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so

12Hanks et al., Law and Policy, p. 150.
13Ibid., p. 151.
fundamentally affecting a person as the decision whether to bear or beget a child . . . the State could not, consistently with the Equal Protection Clause, outlaw distribution to unmarried but not to married persons. . . . 14

Some federal programs have for many years been interested in the availability of family planning. Some public assistance funds from the Social Security Act of 1935 were used for birth control by the health and welfare agencies, but there was no authority for direct governmental involvement. The first direct federal governmental involvement in family planning services was included in Title V of the Social Security Act which provided for "formula grants to the states for maternal and child health care and which, since 1963, has also included a program in low income areas." 15 In 1965, the Secretary of the Interior, Stewart Udall, instructed the Bureau of Indian Affairs to make family planning available on a voluntary basis. In 1967, the Office of Economic Opportunity funded 121 family planning programs. 16

The Family Planning Services and Population Research Act of 1970 was an attempt by Congress to tie together the family planning programs. This Act, otherwise known as Public Law 91-572, was:

14 Ibid., p. 154.
16 Ibid., p. 467.
... a historic first passage on an altogether non-partisan and bi-partisan basis of the first comprehensive U.S. statute designed to provide funds and encouragement for family planning services and population research throughout the nation.17

The law included three areas that might affect future population growth, although it did not make provisions for limiting population growth or for accommodating future population growth. The three areas that made up the body of the act were: (1) Family Planning, (2) Population Research, and (3) Population Education. The act made a firm commitment to provide (on a voluntary basis) family planning to the individual woman who was in need of it. It was estimated that there were "five million American women who want family planning services but cannot get them because they cannot afford them or have no ready access to them."18

Of major concern was the woman's health and the consequent high mortality rates. Many persons believe that mortality rates and high prematurity rates are a part of high fertility rates, and so the act did provide funds for "the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population."19

The act reiterated the policy that no other agency,

17 Ibid., p. 427.
18 Ibid., p. 436.
19 Ibid., p. 439.
either public or private, could require use of the law's family planning services for the individuals' eligibility for other assistance.20

One rather questionable part of the act was the prohibition of use of its funds for any program in which abortion was a part of the family planning program. This seemed to contradict both the emphases on health and on voluntariness. It would seem that the act should be used freely by the women for the purposes that best suited their individual cases. This provision even negated the use of therapeutic abortion for cases of birth defects.21

Although the problem of overpopulation was discussed and although there were no specific solutions in the act, it was the considered opinion of many that if "unwanted" children were not born, the problem would be, in large part, solved. During the years 1966 to 1970, the Office of Population Research at Princeton University reported that 44 percent of all births to married women were unplanned and 15 percent were never wanted. Almost two-thirds of births occurring in families of six or more children were never wanted. All of these statistics add up to 2.65 million unwanted births during these years that would not have happened if perfect fertility control had been available.22

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20 Ibid., p. 449.
21 Ibid., p. 453.
22 Hanks et al., Law and Policy, p. 119.

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any event, the act was considered to be an interesting test of how well voluntary family planning would work as an effective tool for controlling the population growth in a highly industrialized country.²³

From the administrative viewpoint, the act drew all the family planning services into one new office, the Office of Population Affairs, under direction of the Secretary of Health, Education and Welfare and a Deputy Assistant Secretary in Charge of Population Affairs.²⁴

Partly in response to public sentiment and concern, Congress created the Commission on Population Growth and the American Future, and requested that it "look into the various means appropriate to the ethical values and principles of this society by which our Nation can achieve a population level properly suited for its environmental, natural resources and other needs."²⁵ The commission was to consider the needs for the short run as well as the needs for a population policy necessary for the long run.²⁶

Related Montana Laws and Some of Their Discrepancies

In 1972, the Commission reported its findings, part of which consisted of a List of Recommendations for future

²⁴Hanks et al., Law and Policy, p. 149.
²⁶Ibid., p. 447.
action. Some of them have already been mentioned in this paper; some of them Montana would do well to adopt. The ones that are most applicable to the considerations of this paper concerning this state are listed here, some with comments. (The notes are based on the laws that are included at the end of each chapter and/or on interviews.)

**Sex Education.** Recognizing the importance of human sexuality, the Commission recommends that sex education be available to all, and that it be presented in a responsible manner through community organizations, the media, and especially the schools.

**Note.** The Missoula County Superintendent of Schools reported that there is not a law that requires or forbids sex education. Each school district has a school board that has the right to put in the school curriculum any additional courses that they deem advisable, in addition to basic requirements.

**Equal Rights for Women.** The Commission recommends that the Congress and the states approve the proposed Equal Rights Amendment and that federal, state, and local governments undertake positive programs to ensure freedom from discrimination based on sex.²⁷

Note. Montana has ratified the Equal Rights Amendment and a 1977 attempt to rescind the ratification was unsuccessful.

Contraception and the Law. The Commission recommends that: (1) states eliminate existing legal inhibitions and restrictions on access to contraceptive information, procedures, and supplies; and (2) states develop statutes affirming the desirability that all persons have ready and practicable access to contraceptive information, procedures, and supplies.

Note. The Executive Director of Planned Parenthood in Missoula said that Montana has a "gray area" of having no specific law that applies to contraceptives for minors, either "for" or "against." Doctors consider this a "sticky wicket" and are loathe to prescribe contraceptives for minors. Vending machines and advertising are not allowed for contraceptives. Contraceptives are available only through licensed physicians and licensed pharmacists. An inconvenience for Planned Parenthood is the requirement that only pharmacists can package the birth control items.
Contraception and Minors. The Commission recommends that states adopt affirmative legislation which will permit minors to receive contraceptive and prophylactic information and services in appropriate settings sensitive to their needs and concerns.

To implement this policy, the Commission urges that organizations, such as the Council on State Governments, the American Law Institute, and the American Bar Association, formulate appropriate model statutes.

Note. The need for a definite law for minors was noted above. A minor can give valid consent for health services who is or was married, or has had a child, or graduated from high school, or is emancipated, or is separated from parents and is self-supporting, or is pregnant or afflicted with communicable disease including venereal disease, or drug and substance abuse, or needs emergency care. The minor's consent is not allowed for abortion or sterilization. (Montana Code 69-6101)

Voluntary Sterilization. In order to permit freedom of choice, the Commission recommends that all administrative restrictions on access to voluntary contraceptive sterilization be eliminated so that the decision is made solely by physician and patient.
To implement this policy, the Commission recommends that national hospital and medical associations and their state chapters promote the removal of existing restrictions.\textsuperscript{28}

Note. Those individuals who are incompetent can appeal to a Board of Eugenics through the Department of Institutions for a fair hearing and decision (see chapter 3). Otherwise, in Montana, sterilization is a matter decided between the physician and patient. Of course, if the patient is a woman, the hospital can refuse to do the operation on religious or moral grounds.

