No Selves to Consent: Women’s Prisons, Sterilization, and the Biopolitics of Informed Consent

According to a recent report, at least 144 tubal ligations were performed on people in California women’s prisons between 2006 and 2010 (Johnson 2013). Many prisoner advocates decried these surgeries as unethical, unjust, and likely illegal, given federal regulations and state laws passed in the 1970s to reverse decades of coercive sterilization by government agencies. Now, as in the 1970s, government agents have promoted implementing better informed consent procedures as the solution to coercive sterilizations. However, this recent spate of sterilizations requires a re-examination of the relationship of informed consent to racialized, gendered, and classed biopolitical power.

The criminalization of black, Latina/Latinx, Native American, and some Asian women has led to a disproportionate number of people of color in women’s prisons in the United States. According to research conducted by the Sentencing Project, the proportion of black women incarcerated in the United States compared to white women was 2.8 to 1 in 2009, a significant difference despite the decline from nine years earlier, when the ratio was a startling 6 to 1 (Mauer 2013). Latinas/Latinxs also continue to be disproportionately incarcerated at a rate of 1.5 for every 1 white woman. Reliable statistics on Native American incarceration rates are not systematically collected across the nation, but studies done at the state and local levels indicate disproportional arrest, sentencing, and incarceration rates (Ross 1998).

Special thanks to the current and past staff and volunteers at Justice Now for their work to amplify the testimony and activism of people incarcerated in women’s prisons. An extremely special thanks to my friend Sam Page for alerting me to the struggle around reproductive justice in California prisons and for teaching me to think about what was happening in terms of eugenics. Thanks to Dean Mathiowetz and Neda Atanasoski for giving feedback on earlier iterations of this essay and for their seemingly endless intellectual generosity.

1 I use terms such as “person incarcerated in a women’s prison” to acknowledge that not everyone housed in a woman’s prison identifies as a woman. Jail and prison housing assignments are generally made based on the state’s determination of gender rather than individual self-identification. This is also the practice of many activist organizations that work with people housed in women’s prisons.


3 See Ross (1998), Richie (2005), Sudbury (2005), and Law (2009).
A number of scholars, including Michelle Alexander (2010), argue that racially disproportionate mass incarceration has become a means of perpetuating racial disenfranchisement and dispossession in the United States. Those convicted of crimes have civil and political rights revoked, including what are otherwise constitutionally protected freedoms of movement, association, and speech. Locking up people of color at disproportionate rates ends up removing civil and political rights at disparate levels in specific communities.

This racialized curtailment of rights has reproductive effects, limiting or removing the right for people of color to have and raise children (Human Rights Program at Justice Now 2009; Hoffman 2010). The phenomenon is best understood through what Loretta Ross (2002) terms “reproductive justice,” an analytical framework that attends equally to contraception and abortion access, and to population control policies as reproductive issues. Reproductive justice links historical practices of controlling the reproduction of women of color through genocidal sexualized violence, forced reproduction and inheritance of slave status, immigration restrictions, and coercive birth control to the reproductive effects of modern regimes of punishment (Davis 1983; Roberts 1997; Khanmalek 2014). Advocates argue that the prison system specifically perpetuates racialized and gendered reproductive injustice by denying incarcerated people of color the right to have and parent children, exposing prisoners to medical neglect that can lead to reproductive problems, and subjecting imprisoned people to torturous conditions during childbirth. While courts have upheld people’s right to adequate health care while imprisoned, and in some cases these rulings have led to changes in the provision of care, prisoners and their advocates argue that prison health services, including reproductive health care, continue to be inadequate.

Feminist public intellectuals and prisoner advocates draw parallels between prison sterilizations and the surgeries conducted during California’s eugenics era, which lasted from 1909 to 1978, when over twenty thousand people deemed “feeble-minded” or “insane” were coercively sterilized in state institutions (Stern and Platt 2013; Law 2014). However, the implications of this form of biopolitics, either in spite of, or in adaptation to, the state and federal regulations that were put in place to end coercive sterilization, have yet to be

4 See Davis and Shaylor (2001), Human Rights Program at Justice Now (2009), Law (2009), and Hoffman (2010).

5 See, for example, ongoing calls to action posted by California Coalition for Women Prisoners at http://womenprisoners.org/?cat = 10.

6 Some of this information is also taken from “Gender Justice Statement Opposing Prison Expansion and Eugenics,” published by Justice Now and the Committee on Women, Population, and the Environment, circulated at “From Ferguson to Salinas,” University of California, Santa Cruz, March 6, 2015. Hereafter cited as “Gender Justice Statement.”
fully addressed. In this article, I examine how informed consent, which was put in place as a form of protection, operates as one of the mechanisms through which biopolitical sterilization persists. Rather than an argument about the failure of existing regulation, or an essay that dismisses informed consent regulation as irrelevant to the inevitable persistence of biopower, I am instead suggesting that informed consent is itself part of biopolitical power.

I draw on an unconventional archive that includes investigative journalism, state audits, legislative testimony, critical feminist theory, activist materials, and feminist speculative fiction. Putting these diverse sources into conversation disrupts the discursive structures of several fields—legal, activist, theoretical—within which problems are framed and solutions are produced, and exposes the ways that bureaucratic and administrative structures produce some possibilities and deny others. While state agents understand problems in terms of legality and illegality, activist visions expose how these narrow terms of state discourse fail to produce justice. While activists sometimes explicitly draw on feminist theory, and other times organically produce it, their work must be strategic to win concessions that will aid people in prison. In other words, they too must work within certain limits of the possible. Feminist speculative fiction is one way of exploding the discursive and material structures of possible/impossible. Thinking through the terms of alternative futures and parallel universes can provide an alien or outsider perspective that opens up to other imaginaries of problem and solution.

