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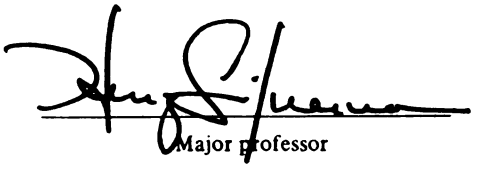

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# *Euthenics, Eugenics and Compulsory Sterilization in Michigan:1897-1960.*

By

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ABSTRACT

EUTHENICS, EUGENICS AND COMPULSORY STERILIZATION IN MICHIGAN: 1897-1960

By

Jeffrey Alan Hodges

The purpose of this paper is to investigate the variety of eugenic practices employed as Public Health policy in the State of Michigan during the first half of the twentieth century. The principal evidence for this survey were the sterilization records compiled by the State of Michigan and held in the State Archives. An historical outline of eugenic theory and legal precedent is included as an explanation to the State's Public Health policy in particular as regards compulsory sterilization. The primary focus of the study deals with the period 1933-1937, when the largest number of sterilizations were performed. A comparison is made to programs in other states and also to the eugenic programs of Nazi Germany. The history of the State of Michigan's program is of special importance because of the large number of sterilizations performed per capita and because of the state's primacy in proposing eugenic legislation for the use of compulsory sterilization as official public policy.

***Euthenics, Eugenics and Compulsory Sterilization In Michigan:1897-1960.***

## *Preface*

This thesis traces the broad outlines of the eugenic theory and practice reflected in Michigan's policy towards sterilization of the "socially deviant". In 1929, Michigan passed Public Act 281:1929,

> "An act to prevent the procreation of feebleminded, insane, and epileptic persons, moral degenerates, and sexual perverts; to authorize and provide for the sterilization of such persons and payment of the expenses thereof...."

When I started this study I had thought this law marked the beginning of compulsory sterilization in Michigan. But the history of Michigan's sterilization legislation began much earlier.

In 1897, Michigan became the first state in the U.S. to promulgate eugenic sterilization legislation.[1] Yet it was not the first state to actually pass a statute, and certainly not the first to implement such a policy. California had sterilized over sixty-two hundred people by the time Michigan passed its most effective law, in 1929.

By today's standards, the Michigan policy might seem

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1 Gosney, E.S. & Popenoe, Paul. Sterilization for Human Betterment. (New York: The MacMillan Co., 1930) pg.15

highly unethical. This was not always the case, and I submit, may not be in the future. What this policy aimed to accomplish was a percieved net benefit to society and to those whom it was to be applied. The people involved in formulating and implementing the policy were honorable and respected individuals. They were, in their own minds, motivated by the highest ethical principles. They did not proceeed secretly with their plans, but enlisted the aid of the electorate, their respective legislators, and the bureaucracies of state government to accomplish their ends. Indeed, support was wide-spread. The laws mandating compulsory sterilization were characteristic of Progressive Era reforms. An era when expediency often prevailed over personal autonomy.

Parallels to the policies of expediency that eventually led to the atrocities of the Nazi regime seem implicit. From the parallels and divergencies, we may better understand the different ethical pathways open to us and the concommitant social costs.

Currently, in the United States, a program called "The Human Genome Project" seeks to identify and conceptualize the entire genetic code of the human species. This project is funded as *the* primary federal science project. Indeed, the 1990s promise to be the decade of biology in the sciences.

The human genome project is projected to be completed by 2015. The knowledge acquired will provide us with inestimable possibilities for good and evil. For example, will insurance companies deny coverage on the basis of a percieved genetic predispostition to a particular disability? Their data will be as good as the actuarial tables used to set rates and exclusions today. In addition, it will based on the government's own data. If the government manages health care directly, will it make use of the data to formulate policy, with a regard to the percieved economic and social costs? Particularly when budget constraints, may make such a move seem practicable or expedient. The 1930s was an era when a policy of compulsory sterilization was thought both practicable and expedient.

In 1923, Michigan acted upon legislation that had circulated in the Legislature for over thirty years. By 1933, the height of the Great Depression, the government bureaucracy had gone a long way towards accomplishing this policy's ends. They did so with broad support among the electorate, the scientific/medical community, the legal establishment and the social-welfare system. When did policy, and support for it, change and why?

I have examined the patient histories and related requests for sterilization compiled in the Archives of the State of Michigan, for the period 1933-1937. In addition, I

have examined the Minutes of the Welfare Commission, to ascertain the philosophy and methodology of the program.

We should not be surprised at the support for a policy of compulsory sterilization. Support for this type of policy still exists. Below is an example from a recent newsmagazine.

> "State district Judge Michael McSpadden of Texas,....an advocate for what he says is a cheaper and more effective way to neutralize the (sexual)predators among us. Citing studies that show the procedure reduces recidivism from 80 percent to 5 percent, he proposes castration." *The Incorrigibles*, Newsweek. 18 January 1993.

Though this report is from a current source, there were counterparts in the 1930s. In 1937, a Lansing man, with a prior conviction for indecent exposure and public masturbation, was sterilized at the request of the state, himself, his wife, and his mother. This was not punishment. It was thought to be a therapeutic treatment. The wife's letter of request blames the husband's actions on her inability to satisfy his sexual desires during pregnancy, states her fear that without treatment she will become pregnant again, with the same outcome. How, she asks, will her husband be able to support their son if the father is imprisoned. The prisoner's and mother's letters were substantially the same.

Before we assume this type of case to be indicative only of the 1930s, consider the following:

> "A 47-year-old Lansing man faces life imprisonment for alledgedly being sexually delinquent because he is suspected of indecent exposure and masturbating several times in public." State News. MSU, 13 January 1993.

