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States of Eugenics: Institutions and Practices of Compulsory Sterilization in California

Alex Wellerstein

Between 1909 and the early 1950s, the state of California sterilized over twenty thousand patients in government institutions for the mentally ill and mentally deficient. Of the many states that had compulsory sterilization programs, California's was by far the largest in terms of patients sterilized, affecting nearly as many people as the sum of the totals from the next four top-sterilizing states combined (figure 2.1).¹ The motivation for these sterilizations has traditionally been associated with the concept of eugenics: the desire to improve the human gene pool by discouraging the reproduction of the "unfit." These mass sterilizations have generally been taken as the most tangible and permanent of all of the American forays into eugenics, and its closest link to the genocidal policies practiced by National Socialist Germany.

The history of eugenics is generally told explicitly as "a history of a bad idea" (e.g., Carlson 2001). It is an intellectual history, an account of the dangerous power of ideology-infected science. This framework, which dominated historical accounts of eugenics since they first started being written in the 1960s, tended to focus on the genesis and transformation of eugenic thought as reflected in the writings of eugenic propagandists and occasionally state legislation.² Aside from legislation for immigration restriction, eugenics had very little federal recognition in the United States, and was prosecuted mainly on a state-by-state basis. In the American case, the intellectual history approach has been used extensively to trace strong connections between the American embrace of eugenics and the case of the Nazis (Black 2003). Such comparisons pack considerable rhetorical impact in a culture that has long prided itself on its crusading role in the Second World War, and the history of eugenics and possible eugenic futures have become the standard case study of the intersection between biology and society.

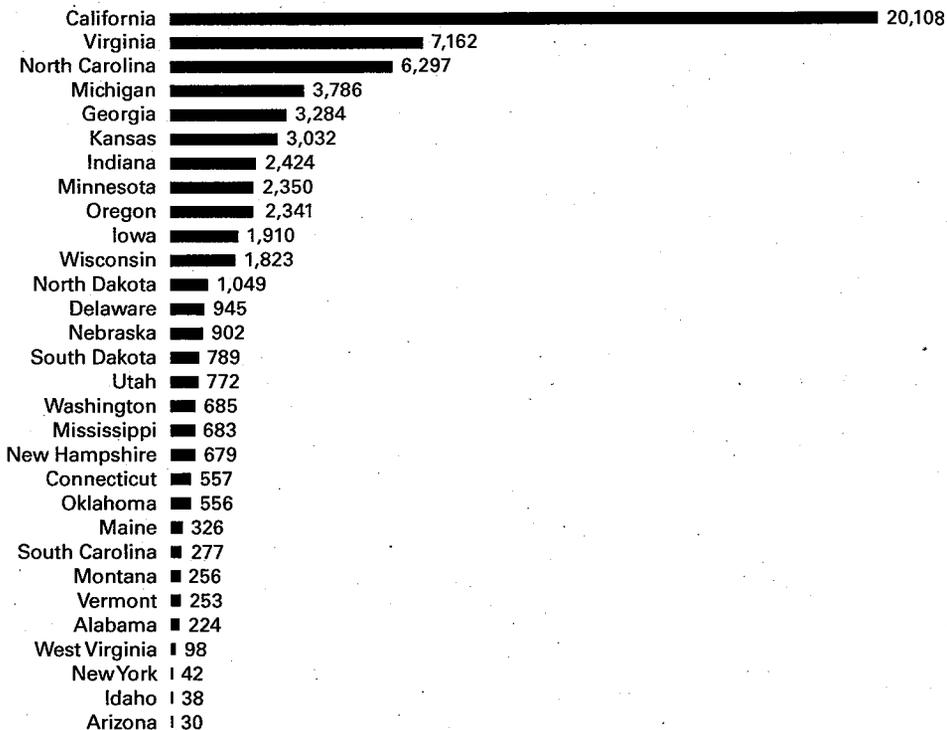


Figure 2.1

Cumulative sterilizations by state, 1907–1964, out of 63,643 total. These statistics are misleadingly precise (many sterilizations no doubt went unreported), but the order of magnitude is probably correct. *Source:* Robitscher 1973, appendix 2; graph by author.

But does this top-down, idea-centric view actually illuminate the American case? I argue in this chapter that California's history of sterilization shows that it does not. A history of ideology neither explains why California's sterilization rates were so much higher than the rest of the country nor gives an account of why they dropped off dramatically in the early 1950s. Although it was the most influential of the state sterilization stories—the Nazis famously pointed to California's success when embarking on their own mass sterilization program (Kühl 1994, 39–44)—California's sterilization program has generally been lumped in with the overall story of American eugenics in a way that neither recognizes nor explains its particularities.³ In this chapter, I look closely at the institutional, organizational basis of sterilization in California, tracing how the power to sterilize—and the questions of who to sterilize, why, and perhaps why *not*—wended their way through legal, medical, and local frameworks.

Because of the particulars of the California case, power ended up being disproportionately concentrated in the hands of individual hospital administrators, who were often intellectually and physically quite distant from the direct influence of eugenics. This institutional view of eugenics paints a more subtle picture of the ways in which ideology undergoes translation and transformation as it becomes practice. The particular model for that process here is one that may call for a more general reevaluation of our overall understanding of eugenics in the American context.⁴

This historical chapter contributes on several levels to a broader work on our contemporary bioconstitutional moment. First, the history of eugenics has been *the* primary lens through which questions of biological power have been read in the late twentieth and early twenty-first century. When James D. Watson decided that the Human Genome Project should, from the very beginning, devote considerable funds to ethical, legal, and social questions, it was because he decided that his failure to do so “might falsely be used as evidence that I was a closet eugenicist” (Watson 2001, 206). Further, our understandings of what is important and what is at stake in questions about the intersections of biology, law, and society are heavily rooted in our historical understanding of past wrongs and their origins. In the case of sterilization laws, the exceptional focus on “ideas” as the motive force has, I argue, diverted our attention from the important ways in which ideas, institutions, and practices are interwoven through processes of coproduction. This chapter adds important nuances and qualifications to the ways in which we think about the application of extreme biological power in a specifically American institutional context; by historicizing the American case, it enriches our understanding of this country's political culture and thereby contributes to the volume's comparative project. At the same time, the chapter points toward the reframing of our historical assumptions in the light of contemporary scientific and technological advances.

Sterilization in the Golden State

In 1922, the Cold Spring Harbor eugenicist Harry H. Laughlin compiled a five-hundred-page monograph devoted to the systematic study of “Eugenical Sterilization in the United States.” Laughlin did this as an enthusiastic promoter of sterilization of the “unfit,” yet it remains one of the most careful studies of the *implementation* of eugenics in the United States. Laughlin was an unreliable narrator with respect to the scientific benefits of eugenic sterilization, but as a reporter of the state of legislative and

political situation in the early 1920s, he displayed a sharp eye for policy analysis (Laughlin 1922; Kevles [1985] 1995, 108–118).

For an avid advocate of eugenic sterilization in the United States, it was not a good moment. There was no federal statute regulating sterilization, and the prospects of one were slim to none. Sterilization laws were adopted exclusively at the state level and were primarily intended for implementation within state-run institutions. By early 1921, fifteen states had passed sterilization statutes, but five of those laws had been struck down as unconstitutional by state courts, and one state had repealed its law. Five other states had pushed sterilization laws through their legislatures, only to have them vetoed by the governor or revoked by popular referendum. Of the nine states that still had sterilization laws on the books, only two—California and Nebraska—seemed to function well administratively, and only California was sterilizing to any great effect (almost 80 percent of the reported 3,233 nationwide sterilizations were performed in the state) (Laughlin 1922, 96–97).