If public policies designed to protect people from state control of reproduction fail to challenge biopolitical power, this adds support to the argument that reproductive justice requires an abolitionist and transformative orientation that is radically distinct from calls for prison reform. Angela Davis (2003) has pointed out that it was through a series of humanitarian reforms that the prison system was consolidated, which has led prison abolitionists to distinguish between reformist reforms and “nonreformist reform[s]” (Gilmore 2007, 242). Ruth Wilson Gilmore similarly argues that many reformist reforms “get caught in the logic of the system itself, such that a reform strengthens, rather than loosens, prison’s hold” on people, economic relations, and social imaginaries (2007, 242). Gilmore points to the possibility of creating “nonreformist reforms” that consciously work to undo the social control logic.

Prison abolitionists use the terms “reformist reforms” and “nonreformist reforms” to help distinguish between reforms that work to strengthen the hold of the prison system and carceral logic on society (reformist reforms) and changes that work to decriminalize people and deconstruct carceral logic (nonreformist reforms). I view informed consent as working in the first category of reformist reforms, because, as Gilmore defines, it strengthens the legitimacy of the prison system. Nonreformist reforms, in contrast, would be those that helped to denaturalize the existence of the prison and the reproductive control function of the prison.
of the prison system and have a result of diminishing criminalization. Informed consent purports to protect vulnerable people from coercive sterilization. However, because biopolitical power persists in spite of or in adaptation to regulations put in place in the name of ending coercive sterilization, informed consent has functioned largely as a reformist reform that works to consolidate carceral regimes. Prison abolition offers a counter to biopolitical disciplinary power and thus is the ground for reproductive justice.

**Informed consent as the solution**

Corey G. Johnson’s investigation into twenty-first-century prison sterilizations received broad media attention across the state and nation ( *Sterilized Behind Bars* 2013; Stern and Platt 2013; Law 2014). Combined with advocacy efforts from the Oakland-based legal clinic Justice Now, the article put pressure on the California State Legislature to act. In August 2013, the Senate Public Safety Committee called on the Joint Legislative Audit Committee to authorize the state auditor to conduct an investigation. Auditor Elaine Howle concluded her inquiry into the sterilization of people in women’s prisons between fiscal years 2005–6 and 2012–13 with a report published in June 2014. The report’s primary conclusion is that at least thirty-nine cases of tubal ligations in the time period surveyed had “deficiencies” in informed consent procedures (Howle 2014, 1).

The auditor’s report belies a desire for easy ethical answers to questions of reproductive sterilization. Yet the report is rife with trouble, where the “problem” of sterilization appears to defy regulatory fixes. For example, appendix A of the article shows that a total of 852 procedures in the time period covered likely resulted in sterilization, including hysterectomies, oophorectomies, and tubal ligations. The auditor wrangled this problem into a more manageable size by reviewing only the 144 cases of tubal ligations. She reasoned that the only purpose of tubal ligations is sterilization, while other procedures that result in sterilization could be justified as medically necessary. It is telling of the desire for easy ethical solutions that the state auditor washed her hands of the more difficult task of sorting out whether consent had been sought from individuals who had been sterilized in cases of medical emergency.8 The latter would have involved investigating a far

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8 Myla Vincenti Carpio (2004) has critiqued a similar practice on the part of the federal General Accounting Office (GAO), which investigated the United Indian Health Service following accusations that the service was coercively sterilizing Native American women during the early 1970s. According to Carpio, “By limiting the evidence to consent forms, investigators ignored possibilities of abuse in the form of coercion or the use of sterilization as a primary di-
greater number of procedures and would have required the auditor to grapple with complicated questions about how consent can be given once a physician has named an intervention as medically necessary. This might have called for an entirely different type of inquiry that involved interviewing the recipients of surgeries in addition to reviewing their medical files.

Another moment of trouble in the report is the comment that the number of procedures where informed consent was not obtained is not 100 percent determinable. The auditor writes, “The true number of cases in which Corrections and the Receiver’s Office did not ensure that consent was lawfully obtained prior to sterilization may be higher” due to hospital documents being regularly disposed of and/or inconsistencies in recording when sterilizations were conducted at the same time as a cesarean section (Howle 2014, 20). Dispensing with the ethical questions surrounding whether any truth could be gained from files that medical staff may have manipulated for their own purposes, the audit merely proceeded to review the available files. The auditor failed to undertake any effort to interview medical staff or sterilized prisoners for the story behind the files.

The very premise of an audit is that combing through the medical files of each sterilized prisoner can get to the truth of whether sterilization was coercive or consensual. Ignoring other questions such as whether prisoners are in a position to give informed consent, the audit portrays consent as a technically measurable legal device. It poses the question “Was informed consent obtained?” and answers with a simple yes or no, measured by how closely the existing forms match the ideal legal version. If informed consent is found to have occurred, then the state can be recused from any obligations for further justice.

The audit speaks of “deficiencies” in informed consent procedures, primarily doctors’ failure to properly complete the consent form. Failures included the lack of a signature showing that the patient was mentally competent and understood the long-term effects of the procedure, and evidence that medical or prison officials had forged the date intended to demonstrate that the necessary waiting period had been completed before performing the surgery. The report also observes a second deficiency: in all but one single case, medical and prison officials did not follow a state law that requires approval from both a state prison medical committee and a committee at the federal receiver’s office overseeing state medical care. According to the auditor, legal counsel concluded that the problem with these deficiencies is that

agnosis without options” (2004, 43). Many of Carpio’s critiques of the GAO investigation inspired the concerns I’ve raised in this section.
they put both prison doctors and the federal receiver at risk of being successfully sued (Howle 2014, 21). However, I argue that framing the problem of sterilization as one of liability elides questions of justice for the victims. The reliance on the term “deficiencies” demands a solution that merely supplements an existing system with a missing ingredient, in this case stricter adherence to existing informed consent law.