These articles illustrate the complexity and continuity of the questions and rationales involved in social and eugenic policies. The people referred to in the *Newsweek* article are not cases of voluntary sterilizations to prevent the procreation of probable, physically or mentally dysfunctional children. They are not scenarios like Huntington's Chorea, where half of each generation is doomed to an excrutiatingly, horrible demise. They are actions taken by well-meaning people, with the information and moral reflection available to them.

This research is relevant to the bio-ethical questions that face contemporary society, and not only those that will face society in the very near future. Biotechnology is providing society with choices with ever increasing speed. Every prenatal test, developed to identify a genetically defective fetus, poses the question of intervention. What is the point of knowing the dysfunctional status of a fetus, if not to pose the choice of intervention? Who shall make the

decision to intervene? Who is responsible? And to whom? Should individuals have the right to compel the state and society to bear the economic and social costs of maintaining their offspring. Does society have the right to intervene in the sexual autonomy of its citizens to the extent of proscribing their propagation? Hopefully, this work will provide a picture of where we have been, how we arrived there, and what we have learned.

**Table of Contents**

# *Chapter One-The Early History of Eugenics in Michigan*

## Michigan's Early Eugenic Movement

Michigan's eugenics movement has a very long history. In the last quarter of the nineteenth century advances in the medical sciences proceeded with incredible speed. Medical progress was epitomized by the success of sanitation procedures, derived from the "germ theory" of disease. Eugenics seemed another success in the progression of the biological sciences, based as it was on the popular theories of evolution and genetics. Michigan became the sixth state in the US to create a Department of Public Health. Among those instrumental in the formation of Public Health policy in Michigan were doctors, John Kellogg and Victor Vaughn. These two physicians were indicative of the two major streams of thought in public health.[1]

Kellogg was influenced by Herbert Spencer's ideas on evolution, and believed in a health strategy, he referred to as euthenics. The medical knowledge of the time perceived disease epidemiology as a parasitic phenomenon. The wide acceptance of the "Germ theory" of disease, and the practical program for public sanitation as a remedy for

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[1]Michaels, Andrew. "John Harvey Kellogg and Victor Clarence Vaughn in the Early Michigan Public Health Movement: Diverging Views on Disease and Race Betterment", Senior Thesis, (Cambridge: Harvard University, 1990).

persistent epidemics, reflected a new scientific orientation towards human biology and human ecology.

The focus of public health policy-makers, from the 1870s through 1930s, was on measures for increased sanitation among the public at large. Euthenics was Kellogg's program for the improvement of human health through a course of sexual abstinence, temperance, personal sanitation and, among other things, a vegetarian diet. Kellogg believed in a Lamarckian mode of evolution. Lamarckianism, was the name given to a set of theories that maintained the mutability of the human germ plasm. In this conceptualization, the course of human evolution could be improved through the betterment of living conditions. The physically improved circumstances of each generation, acquired through a program of euthenics, would be reflected in improved human germ plasm, thus genetically superior offspring. A corollary of this belief set was the theory that decadent living conditions would be reflected genetically in degenerate offspring.

This set of beliefs epitomized the essential questions of human ecology that had led to the formulation of another branch of science, eugenics. Eugenics, as a scientific doctrine, was first promulgated in Hereditary Genius, by Sir Francis Galton in the mid 1800s. Galton observed what he perceived as a definite inheritance of certain characteristics from one generation to the next. In this set of observations, Galton established, by the criteria of his

times, that a definite inheritance of good and bad characteristics occurred from one generation to the next.

The question remained as to what the relative effects of environment were on heredity. Lamarckianism assumed that material and moral improvements in the human condition would constitute "acquired characteristics" that were inherited in the next generation. Thus Kellogg's "euthenics" reflected a particular brand of Lamarckian eugenics that was favorably disposed to programs for the improvement of social welfare. To this end Kellogg founded the Race Betterment Foundation in 1906. This foundation sponsored national conferences on race improvement in 1914, 1915, and 1928. As early as 1897, Kellogg had expounded on what he believed to be the chief causes of racial degeneration in the United States. Listed in his oration at the 1897 Philanthropic Conference were "increased use of narcotics, including alcohol, tobacco, opium, tea and coffee; the abuse of sex; marriage to another with hereditary defects; unhealthful foods; unhealthful recreational activities; and unnatural conditions in schools."[2]

Kellogg's beliefs were in line with much of the scientific thought of the time. In Germany, Wilhem Schallmayer had published his work, Heredity and Selection in the Life-Processes of Nations. This thesis promulgated the idea that government had the obligation to promote

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[2]Ibid. pg. 5-57

national efficiency by regulating the procreation of its citizenry. Schallmayer's concepts held that government policies should foster the procreation and development of the classes of people seen as necessary to the progress of society. Concomitantly, it called for the restriction, through disincentives to procreation, of the supposedly inferior classes. Their contemporary basis for delineation of genetically positive and negative characteristics, would today, generally be viewed as a class biased interpretation.[3]

Schallmayer differed from Kellogg by his belief in Mendelian inheritance. The rediscovery of Mendelian genetics, at the end of the century, seemed to provide a further scientific proof of the genetic basis for this new scientific doctrine of eugenics. While it differed in its concept on the mode of how inherited characteristics were determined, it still supported the class biased approach to national efficiency and racial betterment. The difference was that class differences were perceived as the natural outcomes of human breeding combinations. Superior and inferior genetically endowed individuals' procreation outcomes constituted a continuum of moral and physical types delineated by the social structure of the day. In effect, the social structure was a natural consequence of breeding

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[3]Weiss, Sheila Faith. Race Hygiene and National Efficiency: The Eugenics of Wilhem Schallmayer. (Berkeley: University of California Press, 1987), pg 38-89.

outcomes. To change social structure it was necessary to regulate the procreation of societies' various classes. The criminal, the sexually deviant, the morally depraved, and the mentally and physically degenerate members of society were to be, at minimum, provided with disincentives to produce their supposedly degenerate progeny.