Abortion. With the admonition that abortion not be considered a primary means of fertility control, the Commission recommends that present state laws restricting abortion be liberalized along the lines of the New York statute, such abortion to be performed on request by duly licensed physicians under conditions of medical safety.

In carrying out this policy, the Commission recommends:

That federal, state, and local governments make funds available to support abortion services

\textsuperscript{28}\textit{Ibid.}, p. 142.
in states with liberalized statutes.

That abortion be specifically included in comprehensive health insurance benefits, both public and private.  

Note. Montana has restrictions in its abortion law. "Informed" consent signed by the physician and the woman is required, plus written notice to the parents if the patient is under 18 and unmarried. The physician must set forth in detail in writing the medical facts of the case and must have concurrent written opinions from two other licensed physicians, after an examination. Failure to comply with this regulation is regarded as a felony. No abortion may be performed after viability except to save the life of the mother. Any abortion after the first trimester has to be performed in a licensed hospital. The hospital has the right of refusal based on religious or moral tenets. Detailed records have to be kept by the hospital; all other documents, such as consent forms, are also to be kept on file.

29 Ibid.
The following four suggestions were ones that seemed to be appropriate for future planning and development in Montana:

**Personnel Training and Delivery of Services.** The Commission recommends creation of programs to: (1) train doctors, nurses, and para-professionals, including indigenous personnel, in the provision of all fertility-related health services; (2) develop new patterns for the utilization of professional and para-professional personnel; and (3) evaluate improved methods of organizing the delivery of these services.

**Services for Teenagers.** Toward the goal of reducing unwanted pregnancies and childbearing among the young, the Commission recommends that birth control information and services be made available to teenagers in appropriate facilities sensitive to their needs and concerns.

**Population Stabilization.** Recognizing that our population cannot grow indefinitely, and appreciating the advantages of moving now toward the stabilization of population, the Commission recommends that the nation welcome and plan for a stabilized population.

**State Population Agencies and Commissions.** The Commission recommends that state governments, either
through existing planning agencies or through new agencies devoted to this purpose, give greater attention to the problems of population growth and distribution.\(^{30}\)

The Welfare of Teenagers and Legal Considerations

One of the Commission's major concerns, as is evidenced in the aforementioned excerpts, was the welfare of teenagers. The Conference of Human Rights at Teheran on May 12, 1969 established a right to adequate education and information on family planning, and the U.N. established the right of access to the means of practicing family planning.\(^{31}\) Do these rights not apply to minors?

Legally, a minor is considered "minor" when he is "below the age at which he or she is judged competent in reaching independent decisions on specified matters otherwise allowed to adults."\(^{32}\) The civil status, legally, of the minor is a sword that cuts both ways. The minor is legally protected from such things as signing unwise documents and from being forced to hard labor that would be harmful, but where medical questions are concerned, the minor has too often been victimized.\(^{33}\) Some laws defeat each other. In

\(^{30}\)Ibid., pp. 143, 147.


\(^{32}\)Ibid., p. 310.

\(^{33}\)Ibid., p. 311.
New York, there is the "interesting question of what a girl is supposed to do with the contraceptives she can purchase at age 16, until age 17 when she can consent to sexual intercourse, or age 18, when she can get married." Doctors have been reluctant to give aid without parental consent because of the fear of being sued for assault and battery or for malpractice. According to Eve Paul, currently associated with a New York law firm and long active in the field of population planning, no court has ever held a physician liable for treating a person fifteen years or older when the treatment was for the minor's benefit and when the physician had the minor's consent. Still, physicians and others in health services are reluctant to treat cases without parental consent.

There are exceptions to the parental consent law. One has been in cases of "emergency that endangers the life or health of a minor." In these cases, it has been the responsibility of the doctor to provide proof of the "emergency." Another exception has been for the "emancipated" minor, a minor who is supporting himself and living by himself. In this case, the parents' duties and responsibilities are ended and the courts recognize the minor's right to decide

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his medical treatment. Another category is the "mature" minor, who is mature enough and intelligent enough to understand the nature of the medical care and to give "informed consent." 36

There are two other legal categories which are fairly new. One, that some countries have adopted, is called the "health services to minors act," which, without parental consent, gives medical aid to minors for problems of venereal disease, pregnancy, and drug abuse. In the United States there have been cases of neglect for various medical reasons, such as surgery, blood transfusions, etc., because of a lack of parental consent. Because of these cases, a new segment of law is developing, the "parens patrie" power of the courts, applied to medical cases, where the courts assume the responsibility to make the decision of what is best for the child. 37

Due to the sexual precocity of minors and, thence, to the large number of births to those who are under twenty years of age, the legislatures and courts have become increasingly aware of the rights of minors. The case becomes even more critical when one considers the statistics. According to Planned Parenthood of Missoula, one million teenagers become pregnant each year, and from these pregnancies there are 600,000 live births. Two-thirds of these

36 Ibid., pp. 361-362.
pregnancies are unplanned. Only one-third of the sexually active minors receive contraceptives from clinics or physicians.\textsuperscript{38}

In the cases of adolescent pregnancy, there are much more likely to be health problems with baby and mother than in the age group from twenty to twenty-four. Teenage mothers of unwanted babies are much more likely to resort to abuse and neglect than older women are.\textsuperscript{39}

"The social consequences may be equally shattering. Precipitate marriage, school dropout, marital instability, poverty and dependency, all attend an unwanted pregnancy."\textsuperscript{40}

Recently, there have been many legislative changes. The Twenty-Sixth Amendment to the Constitution reduced the voting age to eighteen and, consequently, many states reduced the legal age to eighteen. In 1972, a federal law required that Family Planning Services be made available to sexually active minors who would be included in the aid to needy families and children program. The states have passed all degrees of laws. Some are very comprehensive and permit minors to consent to medical treatment. Others permit consent for specific cases, such as drug abuse, treatment of venereal disease, and pregnancy.\textsuperscript{41}

\textsuperscript{39}Paul, "Legal Rights of Minors," p. 358.
\textsuperscript{40}Ibid., p. 359.
\textsuperscript{41}Ibid., pp. 364-365.
In June 1972, a Gallup poll indicated that three out of four Americans believed that "minors should have access to effective birth control services on their own consent and initiative." 42