In Laughlin's eyes there were multiple problems. Chief among these were the sterilization statutes themselves. Sterilization was considered a controversial enough operation that it could not simply be justified as a normal operating procedure—unlike an appendectomy, for example, the operation was not deemed as being a medical necessity for the patient, and it required special authorizing legislation. Poorly written statutes created all sorts of difficulties. Physicians at state hospitals were afraid to rely on laws that might be ruled unconstitutional by the courts, as they or their hospitals could then be held liable for mayhem or malpractice. Even in states where statutes had not been challenged, the fear that they might be challenged was significant, as physicians pointed out in testimonials to Laughlin. In states where constitutionality was not a major concern, physicians reported that the administration of the law was so convoluted or contradictory that they were effectively prevented from carrying out operations by excessive “red tape” (Laughlin 1922, 52–92). This was, in the end, Laughlin's impetus for crafting his own “Model Eugenic Sterilization Law” as a guide to state legislators, and to push immediately for a test case to prove its validity. The result was the infamous U.S. Supreme Court judgment in *Buck v. Bell* (1927), in which Justice Oliver Wendell Holmes, Jr., enthusiastically accepted the argument that compulsory sterilization was no more severe a public health measure than compulsory vaccination (Laughlin 1922, 445–452; Lombardo 1985, 2008).

Laughlin had mixed feelings about California. On the one hand, he found its enthusiastic embrace of sterilization encouraging: “To California

must be given the credit for making the most use of her sterilization laws. The history of the application of these statutes shows an honest and competent effort to improve “the racial qualities of future generations” (Laughlin 1922, 52). California seemed to suffer from none of the legal complications that plagued other states. Its sterilization statutes had been revised numerous times since first enacted in 1909, and California's long-serving Attorney General, Ulysses S. Webb, had explicitly endorsed the constitutionality of sterilization soon after it had appeared (Webb 1910). But if “red tape” was not an issue, there was another administrative problem.

Laughlin was well aware that it was not just an “honest and competent effort” that accounted for the actual implementation of state laws. In his analysis, a secure legal environment was required (hence the need for a “Model Law”), and it needed to be implemented in an institutional environment that would not overly complicate it with red tape, contradictory requirements, or other poor “administrative machinery.” Laughlin was no jurist, but he took pains to distinguish between “mandatory and optional elements” of sterilization laws—where “mandatory” and “optional” referred to requirements for the physician, not the patient. If laws gave physicians too much discretion as to whom and why to sterilize, the results would be haphazard:

If a law is meant to be compulsory [for the physicians], then of course there must be no gaps in its chain of mandates, which begins with the order for the appointment of executive officers, and ends with the actual surgical operation of sterilization. A single “may” inserted in the chain of execution makes the whole procedure an optional, or at least a non-compulsory one. The principal elements in the chain are: (1) the appointment of executive agents; (2) the examination of individuals alleged to be subject to the act; (3) the determination of the facts in particular cases, whether the particular person is subject to eugenical sterilization; (4) the order for the actual sterilizing operation. (Laughlin 1922, 114–117)

California got very low marks when judged by this standard. The state sterilization law contained seven “mays,” which Laughlin highlighted in bold type: its “chain of mandates” had considerable gaps. Despite its high rate of use, Laughlin considered the statute “ineffective” because it gave the superintendents of individual hospitals far too much freedom to implement the law or to disregard it. As a psychologist who later opposed the sterilization law put it: “They were not ordered to sterilize—they were permitted to sterilize” (Tarjan 1998, 227).

Laughlin's irritation provides a useful analytic lens. California enacted two laws in 1909 and 1913 under which almost all sterilizations were

performed until the rates suddenly plummeted after 1949 and went to near zero after 1951.⁵ The 1909 statute consisted of a single paragraph:

Whenever in the opinion of the medical superintendent of any state hospital, or the superintendent of the California Home for the Care and Training of Feeble-Minded Children, or of the resident physician in any state prison, it would be beneficial and conducive to the benefit of the physical, mental or moral condition of any inmate of said state hospital, home, or state prison, to be asexualized, then such superintendent or resident physician shall call in consultation the general superintendent of state hospitals and the secretary of the state board of health, and they shall jointly examine into all the particulars of the case with the said superintendent or resident physician, and if in their opinion, or in the opinion of any two of them, asexualization will be beneficial to such inmate, patient or convict, they may perform the same.⁶

“Whenever in the opinion” is the crucial phrase that defines the character of sterilization in California: operations were ordered *at the discretion* of hospital superintendents. Though the laws would change, this fundamental delegation of judgment would not.

The 1909 statute, as noted, did not specify the motivation for sterilization operation too finely; it needed to be only “beneficial and conducive to the benefit of the physical, mental or moral condition” of the patient—a vague requirement centered around value to the *individual patient*, not to any notion of a collective “germ plasm,” “gene pool,” or “future stock,” as eugenicists might have wished. Even the term “asexualization” is vague, being easily associated with castration (an operation with which eugenicists generally did not want their cause to be associated).⁷

The law’s perceived vagueness led to its speedy repeal and replacement with a new, longer sterilization law only four years later. The 1913 statute provided that the centralized bureaucracy that administered the mental hospitals (the State Commission in Lunacy, whose name changed successively to the Department of Institutions and then the Department of Mental Hygiene) could, at its discretion, sterilize a patient. This section seemed to change the lines of authority considerably, but in practice there is no evidence that the centralized bureaucracy went out of its way to identify and order sterilizations without being requested by a hospital superintendent. (Many decades later, California’s Director of Mental Hygiene noted that “this provision of law has not been followed since its enactment.”⁸) Importantly, the first section of the 1913 statute specified that the patient must be “afflicted with hereditary insanity or incurable chronic mania or dementia,” introducing heredity into the determination for the first time, and thus providing concrete evidence that eugenics was a consideration.⁹ Yet the law’s second section was simply an exact duplicate of the original

1909 statute, which enabled sterilization at the discretion of physicians, with no further specification of the kinds of reasons that had to be given.

Additional statutes enacted in 1917 and 1923 changed some of the grounds for sterilization. The 1917 statute added “those suffering from perversion or marked departures from normal mentality or from disease of a syphilitic nature” to the classes of persons who could be sterilized, and the 1923 statute specified that prisoners who had committed sexual abuse on girls under the age of ten could be sterilized “for the prevention of procreation.” Neither revision, however, changed the lines of command or refined the reasons why a medical superintendent could request sterilization.¹⁰ No further changes to this legislation took place until 1951, when the law was substantially rewritten as part of a general overhaul of mental health legislation.¹¹

After the 1913 revision, then, California law allowed for sterilization of hospital inmates for a variety of reasons, including both what could be considered eugenic grounds (heredity) and what could plausibly be considered therapeutic grounds (benefits to individual patients), as well as provisions for punitive sterilizations of prisoners who had committed certain sexual crimes. And the law allowed both the state hospital administration and individual hospital superintendents to determine who would be a candidate for sterilization, although in practice only the latter recommended patients for sterilization.

California, like many other states, had an enthusiastic eugenicist lobby in the form of the Human Betterment Foundation, founded by financier E. S. Gosney with the aid of biologist Paul B. Popenoe, in 1928. Gosney and Popenoe had been involved in tracking the progress of sterilization in California since 1925, and had been using it to proselytize elsewhere (including, notably, Germany) (Popenoe 1934; Stern 2005, chap. 5). But these eugenicists, however eager, were disconnected from the actual practice of sterilization: they corresponded with state superintendents primarily in seeking information for their reports (Gosney and Popenoe, 1929). Although they actively set up networks of allies, as well as attempts to influence both public and private opinion in favor of sterilization, they were ultimately outsiders (Stern 2005, chap. 5). This is not to say that Gosney, Popenoe, and the other eugenic “propagandists” were completely powerless—at times they enjoyed wide popular support, as most histories of this period document. But they had no power over the operations of individual mental institutions or of the medical system as a whole. Wide influence on thought and discourse is a very different thing from the translation of ideas into concrete, localized practice.

If one followed Laughlin's model law, eugenic ideology would have been written into the text of the law itself. In the California case, this clearly did not occur. The original 1909 text of the law was drafted and encouraged by the Secretary of the State Lunacy Commission, Dr. Frederick W. Hatch, Jr., a physician with definite eugenic inclinations. Until his death in 1924, he retained the ability to approve or veto suggestions for sterilization from the state superintendents, but he could not nominate candidates himself. The examples of sterilization requests approved by Hatch that Laughlin includes in his study do not show Hatch exercising the statutory discretion he possessed: he approves all requests, whether they indicate heredity as a factor or not (Laughlin 1922, 52–53). The law he wrote may have had eugenics as one of its motivations, but it did not impose those motivations on physicians. To understand the practice of sterilization, then, we must look away from the eugenicists, and even the expressed intentions of the law, and turn to the practices of the superintendents themselves.