Documents from Justice Now reveal a more complicated picture about the possible ethical violations and injustices surrounding the sterilizations. For one, they note that nonconsensual tubal ligations were only a small part of reproductive state violence against people imprisoned in women’s prisons. In a March 2012 report to the California Legislature’s Public Safety Committee, the then-executive director of Justice Now Cynthia Chandler shared that in one case, “a 40-year-old black woman imprisoned at [Valley State Prison for Women] was asked just before her cesarean section birth if she wanted her tubes tied while she was on the delivery table with her arms strapped down and out from her body. The doctor asked, ‘Are we tying your tubes here?’ The birthing woman adamantly refused and stated that she only consented to the cesarean birth. She still is not certain whether her refusal was acknowledged or ignored.”

The most glaring ethical issue here is that informed consent was sought while the patient was in active labor, which would be a violation of federal regulations regarding sterilizations if this surgery were funded by federal dollars. In another case, a Latina woman was offered a tubal ligation while sedated for a hernia surgery. Both of these cases raise a second serious concern stemming from the note that each patient was unsure whether her denial of consent was honored. As the auditor’s report observes, prison doctors could easily document a procedure as a cesarean section or other medical procedure without mentioning that a tubal ligation also occurred and so avoid triggering state oversight (Howle 2014). On a related note, Chandler testified, “Our documentation process has uncovered a number of cases which suggest that hysterectomies and oophorectomies have been used as the first response to problems such as uterine fibroids or ovarian cysts, when far less invasive remedies were available.”


10 Ibid.
but document it as necessary for another medical purpose and thereby avoid oversight.

Auditing informed consent allowed the state to respond fairly swiftly to the problem of prisoner sterilizations. However, the desire for easy solutions to sterilization undermines more complicated questions about consent, including the overuse of surgeries that could result in sterilization, the ease with which physicians could potentially manipulate medical documents, epistemological questions about authoritative evidence, and the possibility of justice in a liability-focused state. As I will pursue below, a critical reading of informed consent that attends to biopolitical and disciplinary power highlights other problems with informed consent as an ethical and legal solution to California’s embarrassment over reproductive sterilization in the twenty-first century.

**Entrepreneurial biopolitics**

Twenty-first-century prison sterilizations confirm the claim of reproductive justice theory that biopolitical power persists beyond the legal termination of the eugenics era (Roberts 1997; Ross 2002; Stern 2005). Yet questions remain as to why population control practices continue to emerge, despite state regulations designed to protect vulnerable populations. I speculate that it is because practical solutions to coercive sterilization, such as informed consent, do not resolve the racialized anxieties about the health of the body politic that drove earlier iterations of biopolitics, such as neo-Malthusian eugenics. Racialized, gendered, and classed biopolitical discourses are cited and adapted to twenty-first-century conditions, including the existence of informed consent regulations.

In her groundbreaking *Killing the Black Body*, Dorothy Roberts (1997) argues that reproductive control through the criminal legal system repeats earlier racial discourses and is highly adaptive to new legal and social terrains. Roberts suggests, “A popular mythology that portrays Black women as unfit mothers has left a lasting impression on the American psyche” (1997, 8). She sketches out some of the archetypal figures that make up this mythology, including the Jezebel, the Mammy, and the Matriarch, who she argues were developed to justify control of black reproduction under slavery. Roberts finds that these figures continued to be deployed in public policy debates throughout the twentieth century to justify coercive birth control and sterilization, family planning programs that pathologized black motherhood, and eventually racist welfare policies that destroyed public social safety nets. This racist discourse, as Roberts so thoroughly illustrates, had material effects. Operating under racist rubrics, medical professionals continued to coerce poor women
of color to take dangerous forms of birth control in the 1980s, ostensibly to promote the greater public good.

Using Roberts’s framework encourages an analysis of prison-medical discourses that cite and adapt long-standing tropes about women of color and poor women. For example, physicians in the recent California case put forward justifications that were suggestive of Thomas Robert Malthus’s (now debunked) mathematical modeling, which purported to demonstrate that food production could only increase arithmetically while human population naturally increased at an exponential rate. Because of these different rates of return, famine and disease would inevitably lead to population collapse, and there was no way for the rich to alleviate the suffering of the poor. By allowing poor people to have children that they can’t otherwise support, Malthus believed, charity works to “create the poor” ([1798] 1999, 39). Although Malthus regarded birth control as a useless and even harmful intervention into the poor’s uncontrollable reproduction, twentieth-century doctors took it upon themselves to fix the Malthusian population problem that they believed was draining state resources and causing the poor so much misery. This active engagement in managing reproduction marks a shift in population politics from Malthusian pessimism to neo-Malthusianism and early twentieth-century eugenics, the exemplar par excellence of Foucauldian biopolitics (Foucault 1990).