It was not until very recently that the U.S. Supreme Court confirmed the sex-related privacy rights of minors. On June 9, 1977, the Court decided that contraceptives could be advertised and sold anywhere and to children as well as to adults. 43 Previously, several of the lower courts had delivered opinions that were favorable. A federal district court opinion in regard to a school questionnaire stated: "The fact that the students are juveniles does not in any way invalidate their right to assert their Constitutional right to privacy." 44

In several cases, the U.S. Supreme Court has upheld the individuals' "right to privacy" unless a "compelling state interest" can be shown. In keeping with this finding, a New York court recently maintained that "the state must show a compelling state interest to justify treating juveniles different from adults." 45

Usually these compelling state interests are to pro-

42 Ibid., p. 365.
45 Ibid.
ect a minor from his own inexperience and to bolster parental control, but in the face of pregnancies and sexual precocity among minors, the compelling state interest quickly evaporates. However, it should be reiterated that, despite the above-mentioned changes, many minors still have trouble getting sex-related medical care.

The American Bar Association, the American Medical Association, The American College of Obstetrics and Gynecologists and other medical associations have endorsed the advisability of making contraceptive services available without parental consent. Several states have followed this endorsement, and the federal law has supplied services for those who are indigent. Any question as to the safeguarding of the welfare of the minor could be satisfied by the stipulation that only intelligent and mature teenagers could consent to medical care.46

In Montana, even the "emancipated" minor is not completely free to make medical decisions. In the Montana Abortion Control Act (94-5-613 to 94-5-624), notification is required to be sent to the parents. Also in the Montana Code (69-6101) a minor is considered eligible to give consent for medical treatment for certain conditions, as noted previously, but Section 69-6102 states that the treating physician may inform the spouse, parent or guardian if he

46 Ibid., p. 377.
believes that there may be severe complications, or major surgery, or if divulgence would benefit the minor and family harmony, or failure to inform might harm the minor, younger siblings or the public, or if the hospital desires a third party commitment to pay for services. Such notification by the health professional would not constitute libel, slander or violation of privacy.

As has been mentioned, there is no Montana law that expressly permits minors to have contraceptives and physicians are leary of the entire procedure.

Laws Affecting the Manufacture and Distribution of Contraceptives

Another area that can have a restrictive effect on family planning and that can affect everyone, not only minors, is the body of laws that controls the manufacture and distribution of contraceptives, defined in legal terms as "an agent which extends the length of time it takes a woman to become pregnant." Some of the manufacturing laws are quite restrictive. In Japan, steroidal contraception (the "Pill") is not manufactured because of the fear of side effects. In other countries, the fear of reprisal due to harmful results prevents the rapid development and dissemination of possible new methods. Sometimes it is not possible

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to test results until the effects on the new generation can be observed. There are several medico-legal questions that have to be settled. One is the liability of the manufacturer for future side effects; another is the degree to which the manufacturer is responsible when the user has been warned of possible side effects. "It is the responsibility of law to develop consumer protection without being aggressive about the unusual cases that could result in suits that would force an increase in the price of the contraceptives." 48

Tariffs and taxes affect the price of contraceptives and, consequently, the availability of them.

Some apparently minor laws, such as the laws against vending machines and advertising, have major effects. Vending machines make condoms privately available. It is a fact that youths may be too embarrassed to buy them at a drug counter. The removal of the restrictions on advertising would have the effect of making family planning more available without raising the cost. It would be cheaper and more effective for manufacturers to advertise their product than it would be to set up more family planning clinics. 49 "If it is assumed that family planning is a basic human right and if it is accepted that fertility regulation has beneficial social

48 Ibid., p. 85.
49 Ibid., p. 90.
and medical consequences, then it is inappropriate to consider altering restrictive legislation in the area of contraceptive manufacture, distribution and promotion."  

The amount of effort to be expended in changing anti-contraceptive legislation should not be judged on the basis that many individuals can circumvent almost any barrier to obtain contraceptives, but by the fact that the socially most disadvantaged are usually most hurt by restrictions, however, trivial, that increase the social, economic, cultural and geographical distance between them and the service they need.  

In the United States, until the 1970s, obscenity and postal laws affected the distribution and use of contraceptives. It was not until January 8, 1971, that the 1873 Comstock Act was repealed by Congress and as the Commission on Population Growth and the American Future states:

This was a broad gauge obscenity law which had prohibited in its omnibus sweep the importation, transportation in interstate commerce, and mailing of any article whatever for the prevention of conception. Thus, the anti-contraception law of the federal government is now substantially limited to unsolicited contraceptives and to unsolicited contraceptive advertising. . . . The states, too, have substantially limited their 'little Comstock laws'. . . . However, more than half the states retain, in effect, statutes which prohibit or restrict the sale, distribution, advertising and display of contraceptives.  

Dr. Malcolm Potts, a consultant with the International Planned Parenthood Federation, recommends that all laws be repealed that "regulate the manufacture, sale, display,  

50Ibid., pp. 89-90.  
51Ibid., p. 90.  
52Hanks et al., Law and Policy, pp. 154-155.
advertising and importation of contraceptives." He points out that a reasonable application of the usual obscenity laws, trade description acts, standards of production, labeling and honest advertising would safeguard both the product and the consumer.\textsuperscript{53}

The Family Planning Program in the State of Montana

Family Planning in Montana is an umbrella organization that contracts its services to fifteen agencies in the state. Four of them are operated by incorporated boards, such as the Planned Parenthood in Missoula; three are State programs; four are in the local Health Departments; three are private, nonprofit corporations; one is run by the County Commissioners.

Funds come from several sources. Federal Title X grants some through the Child Health Bureau of the Montana State Department of Health and Environmental Sciences. Family Planning also contracts with the Department of Social and Rehabilitative Services for money from Title XX. The state legislature allocates $30,000 yearly to Family Planning to use as matching funds for the money that is available from Title XX. The program is also reimbursed by Medicaid and by some patients, who can afford to pay, by the United Way and by County Commissioners.

Since the administrators of the Family Planning

\textsuperscript{53}Potts, "Laws Regulating Contraceptives," p. 91.
Program consider the state law, that concerns minors, to be ambiguous, each advisory board decides whether to allow prescribed contraceptives. Some clinics allow the prescriptions with the consent of the parents. Of course, the prescriptions have to be supervised by a doctor.

The two goals of the program are to encourage the voluntary control of one's own fertility and to improve the state of one's health.