Dr. Vaughn reflected this latter view of eugenics. Vaughn was an early believer in the science of bacteriology, and like Kellogg, supported the policy of improving public and private sanitation. Both, Vaughn and Kellogg, initially, believed in the filth theory of disease. This theory held that decaying matter was the source of disease. Later, Vaughn became an adherent of the "contact infection" theory of disease epidemiology; this theory emphasized the individual nature of disease. Thus, his focus on disease was shifted from environmental factors to those of individual characteristics. In his eugenic thought, this focus on individual nature was reflected in his acceptance of the Mendelian laws of inheritance.

Mendelian inheritance held that the germ plasm was essentially immutable, but was constituted by a random selection of parental traits derived equally from both parents. The difference, between Mendelian and Lamarckian inheritance, was that Mendel's laws held that altered environmental factors in the parents situation did not change the germ plasm(with the resulting transfer of

"acquired characteristics" to their progeny). Therefore, Vaughn's eugenics focused on the individual's genetic merit.

Kellogg and Vaughn represented the dichotomy within the field of eugenics itself. While Mendelian genetics was eventually accepted by the scientific community, this outcome was not at all certain in the first part of this century. Indeed, in the USSR in the 1950s , the President of the Soviet Academy of Sciences, dogmatically clung to Lamarckian laws of inheritance, much to the chagrin of the Soviet sciences and agriculture.[4]

This dichotomy was reflected in the Michigan eugenics movement's theories on class origin. Lamarckianism held that positive environmental changes would lead to beneficial change in the class structure. Thus efforts geared to changing the habits and surroundings of the lower strata of society would lead to their social uplift. The corollary to this was that the supposedly anti-social and degenerate members of society constituted an environmental threat to their progeny's genetic inheritance. This would result in the "acquired characteristics" of social degeneracy being passed on to a new class of social misfits.

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[4]Huxley, Julian. Soviet Genetics and World Science: Lysenko and the Meaning of Heredity. (London: Chattus and Wildon, 1949). Joravsky, David. The Lysenko Affair. (Cambridge: Harvard University Press, 1970). Trofim Denisovich Lysenko believed that he could improve the spring wheat crop by a Lamarckian process called vernalization.

In the Mendelian paradigm, position in the social structure was a reflection of one's inherited characteristics. Since environmental influence played a minimal role in heredity(direct environmental insult(toxic action) to the germ plasm was accepted), efforts at improvement of the social environment would not result in changes in the class composition of society. The only way to manipulate class structure, in this paradigm, was by regulation of class propagation. Amelioration of social ills, by social welfare initiatives, was not only pointless in solving perceived social problems, but was counterproductive. Social welfare programs that sought to improve environment, actually worked to negate the action of "survival of the fittest" mechanisms within the social structure. Thus, poverty and its related social evils(e.g. chronic disease, crime, and social deviancy) were viewed as the mechanisms of negative social selection. In the eugenic terminology of the era, negative selection meant the elimination or restriction on the propagation of negative genotypes, in effect, the genetic bequest of socially degenerate phenotypes, the socially disadvantaged.

Michigan's public welfare/eugenics paradigms did have similarities, none the less. They both held that the socially degenerate classes would propagate their degenerate characters in their offspring. Whether through their degenerate, environmentally-induced "acquired

characteristics", or through the propagation of their relatively immutable "bad genes".

Eugenics movements were not isolated to the US and Germany, although these two nations had the most notable concurrence of views. Russia, Brazil, France, Britain and many other nations(particularly the Scandinavian countries) all had indigenous eugenic movements. The dichotomy of thought on eugenics policies, Lamarckian environmental amelioration versus Mendelian selection, was evident in all the movements. There was also a debate as to the relative benefits of positive and negative selection measures. In each country, different outcomes were arrived at. In most, negative selection, the restriction on propagation of negative genotypes was seen as a minimum requirement to halt the perceived social degeneracy of the period.[5]

In the first decade of this century, in the mid-western United States, several individuals of national prominence were active in the pursuit of "negative selection" policies. In 1909, Dr. Harry Sharp reported in the Journal of the American Medical Association, that between 1899 and 1909, he had performed 456 sterilizations on inmates of Indiana's Jeffersonville Reformatory, with no adverse effects, and in most cases highly favorable results. Chicago's eminent

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[5]Adams, Mark(Ed.).The Wellborn Science: Eugenics in Germany, France, Brazil and Russia. (New York: Oxford University Press, 1990), pg v-viii, 3-7, 217-226.