It isn’t common knowledge that California was the nation’s most prolific sterilizer during the eugenics era. According to California Senate Resolution No. 20, passed in 2003, over twenty thousand people were sterilized coercively in California between 1909 and 1964. This represents almost one-third of the estimated sixty to seventy thousand people coercively sterilized nationwide in the same period. California eugenics law did not contain provisions for a state eugenics board, so physicians in state hospitals and state homes were given wide latitude to sterilize candidates who fit state criteria, as long as the physicians could convince the superintendent of state hospitals, the secretary of the State Board of Health, or the State Lunacy Commission that the procedure was necessary (Wellerstein 2011). The law also provided for the “asexualization” of people in state prisons through more restricted criteria, although the official number of people sterilized this way is unknown. Alexandra Stern has uncovered evidence of at least six hundred

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sterilizations in California prisons during the eugenics era that have still not been officially acknowledged (2005).

The eugenics era laws did not require what we now call “informed consent” for adults until the 1950s, but physicians conducting the sterilizations did ask for consent from their patients’ family members as a kind of courtesy (Stern 2011). Prominent California eugenicists who studied the state’s early sterilization practices, Ezra Gosney and Paul Popenoe, praised institutional heads for securing consent for sterilizations that were to be performed even though that consent was not yet required under the law (Gosney and Popenoe 1929). Gosney and Popenoe also claimed that patients asked for and were mostly enthusiastic about the opportunity to receive the very sterilizations that were later (in 2003) deemed by the state to be coercive.

While institutional sterilizations declined in California in the 1950s due to court rulings that made it more burdensome for physicians to secure state approval, coercive sterilizations continued, as alleged in the Madrigal v. Quilligan class action lawsuit against Los Angeles County Hospitals, decided in 1978. The plaintiffs in Madrigal argued that in California, doctors were targeting Mexican women and other Latinas/Latinxs for sterilization, using tactics ranging from refusing to translate the consent documents into the patient’s native language to threatening to cause injury to coerce them when they refused (No más bebés/No More Babies 2015). Similar accusations were made in the same time period by African American, Puerto Rican, and Native American women against a variety of federal and state institutions in other parts of the country.

Women-of-color activists worked to end sterilizations in the 1970s, despite conflict on this issue with mainstream women’s organizations dominated by white middle-class women (No más bebés/No More Babies 2015). Government regulators proposed strengthening informed consent as a response to sterilized women of color’s claims that they were being systematically targeted for sterilizations (Carpio 2004). One idea was to increase the waiting period between the time when the consent form was signed and the time when the procedure took place. In 1979, federal regulations went into effect that required strict informed consent procedures for reproductive sterilization, including a thirty-day waiting period, for anyone receiving medical care under a program that is fully or partially funded by the federal government (Carpio 2004). That same year, concerns about medical research being conducted on

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incarcerated people detailed in the Belmont Report led to federal regulations that required strict informed consent procedures for people in prison and institutional review oversight (US Department of Health, Education, and Welfare 1979). The Belmont Report and subsequent regulations are not about sterilization per se, but they have nevertheless become an important legal resource for reproductive justice activists because the regulations describe incarcerated people as a vulnerable population who require a higher standard of informed consent than nonincarcerated people. In California specifically, the legislature repealed its eugenics laws in 1979 in response to the Madrigal case (Stern 2005). However, after 1979 sterilizations of people in prison could still technically be performed by states as long as federal funds weren’t used and as long as it wasn’t in the name of eugenics. Additional protections specifically for prisoners were added to California’s Title 15 in 1994, which released state funds for surgical procedures that resulted in sterilization only if the life of the patient was at risk and only if top medical officials gave approval in advance of the surgery (Howle 2014).

This biopolitical history of slavery, eugenics sterilization, and twentieth-century anti-immigrant panics must be considered when reading the comments of twenty-first-century prison doctors about why they worked to sterilize prisoners. Johnson’s report on California’s prison sterilizations included interviews with medical staff at Valley State Prison for Women, notably OB-GYN James Heinrich and Chief Medical Officer Daun Martin (Johnson 2013). Both Heinrich and Martin expressed concerns about poor imprisoned women as reproductively out of control and as threats to the health of the body politic. Heinrich implied that prisoners who have children are straining state resources, and he “described the $147,460 total [for a tubal ligation] as minimal. ‘Over a 10-year period, that isn’t a huge amount of money,’ Heinrich said, ‘compared to what you save in welfare paying for these unwanted children—as they procreated more’” (Johnson 2013). Martin similarly expressed the opinion that women in prison were desperately resorting to crime in order to go to jail and receive health care there. Johnson writes, “Martin, a licensed psychologist, also claimed that some pregnant women, particularly those on drugs or who were homeless, would commit crimes so they could return to prison for better health care. ‘Do I criticize those women for manipulating the system because they’re pregnant? Absolutely not,’ Martin, 73, said. ‘But I don’t think it should happen. And I’d like to find ways to decrease that!’” (Johnson 2013).

Heinrich also preempted public concern about the sterilizations by adamantly rejecting the idea that any of the surgeries that resulted in sterilization were coercive. He told Johnson: “They [prisoners] all wanted it done. . . . If they come a year or two later saying, ‘Somebody forced me to have this done,’
that’s a lie. That’s somebody looking for the state to give them a handout. My guess is that the only reason you do that is not because you feel wronged, but that you want to stay on the state’s dole somehow” (Johnson 2013). In Heinrich’s view, any formerly imprisoned person who claims not to have consented to sterilization is engaged in a ploy for financial gain, manipulatively trying to sue the state for medical treatment that was actually desired at the time it was offered. This is similar to what eugenicists Popenoe and Gosney argued in 1929, when they insisted that any mentally disturbed person who complained about sterilization was merely acting out of mental disturbance. Denying initial consent is exactly what a crazy person would do, Gosney and Popenoe maintained, just as Heinrich asserts eighty years later that it is just like women prisoners to try to get money for a procedure they wanted all along. These discourses discredit any sterilized people who might be seeking justice by portraying them as out-of-control, manipulative liars.