The programs, preventive health based, provide counseling in all aspects of family life; educational services; blood tests for anemia, rubella, and syphilis; immunizations for rubella; blood pressure recordings; physical examinations; cervical cancer screening; gonorrhea screening and treatment; pregnancy tests; urine analysis for sugar and protein; self-breast examination instructions; diagnosis and treatment of vaginal infections; infertility examinations; dispensation of contraceptive devices; and payment of voluntary sterilizations.

Besides the clinical programs, there are contributions to community and school education. Individual counseling is provided.

There has been a marked increase in the number of clients, from 7,993 in 1974 to 14,730 in 1976. This trend indicates a need in the State, that should not be neglected.

**Planned Parenthood of Missoula**

Barbara Burke, the Executive Director of the Missoula

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Planned Parenthood, stated that the laws which affect their organization the most are these same obscenity and pornography laws that prevent advertising and commercial vending of contraceptives. She also mentioned that "gray area" of a lack of a specific law governing the availability of contraceptives to minors, which causes difficulty for the physicians. Another law that she mentioned as being awkward was the pharmaceutical one that requires a pharmacist to package the contraceptives.

She said that their patients come in for an interview and, if necessary, a physical and have the contraceptive prescribed. Contraceptives are not given to those who are not patients. Most of their clients are low-income, mostly unmarried, and most have not had their first child. Contraceptives cannot be sold, but contributions are accepted and encouraged. An in-house physician has to sign for the contraceptives.

Planned Parenthood has been in Missoula for nine years and works very closely with Public Health. Prior to that time, private physicians took care of family planning. In the state there are fifteen Family Planning Clinics which are community organizations, under the State Board of Health, supported federally and locally. 55

According to Barbara Burke, Planned Parenthood is a

national organization of 190 affiliates. It has bylaws, supportive backup and technical advice, purchasing power and arranges regional meetings that keep local chapters current. There is a lot of local autonomy. Local services are decided by the local board of directors.

In 1973, 1974 and 1975, the Missoula organization doubled its patient caseloads. In 1976, they served 1,439 female patients, of which 820 were new patients and 619 were continuing patients. Forty-five percent of these were from 20 to 24 years old. Nineteen percent were eighteen and nineteen, and 9 percent were under eighteen. Fifty-four percent of the birth control methods was accounted for by the Pill; 2 percent of the methods was sterilization.56

In January 1977, the patient load was expanded to include women who can pay for their medical care. This was because the Missoula Planned Parenthood is one of the few chapters which relies heavily on federal funding (80 percent from federal grants) and because federal funding is always uncertain. "All patients are encouraged to pay for supplies, medications, contraceptives and pregnancy tests."57

Barbara Burke mentioned that their goal is to try to change the obscenity laws to allow condom vending machines and advertising, and to establish an actual legal minors' right to consent to health services.

56 Alves, Newsletter, p. 2.
57 Ibid., p. 1.
Both the accomplishments and goals of family planning seem to be included in this opinion:

The legal aspects of birth control legislation in America are illustrations of the type of problem with which federal courts in this country have had to concern themselves over the past three decades. Here one encounters some of the more complicated problems related to the judicial process: judicial restraint vs. judicial activism; the balancing of state police power with individuals' freedoms; the extent and breadth of the coverage given under the Bill of Rights; the problems of posture and standing before the courts; and the evolving concern of the Supreme Court for fundamental freedoms. In short, the study of birth control legislation before the American courts is the study of line drawing over an extended period of time: the establishment of a line drawn by the legislature; the definition of the line by the courts; the modification of the harshness of the line by what Mr. Justice Cardozo called "interstitial legislation;" (interstice is a small crack between things); and finally the establishment of a new line by the courts more closely conforming with changed social norms, literally in the face of legislative inability to act.58

The Effectiveness of Family Planning as a Tool of Population Control

In order to expand the parameters of the consideration of population control by legal methods it seemed beneficial to study the effectiveness of family planning.

For the past few years, there has been considerable debate about whether family planning can be effectively used to control population growth. It has been agreed that family planning is a fundamental human right, but the Environmental Fund figures show that in India, where the most money has been

58 Abraham and Hazlewood, "Comstockery at the Bar," p. 220.
spent over the longest time--24 years, the population is still increasing. In 1951, the population grew by 3.6 million. In 1976, it grew by 16.2 million yearly. In Mexico, where family planning was adopted three years ago, the birthrate as of 1976 was rising sharply.59

The fault with family planning, says the Environmental Fund, is that family planning advocates that a family be free to choose its own number of children. Many families want more than two.60

Kingsley Davis, of the Department of Demography at the University of California in Berkeley, insisted in a paper that he delivered to the National Research Council of the National Academy of Sciences, that the current family planning program was like an ostrich hiding its head in the sand. According to him, although more than 30 nations were trying to do something about population control and although there seems to be a general consensus about a population crisis, family planning was not much more than a system of distributing contraceptives.61 It is geared to whatever religious and social mores there are in the country and disregards those women who want more children as well as those women who want abortions, one of the oldest and most effective means of birth control.

The term family planning cannot be used as a term

60Ibid.

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synonomous with population control or population planning as these terms imply influencing all aspects of population: age-sex structure, geographical distribution, racial composition, genetic quality, and total size. Current population policies deal only with the birth input. One cannot even use the term "fertility control" to define family planning as it does not take into account all the factors that determine the fertility rate. The only goal of family planning, according to Kingsley Davis, should be to reduce birthrate by a certain amount in a given time.62

The industrial nations are supposed to be demographic models for the nonindustrial, but "the average total of reproduction since 1940 has been high enough to give these countries with their low mortality, an extremely rapid population growth. The rising share of their supposedly high per capita income, which itself draws increasingly upon the resources of the underdeveloped countries (who fall farther behind in relative economic positions), is spent simply to meet the costs, and alleviate the nuisances, of the unrelenting production of more and more goods by more people."63

Family planning cannot advocate zero population growth because it would not be approved of by ethnic and religious groups, and the whole program would be in jeopardy. Even the supposed freedom of each couple to choose family size and

62 Ibid.
63 Ibid.
birth control methods is often dictated by religious tenets which family planning conveniently overlooks. According to Kingsley Davis, "the conscience dictating the method is often not his but that of religious and governmental officials." Population policy programs often do not accept abortions as a control method and thereby negate their own policies. Davis declares that, "the U.N. excludes abortion from family planning and in fact justifies the latter by presenting it as a means of combatting abortion." Kingsley Davis, in his paper, did not argue against the beneficiality of family planning for the individual woman as it enables her to limit the number of children that she wants, but he did reiterate that no further steps are being taken toward major social changes that would change motivational forces in the different societies.