Professor of Genito-Urinary surgery and Criminal Anthropology, G. Frank Lydston, published the highly influential Diseases of Society and Degeneracy in 1903. This was the first book in the US to recommend the use of mass sterilization to curtail "social disease." Dr. Lydston also specifically recommended castration as a means of controlling behavior. In 1907, Dr. William Belfield addressed a joint meeting of the Physician's Club and the Law Club of Chicago. He presented a paper entitled, "Race Suicide and Social Parasites", in which he stated the view that involuntary sterilization was the only means to prevent the US from being overrun by habitual criminals. This paper was later abstracted, with a favorable review, in the Journal of the American Medical Association. The focus was on the prevention of socially inadequate offspring.[6]

In 1930s Germany, both positive and negative selection measures were pursued. Negative selection measures were the registration and eventual sterilization of genetically "degenerate" phenotypes. Typical of the positive selection measures were the "marriage loans" granted to "socially valuable" married couples, as an incentive to propagate. These loans amounted to several months salary, and payment

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[6]Lydston, G. Frank. Diseases of Society and Degeneracy. (Philadelphia: J.B. Lippincott Company, 1904), pg 562-565; Reilly, Philip. The Surgical Solution: A History of Compulsory Sterilization in the United States. (Baltimore: John Hopkins University Press, 1991), pg 32-37; Belfield, William. "Race Suicide for Social Parasites", JAMA. 1908, Vol. 50, pg 55-56.

was deferred upon the birth of children.[7] Some US states had similar positive measures reflected in tax credits(exemptions of income) for children, a practice current in the Federal Tax Code.

In the sphere of negative selection eugenics, legislative proposals were being promulgated as early as 1897, with the submission of Michigan's first sterilization Bill to the Legislature. Though this Bill did not become law, Michigan in 1913, became the 7th state to pass a eugenic sterilization statute. Between 1907 and 1913, sixteen state legislatures passed sterilization laws, four of which were vetoed by their governors.[8]

Passing a law and implementing it proved to be an entirely different matter. By 1918, only one sterilization had been performed under the aegis of Michigan's 1913 sterilization law. The 1913 law was challenged as a constitutional violation of the "equal protection clause" in the case of *Haynes vs. Williams*(201 Mich. 138-166 N.W. 938). Because the law applied only to those people in state institutions and not to other citizens it was amounted to class legislation. Ironically, though the legislation would be reformulated so as to be within the constitutional bounds

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[7]Weindling, Paul. Health, Race and German Politics Between National Unification and Nazism: 1870-1945. (Cambridge: Cambridge University Press, 1988).

[8]Reilly, Philip. The Surgical Solution: A History of Compulsory Sterilization in the United States. (Baltimore: John Hopkins University Press, 1991). pg 37.

set by continuing litigation; invariably, the people who went under the state's knife were those who fell under the jurisdiction of two state departments, Corrections and Welfare.

Eugenic sterilization, with state sanction and compulsion, was an unprecedented invasion into the reproductive autonomy of its citizens. In response, court cases were pursued to the highest levels of the judiciary in an effort to establish legal precedent. In 1927, the case of *Carrie Buck versus Bell(State of Virginia),* was heard before the US Supreme Court. This case was generally recognized as the legal precedent for all future cases.

Carrie Buck was sterilized on October 29th, 1927 in the operating theater of the Virginia State Colony for Epileptics and the Feebleminded. Carrie Buck was selected as a legal test case; her state-sanctioned sterilization was the culmination of a legal battle to validate the constitutionality of a new type of sterilization law.[9] The outcome of this case represented a constitutional validation of the sterilization law in "at least three respects: that it was not an abuse of "Police Power", nor was it without "Due Process of Law", nor was it punitive or "Cruel or Unusual Punishment"".

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[9]Smith, J. David & Nelson, K. Ray. The Sterilization of Carrie Buck. (Far Hills: New Horizon Press, 1989), pg ix-6, 89-184.

The United States Supreme Court based its decision confirming the "Police Power" of the state to perform sterilizations, upon the precedent of compulsory vaccination in the case of *Jacobson vs. Massachusetts*,(197 U.S. 11; 25 S. Ct. 358; 49 L.Fd. 643). In referring to the Supreme Court opinion in *Buck vs. Bell*, Chief Justice Holmes said,

> "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian Tubes".[10]

The reference to Fallopian tubes would seem to have an ironic significance beyond its relation to the Buck case; well over half(57%) of the sterilizations "recorded" nationwide through January 1, 1935 were performed upon women. In Michigan, the ratio varied from one to one, to over one to ten(men to women). The average male to female ratio in Michigan, over a twelve year period from 1923 through 1935, was three to one. [11]

The objective result of the legislation and court decisions was to emphasize the eugenic nature of the

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[10]Reilly, Philip. The Surgical Solution. pg 87; Smith, J. David and Nelson, K. Ray. The Sterilization of Carrie Buck. (Far Hills: New Horizon Press, 1989), pg 177-178.

[11]Gillein, Hilmer. "Memorandum", pg 1.; Gillein, Hilmer. "Memorandum to Ruth Bowen(Deputy Director, State Welfare Department)", Sterilization Records: Archives of the State of Michigan(hereafter *ASM*), pg 1-2, Table 1.

statutes, the restriction of the propagation of the supposedly socially inadequate. In Michigan, the most commonly used term in justifying sterilization requests was the likelihood for propagation of children with *TTIMD*, "tendency towards insanity or mental deficiency". Chief Justice, Oliver Wendel Holmes, in his written majority opinion(*Buck vs. Bell*), went so far as to say, "Three generation of imbeciles are enough".[12]

Carrie Buck, was adopted by her foster parents, Alice and J.T. Dobbs. Carrie had been in their care since age three, when her mother had given her to the Dobbs. In 1923 the Dobbs petitioned for Carrie's commission to the Virginia Colony for the Epileptic and Feebleminded. Three years earlier, her natural mother, Emma Buck, had been committed to the same institution. Smith and Nelson, in The Sterilization of Carrie Buck, assert that Carrie's institutionalization was a result of her pregnancy by the Dobb's nephew. Carrie, her mother, and sister Doris, were all institutionalized and sterilized.[13]