Although Heinrich and Martin do not explicitly mention race, they implicitly invoke the image of women of color. Earlier racialized biopolitical discourses—from neo-Malthusian eugenics, to 1960s development and population politics, to late twentieth-century antiblack and anti-immigrant welfare policies—have become common sense in the United States. References to welfare, drug use, homelessness, and manipulative criminals are all racialized in the public imagination. The prison doctors’ comments appeal to racialized, classed, and gendered public anxieties and justify the doctor’s entrepreneurial pursuit of loopholes in the state regulations allowing sterilizations to continue in the twenty-first century.

I use the term “entrepreneurial” deliberately here, drawing another parallel between this case and the eugenics era. In the eugenics era, California was unique in the nation in that it had no state board overseeing sterilizations. Alex Wellerstein (2011) argues that this structure enabled wide variation in the number of surgeries performed at similar facilities, based solely on the interests and beliefs of the medical superintendent. In the twenty-first century, Martin was similarly entrepreneurial as an institutional supervisor who collaborated with doctors like Heinrich to implement a proactive sterilization program at Valley State Prison for Women. Though her comments are couched in the language of care, they are, I argue, a form of entrepreneurial biopolitics.

The California state auditor’s report gives evidence that the recent prison sterilizations were indeed classed and racialized. Thirty-four percent of tubal ligations were on people in women’s prisons with less than a seventh-grade reading level, a number that jumps to 50 percent for women with less than a ninth-grade reading level (Howle 2014). Given that completion of high school is a significant marker for financial earning power, it can be assumed
that many of the women in this category were living at or below the poverty level upon entering prison. The report also found that 24 percent of the 144 tubal ligations were performed on black women, far outstripping their proportion in the California population as a whole (6.2 percent according to the 2010 US Census), although slightly less than their representation in the California prison system (29.3 percent in June 2008; Howle 2014).\textsuperscript{14} Thirty-seven percent of surgeries were performed on prisoners classified as Hispanic or Mexican, which is comparable to the overall population of Hispanics in California (37.6 percent) but outpaces the representation of Hispanic women in the prison system (29.4 percent of total women’s prison population) and hearkens to the claims made in the \textit{Madrigal} case. Six percent of the sterilizations were conducted on people of “other” races, which would include Asians, Pacific Islanders, and Native Americans. This means that whites made up about one-third of those sterilized, an underrepresentation both in relation to the white population in the state (40.1 percent) and the white prison population (36.1 percent of total women’s prison population). However, this also means that poor white prisoners were not immune to being targeted for coercive sterilization.

This data is a testament to the role of the entrepreneurial state actor in turning discourse into materiality. The prison doctors’ anxiety about the threat these prisoners posed to scarce state resources and the health of the body politic signals that the racialized, gendered, and classed anxieties that undergird biopolitical power persist despite regulatory reforms such as informed consent. If racialized and gendered anxieties are not resolved, state regulations become mere obstacles for doctor-entrepreneurs to circumvent in order to continue to control population and reproduction to secure the health of the body politic.

\textbf{Consent in a time of social death}

Misty Rojo, a formerly incarcerated person and current codirector of Justice Now, argues that most of US society views imprisoned people as “throwaways” or “trash” (\textit{Sterilized behind Bars} 2013). Rojo’s comments are consistent with feminist critical race theory and postcolonial theory’s insistence

\textsuperscript{14} Percentages in this paragraph come from the state auditor’s report (Howle 2014). Percentage of state residents come from the 2010 US Census: https://www.census.gov/2010census/popmap/ipmtext.php?ll=06. Percentage of prison population come from the California Department of Corrections and Rehabilitation daily population totals: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Monthly/TPOP1A/TPOP1Ad0806.pdf.
that women of color and colonized people become available for violence through the law’s systematic denial of their personhood and subjectivity. Lisa Marie Cacho (2012) calls the spatial and temporal realm to which racialized and gendered populations have been relegated “social death.” Cacho describes this realm as one where people are not eligible for legal recognition of civil and political rights or for public empathy for their dispossession of these rights—nor is it possible to value their lives and resistance under the imperatives of biopolitics.

The social death thesis indicates that noncoercive consent is not actually possible for people who are locked up, because the disavowal of their agential and autonomous personhood constitutes the very ground on which the notion of consent is consolidated (Cacho 2012). Echoing other critiques of liberalism that have considered how concepts such as freedom, property, and individuality are constituted through the devaluing of the other, Cacho insists on viewing “criminalization as both a disciplinary and regularizing process of devaluation that does not just exclude some people from legal ‘universal’ but makes their inclusion a necessary impossibility” (2012, 64).

In other words, the denial of personhood to people imprisoned in women’s prisons, including the denial of their individuality, agency, autonomy, and ability to consent, is formulative of these concepts in the free world outside of the prison.

Prisoner advocates have used something like the social death thesis to complicate the state’s claim that informed consent constituted a sufficient ethical practice for reproductive sterilization. Pointing to the Belmont guidelines on informed consent for medical research, which indicate that informed consent is not possible during times of “stress, undue pressure, duress, or undue influence,” prisoner advocates argued that imprisonment is exactly such a time of duress. Rojo testified at the 2013 hearings at the California State Capitol: “When you are in prison, you do what you are told to get out. Period. So even in the idea of medical care, if a doctor tells you should do this, you are automatically inclined to feel like you should do it, simply because of the environment that you are in. And you are likely to sign a paper without understanding the lifelong ramifications, they hand you a paper, you sign it, that’s it. Some people may be happy with that decision, but at the end of the day it is not informed consent, and it is coercive” (in Sterilized behind Bars 2013). Rojo argues, in short, that because prison is an inherently coercive environment, an imprisoned person is unable to give noncoercive consent to sterilization.