If excessive population growth is to be prevented, the obvious requirement is somehow to impose restraints on the family. However, because family roles are reenforced by societies' system of rewards, punishments, sentiments, and norms, any proposal to demote the family is viewed as a threat by conservatives and liberals alike, and certainly by people with enough social responsibility to work for population control. One is charged with trying to "abolish" the family. What is required is selective restructuring of the family in relation to the rest of society.

Davis suggested that there are two areas that should be socially promoted that would be effective in reducing the

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64 Ibid.
65 Ibid.
66 Ibid.
birthrate. One was to postpone marriage, while simultaneously controlling illegitimate births, and the other was to keep families small. Some of Davis' suggestions for keeping the family small and for postponing marriage were to institute economic advantages for each. Some of the more radical ideas were for government to pay abortion costs and to pay people to be sterilized, to charge a large fee for marriage license, to levy a "child-tax," and to require that illegitimate pregnancies be aborted. Other less radical suggestions were to reduce paid maternity leaves, make legal all abortions and sterilizations, change income tax so there is no discrimination if the wife works, relax laws that allow use of harmless contraceptives by prescription. Also he believed that women's roles should be equalized with men's roles so that the educational and job opportunities would be the same. 67

According to Davis, the people who should be most involved with world population planning should be specialists in education and economics and not health departments. After the publication in Science magazine of an abridgement of a paper by Davis, a rebuttal by members of the Committee on Population of the National Academy of Sciences appeared in 1968. In essence, they agreed that supplementary programs would be essential and that ZPG would probably be a good idea, but they reaffirmed that few if any countries are ready to accept such stringent measures and that family planning was

67 Ibid.
an excellent beginning step and that all steps had to be taken in context with each particular country's founders.68

Kingsley Davis retorted that the rebuttal was too conservative and was so satisfied with current policy that the attitude negated the desire to analyze and probe for solutions. He reiterated that "existing values" of society are at the heart of the problem, that one has to break away in order to find the "painful social and economic changes necessary to achieve fertility control."69

President Carter, in his support of the family as an institution, had some suggestions that would have found favor with Kingsley Davis and one that would not. The President would change the tax laws that favored two single working people who lived together over a working married couple. Otherwise, he favors women working and expansion of day-care centers and/or expanding use of schools to care for the children.70 Kingsley Davis recommended that taxes be higher for married people, but he also recommended that women work to develop interests outside of the home and also because working women do not have so many children.

The latest Factbook from the Population Council published in 1976 seems to bear out quite a few of Davis' assertions. Foremost is the question as to whether family planning can be really effective if there are not also changes in

69 Ibid.
70 The Missoulian, June 19, 1977, pp. 1, 2.
economic and social frameworks. To be truly effective it seems that individual and societal values have to correlate and that fertility changes do little good in a society of traditional values. "Rooted in ever-changing custom and tradition, laws are often archaic long before they are repealed and are often passed to legitimize long established practice." 71

There are many factors besides family planning that can influence a drop in the birthrate. One is a rising age of marriage, as in the Philippines; another is the changing age structure of our population. The migration of husbands in order to find work affects the frequencies of pregnancies. All of these factors make it difficult to isolate the contribution of government-sponsored family planning programs. 72

Stringent methods that can contribute to a lower birthrate include a forced sterilization program (that proved politically hazardous in India);

Improvement in the literacy and the status of women; rural development; access to social and occupational mobility; redistribution of income to increase a possibility of achieving the consumption patterns of the next higher class; imposition of the social costs of high fertility on those responsible; and initiation of population and education programs. 73

By withholding benefits from those who had large families,

71 Population Council Factbook, p. 97.
72 Ibid., p. 3.
73 Ibid.
Singapore successfully encouraged enrollment in family planning programs. In the Dominican Republic, a remarkable drop in the birthrate in one year was explained by an erroneously conservative estimate of the impact of sterilization. However, in the majority of cases reported in the Factbook, it did not seem wise or timely for governments to use these more stringent methods. The two most widely accepted plans were to make available voluntary family planning programs and to make abortion more accessible.\textsuperscript{74}

Despite the fact that thirty-three developing countries, 76 percent of the population in the developed world, have adopted an anti-natalist policy, and that thirty-one countries, 16 percent of the population, have adopted a family planning program for other than demographic reasons, such as for health and human rights, it is predicted that the world population in 1985 will be twice that of 1950, a 44 percent increase in the developed regions and a 110 percent increase in the developing regions.\textsuperscript{75} Although the picture looks grim, it was only a generation ago that family planning was ignored or condemned altogether.\textsuperscript{76}

\textsuperscript{74} Ibid., p. 4.
\textsuperscript{75} Ibid., p. 97.
\textsuperscript{76} Ibid.
The Laws Coded by the Fletcher Plan

Title 94, Revised Codes of Montana, the Criminal Code of 1973, As Amended through the 44th Legislature in 1975
(94-8-110.2[1] to 94-8-110.2[4]). (The sequence of Sections has been rearranged to correspond with the Fletcher Code.)

100 - FERTILITY REGULATIONS

120 Contraception

Contraceptive Drugs or Devices

120.2 Restrictions and Prohibitions Generally (94-8-110.2[3])

Any officer of the law shall have the power to cause the arrest of any person violating any provision of this Act, to seize stocks illegally held, and to make seizure of any mechanical device or vending machine containing any merchandise coming within the provision of this Act, holding the owner of such machine, the occupier and the owner of the premises where seizure is made to be in violation of this Act.

(94-8-110.2[4]) Any person or any member of a firm, or co-partnership or the officers of a corporation or association who or which knowingly violates any of the provisions of this Act shall be guilty of a misdemeanor and shall upon conviction, be punished by a fine not to exceed five hundred dollars ($500), or by imprisonment of not to exceed six (6) months in the county jail or both; provided, however, that the justice of the peace courts and the district courts of the state shall have concurrent jurisdiction in all prosecutions and causes arising under this Act.