Carrie's case was chosen as the test case for the new Virginia Law, by Dr. A. S. Priddy, Superintendent of the Virginia State Colony for the Epileptic and Feebleminded. Dr. Priddy had a personal reason to want the law validated,

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.[12]Reilly, Philip. The Surgical Solution. pg. 87

[13]Smith, J. David. The Sterilization of Carrie Buck. (Far Hills: New Horizon Press, 1989), pg 1-38.

as he had recently "been sued in a Richmond court for a large amount of damages for having sterilized a feebleminded women patient in the Colony".[14]

The eminent eugenicist, Harry Hamilton Laughlin, was asked to testify as to the efficacy of the law and its applicability to Carrie Buck. Though Laughlin never personally examined Carrie, he was able to render a convincing indictment of her mental and hereditary defects. The results of IQ testing on Carrie, her sister, mother and daughter were never presented in court. Indeed, though there was ample subjective testimony as to their familial defects, no objective testing had been done. This was nature of the case that set the legal standard for compulsory sterilization for the next several decades. Further legal confirmations would follow, but this case would remain the legal standard.[15]

The first constitutional attack following the Buck vs. Bell decision was directed upon a presumed infringement of the Fourteenth Amendment's "equal protection clause". The 1928 case of *Smith(Kansas Attorney General) vs. Schaffer*,(270 Pac. 604) held that compulsory sterilization was not a constitutional violation of the Fourteenth

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[14]Ibid. pg 49.; "Conversation with Audrey Strode". Strode had written the Virginia legislation and was chief administrator of the Virginia Colony. He stated that Dr. Priddy had approached him with a proposal for the law, following Dr. Priddy's aforementioned Richmond court case.

[15]Gellein, H. "Memorandum", *ASM*. pg 89-184;

Amendment, nor did it exceed the "Police Power" of the State. In addition, it was found not to constitute a violation of the constitutional provision for "Due Process of Law".[16]

In 1929, Nebraska's sterilization statute was "upheld as far as the constitutionality of sterilization of insane or feebleminded persons in the case of *Clayton vs. the Board of Examiners of Defectives*,(234 N.W. 630). As late as 1937, the Director of the Michigan Department of Corrections, Hilmer Gellein could claim,

> "I might state that the law is well settled as far as idiots, imbeciles, insane, epileptic and feeble minded persons are concerned. The law relative to feeble minded persons can be considered a matter of universal recognition".[17]

*Buck vs. Bell* and related cases provided the legal precedent for states to pursue their eugenic policies. The decisions also provided, by example, a model statute(the Virginia law), on which to model their own legislation. Indeed, several groups were active in formulating and disseminating "model eugenic statutes". Typical of these individuals and their endeavors was Paul Popenoe, editor of The Journal of Heredity. Popenoe's journal was influential

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[16]Gellein, Hilmer. "Memorandum" *ASM*. 18 March 1937, pg 2-4.

[17]Gellein, Hilmer. "Memorandum" 18 March 1937, pg 2-6.

among scientists, doctors, legislators, and the lay public.[18]

In 1929, Michigan passed Public Act 281:1929, commonly referred to as the "sterilization law". This law was enacted as a replacement for Public Act 285:1923 and its subsequent amendments. The 1923 law was utilized even with the confused legal picture. Its history of amendments is reflective of attempts to bring it into compliance with changing legal perspectives.[19] From 1923-1933, despite the legal quandary, one thousand sixty-five sterilizations(vasectomy or salpingectomy) and twenty castrations were performed, in just two institutions.[20]

The 1929 Michigan sterilization statute(P.A. 281:1929) was challenged the year it was enacted. In the case of *Smith vs. Command*(Wayne County Probate Judge: 231 Mich. 409), the statue was found not to constitute "a derogation of any of the "rights, privileges and immunities" in the Federal Constitution". Further, the Michigan statute was "upheld in this opinion as a reasonable exercise of "Police Power".[21]

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[18]Popenoe, Paul. The Journal of Heredity.

[19]Public Act 285:1923, amended per Public Act 71:1925. The latter act established a broader jurisdictional basis by sanctioning County Court's sterilization proceedings against "mentally defective persons."

[20]Gellein, Hilmer. "Memo to Miss Bowan", pg 1.

[21]*Smith vs. Command*. Wayne County Probate Court, 1929; Gellein, Hilmer. "Memorandum", 18 March 1938. pg 3.

Even with the passage of the law, full implementation did not begin until 1930(Full implementation is meant as the inclusion of *all persons* who fell under the jurisdiction of the various agencies of the State Department of Corrections and the Welfare Commission). By 1933, the year Hitler rose to power, and implemented Germany's first national sterilization law, Michigan had sterilized over one thousand of its citizens.

Though parallels between eugenics policies in Germany and the US were somewhat apparent by the 1930s, in actuality, a public scientific discourse between the eugenicists of the two nations had been going on since the latter half of the 19th century. This discourse would continue until the outbreak of war in 1939. The eugenicists and their legislative representatives, used each other's national records on eugenics legislation, as an example of and stimulus for, their own legislative endeavors.

There was also an on-going educational and cultural exchange between the two countries, that had really begun in the late nineteenth century and continued through the 1930s. Vaughn, with his assistant, went to Berlin in 1888 to study under Drs. Robert Koch(discoverer of the tubercle bacillus in 1882) and Carl Fanckel. Many Americans traveled to study at German universitates, considered the best in the world in

many fields.[22]

In the 1920s, perceived social degeneracy was seen, in the industrialized nations, as a problem reaching a critical juncture. Perceived social degeneracy was evident to eugenicists in the population growth within the criminal and socially-deviant classes. The fear, of the middle and upper classes, a disruption of the social and economic status quo, tended to place the onus of social-deviancy on all those individuals with behaviors considered outside of the social norm. Anarchists, socialists, trade unionists, communists, people with unconventional lifestyles(e.g. hobos), and those with non-straight sexual lifestyles, were among the categories of people sometimes included among the socially-deviant classes.