See Butler (2004), Hong (2012), Mignolo (2013), and INCITE! (n.d.).

Panels for Alternative Custody Expansion.
Lobbyists for prison doctors also recognize the difficulties of securing noncoercive consent from imprisoned people. In a letter to the chair of the California Senate Public Safety Committee, the American Congress for Obstetricians and Gynecologists District IX (ACOG-IX) asserts that, “given the inherently coercive environment of incarceration, as cited in The Belmont Report, which recognized the challenges of incarcerated persons being able to have true informed consent for research while incarcerated, and as well as the recent evidence of abuses in the California [sic], an adequate process may be difficult if not impossible to design, but we would like the opportunity to try.”

Shannon Smith-Crowley, director of government relations for ACOG-IX, insists that there are “medically indicated sterilizations for the purpose of birth control. . . . There are some women whose medical history is so concerning,” Smith-Crowley explains, “that a subsequent pregnancy has a high likelihood of death or severe complication . . . a tubal ligation at the time of delivery of the current pregnancy is medically indicated.”

ACOG-IX’s position differs from the social death thesis and from that of prisoner advocates, because they interpret the improbability of noncoercive consent as a challenge they are capable of taking on in order to preserve the right of incarcerated people to be sterilized. According to Johnson, this initiative began with prison doctors: “After learning of the restrictions . . . [Martin] and Heinrich began to look for ways around them. Both believed the rules were unfair to women, [Martin] said. ‘I’m sure that on a couple of occasions, [Heinrich] brought an issue to me saying, “Mary Smith is having a medical emergency” kind of thing, “and we ought to have a tubal ligation. She’s got six kids. Can we do it?”’” Martin said. ‘And I said, “Well, if you document it as a medical emergency, perhaps”’” (Johnson 2013). In the state auditor’s report, doctors indicate that they sought loopholes to state law merely to bend to the “desire” of the prisoners to be sterilized (Howle 2014, 25).

Despite this seemingly feminist position that purported to preserve both imprisoned people’s choice and their access to medically indicated surgery, it is clear from other documents that Martin articulated the “medical emergency” not as an exceptional case but as a systematic way to justify reproductive sterilization. Chandler from Justice Now points out that Martin introduced the idea of using the medical emergency as a loophole in the sterilization law in 2006. The state auditor affirms that at around the same time, some prison

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17 Letter from Shannon Smith-Crowley, Director, Government Relations, American Congress of Obstetricians and Gynecologists, District IX, to California Senator Lonnie Hancock, Chair of Senate Public Safety Committee, April 17, 2014. On file with author. Emphasis added.

18 Ibid.

19 Panels for Alternative Custody Expansion.
doctors used the medical emergency as a shortcut to avoid having to wait the full thirty days after obtaining informed consent and to avoid getting preapproval from prison and state officials for nonessential surgery (Howle 2014). Thus, it is suspicious that ACOG-IX positions prison doctors as generous in their willingness to take on the task of securing what they admit to be elusive patient consent. The medical emergency argument is ultimately more empowering for doctors than for patients, in the sense that it accumulates heroic expertise for medical professionals and positions them above regulations as those who know what is best for patients experiencing out-of-control reproduction. In this sense, the medical emergency loophole exacerbates existing power imbalances between “free-world” doctors and imprisoned people, not to mention disproportionately white, male doctors treating women and gender-nonconforming, racialized, and poor imprisoned people.

Justice Now insists that we read these efforts of prison-doctor lobbyists to protect the right to sterilize as a red herring. In the early 2000s, a federal court found California prisons to be constitutionally negligent of prisoner health (Howle 2014). Despite reforms overseen by the federally imposed receiver’s office, Justice Now’s 2012 testimony to the state legislature lists multiple examples of lifesaving medical procedures that continued to be routinely denied to people in women’s prisons. Chandler writes, “There is now virtually no specialized treatment provided to people with ongoing chronic conditions and many standard medications have been dropped from the prison formularies.” Her testimony raises the question of why prison doctors performed so many elective sterilization procedures while other lifesaving procedures were systematically denied despite also being eligible for the medical emergency clause.

What should we make of this recognition of consent in the instance of sterilization, when the agency to make decisions about a number of other issues is utterly denied to prisoners under the regime of social death? The signature on the informed consent form is a legal recognition extended to people who are otherwise denied autonomy over themselves and, the vast majority of the time, denied the legal recognition of a self that can consent freely. Saidiya Hartman (1997) argues that the recognition of legal subjectivity for those under the regime of social death should be interpreted as part of state violence. In her work on the US Reconstruction era and the extension

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20 “Gender Justice Statement.”
21 See Panels for Alternative Custody Expansion. My own experience as a prisoner advocate in California for almost ten years also attests to this neglect. I routinely wrote support letters for people in prison receiving inadequate medical treatment and ultimately dying of illnesses such as hepatitis C, diabetes, and liver cancer.
of legal personhood to formerly enslaved people, Hartman recalls that under slavery, the racialized other is recognized by the law to have a “will” only at the single instant when she needs to be held accountable for violence against white individuals. Under these conditions, the enslaved person (who does not possess herself) who exerts agency is viewed as a threat to legally recognized subjects and therefore can be understood only as a criminal. What appears as a gesture of humanity, to legally recognize the enslaved person as a subject, according to Hartman, merely works to reinscribe the “object status and absolute subjugation of the enslaved” (1997, 62). Hartman argues that during Reconstruction, subjection under slavery transformed into a new type of legalized subjection of “free” black people through similar terms of juridical personhood, which seemingly recognized only criminal forms of agency. I suggest that the informed consent of prisoners relegated to social death operates in much the same way as Hartman has described: it is a seemingly humane legal fiction that recognizes “will” only at the instant when it is useful for the biopolitical state.