122 Advertising (94-8-110.2[2])

It shall be unlawful to exhibit or display prophylactics or contraceptives in any show window, upon the streets or in any public place other than in the place of business of a licensed pharmacist, or to advertise such in any magazine, newspaper or other form of publication originating in, or published within the state of Montana; to publish, or distribute from house to house or upon the streets, any circular, booklet or other form of advertising, or by other visual
means, or by auditory method or by radio broadcast; or by the use of outside signs on stores, billboards, window displays or other advertising visible to persons upon the streets or public highway provided however that nothing in this Act shall prevent the advertising of prophylactics or contraceptives in the trade press of those magazines whose principal circulation is to the medical and pharmaceutical professions; or to those magazines and other publications, having interstate circulation, originating outside the state of Montana where the advertising does not violate any U.S. law or federal postal regulation; nor to the furnishing within the store or place of business of a licensed pharmacist, to persons qualified to purchase and then only upon their inquiry, such printed or other information as is requisite to proper use in relation to any merchandise coming within the provisions of this Act.

Provided, nothing herein shall prevent the dissemination of medically acceptable contraceptive information by printed or other methods concerning the availability and use of any merchandise coming within the provisions of this Act.

123 Official Distribution (94-8-110.2[1])

It shall be unlawful for any person, firm, corporation, copartnership or association to sell, offer for sale, give away, through the medium of vending machines, personal or collective distribution, by solicitation, peddling or in any other manner whatsoever contraceptive drugs or devices, prophylactic rubber goods or other article for the prevention of venereal disease. The foregoing shall not apply to regularly licensed practitioners of medicine, osteopathy or other licensed persons practicing other healing arts, and registered pharmacists, nor to wholesale drug jobbers or manufacturers who sell to retail stores only.

300 - CHILDREN AND CHILD WELFARE


Approved March 26, 1974

350 Consent of Minors to Medical or Surgical Care (69-6101 to 69-6105)
350.1 Inducement and Assistance Generally (69-6101)

The consent to the provision of medical or surgical care or services by a hospital, public clinic, or the performance of medical or surgical care or services by a physician, licensed to practice medicine in this state may be given by a minor who professes or is found to meet any of the following descriptions:

(1) A minor who is or was ever married, or has had a child, or graduated from high school, or is emancipated; or

(2) A minor who has been separated from his parent, parents, or legal guardian for whatever reason and is supporting himself by whatever means; or

(3) A minor who professes or is found to be pregnant, or afflicted with any reportable communicable disease including venereal disease, or drug and substance abuse including alcohol. This self-consent only applies to the prevention, diagnosis, and treatment of those conditions specified in this subsection. The self-consent in the case of pregnancy, venereal disease, and drug and substance abuse also obliges the health professional, if he accepts the responsibility for treatment, to counsel the minor by himself or by referral to another health professional for counseling; or

(4) A minor who needs emergency care, including transfusions, without which his health will be jeopardized. The parent, parents, or legal guardian shall be informed as soon as practical except in conditions mentioned in subsections (1), (2), (3), or (4) of this section; or

(5) A minor who has had a child may give effective consent to health service for his child; or

(6) A minor may give consent for health care for his spouse if his spouse is unable to give consent by reason of physical or mental incapacity.

350.2 Consent Requirements Differ (69-6104)

(1) Any health professional may render or attempt to render emergency service or first aid, medical, surgical, dental, or psychiatric treatment without compensation to any...
injured person or any person regardless of age who is in need of immediate health care when, in good faith, the professional believes that the giving of aid is the only alternative to probable death or serious physical or mental damage.

(2) Any health professional may render nonemergency services to minors for conditions which will endanger the health or life of the minor if services would be delayed by obtaining consent from spouse, parent, parents, or legal guardian.

(3) No consent shall be required of any minor who does not possess the mental capacity or who has a physical disability which renders him incapable of giving his consent and who has no known relatives or legal guardians if a physician determines the health service should be given.

(4) Self-consent of minors shall not apply to sterilization or abortion.

351 Regulation

351.1 Regulations of Individuals or Agencies Performing Act (69-6102)

(1) A treating physician or other health professional, may, but shall not be obligated to, inform the spouse, parent, custodian or guardian of any such minor in the circumstances as enumerated in section 69-6101, of any treatment given or needed when:

(a) in the judgment of the health professional severe complications are present or anticipated; or

(b) major surgery or prolonged hospitalization is needed; or

(c) failure to inform the parent, parents, or legal guardian would seriously jeopardize the safety and health of the minor patient, younger siblings, or the public; or

(d) to inform them would benefit the minor's physical and mental health and family harmony; or

(e) the hospital desires a third party commitment to pay for services rendered or to be rendered.

(2) Notification or disclosure to the spouse, parent, parents, or legal guardian by the health professional shall
not constitute libel or slander, a violation of the right of privacy, a violation of the rule of privileged communication or any other legal basis of liability. When the minor is found not to be pregnant, or not afflicted with venereal disease, or not suffering from a drug or substance abuse, including alcohol, then no information with respect to any appointment, examination, test, or other health procedure shall be given to the parent, parents, or legal guardian, if they have not been already informed as permitted in this act, without the consent of the minor.

352 Control of Fees and Costs

352.1 Financial Responsibility (69-6103)

Consent of the minor shall not be subject to later disaffirmance or revocation because of minority. The spouse, parent, parents, or legal guardian of a consenting minor shall not be liable for payment for such service unless the spouse, parent, parents, or legal guardian have expressly agreed to pay for such care. The minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services except those who are proven unable to pay and who receive the services in public institutions. If the minor is covered by health insurance, payment may be applied for services rendered.

353 Malpractice

353.1 Immunity and Responsibility (69-6105)

(1) No physician, surgeon, dentist, health or mental health care facility may be compelled to treat a minor on his own consent against their best judgment.

(2) Nothing contained in this section shall be construed to relieve any physician, surgeon, dentist, health or mental health care facility from liability for negligence in the diagnosis and treatment rendered such minor.

353.2 New Definition (69-6105.1)

Health professional as used in this act shall include only those persons licensed in Montana as physicians, psychiatrists, psychologists or dentists.
Additional Service to Minors--Psychiatric (69-6106 to 69-6107--approved 1971)

Consent of Minor to Psychiatric or Psychological Counseling Valid under Urgent Circumstances (69-6106)

The consent to the providing of psychiatric or psychological counseling by a physician or psychologist licensed to practice in this state, under circumstances where the need for such counseling is urgent in the opinion of the physician or psychologist involved, because of danger to the life, safety or property of a minor or of other person or persons, and the consent of the spouse, parent, custodian or guardian of the said minor cannot be obtained within a reasonable time to offset the said danger to life or safety, when executed by the said minor shall be valid and binding as if the said minor had achieved his or her majority, that is such minor shall be deemed to have and shall have the same legal capacity to act and the same legal obligations with regard to the giving of such consent, as a person of full legal age and capacity, the infancy of said minor and any contrary provisions of law notwithstanding, and such consent shall not be subject to later disaffirmation by reason of such minority; and the consent of no other person or persons (including, but not limited to a spouse, parent, custodian or guardian) shall be necessary in order to authorize the psychiatric or psychological counseling to such minor, provided, however, that no parent shall be obligated for the cost of such counseling without his consent.