In Nazi era Germany, the resultant outcome, was down, what is known as the "slippery slope" of bioethics. In Michigan, the outcome was different in many ways, yet parallel in many others. Michigan did not traverse the slippery slope as far as the Nazis, but Michigan's law did aim to:

> "prevent the procreation of feeble-minded, insane and epileptic persons, moral degenerates, and sexual perverts; to authorize and provide for the

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[22]Michaels, Andrew. "John Harvey Kellogg and Victor Clarence Vaughn in the Early Michigan Public Health Movement: Diverging Views on Disease and Race Betterment", Harvard Senior Thesis. (Cambridge: Harvard University, 1990), pg 18-22.

sterilization of such persons...."[23]

The point must be made clear, that sterilization was viewed as a medical treatment and in no sense as punishment. The thirty or more castrations were also viewed as a therapy for changing behavior. The eugenicists and their supporters believed they had the scientific proof that the conditions listed in the law were demonstrably inheritable, either as dominant or recessive genes. Most of these conditions were seen as examples of a recessive inheritance. In recessive inheritance, it is required that both parents have the dysfunctional gene or gene combination, statistically, at most half of their children would have the related condition. The eugenic quandary with recessive genes was that they were only expressed when two people with that particular recessive set mated and those two particular genes randomly combined. The recessive, degenerative genes could be fairly ubiquitous in the general population and yet have a relatively random distribution as the spread of the genes occurred. The proof of a wide heterozygous spread(non-expression of the trait equals one of the two necessary genes) of the gene in the general population would be an increase in the number of pathologic conditions(expressed trait equals both genes) that began to appear. This meant there was a lag time between the spread of the genes and

[23]Public Act 281:1929, Archives of the State of Michigan.

appearance of the increasing disease rates that would follow. By the 1920s, most eugenicists believed the evidence was in on increasing rates of genetically-derived social disease.

There were several reasons for this belief. The reported incidence of hereditary diseases was much larger than initially predicted. As new studies and census data became available, the picture seemed to becoming progressively more bleak.

These studies documented an increase in the number of institutional cases; and this, put together with data on a rising crime rate, led many to believe that degeneracy in the gene pool was reaching epidemic proportions. The data seemed to indicate that the socially deviant, along with the lower classes were reproducing at much greater rate than the more valuable classes. The genetic threat was perceived as insidious(by the "hidden spread", recessive nature of inheritance) and on the rise.

In two oft-quoted, US studies on hereditary social pathology, the Kallikaks Family Study and a similar study of the "Jukes", a genealogical trail of socially deviant behavior was documented and publicized. The Kallikaks family supposedly demonstrated that from the mating, of one man of good breeding(gentleman, colonial officer in the revolutionary war, judge) with a social deviant(retarded, poor camp-follower), a line of unremitted social depravity

had sprung. Of 480 Kallikaks descended from the mating with a social deviant(moron), 434 were classified as social deviants or degenerates. This study also included the genealogy of this same man as conceived with his wife, a Quaker woman of good moral standing. This line was distinguished by the large number of doctors, judges, officials and churchmen. Only one member of this line had transgressed society's bounds.[24]

The original "Jukes" study was done by Richard Dugdale in 1874. He traced 709 members of this degenerate family, and found that eighteen had kept brothels,128 had been prostitutes, over 200 had been on relief, and over seventy-six had been convicted criminals". He estimated that the cost of this familial degeneracy had amounted to a minimal cost to the state of New York of $1,306,000. In 1911, the "Jukes" family was once again traced, this time by Harry Laughlin's protege, Arthur Estabrook, of the Eugenics Record Office. By this time, Estabrook could trace 2,111 Jukes. Estabrook found 1,258 living Jukes. In his book, The Jukes in 1915, he stated "one half of all Jukes are feebleminded.....and all of the Juke criminals were feebleminded". This finding was contradicted within the body of his own work, in that the stated figures for the number of feebleminded family members was 131. While Dugdale's

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[24]Haller, Mark. Eugenics. (New Brunswick: Rutgers University Press, 1963), pg 20-23.

original study included the effects of environment, Estabrook's work focused on a supposed genetic predisposition.[25]

To many, these reports and similar studies and results from other countries seemed proof positive of the linkage of social behavior and heredity. In Germany, France, Brazil, Russia and England similar studies had been done.[26]

To those with a knowledge of eugenics, the evidence called for immediate action; not only to preserve the gene pool from contamination through bad breeding, but to remove the crushing economic costs to society of the socially deviant. Who were these Americans with a knowledge of eugenics? These individuals occupied positions, similar to their counterparts in Germany, who worked in the Nazi sterilization program: doctors, nurses, aides, hospital administrators, social workers, lawyers, judges, and the rest of the apparatus of the social-welfare, medical and legal fields.

In Germany, the slide down the slippery slope of eugenics to torture, slavery and genocide was blamed on

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[25]Haller, Mark. Eugenics. pg 106-109. Estabrook's study claimed that in nine generations he found 366 pauperized adults, 171 criminals, 175 prostitutes, 282 alcoholics, and 131 feebleminded.