I am not suggesting that informed consent to sterilization is merely a sham legal cover for the inevitable violence of the state. Instead, I speculate that informed consent came to be part of the process of disciplining people in women’s prisons for their out-of-control reproduction. Here I invoke Michel Foucault’s theorization of discipline as an aspect of biopower. In volume 1 of The History of Sexuality, Foucault proposes that in the seventeenth century, sovereign power was transformed from the arbitrary power of the king to kill to a more diffuse and pervasive power that had the “function of administering life” (Foucault 1990, 138). Biopower for Foucault is thus made up of twin techniques: first, disciplinary power, which is invested in “the body as a machine, its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls” (1990, 139). Second is the “bio-politics of population,” a macrointervention focused on the “species body” and the regulation of health, reproduction, and longevity of the body politic (139).

Because disciplinary and regulatory power are intertwined, I insist that disciplinary power targets even those who exist in the realm of social death. Sterilization surgery is, and has been since the eugenics era, both a regulatory action to control populations and a disciplinary action against bodies that are out of control. In the early twentieth century in California, one of the groups targeted for sterilization included people assigned to the category of woman who had sex outside of heterosexual marriage, those who engaged in masturbation, or those who passed on “defective” traits to their children.
within heterosexual marriage (Gosney and Popenoe 1929, xiii; see also Pope-
noe and Gosney 1938).22 During the eugenics era, reproductive steriliza-
tion worked to normalize those associated with sexual deviance by curtailing
their pathological reproduction, which threatened middle-class community
values and the health of the (white) race. As I’ve illustrated above, prison
doctors in the twenty-first century articulate similar disciplinary motivations
for sterilizing prisoners; their comments portray prisoners as so incapable
of reproductive self-governance, and so threatening to state resources, that
they require the intervention of the prison doctor. The documentation of in-
formed consent assists both doctors and the state in justifying disciplinary
sterilizations. Heinrich is ready to shame prisoners for suggesting they didn’t
give consent, and to accuse them of manipulation and greed, because he in-
sists, “they all wanted it” as evidenced by the completed consent form (John-
son 2013). Even with documented deficiencies in informed consent, the
state auditor justifies the sterilizations by explaining that prison doctors
might have been “confused or misinformed” about the regulations (Howle
2014, 26).

Under the regime of social death, disempowerment through discourses
of medical emergency, and the disciplinary effect of sterilization, the com-
mitment of entrepreneurial state actors to informed consent appears not be-
nevolent but rather part of the continuum of state biopolitical violence. Yet
even if the case is made that those who were sterilized were targets of state
violence, Cacho’s conceptualization of social death suggests that empathy is
unavailable for the racially criminalized other (2012). According to Cacho,
we in the free world are unable to value their lives without playing into a
system of respectability politics that perpetually disavows someone and re-
egates them to the realm of social death. How then can we build the polit-
ical imaginaries and political will to generate abolitionist reforms that chal-
lenge rather than perpetuate institutional sterilizations?

Biopolitical fiction
One possible way to explode our current political imaginaries out of the bina-
ries of legal/illegal, and even legalistic notions of justice/injustice, is through
a switch in genre. From genres insistent on the factual, or real, including in-
vestigative journalism, state audits, legislative testimony, critical feminist the-

22 This is a point made by Stern (2005) that I have also observed in my own research into
state hospital patient case files at the California State Archives.
ory, and activist flyers, I turn to feminist speculative fiction as a genre that is far less invested in being “real.” Feminist speculative fiction disrupts discursive and material structures of what is politically possible/impossible. For example, by employing an alien perspective, Octavia Butler’s 1987 book *Dawn* renders fresh, yet hauntingly familiar, the dynamics of biopolitical power, consent, and reproductive discipline.23 In this section I experiment with literary analysis, suggesting that biopolitical fiction like Butler’s could play a role in creating empathy that doesn’t rely on a politics of respectability for those targeted for biopolitical discipline. Butler creates a world where, because it is simultaneously unfamiliar and has obvious parallels to our world, biopolitical disciplinary power appears to be “alien” in a way that denaturalizes the biopolitics of our world and builds the empathy and political will to create change.

*Dawn* centers on Lilith Iyapo, a black woman anthropologist who awakens in a doorless, windowless room on what she later learns is a spaceship orbiting near Earth. Lilith is told that after life on Earth was nearly wiped out by nuclear war, the few people who remained were scooped up by an extraterrestrial species known as the Oankali. The Oankali reveal to Lilith that they want to produce hybrid or “construct” children with willing humans. Those humans who do not consent to mate are to be returned to Earth, but they will be sterilized, unable to reproduce children without the intervention of the Oankali; their health will also be improved so that they will live hundreds of years longer than an average human. Lilith is given the task of waking up the first group of humans and explaining this “choice” to them, a task she dreads because she knows she will be scapegoated for forcing the humans to choose between abandoning their distinct humanity to become hybrid or living long, childless lives. The alienness of the Oankali means they can’t understand the torture this choice produces in their human rescues/captives.