Malpractice

Immunity of Physician or Psychologist (69-6107)

In any case arising under the provisions of this Act, the physician or licensed psychologist who provides the psychiatric or psychological counseling services shall incur no civil or criminal liability by reason of having provided the counseling services, but such immunity shall not apply to any negligent acts or omissions.
CHAPTER V

SUMMARY AND RECENT TRENDS

It is entirely possible that the most urgent conflict confronting the world today is not that between nations or ideologies, but rather between the pace of growth of the human race and the disproportionate increase in the production of resources necessary to support mankind in peace, prosperity and dignity. Oddly, it has been only within the past decade that the problems associated with population growth have seemed to be a proper subject for legal concern. Similarly, the conscious relating of basic human rights to the subject of world population in general and family planning specifically is of comparatively recent origin.1

Although there does seem to be general consensus about a world crisis that involves increasing population and the press of people on resources and food, there have recently been two rather disturbing prophecies that should be considered and not neglected in the complacency that might develop from the knowledge that "things are being done." On March 22, 1977, Ronald D. Lee, economist and demographer at the University of Michigan, predicted that the apparent long-term birth decline due to changes in contraception, women's roles and environmental concerns, was only a "passing response of the postwar baby boom generation to their own numbers."2 His

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theory is that the reproductive rate of any generation is a response to the economic times. He believes that the current generation does not feel as prosperous as their parents, but he predicts that their children will face less competition, that they will feel more prosperous and that they will again marry at a younger age and will have larger families.3

Another report on June 28, 1977, by Philip M. Hauser, demographer, urban sociologist and director of the University of Chicago's Population Research Center, indicated "that we may be entering the beginning of the 'echo effect' of the post-World War II baby boom."4 Hauser was present at a conference sponsored by Zero Population Growth, which is asking the federal government to "act immediately to curb population growth."5 He reported that the March 1977 birthrates show a significant increase and could mark the end of a period of declining birthrates.6

On June 24, 1977, a committee of the National Academy of Sciences Research Council reported that developing countries must double food production and take steps to reduce birthrates or face the devastation of famine. Any success in averting this tragedy depends on governmental decisions and worldwide cooperation. The panel suggested that the

3 Ibid.
5 Ibid.
6 Ibid.
U.S. increase its funding for research on agricultural methods that would be successful in developing countries, and for research for improved nutrition.\(^7\)

The panel reported that one-fourth of the world's four billion persons are hungry or suffer from malnutrition, and that by the year 2000 the developing countries will have to feed an additional 1.8 billion.\(^8\)

In December 1976, it was noted in *Newsweek* that Lester Brown, Director of Worldwatch Institute, reported that the world population growth rate fell from 1.9 percent in 1970 to 1.64 percent in 1975. Dr. R. T. Ravenholt, population director of the U.S. Agency for International Development, projected that the growth rate would fall below 1 percent by 1985. From these figures, it was estimated that world population would equal 5.4 billion by the year 2000 rather than the 6.3 billion previously predicted in 1970.\(^9\)

The *Newsweek* article, interestingly enough, credited the drop in births to the increased use of contraceptives, the Pill, condoms, IUD's, and the establishment of family planning clinics. Credit was also given to increased male sterilization and to more liberal abortion laws. "The Worldwatch study showed that in 1971, 38 percent of the world's people lived in countries where abortions were legal.  

\(^{7}\) The *Missoulian*, June 24, 1977, p. 28.  
\(^{8}\) Ibid.  
\(^{9}\) *Newsweek*, December 6, 1976, p. 58.
Today, the figure is 64 percent.\textsuperscript{10}

In the same article, Dr. Joseph Speidel, chief of research for the Office of Population, stated that: "There is no place where family planning has been made available that fertility has not decreased."\textsuperscript{11} This statement is in direct contrast to Kingsley Davis' argument, noted in chapter 4.

However, in the United States, it would appear that several things threaten the continued low birthrate. What does the "sharp increase" in the March birthrate, indicated by Philip Hauser, portend? What will be the ultimate outcome of what appears to be a growing strength in the Right to Lifers Organization? Of considerable disappointment, to those who are interested in population reduction, is the most recent decision of the U.S. Supreme Court that negated the legal duty of the states to pay for poor women's abortions, and the decision of the U.S. House of Representatives that no federal funds should be used to pay for abortions even to preserve endangered life. (The final decision rests with the Senate.)

It really seems that Kingsley Davis is correct in asserting that the root of the population problem is in the social and religious values of each country. That philosophy seems to be borne out in the United States. A genuine and sustained belief in the crisis caused by the crunch of num-

\textsuperscript{10}Ibid.
\textsuperscript{11}Ibid.
bers would not give in to such an apparent reversal in only four years.

Many of these social and religious values are expressed in legal form and cause a great deal of legislative and judicial debate, as in the heated controversy about abortion. Harriet Pilpel firmly believes that if all the pro-natalist laws were abolished there would be no population problem in the United States. In her opinion, some of these laws are those that restrict abortion, voluntary sterilization, and advertising of contraceptives. Other legal approaches include the establishment of family planning as a legal right at the Teheran Conference in 1968. Luke T. Lee believes that there needs to be an "in-depth, world-wide study and reform of laws which inhibit family planning."¹² Kingsley Davis believes that stringent laws are needed that would change the basic social structure, such as "child-tax" laws, raising the marriage age, legalizing all abortions and sterilizations, equalizing women's jobs with men's jobs.

In the summer of 1977, the U.S. Supreme Court made decisions that may have a direct effect on the birthrate. On June 9, 1977, the Court decided that contraceptives could be advertised and sold anywhere and to children as well as to adults.¹³ The second decision was the abortion decision. These decisions seem to bear out the Carter Administration

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policy of major funding for contraceptive and adoption services, counseling and sex education research projects. Carter is opposed to the policy of abortion, even though it is much more expensive for the government to care for unwanted babies than it is to pay for abortions through Medicaid. An abortion costs roughly $150.00 during the first trimester, whereas a child costs welfare about $2,000, plus the costs for the remaining years on welfare that might be necessary before the child is eighteen.