Superintendents' Views on Sterilization

When the first sterilization law came into effect in 1909, California had five state hospitals for the mentally ill (Agnews, Mendocino, Napa, Patton, and Stockton State Hospitals) and one home for the mentally deficient (Sonoma State Home). All but Patton were in the northern part of the state. In 1916 and 1917, respectively, additional hospitals for the mentally ill (Norwalk State Hospital) and the mentally deficient (Pacific Colony) were founded in southern California, to help accommodate the increasing demand for state mental hygiene resources. Three more hospitals for the mentally insane were added in the late 1930s through the 1940s (Camarillo, DeWitt, and Modesto State Hospitals), adding up by the end of California's sterilization period to a total of nine hospitals for the mentally insane and two homes for the mentally deficient in which sterilizations were performed (figure 2.2).¹²

Operations were not equally distributed among these hospitals. By 1950, the last year in which hospital-by-hospital sterilization rates are available, three institutions alone accounted for 68 percent of all sterilizations performed (table 2.1). Though some differences can be attributed to the small size of a number of the institutions (DeWitt and Modesto had both just become operational by the late 1940s), on the whole the population differences were not large enough to account for the disparities in sterilization numbers. Camarillo, for example, had eclipsed all other institutions in patient population by the 1940s, yet it accounts for an

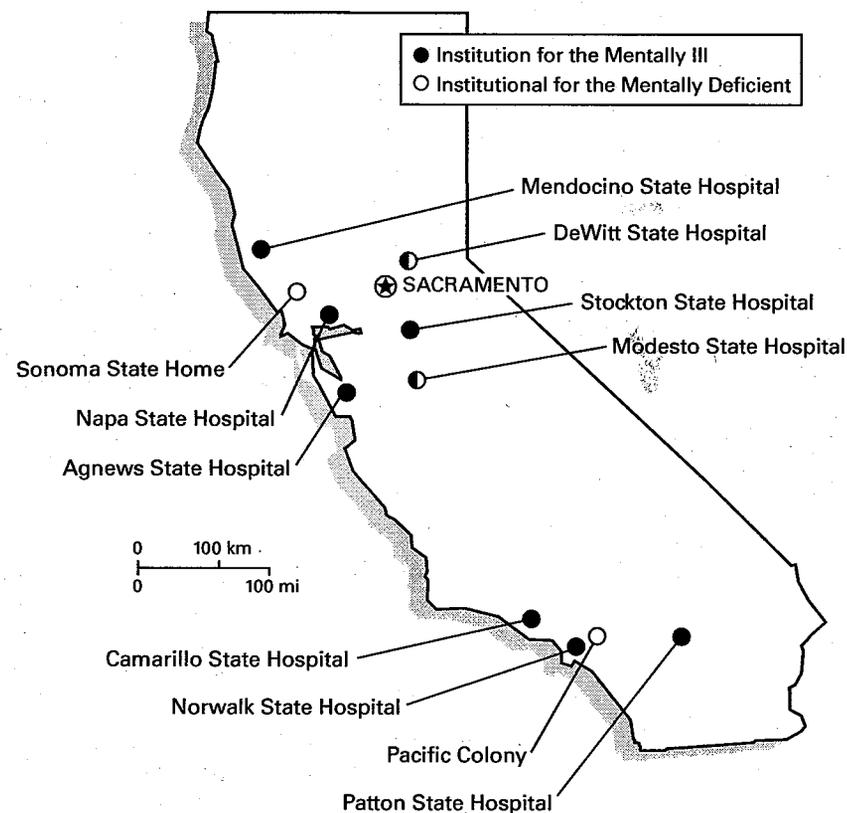


Figure 2.2

California's state mental health system for the primary period of compulsory sterilization as of 1950. Source: Adapted by author from California Department of Mental Hygiene 1950, chart I, 3.

insignificant fraction of the total sterilizations. Agnews always had considerably more patients than Norwalk, Pacific Colony, and Sonoma, yet it sterilized considerably fewer than these.

Three institutions—Stockton, Sonoma, and Agnews—vividly demonstrate the different varieties of sterilization practice that flourished within an institutional model that stressed the autonomy and the discretion of hospital superintendents. I have chosen these not because they are necessarily representative of all sterilizing institutions (though together they account for nearly 50 percent of all sterilizations performed in the state), but because they illustrate the almost limitless power that their long-tenured administrators wielded with regard to sterilization policy.

Table 2.1
Cumulative sterilizations at California state institutions, 1909–1950

Sonoma	5,530	29.4%
Patton	4,585	24.4%
Stockton	2,669	14.2%
Napa	1,843	9.8%
Pacific Colony	1,759	9.4%
Norwalk	1,167	6.2%
Agnews	799	4.3%
Mendocino	364	1.9%
Camarillo	58	0.3%
DeWitt	15	0.1%
Modesto	3	0.0%
Total	18,792	100%

Source: Compiled from California Department of Mental Hygiene 1950, tables 60 and 121, on 142 and 239.

Stockton State Hospital

The historian of medicine Joel Braslow provides the most definitive study of sterilization practices at Stockton State Hospital (Braslow 1996; Braslow 1997, chap. 3). The oldest such institution in California, Stockton operated from 1906 until 1929 under the directorship of Dr. Fred P. Clark, who, quite unusually for the period, had inherited this mantle from his father. In both his published writings and, as Braslow has shown, in his administrative practices, Clark favored sterilization as a form of therapy. Clark wrote in a 1924 report to the governor and the other superintendents that vasectomies, in particular, had a positive effect on his patients' mental activities:

The law permitting the sterilization of the insane to my mind is one of the best things that has been done to prevent the unfit from reproducing their kind. Besides this feature of the law, in many cases of the men the operation has had a very beneficial effect upon their mental condition, that is, we have had numerous cases whose mental condition improved up to a certain point and then remained stationary. After these patients were sterilized many of them recovered completely and have had no recurrence of their mental trouble. (Clark 1924, 101–102)

Clark subscribed to what was known as the “Steinach method” of sterilization, named after the Austrian endocrinology pioneer Eugen Steinach, who had studied the supposed revitalization obtained in rats, guinea pigs, and eventually humans after vasectomies. Steinach formulated a theory

that the severing of the *vas deferens* forced the testicles to increase their production of hormones, giving new energy and life to the patient. Other theories involved speculation on the effects of reabsorption of testicular fluids into the bloodstream.¹³ As Clark explained in 1916:

By this interruption in the continuity of the vas, the testicular secretion is absorbed. Since performing these operations we are led to believe, by the improvement in general and mental health, there is a distinct beneficial result from the absorption of the testicular secretion. . . . Many of the results claimed [by others, in the past, for such operations] were evidently due to suggestion. However, since beginning these sterilization operations, we are led to believe that by the improvement in mental and general health that there is a definite beneficial effect from [vasectomy] and may lead to important findings as an organo therapeutic agent. (Laughlin 1922, 56)

Theories of therapeutic sterilization were not widely held in the medical community and were viewed with skepticism by most eugenicists. California sterilization advocates Gosney and Popenoe skeptically noted in 1929 that “the patient seems to get ‘rejuvenation’ when he expected it and paid for it; when he did not expect it, and paid merely for sterilization, he got nothing but sterilization” (Gosney and Popenoe 1929, 89). Another text on eugenic sterilization endorsed “the Steinach method” as yet another reason why sterilization was desirable for mental patients, but offered it simply as an additional benefit to counter claims that sterilization would have negative physiological effects (Landman 1932, 235–236).