The Oankali endlessly roam the universe, making deals with the creatures they encounter in a constant biopolitical effort to maximize life. In the project detailed in the novel, the Oankali have set up a rigid disciplinary system to control any human or community that tries to assert agency over life, because humans left to their own agency fundamentally threaten Oankali biopolitics. According to the Oankali’s subcellular perception, humans have a biological fatal flaw in the contradiction between high intelligence and hierarchical behavior thatdestines them to self-destruction. Because the Oankali perception

23 Feminist speculative fiction, and especially the work of Octavia Butler, has been an important resource for feminist theorists exploring the ethics of science and medicine from Donna Haraway’s groundbreaking “A Cyborg Manifesto” (1991) to Karla Holloway’s more recent *Private Bodies, Public Texts* (2011).
is that humans will inevitably destroy life if left to their own devices, they sterilize them, without consent, in the name of maximizing life.

This alien power thinks of itself as benevolent, not just because it saves humans and Earth from complete nuclear destruction but also because it asks for consent before impregnating humans. The human characters, however, experience this benevolence as coercive. Humans in the story repeatedly express that they don’t experience this as a choice at all and are anguished by the fact that the “resister” communities have no children. Lilith and the other characters are confronted with a paradox: they can “choose” to consent to mate with the Oankali and thus ensure the perpetuation of the human species by making it part of a new hybrid or they can “choose” to resist Oankali biopolitics, and thus ensure the slow death of the human species by preserving it in its human form.

Rendering biopower as “alien” through a fictional portrayal sparks the reader’s empathy for those humans suffering under biopolitical power. This is an uncomfortable empathy, however, precisely because the Oankali project is to maximize life. The human resistance in the text challenges the reader’s own internalization of what makes a good citizen under what Nikolas Rose and Carlos Novas (2005) call “biological citizenship.” Rose and Novas describe biological citizenship as an umbrella term for projects that delineate good and bad citizenship and the rights and responsibilities of citizens in terms of their effects on life. Ruha Benjamin names those who resist conscription into this “biologically based citizenship” “biodefectors” (2016, 968) who insist on talking back to scientific discourses, “refusing the terms set by those who exercise authority” (971). Biodefection in Dawn consists of a refusal to invest in one’s life, which as Cacho points out inspires empathy among others in our own world. Asserting agency over life includes choosing when, where, and how to reproduce, as reproductive justice argues, but agency also means taking actions that risk death, destroy one’s own life, or otherwise diminish lifely productivity. Cacho suggests that this kind of un­valuable living is included in what Cathy Cohen calls “a politics of deviance,” a queer politics that challenges the heteronormative “logics of capital accumulation and bourgeois reproduction” (2004, 29).

When biopolitical power is depicted as alien, humans can inspire empathy, even if, perhaps because, they are risking the death of the human species. Their threatened humanity becomes valuable to readers in a way that counters the commonsense reading of racialized, gendered, and classed prisoners who resist biopolitical disciplining as dangerous to the social order. The novel reminds us that power that portrays itself as benevolent because it asks for consent can be experienced as coercive. It reaffirms the resistance to biopolitical discipline through attempts to assert agency over life. In the face of what
seems like the inevitability of social death, as Karla F. C. Holloway (2011) has argued, biopolitical fiction offers one way to reorient ourselves to questions of ethics and justice.

Conclusion

The debate about twenty-first-century prisoner sterilization in California reached a crescendo in mid-2014. California’s efforts to comply with a federal court ruling on overcrowding during the same time period converted Valley State Prison into a men’s facility. People previously incarcerated at Valley State were transferred to one of the state’s other women’s prisons or to the custody of the county of sentencing for supervision (California Department of Corrections and Rehabilitation 2013). This move halved the number of people in California women’s prisons between 2006 and today, although remaining women’s facilities continue to be crowded and experience problems with mental health and other medical services (Associated Press 2016). The auditor’s data suggests that the number of tubal ligations performed in women’s prisons had already significantly decreased starting in 2010, when the Federal Receiver’s office overseeing health care in California’s prisons clarified to its medical employees that tubal ligations should cease (Howle 2014). Furthermore, during the same month when the auditor’s report was released, the California Legislature passed SB 1135, amending the Penal Code to ban “sterilization for the purpose of birth control.” Legally, there can now be no elective sterilization for the stated purpose of birth control in California prisons, even if informed consent is obtained. Finally, prisoner advocates and formerly incarcerated people continue to press the state of California for reparations for those who were coercively sterilized. Work also remains to be done to hold individual doctors accountable, for despite some legislators’ calls for the Medical Board to investigate sterilizing doctors, a recent search of the state’s medical licenses shows that James C. Heinrich is licensed through 2019 to practice as an OB-GYN with no negative marks on his record.

While these last two points indicate ongoing demands for reproductive justice activists, I’ve argued that racialized, gendered, and classed systems

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25 Other loopholes to antisterilization law remain, including the use of unnecessary hysterectomies when less invasive treatment options remain. This could mean coercive sterilizations are ongoing, even though tubal ligations have ceased.

26 See, for example, the 2016 California Democratic Party Platform section on “Women”: http://www.cadem.org/our-california/platform/2016-platform-women.
of biopolitical power can persist despite regulatory reforms. Prison abolitionists have described the many ways that reformist reforms are not always progressive but can become vehicles for reentrenching carceral systems (Davis 2003; Gilmore 2007). As I’ve shown here, well-intentioned reforms can also become a means of biopolitical discipline. For these reasons, reproductive justice for imprisoned people demands an alignment with the vision of prison abolition. Only by seeking a future without walls and cages can we hope to dismantle biopolitical power and carceral population politics.

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