Recently, the U.S. Supreme Court refused to hear an appeal from three private hospitals in New Jersey, which were asking to use the plea of "conscience" to exempt them from performing abortion surgery. The New Jersey State Supreme Court had decided that a hospital which is open to the general public has an obligation to "serve the public" and cannot evade that obligation for moral reasons. This court action may be a boon to women who live in small towns and can afford to pay, if courts and legislatures decide to follow the New Jersey lead.

Abortion Recommendations for Montana

In Montana, the abortion, sterilization, and contraceptive laws can all be revised in parts, both to satisfy "the

16 The Missoulian, June 29, 1977, p. 25.
spirit of the law" and to clarify the law. When the federal
district court, on November 9, 1976, decided against two pro-
visions in the Montana Abortion Control Act, it neglected to
rule against three more provisions that the plaintiffs con-
sidered had a "chilling effect" on the woman's right to pri-
vacy when seeking an abortion. It is possible that the
plaintiffs may appeal the following sections to the U.S.
Supreme Court.

It is a misdemeanor for a physician to perform
an abortion in the absence of informed consent
which requires the physician to certify on state
forms that the patient has been advised of the
nature of the surgical procedure, its consequences
and alternatives and that the patient has volun-
tarily consented to the procedure. This type of
requirement is placed on no other medical proce-
dure.

Require the attending physician to obtain the
consent of two additional physicians before per-
forming an abortion not necessary to save the
woman's life in cases where the woman may be
carrying a viable fetus.

Provide criminal liability for any person
cau sing the death of a viable fetus delivered
during an abortion. Viable is defined as the
ability of the fetus to live outside of the
mother's womb with artificial aid.17

Altogether there have been five U.S. Supreme Court de-
cisions that have been against certain sections of the Mon-
tana Abortion Control Act.

1. During the first trimester the decision should be
only between the doctor and patient. (Informed consent

17Newsletter, Planned Parenthood of Missoula (October/
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is required in Montana.)

2. The Doe v. Bolton case established that in no other surgical procedure are two concurring opinions required from physicians. (They are required in Montana.)

3. A decision in 1976 established that the states could not impose blanket restrictions for women under eighteen years of age. (Consent is required for minors in Montana.)

4. The U.S. Supreme Court refused to hear a case brought by three New Jersey hospitals asking for exemption from abortion surgery because of their "conscience clauses."

5. The U.S. Supreme Court struck a Missouri law that required physicians to use as much care to preserve the life of an aborted fetus as of a fetus intended to be born alive. (There is criminal liability in Montana for any person causing the death of a viable fetus delivered during an abortion.)

Sterilization Recommendations for Montana

The Model Outline that was developed at the International Meeting of the Voluntary Sterilization Association in 1973 would offer some improvement over the Montana law which limits itself to safeguarding the rights of the mentally incompetent. The Model Outline would require that doctors and hospitals refer patients to available facilities when religious and moral regulations of the hospitals or doctors were a hindrance. Also, there is a "compelling state interest" that develops when the mentally incompetent have children
and are unable to care for them. In these cases, parents and/or guardians and a physician could apply to a board of lay and professional people who would by a vote decide on the necessity for the operation. The intent of the plan was that it was the government's obligation to see that the service was made available. These safeguards are ones needed in Montana to provide for both types of cases, those seeking voluntary sterilization and those who would be unable to care for their own children.¹⁸

Family Planning Recommendations for Montana

There are complaints from professionals in the field of family planning that the Montana law concerning contraceptives does not make them as available as possible because of restrictions about advertising and selling and because of that "gray area" that does not either expressly make them available to minors or expressly denies them. Apparently, this law is unconsitutional as of June 9, 1977, when the U.S. Supreme Court, as reported in the Missoulian, ruled that "states cannot restrict where contraceptives can be sold and cannot prohibit advertising or public display of birth control devices."¹⁹ At the same time, the Supreme Court also ruled that contraceptives could be sold to minors, which

should help eliminate Montana's "gray area." \(^{20}\)

In Montana, it is quite apparent from the statistics that there is a need for the services provided by such facilities as the Blue Mountain Women's Clinic, Planned Parenthood, and Family Planning. The Blue Mountain Clinic was opened on February 19, 1977, and, at that time, the plan was to do six abortions per week and to be open only two days a week. The last two weeks of June and the first two weeks of July, they have done and are planning to do fifteen a week, and they are open four days a week. \(^{21}\) Planned Parenthood, in Missoula, increased services by doubling its caseload in 1973, 1974 and 1975. In 1976, they served 1,439 patients. \(^{22}\) Family Planning, in Montana, according to Suzanne Nybo, Director of Family Planning in the state who quoted from the National Report System, almost doubled its total number of clients in two years. In 1974, the caseload was 7,993; in 1975, it was 11,959; in 1976, it was 14,730. \(^{23}\)

From the perspective of the problems caused by numbers of people, it could be concluded that, no matter what the debates about different issues involve, the total population has been affected by the above organizations, not only in Montana

\(^{20}\) Ibid.

\(^{21}\) Interview with Pat Tucker, Compiler of Statistics, Blue Mountain Women's Clinic, July 5, 1977.


\(^{23}\) Interview with Suzanne Nybo, State Director of Family Planning, July 5, 1977.
but in the world as well. Abortion, sterilization and family planning are credited with reducing the predicted number of people by 900 million by the year 2000.\textsuperscript{24}

For those who may doubt that there is a population problem, the definition from the Commission on Population Growth and the American Future is repeated here:

Every country has a population problem, trying to balance size, growth, and distribution of the quality of life to which all aspire. The population problem is defined as lack of fulfillment of dreams, spreading out of population and consequent deterioration of the environment, concentration in metropolitan areas, irreversible inroads on natural resources by increasing number of people who always expect a better way of life, and pro-natalist pressures from outmoded traditions.\textsuperscript{25}

Those who are interested in the press of population should be always vigilant and informed about legislative and judicial decisions and should add their opinion to the public pressure that, however quickly or slowly, can change the accepted parameters of the problem. As far as is possible, individuals should support those who are interested in testing the constitutionality of state laws that may have been superseded by U.S. Supreme Court decisions. These are two of the ways by which one can help chart the legal course of his state and, thereby, hope to chart the legal course of the nation as well.

\textsuperscript{24} Newsweek, December 6, 1976, p. 58.

\textsuperscript{25} Hanks et al., Law and Policy, p. 94.
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82A-805 -- Board of Eugenics
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