It is precisely the legal and bureaucratic decentralization of sterilization in California that allowed the Steinach method to be translated into practice. This was exactly the sort of noneugenic discretion that Laughlin feared would thrive under such imprecisely worded laws. The legal arrangement invested Clark with the power to choose whom he sterilized and why—even if it was in the name of a medically fringe theory, one that other California superintendents did not embrace.¹⁴ The anomaly of the Stockton program is exactly what makes it so revealing of the overall organization of sterilization in California, and what makes drawing a straight line from national ideologies to the idiosyncrasies of local practice so difficult.

Theories about vasectomies and testicular fluid clearly applied only to male patients. For females, Clark took a somewhat different position, one equally centered on the benefits of the sterilization to the individual, but he expressed that benefit in social rather than physiological terms. As he wrote in his 1922 biennial report, “We have sterilized quite a number of patients during the past year, both men and women. In many of the men, we have noticed very marked improvement in their mental condition after

they have been sterilized. In the women it has prevented a recurrence of their mental trouble where it was due to childbirth" (Clark 1922, 88).

Was this eugenics? Braslow has categorized this motive as therapeutic, and distinguished it from eugenics because the latter "was meant to treat a sick and degenerating society, not the suffering of individuals" (Braslow 1996, 40). Wendy Kline, in contrast, has argued that such paternalism toward women patients was always present in the eugenics movement, whose notions of masculinity and femininity often led to the targeting of the "misfit mother" (Kline 2001, chap. 4). In either case, what was at work in these cases is not a simple ideology of gene purification.

Braslow's research has shown that these claims of the therapeutic value of male sterilization were not simply rhetorical. Therapeutic motives can be seen quite explicitly in private interactions between patients and physicians at Stockton, reconstructed from verbatim transcripts of patient interviews and meetings between physicians. During Clark's long tenure, explicitly hereditarian concerns played a minor role in sterilization requests by physicians at Stockton. In many cases, the sterilizations were not compulsory in the sense of being done completely against the will of patients or their family members. According to Clark, despite the compulsory option in the state sterilization laws, patient or guardian consent was usually procured: "It is not necessary to obtain the consent of the relatives of the patient or of the patient himself but it has always been our custom to obtain to the consent of the relatives when possible. We find very few relatives who make any objection, in fact, we have many requests from relatives to have this operation performed" (Clark 1924, 100).

This practice of obtaining "consent" seems quite common in the reports of other superintendents as well. From an ethical point of view, it was unlike what would today be considered informed consent; in some cases, it was explicitly conditional on the patient's mental health improving or to their release from the institutions.¹⁵ Consent can probably be best understood as a form of legal insurance rather than a bow to patients' rights: by securing consent in some form, the hospital superintendents felt they were avoiding any possible legal trouble in the future. Ordering sterilization against a guardian's consent was challenged only once in California, in a case that was dismissed on a legal technicality.¹⁶ Nevertheless, despite ethical deficiencies in this form of "consent," it does attenuate the image of the authoritarian state usually associated with compulsory sterilization. Braslow's work paints a rich picture of sterilization at Stockton as something done not in the spirit of diminishing patients, but enabling and even curing them.

Sonoma State Home

Sonoma State Home was California's chief institution for the mentally deficient and developmentally disabled, and was known until 1909 as the California Home for the Care and Training of Feeble-minded Children. It had by far the most vigorous sterilization program in the state from 1918 until 1949, under the long tenure of Dr. Fred O. Butler, perhaps the most eugenically inclined of all the California superintendents. A trained surgeon, Butler performed a number of the operations himself in the early days of his directorship; over 5,500 people were sterilized at Sonoma on his watch, and he maintained close contacts with California eugenics organizations throughout his career (Kline 2001, 81–98; Stern 2005, 106–107).

As recalled in an oral history interview many decades later, Butler set sterilization as one of his top priorities almost immediately after taking on the directorship after the death of his predecessor:

I proposed at our first board meeting, when asked what I had in mind to do for the improvement of mental retardation in California, I said that the first thing is to get plenty of water, and second, we should start the program of sterilization. . . . The board approved it providing I got the approval of other departments in Sacramento including the governor. I obtained their approval, and started within three months doing sterilizations, with the idea that we would get social service workers to help in planning and training, so by 1919 we were placing patients out, by giving them jobs, or letting them return home after they had been sterilized. (Butler 1970, 2)

For Butler, the ability to discharge patients was a high priority, both for economic reasons (state institutions were always felt to be overburdened and underfinanced) and because he expressed doubt that institutional life was positive for patients. In his mind, sterilization was one aspect of an overall approach that would allow patients to be successfully cared for in a noninstitutional context.

Butler believed that heredity played an important role in mental deficiency, but his belief in sterilization was multifaceted. Much of it was couched in the language of deinstitutionalization, of the importance of patients being able to "safely" return to the outside world; as at Stockton, the concern seems to have been more for patients' welfare than their liberty rights. In a 1921 letter, which Laughlin reprinted, Butler couched this self-sufficiency in explicitly hereditarian terms:

I think sterilization of a certain class of our inmates is most important; aside from the training and discipline obtained while here, the operation for sterilization renders them unable to propagate their kind; therefore, many of them are able to go on parole or be discharged and make their way in the world. This relieves the

state and counties of the expense for their support as well as making them happy in the thought of being self-supporting. This procedure naturally makes more room in the institution for that class not able to cope with outside conditions, and relieves the relatives and various organizations of this burden. (Laughlin 1922, 59)

Yet Butler's belief in the importance of sterilization for self-sufficiency was not strictly limited to the idea that mental deficiency was spread through heredity. In 1930, at the height of his own eugenic interests, Butler observed that at his institution, "we have reached the point where we practically disregard whether they are the hereditary or non-hereditary type, for the reason that rarely is it possible for a feeble-minded mother to care for children properly" (Kline 2001, 100). This is a language he would return to in later comments on the subject as well: "Chiefly [sterilization] would give [the mentally disabled] an opportunity to have a normal life, extramurally without the burden of children. Of course I felt that no person should have children, even though [mental deficiency] might not be hereditary, [if] they are not able to care properly for children in their home. Therefore I felt that unless a person can be born of a normal parent, they'd better not be born at all. That was always my premise and I still carry that though, whether I am right or whether I am wrong" (Butler 1970, 4).

Butler's account of his activities decades later is largely unapologetic and no doubt highly self-serving, but aligns with many of his earlier writings as well. Even this die-hard eugenicist saw fit to argue that sterilization was, in his mind, a beneficial activity for patients even if heredity was a minor factor in their condition. It is a paternalistic attitude similar to Clark's rationale for the sterilization of mentally ill women: the "burden" of children would prevent marginal individuals from being fully self-sufficient. There is no doubt that Butler was a eugenicist—he was explicitly concerned with the dangers posed to society by mentally deficient people, believed in a hereditarian component, and was a frequent correspondent with Popenoe and other eugenicists (and, after retirement, became medical advisor for a voluntary sterilization group founded by Popenoe). Yet even Butler claimed to get more out of sterilization than eugenics alone, and he justified it to himself on grounds of benefit to the patient as well as to society. Even the most eugenic of the superintendents had multiple reasons to support sterilization, including his commitment as a physician to improving the health of individuals (Lombardo 2008, chap. 17).

Agnews State Hospital

Agnews State Hospital, an institution for the mentally ill located near San Jose, presents a foil to Stockton and Sonoma because sterilizations

did not occur there in large numbers, despite its being an institution of considerable size and facing the same pressures as those that did sterilize. Unlike some other institutions that sterilized in middling to low numbers, Agnews was operating at full strength for most of the time during the years that sterilizations took place. Some places, such as Mendocino, had such a high level of superintendent turnover (nine different superintendents over the course of some forty years, and none there longer than eleven years) that their low sterilization rates quite possibly reflected simply a lack of coherent policy. Agnews, on the other hand, was under the control of a single administrator, Dr. Leonard Stocking, from 1903 to 1931. Why, then, did it have such a low rate of sterilizations?