[26]Reilly, Philip. The Surgical Solution. pg. 20-22, 55; Haller, Mark. Eugenics. (New Brunswick; Rutgers University Press, 1963). pg 106-107, 120; Adams, Mark. The Wellborn Science.pg 3-7, 70-92, 11-114, 115-200; Soloway, Richard. Race and Degeneracy.

Adolf Hitler. Orders for the incremental violation of medical-legal ethics originated from the Fuhrer's Chancellery and its bureaucratic apparatus. Arthur Caplan has labeled this period of medical practice under the Nazi regime as the time "When Medicine Went Mad". This disguises the fact, that the participation of a larger part of the government bureaucracy must be involved in implementing policies of this logistical magnitude.

Michigan is a good example of the breadth of involvement. In Michigan, there was no Fuhrer to issue orders. Politicians, acting in the interests of their electorate, formulated, enacted, and implemented Bills to sterilize their fellow citizens. This was not a mere historical aberration. These Bills had been circulating in the State Legislature for over thirty years. More than one had passed. Obviously, either a majority of the electorate supported the measures or the Legislators thought the situation called for draconian action. Books on eugenics by Popenoe, Laughlin, Dugdale, Estabrook, and many others convinced much of the electorate that eugenics was the answer to an ever progressing social degeneracy.

Nor was this merely a regional phenomenon. Michigan was not the first state to pass a compulsory sterilization statute. It was certainly not the first to begin sterilizations. By 1929, the State of California had sterilized 6,255 of its citizens. Three thousand citizens of

other states had also received this treatment by the time Michigan had passed its 1929 sterilization statute.[27]

By 1935, when over twelve-hundred sterilizations had been performed in Michigan, over twenty-thousand operations had been performed nationwide. Only three states had performed more sterilizations, California, Virginia and Kansas. By 1950, Michigan had surpassed Kansas, with over three thousand operations. Nationwide, more than fifty-thousand sterilizations had been performed by 1950.

Indicative of a particular subset of public opinion, supporting the legislation, was a 1937 Fortune magazine poll, claiming that 63% of Americans endorsed the compulsory sterilization of habitual criminals, and 66% favored the sterilization of mental-defectives.

The sterilization records, that I was able to access, list compilation dates as late as 1968, though the latest file date was 1961. The records are very incomplete from at least 1947 onwards. For example, the Sterilization Records contain totals of twenty-three and twenty-five requests for 1948 and 1949, respectively; figures supplied by state officials to Birthright show totals of 131 and 88 for those years.[28]

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[27]Gosney, e,s, and Popenoe, Paul. Sterilization for Human Betterment. (New York: The Macmillan Co., 1930), pg 13-20, 183.

[28]"Sterilizations officially reported up to January 1, 1950, from States having a Sterilization Law", Birthright: 1950. (Princeton: Birthright, Inc., 1950), Table 1;

## *Chapter 2-State Institutions and the Law*

### Sterilization in State Facilities

The Archives of the State of Michigan maintain a collection of four file boxes, each four inches wide, containing the sterilization requests and authorizations, from 1929 through the 1952. A total, according to the records available, of over 900 state-sanctioned sterilizations.[1] These sterilizations were all performed on the authority of the State of Michigan, under the provisions of Public Act 281:1929 and Public Act 285:1923. These records are only the tip of the iceberg. According to other records, the State of Michigan had authorized the sterilization of 3,070 citizens, by the first of January 1950.[2]

The institutional framework for this policy was spread

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[1]"Sterilization Records", Department of Corrections and Charities, Archives of the State of Michigan. This may be a slight over-estimate. For the period I studied. There were a total of 338 files, of which 7 represented duplicate requests, representing 2% of the total.

[2]"Sterilizations officially reported up to January 1, 1950, from States having a Sterilization Law", Birthright,1950. (Princeton: Birthright, Inc., 1950), Table 1, This table was compiled by Birthright, Inc., the successor organization to Gosney's Human Betterment Foundation of California. HBF had compiled official data on sterilizations nationwide. This information was submitted by the states to HBF, up to Gosney's death in 1942, with Birthright continuing the compilation thereafter. The Michigan Archives still retain the state's correspondence with Mr. Gosney. That these figures received official recognition, is demonstrated by their citation in many inter-departmental memoranda.

through principally two state bureaucracies, the Department of Corrections and Charities and the Welfare Commission. These two agencies had departmental control over state hospitals, correction facilities, and institutions for the mentally ill and deficient.

This represented a important change in the jurisdictional breadth of Michigan's sterilization legislation. Michigan's first successful sterilization statute was Public Act 285:1923. Individuals who fell under the jurisdiction of this law were the feebleminded . "The words "mentally defective person" or "defective" in this act shall be deemed to include idiots, imbeciles, and the feebleminded, but not insane persons."[3]

Inmates at Michigans penal institutions were not included in the initial sterilization program either. The 1929 statute brought both of these latter groups, the insane and the criminal, within the bailiwick of sterilization legislation. Indeed, seven of the eight requests from 1929 are from the Ionia institutions, noting criminal sexual behaviors, four Rapes and three cases of Gross Indecency. The legal precedents, for the inclusion of the sexual offenders and habitual criminals in such programs, would not be elucidated until after the famous *Buck vs. Bell* case in 1927.

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[3]Public Act 285:1923. Public Acts of Michigan: 1923. Archives of the State of Michigan.