It appears that Stocking himself had little to no enthusiasm for sterilization. This does not appear to have been rooted in a strong belief in patient autonomy, but rather in his own idiosyncratic beliefs about the nature of mental health. His opinions on mental health are difficult to summarize, in part because they were originally vague and changed quite often: although he was not strictly a Freudian, by his own admission, through the 1920s he flirted with quasi-psychoanalytical approaches to mental illness, augmented by various physiologically inspired forms of treatment. In one report it was electrical stimulation, in another ultra-violet ray exposure, and in a yet later one hypnotic trance states—always described by Stocking as "new" treatments. When he did sterilize, it seems to have been for generally noneugenic reasons. In 1921, for example, Stocking requested the sterilization of a woman patient because "further pregnancies would be a decided hindrance for (the patient) remaining able when she again goes home," and he gave no indication that he considered heredity to play any role in her situation (Laughlin 1922, 54).

Stocking's views of mental health not only did not hold heredity as central, but also disparaged those who thought it was important. As he wrote in 1930, "Though heredity is of great importance in physiology, it is of only minor importance in psychology. Physical and psychical inheritance do not connect and run together" (Stocking 1930a, 221). In long essays on psychology published in a biennial report just a year before his death, Stocking mused that believing in heredity as the source of mental illness was like thinking that electric lighting was dependent on the presence of a switch: "But the novice in electric lighting is somewhat nonplussed when he notices that another light in the same room burns independent of any chain. An inhuman murderer comes from normal, respectable family, or a genius is born to commonplace, uninspired parents, and the heredity theory is somewhat discredited" (Stocking 1930b, 199).

In any case, Stocking did not sterilize in great numbers, which looks to have been a deliberate choice. Like Clark and Butler, he was given a free hand to act on his own idiosyncratic beliefs about the nature of mental health, and when he did sterilize it was for paternalistic reasons, though he too always claimed to get patient consent before sterilization. If he is a hero in this story, he is an odd hero, distinguished by ad hoc, changing beliefs about mental health, rapidly changing therapeutic strategies, and remarkable primarily for his choice not to sterilize, a choice not stemming from any apparent fundamental ethical regard for patient rights.

The foregoing evidence can be criticized as being rather broad, and concerned with superintendents' writings rather than records of daily practice (with the exception of Braslow's work, which is one of the few studies benefiting from access to such archives), and characterizes only three institutions with long-serving superintendents. Nevertheless, I think these cases quite vividly illustrate the relationship of institutional autonomy and sterilization practice, as well as the range of possible opinions that hospital administrators could hold toward sterilization. They also point toward what a more thorough study of sterilization in California would look like: considering hospitals as singular sites and paying close attention to what influences actually mattered in the case of individual, powerful superintendents, rather than gesturing vaguely toward connections between "popular" attitudes and sterilization practices.

Eugenics?

Sterilization and its motives in California were, as we have seen, deeply tied to the individual beliefs and personalities of the superintendents who ordered them. Those superintendents who had long tenures, such as Clark, Butler, and Stocking, exercised disproportionate influence over state sterilization trends compared with superintendents with very short tenures, not to mention disproportionate with respect to eugenics advocates, strategists, or think tanks. Parsing out the sterilizers' motives, and determining which of them deserve to be called "eugenics," requires some discussion.

As Diane Paul has noted, *eugenics* "is a word with nasty connotations but an indeterminate meaning. Indeed, it often reveals more about its user's attitudes than it does about the policies, practices, intentions, or consequences labeled" (Paul 1994, 143). Used almost exclusively in a pejorative sense in contemporary discourse, eugenics has been applied to practices from expectant mothers taking vitamins for the health of the

fetus to the worst atrocities of Nazi genocide (Mahowald 2003). As Eloff Axel Carlson aptly put it:

Historians of science, however, have found that the term is chameleon-like, changing definition, purpose, scope, and values in different eras, countries, and social settings. At one extreme, eugenics is a gigantic umbrella that covers almost all social movements in which sex, gender, heredity, family planning, reproductive options, marriage, immigration, social status, and social failure are involved. It ranges from concerns about the most dependent children and adults to interest in the most successful and eminent high achievers and their roles in shaping future generations of humanity. At a more restricted level of historical interpretation, eugenics is the application of human heredity to an analysis of differential birthrates. The broader historical approach makes eugenics a more difficult target for those concerned about personal liberties. The narrower approach makes the old-line eugenics of the first half of the twentieth century a dead horse that is no cause for present worry. (Carlson 2003, 761)

Taking the "umbrella" view, to use Carlson's term, has historical justifications: the eugenics *movement* was a disparate group of individuals with beliefs that shared family resemblances but were not at all necessarily connected. Many eugenicists had very low regard for one other and routinely disagreed with others in the community. No one has illustrated these historical discontinuities better than Diane Paul, who herself has argued that the attempt to stipulate a definition of "eugenics" is usually a meaningless exercise that avoids discussion of politics and ethics (Paul 1994, 1995, 2007).

At the same time, when dealing with historical episodes, as opposed to determining future policy, there can be value in making distinctions. If eugenics can encompass everything from vitamin consumption to genocide, then it loses its meaning. As my purpose is not to establish "guilt by association," but rather to understand the motives of the California superintendents and the means by which they were enabled by their institutions, I would argue for the relatively limited definition of eugenics proposed by Braslow. That definition refers to policies aimed at effecting *collective* change—at the level of society, nation, the human race, or the gene pool—rather than the *individual*. As Paul has noted, this is not an uncommon demarcation criterion, and is often favored by those who argue that technologies of consumer-driven genomics are *not* "eugenics" (Paul 1994, 144–149).

One could potentially abandon the term "eugenics" altogether, and refer only to *hereditarian* concerns, as it is exactly the hereditarian concerns, coupled with state coercion, that disturb people most about the

eugenics of the first half of the twentieth century. Sexism, racism, and even authoritarian tendencies were often coupled with and mutually reinforced by hereditarian eugenics in the early twentieth century, but they were not necessarily an integral part of that worldview. To consider racism a central component of eugenics simply because the two were often coupled is similar to considering racism a central component of Darwinian evolution simply because many proponents of Darwinism held what would be today considered racist beliefs. For purposes of this volume it is important to recognize that eugenics did not inevitably lend scientific support to other pernicious social ideologies: one could be a eugenicist without being a racist, and a sexist without being a eugenicist, and so forth.

In the final analysis, though, attempts to fit practices into preformed and pejorative categories miss a larger point. As Johanna Schoen has argued, reproductive regulations existed on an ethical “continuum”—at times enabling, at other times destroying, reproductive autonomy (Schoen 2005, 7). Understanding the implementation of these practices, and focusing on the specific institutional instantiations and translations of various ideological and public health goals, must take precedence over a simple classification of practices into those that resemble Nazis and those that do not.

The California superintendents surveyed thus far clearly sought a number of different goals through sterilization. The designation *therapeutic* sterilization is best reserved for those who hoped, like Stockton’s Clark, that the procedure would effect marked physical and mental benefits for the patient. Sterilizations ordered because physicians believed that child-birth would cause another breakdown could be considered *preventive*, whereas those motivated by the belief that the patient was mentally unfit to be a good parent could be called *paternalistic*. In this case, the paternalistic impulse arose from the physician’s conviction that he or she was better qualified than the patient to judge the patient’s fitness as a parent.¹⁷ And finally, of course, there was the purely *eugenic* or *hereditarian* justification, which I have defined as any intent to reduce the incidence of mental illness or mental deficiency in society at large by blocking the transmission of “defective” genetic material.

All of these justifications seem to have been more or less sanctioned by the state Department of Institutions in approving sterilization requests from the superintendents. The amount of oversight appears to have been quite low—short letters from superintendents requesting sterilization were all that was required, and there are cases of patient diagnoses being specially modified to make sterilization easier.¹⁸ In many cases, multiple

motives were obviously at play. Sonoma’s Butler, as we have seen, sterilized mainly for eugenic and paternalistic reasons, and Stockton’s Clark sterilized for therapeutic, paternalistic, and preventive reasons. None of these rationales were mutually incompatible, and in the end eugenics advocates such as Popenoe and Gosney could be reasonably happy with sterilizations for any reason as long as they were taking place within mental hospitals. Only the case of Stocking at Agnews points to a specific intent *not* to sterilize, but he was the exception, and even he approved at least some paternalistic sterilizations, though he rejected eugenics.

The Consequences of Decentralization

The sterilization trends in California can be traced, as we have seen, largely to a handful of superintendents who either had strong reasons to sterilize or strong reasons not to. Institutions that had individual superintendents for long tenures (i.e., multiple decades) tended to have extremely high sterilization rates, with the exception of Agnews State Hospital, whose superintendent was simply not interested in sterilization. Institutions with rapid turnover in superintendents all have middling rates. The delegation of discretion to superintendents resulted in many sterilizations clustered in few institutions, and carried out in some cases with documented non-eugenic motivations.

Despite its somewhat confusing language, the law enabled superintendents to implement their policies efficiently. By the 1940s, they even had standardized forms for requesting sterilization, with tiny checkboxes to indicate various patient afflictions, and even a section dedicated to consent from legal guardians—all so routinized that requests could be approved the very day they were received (figure 2.3). Perhaps the plurality of justifications supported by California policy also aided in maintaining the superintendents’ authority: sterilization could be, as the State Attorney General had argued in 1910, just another medical procedure for physicians to use in accordance with their professional judgment (Webb 1910). By law, the California superintendents could sterilize, and because of the multiple reasons that the law recognized and the medical culture of the period sanctioned, they usually did. Importantly, the law had no mechanisms for appeal.

California’s legal situation allowed its superintendents to start sterilizing earlier than in most institutions in the country, and the flexibility of the law drove California to become the premier state for sterilization. Although California superintendents felt free to request sterilizations for

Operation by Dr. Traver, 7.4.45

FORM 787
5

**Recommendation and Approval for Vasectomy or Salpingectomy
for the Purpose of Sterilization**

Name _____ RECEIVED
JUN 18 1945
Institution PATTON STATE HOSPITAL DEPT. OF
INSTITUTIONS

PERSONAL HISTORY

HOSPITAL CASE No. _____

Age 27 yrs. Nativity California Religion Protestant Education High School
Marital status married Sex Female No. of children One Ages Seven yrs.

FAMILY HISTORY (for additional space use reverse side): None

CLINICAL HISTORY (for additional space use reverse side):

Date admitted May 1945 Present diagnosis Dementia Praecox, Catatonic Type.

Attacks (previous, and diagnosis of each): Norwalk St. Hosp. 5-22-42 to 3-24-43-Manic Depressive
Psychosis, Depressed Type.

LEGAL PROVISIONS (compliance with):

This form is submitted in accordance with section 6624 of the Welfare and Institutions Code of the State of California.

1. Legally signed and prepared commitment papers { are } on file at this institution.
2. This patient is afflicted with:
 - Mental disease which may have been inherited and is likely to be transmitted to descendants.
 - Feeble-mindedness, in any of its various grades (specify grade) _____
 - Perversion or marked departures from normal mentality.
 - Disease of a syphilitic nature.

Written consent { not given } by _____ Mother
{ given } by _____ Name Relationshipunder date of June 4, 1945 copy of which is attached hereto.
(If consent not given, submit separate letter giving circumstances)

After careful consideration of the case of _____
by the members of the Medical Staff of this institution, it is their belief that this patient is suffering
from the affliction above noted and it is their recommendation that the operation for the purpose of
sterilization be performed, with which opinion and recommendation I concur and do hereby request
your approval.

[DATE] June 14, 1945

G. W. Webster
Medical Director and Superintendent

Approved and authorization for operation for sterilization granted this 18th day

of June 1945.

Dora Shaw Heffner
Director of Institutions

Figure 2.3

Form 787, "Recommendation and Approval for Vasectomy or Salpingectomy for the Purpose of Sterilization," submitted to the California Department of Institutions June 1945, by G. M. Webster, medical superintendent of Patton State Hospital, and approved by Dora Shaw Heffner, Director of Institutions. Source: Department of Mental Hygiene, Mendocino State Hospital Records, California State Archives, Sacramento, California. Nongeneral personal information has been blacked out by author.

varied reasons, physicians elsewhere complained that their laws were cumbersome, contradictory, and subject to legal challenges (Laughlin 1922, 52-92). This institutional explanation for why California's sterilization rates were so much higher than in any other state is appealing in that it requires no abstract notions such as public opinion, state or national fads, or even mainstream scientific or medical opinion. Rather, the impetus to sterilize, in this narrative, falls squarely on the shoulders of the individuals who had the means, motives, and opportunity to sterilize.

Between 1951 and 1952 the rate of sterilizations dropped by 80 percent, and from then on the practice declined to less than a half-dozen per year in 1960 (figure 2.4). This abrupt change came with no fanfare and no hand-wringing, no comparisons to Nazi Germany, and no discussion of rights to reproduction. The horror we attach to the sterilizations today, and to eugenics in general, did not become widespread until the 1970s, with the rise of interest in patient autonomy, women's rights, the power of the medicalized state, and a right to reproduction that were conspicuously absent from earlier discussions of eugenics (Paul 1995, chap. 7; Lombardo 2008, chaps. 17-19; Paul 2002). In other words, profound social transformations happened in American understandings of the human body and its rights in the late twentieth century, but they do not seem to account for the rise and fall of sterilization.

So why did California stop sterilizing when it did? A number of organizational changes seem important. First, the newer superintendents did not sterilize at the rates of the older ones. This is most likely due to changing medical attitudes toward mental health. The last of the enthusiastic sterilizers, Fred O. Butler, recalled the change:

Oh, [the mindset] changed materially. Well it was shortly after I left up there. I know I went back about the following year or two, the superintendent [Dr. Porter] asked me to come back and talk on it, on sterilization, and I found the dissenters on it were mostly psychologists. They didn't agree, and social workers were second, and physicians, I think, were third, I would say. That is, [they] question[ed] the advisability and so forth of sterilization. Some thought that we didn't have enough information as a basis for sterilization. Of course they didn't go for my premise that they should be sterilized regardless of their heredity or not. (Butler 1970, 14)

Butler himself retired in 1949, having served as the director of the Sonoma State Home for over three decades.¹⁹ At the time, Sonoma was responsible for 53 percent of all annual sterilizations in California—four times as many as any other hospital. With Butler gone, there were no strong advocates for sterilization left in the California system.

At the same time that enthusiasm for sterilization was winding down within the medical system, important organizational shakeups were

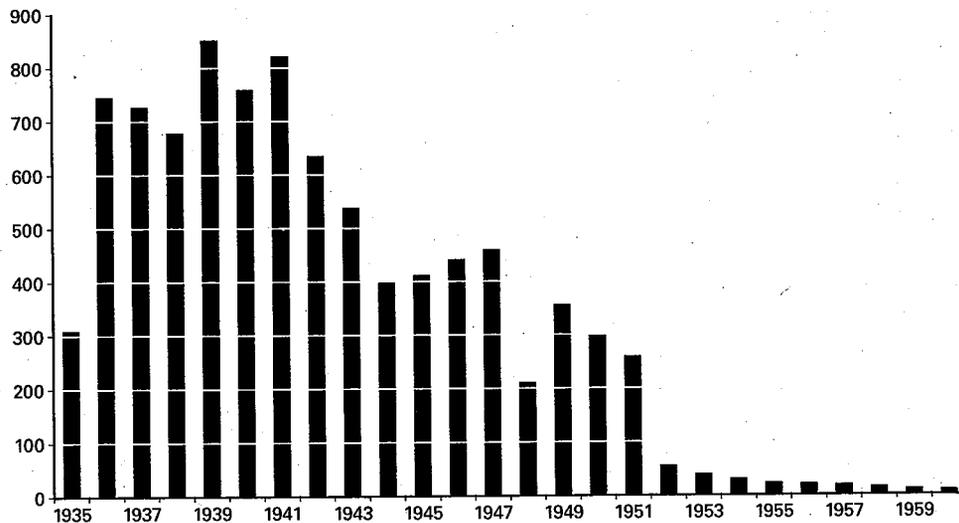


Figure 2.4

Annual sterilizations, all California state hospitals, 1935–1960. *Source:* Data from “Sterilization Operations in California State Hospitals for the Mentally Ill and for the Mentally Deficient, April 26, 1909 through June 30, 1960,” Statistical Research Bureau, California State Department of Mental Hygiene (October 5, 1960), received from the California Department of Mental Health (Statistics and Data Analysis), on July 17, 2003. Graph by author.

occurring in the state. In the late 1940s, Governor Earl Warren developed a strong personal interest in modernizing the California mental health system. He considered the old institutions (like Stockton, Agnews, and Sonoma) to be “regular ‘snake pits,’” a throwback to the previous century, so “appalling” that after visiting a number of them, “I did not have a peaceful night’s sleep for over a month.” Moreover, the hospitals were, he later recalled, “a loose organization that left a great deal of local autonomy and enabled each group [of administrators] to operate more or less as a political entity.” He wanted comprehensive reform—literally destroying the nineteenth-century brick buildings that were still housing some patients—in order to “take California out of the asylum age and put it in the hospital age” (Warren 1977, 178–183).

The same year that Butler retired from Sonoma, 1949, Warren appointed a new director to head up the overall organization, which he had renamed the Department of Mental Hygiene. Dr. Frank F. Tallman was an outsider to the California system, brought in from an identical position in Ohio (a state that never had sterilization legislation). Neither Tallman nor Warren ever publicly distanced themselves from the state sterilization program. Both were interested in general organizational reform. Tallman

saw as one of his chief objectives the centralization of the Department of Mental Hygiene’s power over its sprawling institutions, full of superintendents whom he derided as “foot-draggers” (Tallman 1973, 42). He later recalled that in this, he had a partnership with Warren: “[Warren] felt that the superintendents of the individual institutions should have a less parochial and isolated attitude and role and ought to be helped to be active in community mental health affairs. Also he thought that they needed encouragement in realizing the helpful importance of the central governing body—namely the State Department of Mental Hygiene” (Tallman 1973, 19–20).

To implement this policy, Tallman initiated a rewrite of many state mental health statutes, including the sterilization law. The 1951 revision, which modernized the statutory language and made it more compliant with *Buck v. Bell*—adding an appeals mechanism, for example—changed little in the procedures for requesting patient sterilization.²⁰ Though the law changed very little on its face, the attitude of those responsible for enforcing it shifted quite a lot. They were, privately, dubious of the local expertise of the hospital superintendents, and wanted far more documentation of consent and need than before.²¹ Sterilization was now a centralized concern, and the few official statements on sterilization available from his department explicitly endorsed what I have labeled paternalistic sterilization and omitted reference to any hereditarian motivation.²²

Following the centralization of state mental health policies, and a tightening up of the state law, sterilization rates plummeted. What ended sterilization in the state was not a reframing of eugenics as an ethically unacceptable practice endangering basic human rights, nor any apparent association of the practice with National Socialism. No one took credit for killing the practice, and no one at the time appears to have noticed that it had ended. Administrators interested in bureaucratic efficiency centralized the system and reduced the autonomy of hospital superintendents at about the same time that the last influential advocate of sterilization retired. Sterilization in California died not with a bang but a whimper.

If the new mental hygiene administrators seemed unconcerned with the practice of sterilization, neither was the public. The *Sacramento Bee*, which devoted ample attention to any state legislation of perceived significance, put the notice of the 1951 revisions to the sterilization law in a single line of text, in the smallest possible font, typically used for only the most uninteresting legislation: “SB 730, Dillinger—Eliminating sex perversion of syphilitic disease as the basis for sterilization of persons in state mental institutions and allowing sterilization for mental illness or mental deficiency only. Also, provides for notices and hearings

on intended sterilization."²³ The *Los Angeles Times* ran a similarly brief notice.²⁴

Behind-the-scenes evidence indicates that modernizing administrators such as Tallman found the existing sterilization practices out of date, not ethically disturbing. In a 1951 memo to Warren, Tallman emphasized the parts of the new law that centralized the ultimate discretion for sterilization with the Director of Mental Hygiene (that is, himself), and improved patient and family notification. He also pointed out that they had carefully crafted the new law to avoid offending the Roman Catholic Church, the only long-time opponent of sterilization.²⁵ This and other correspondence about the bill makes it clear that the state administrators were starting to see sterilization as something to be sparingly used and not of primary importance to the overall treatment of mental health.

California's sterilization boom was institutional in its beginnings and institutional in its end. Broader "scientific ideas" were not irrelevant—indeed, part of my explanation in this chapter rests on changing conceptions of mental illness, which meant that new administrators coming into the system were less focused on heredity than previous generations. But the end of sterilization did not come about simply because ideas changed. Rather, it came about because of specific changes in institutional and legal structures for managing public health. That attitudes towards sterilization changed is an insufficient explanation by itself, without taking into account the way that discretionary authority was distributed throughout the mental health bureaucracy.

A practice-based account of sterilization in California emphasizes that the link between ideology and action is rarely direct, but instead is mediated by specific legal, social, professional, and organizational factors. In California, the policies of relatively few individuals with long tenures had massive statistical effects in a system that delegated power over the bodies of mental patients to the institutions that held them. This decentralization of power—or perhaps more accurately its distribution into independent nodes—is a familiar feature of American bureaucracy.

We might in conclusion extend, briefly, this analytic approach to the infamous sterilization program in Germany. Like so many other efforts at "coordination" (*Gleichschaltung*) in the German state, the German sterilization law attempted to eliminate discretion among practitioners, making mandatory the reporting of patients to be sterilized. Under German law, physicians—not merely those working in state institutions—could be fined for not reporting candidates for sterilization to centralized sterilization courts.²⁶ The hierarchical Nazi system made a conscious effort

to ensure that ideology was intimately tied to law and practice, extending state authority into the capillaries of bureaucratic behavior; in the United States as a whole, and especially in California, there was no such attempt at top-down "coordination."²⁷ This structural difference, combined with the fact that the Nazi sterilization law applied to the general population (not simply those in state institutions), no doubt accounted in large part for the ability of the German regime to sterilize over four hundred thousand individuals, most in the first four years of operation; six decades of sterilization laws in the United States did not reach one-sixth that figure (Proctor 1988, 108; Bock 2004).

The history of compulsory sterilization in California holds a complicated lesson for commentators on genetics in society. The results, in this case, were less about sweeping, science-driven ideas about individual and social health than they were about the idiosyncrasies of an enabling system; they were less about the overall coordination of a grand plan than they were about unchecked local authority and discretion. Ethically, that makes the issue of what precautions should be taken in the future more problematic in a sense: instead of being motivated by a single, wrong-headed idea of genetic perfection, which could be fought with "better" science, we see an unfortunate convergence of heterogeneous motives, most centered around faulty perceptions about what would be most beneficial to the individual patient, not to society as a whole. We do not find Nazis in Californian mental health institutions.

Tying this chapter to the broader cultural and normative concerns of this volume, we find Americans doing things in an American way, yet, when judged by the sheer number of sterilizations, ending up with results disconcertingly similar to those attained by German centralized coordination. One is tempted to speculate that any future eugenics in America, however defined, will remain of a distinctly American character: decentralized, well-intentioned, quiet, but—if left unregulated—deeply troubling in its ramifications.

Acknowledgments

The number of people who have read, heard, and given opinions on various iterations on this long-evolving work are too many to list at this point. For this version in particular, and for the encouragement to publish it, I must acknowledge the help of Ellen Bales, Alison Bashford, Cathryn Carson, Miroslava Chavez-Garcia, Sheila Jasanoff, Diane Paul, and the anonymous reviewers.

Notes

1. American sterilization statistics are often quite difficult to come by in consistent datasets (that is, those made with the same methodologies, counting the same things). Most sterilization statistics are self-reported and compiled by eugenics organizations (with various levels of detail and accuracy). The most complete single dataset for national sterilization statistics is Robitscher 1973, appendix 2.
2. The first significant postwar history of eugenics was Haller 1963. Previous “histories” of eugenics were primarily works by active eugenicists, for example, Landman 1932. The current standard account of eugenics in the United States has long been Kevles [1985] 1995. Since the Human Genome Project, new monographs on American eugenics have been appearing at the rate of at least one per year.
3. An important exception to this is the recent book by Alexandra Minna Stern, which goes to considerable lengths to understand California eugenic thought as a phenomenon in and of itself. Stern 2005, especially chap. 3. Similarly, Edward Larson’s book on eugenics in the South does an excellent job of providing a regionalized analysis that combines the more traditional intellectual approach with the specifics of the southern legal and political context (Larson 1996).
4. There is something of a deliberate muddling here between the two uses of the terms “institution”: the specific sense of state institutions for the mentally ill (hence California’s Department of Institutions), and the more general sense of institutions of government, power, and society. In this particular case, there is a considerable overlap between the two meanings. In the latter sense of the meaning, particularly useful is Lenoir 1997.
5. There were two additional amendments to the sterilization laws in 1923, but they pertained to special cases and did not change the overall framework of the legislation.
6. California Statutes of 1909, Chapter 720, 1093.
7. That castration was not considered to be a valid use of the law was made clear early on by the state Attorney General, who strongly favored the use of vasectomy for males (Webb 1910). Compare “Casts Doubt on New State Law: Validity of an Asexualization Act is Questioned by the Attorney-General,” *San Francisco Chronicle* (March 6, 1910), 29. Early sterilizations were in fact done by castration; vasectomies were still a new procedure, having only been developed in the 1890s (Gugliotta 1998).
8. Frank F. Tallman to Earl Warren, Inter-Departmental Communication, “Subject: Assembly Bill 2683” (March 31, 1953), in the California State Archives, Sacramento, California, file on Assembly Bill 2683. This was in the context of a legal review of the statute completed after the practice had essentially stopped.
9. California Statutes of 1913, Chapter 363, 775.
10. California Statutes of 1917, Chapter 489, 571; California Statutes of 1923, Chapter 224, 448. “Punitive” sterilization—that is, sterilization as a punishment for prisoners, was rare in the California context, as it was considered from the beginning to be likely unconstitutional, a point reaffirmed years later by the Supreme Court in *Skinner v. Oklahoma* (1942).
11. California Statutes of 1951, Chapter 552, 1706.
12. All of these institutions went through at least one name change over the years. The names used here were what they were referred to as during the majority of the period here surveyed. DeWitt and Modesto State Hospital were, during this period, primarily for the mentally ill, but also were equipped for a small amount of the mentally deficient as well, hence their dual-use designations in figure 2.2.
13. Earlier work on the “revitalizing” effect of testicular fluids was performed by the nineteenth-century physiologist Charles-Édouard Brown-Séquard, whom Clark credited highly (Braslow 1996, 39–40).
14. Braslow suggests that the therapeutic motivation may have been responsible for sterilizations in California outside of Stockton as well; the *Biennial Reports*, however, seem to indicate that while other superintendents elsewhere were aware of Clark’s claims, they is little evidence that they subscribed to them. There is evidence, however, that therapeutic goals played a role in some sterilizations in other states, as well (Gugliotta 1998).
15. Paul Lombardo makes a strong case for how flimsy “consent” claims could be in other states—that a physician could easily mislead a patient as to the permanence and nature of the operation (Lombardo 2008, 247–248). For further complications on the question of voluntary/involuntary sterilizations, see especially Schoen 2005.
16. *Garcia v. State Department. of Institutions*, 36 C.A. 2d, 152.
17. The statutes also permitted *punitive* sterilization as a form of punishment for a crime. Punitive sterilization played a larger role in other state programs before it was declared unconstitutional in *Skinner v. Oklahoma* (1942), but was never widely used in California, where it was judged early on to be constitutionally problematic by the state Attorney General (Webb 1910). On punitive sterilization in Oregon, see Largent 2002; in Indiana, see Gugliotta 1998.
18. Braslow gives evidence of an instance in which physicians at Stockton agreed upon an official patient diagnosis, which would make it easier to request a (therapeutic) sterilization (Braslow 1996, 37).
19. Butler then became the medical advisor for a *voluntary* sterilization group founded by eugenicist Paul Popenoe.
20. California Statutes of 1951, Chapter 552, 1706. On the purpose of the law, see Wallace G. Colthurst, Deputy Attorney General, to Earl Warren, Inter-Departmental Communication, “Subject: Senate Bill No. 730” (May 14, 1951), and Frank F. Tallman to Earl Warren (May 15, 1951), both in California State Archives, Sacramento, CA, file on S.B. 730/A.B. 2037.
21. An interesting but problematically retrospective look at various concerns that some hospital administrators had about sterilization can be found in Tarjan 1998, 204–245.
22. See, for example, the short blurb in the *Biennial Report* for 1950–1952, on 63, which begins by acknowledging that those “interested in the study of eugenics” had asked questions about the sterilization policy, but then immediately emphasized that “the ultimate therapeutic benefit to the patient is the chief concern of the

medical staff of each hospital," by which the threat of pregnancy (not "therapy" in the sense of Stockton's Clark) was what was to be averted.

23. *Sacramento Bee* (May 23, 1951), 12. To give a sense of context, it is worth noting that the line is placed under a five-paragraph article on the governor vetoing a bill which would give thirty days pay to state workers who joined military service, and over an article announcing that, "Congressmen may visit Sacramento in redistrict study." The line is listed with another bill which was signed at the same time by the governor which gave the Department of Mental Hygiene the power to enforce regulations on private homes for the mentally ill.
24. Associated Press, "The Day in Sacramento," *Los Angeles Times* (May 23, 1951), 7. Of note is that on the same day the *Los Angeles Times* ran its own one-line summary of the revision of the state sterilization law, it carried a far more prominent headline relating to a city Supervisor who declared that "sex criminals be incarcerated, sterilized or thoroughly controlled." "Sterilization Urged for Sex Degenerates," *Los Angeles Times* (May 23, 1951), 4.
25. Frank F. Tallman to Earl Warren (May 15, 1951), California State Archives, Sacramento, CA, file on S.B. 730/A.B. 2037.
26. "The law for the prevention of hereditarily diseased offspring (Approved translation of the 'Gesetz zur Verhütung erbkranken Nachwuchses')." Enacted on July 14, 1933. Published by *Reichsausschuss für Volksgesundheitsdienst* (Berlin: Reichsdruckerei, 1935), 12 (Order 1, Article 9). The fine was up to 150 Reichmarks per patient (around \$750 in current dollar value).
27. On the National Socialist "coordination" of the medical profession, see especially Proctor (1988). It is of note that even with such "coordination," there was plenty of room for power struggle between rival factions (e.g., Walker 1995, chaps. 2–3).

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3

Making the Facts of Life

Sheila Jasanoff

On August 9, 2001, nine months after taking office and one month before the terrorist attacks that changed the course of his administration, U.S. president George W. Bush held his first nationally televised news conference. The subject was not Osama Bin Laden or Al Qaeda, news of which had already percolated into America’s intelligence services, but a surprisingly partisan issue on the frontiers of biomedical science. The topic was research with human embryonic stem cells (hESCs). That August evening, from a monthlong working holiday at his Texas ranch, the president announced that he would permit federal funds to be used only for research on some sixty embryonic stem cell lines that existed as of that date; no newer cell lines would be covered. This policy, Bush said, would allow U.S. scientists “to explore the promise and potential of stem cell research without crossing a fundamental moral line, by providing taxpayer funding that would sanction or encourage further destruction of human embryos that have at least the potential for life” (Bush 2001). The theme that one form of “life” should not be sacrificed for the sake of others resounded throughout his presidency. For example, in July 2006 the president exercised his first legislative veto on H.R. 810, the “Stem Cell Research and Enhancement Act,” while expressing “the hope that we may one day enjoy the potential benefits of embryonic stem cells without destroying human life” (Bush 2006).

Bush’s statements about stem cells underscore the point made a generation or so earlier by the French social theorist Michel Foucault (1998) that life itself has become the primary object of modern governmental power; in governing life, states engage in activities that Foucault termed *biopolitics*. Since the latter part of the twentieth century, biology and biotechnology have transformed the territory of biopolitics. Public policy today concerns itself not only with governing potentially unruly human subjects, as in California’s sterilization-happy mental health clinics (Wellerstein, chapter