In the case of *State vs. Filen*, 76 Washington 65, it was held that sterilization was not "Cruel and Unusual Punishment" in the case of Statutory Rape. In the Federal Appellate decision of *Davis vs. Berry*, 216 Federal 413, sterilization was held to be "Cruel and Unusual Punishment" in the case of a Second Felony Offender. The upshot of these and other adjudications was that in six states, three time felony criminals could face sterilization; in eight states, various categories of sexual offenders had a similar fate. [4]

Michigan, among seven other states provided specifically for the "sterilization of moral degenerates and sexual perverts, ***showing hereditary degeneracy***." In three states, Indiana, Oklahoma and Utah, sterilization statutes specified an additional punitive motive in regard to sex crimes.[5] The Michigan law, by requiring a hereditary justification, was not considered punitive, but socially eugenic in nature. In regard to the inmate concerned, the State's sterilization program was presented as a therapeutic

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[4]Gellein, Hilmer. "Memo to Mr. Bryant", pg 3-5. Other cases of interest: *Warden Davis vs Walton*, 74 Utah 80, 276 Pac. 921; *State vs. Troutman*, 50 Idaho 673-299 Pac.668; *Clayton vs the Board of Examiners of Defectives*, 234 N.W. 630(Nebraska); *State ex. rel. Smith Att. Gen. vs. Schaffer*, 270 Pac. 604(Kansas); *In Re Main*, 19 Pac.(2nd) 153(Oklahoma).

[5]*Davis, Warden vs. Walton*, 74 Utah 80, 276 Pac. 921, upheld the punitive aspects of the Utah Act, and was considered as legal precedent in upholding similar provisions of the Indiana and Oklahoma statutes.

procedure.

For this reason, the "supposed" therapeutic nature of the procedure, the Hospital Commission provided the State's "official" medical sanction. The Hospital Commission is an interesting body, in that its jurisdiction crossed several departmental barriers. Though the Hospital Commission was a entity of the Welfare Commission, the Hospital Commission's oversight extended from the Welfare Commission, through Public Health, to the Department of Corrections and Charities. This would seem a reasonable purvue, in that, the aforementioned agencies were all involved in various aspects of public health.[6]

In regards to the sterilization program, the Hospital Commission represented an administrative corollary to the Hereditary Health Courts responsible for carrying out German's sterilization legislation. As later in Germany, the vast majority of requests for sterilization procedures were initiated, examined, medically sanctioned and finally, performed by the State's doctors.[7]

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[6]Michigan's penal system was organaizationally within the Department of Corrections and Charities. The latter agency had oversight of some public and private charitable institutions, along with responsibility for providing medical care to inmates of the reformatories, prisons and institutions for the criminally insane.

[7]Weindling,Paul. Health, Race and German Politics Between National Unification and Nazism: 1870-1945. (Cambridge: Cambridge University Press, 1988). Proctor, Robert. Racial Hygiene. (Cambridge: Harvard University Press, 1988).

They were by no means alone in their activities. The reporting of potential victims of compulsory sterilization proceedings, was assigned to a number of other health care providers, social workers and judicial officials. Although the judiciary could not order sterilization as part of a punitive sentence, it could instigate proceedings at a civil level.[8]

The Welfare Commission's overall jurisdiction, in determining those individuals thought to be in need of treatment, included all those individuals admitted to state hospitals and institutions who were found to be suffering from mental illness, feeblemindedness, epilepsy and/or moral-degeneracy. While all those in prison were also under the jurisdiction of the Department of Corrections and Charities, very few prisoners were actually sterilized. Of the prisoners sterilized during my period of study(1933-1937), all were incarcerated for criminal sexual behaviors; all were repeat offenders.

In addition, these bureaucracies had jurisdictional control of non-instutionalized citizens as well. Individuals on parole from state prisons or institutions were also subject to the provisions of the law. Those individuals and families that came under the care of the state social-welfare system could also be sterilized under Act 281:1929.

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[8]P.A. 281:1929 held that judicial involvement was limited to the Probate Courts. Thus, all proceedings were considered part of civil law, not criminal.

Throughout the Depression of the 1930s, a significant percentage of the state population would fall under the provisions of this law.

Indeed, the breadth of jurisdiction was constitutionally necessary, to meet the provisions of the equal protection clause of the Constitution. This was one of the key constitutional questions answered by the 1927 *Buck vs. Bell* Supreme court case.

The question was not whether the state had the right to intervene in the sexual autonomy of its citizens, but whether the law was applied equally. If only applied to the institutionalized, then this would constitute a statute aimed at a specific class, and thus be a violation of the equal protection clause.

Michigan's first eugenic sterilization law, enacted in 1913, had been found unconstitutional in 1918 as a violation of the equal protection clause. The 1913 law applied only to those in state institutions, thus it constituted class legislation.[9] Through the five year period this law was in effect only one sterilization occurred.[10]

In 1923, Michigan passed a more successful piece of eugenic legislation, P.A. 285:1923. Under the provisions of

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[9]Public Act 34: 1913. Public Acts of Michigan: 1913.

[10]Author Unknown(submitted by Director of Corrections, Hilmer Gillein). "Memorandum to Hilmmer Gillein Upon the Legality of Sterilization in the Several States", Sterilization Records: State of Michigan Archives. 11 March 1938.

his law, at least 850 people were sterilized. Of the total umber of sterilizations for this period, more than three-uarters were performed on women. According to a memorandum submitted by the Director of Corrections, Hilmer Gillein, 95% of these operations were performed at the Michigan Home and Training School at Lapeer, a school for the mentally retarded. The remainder of the procedures, two or three a year, were performed at the Michigan Farm Colony for Epileptics.[11]

Another constitutional criteria the law had to meet was due process. This criterion made several requirements, considered safeguards for the individuals' rights. It also protected the state and its employees from litigation stemming from the cases. Due process required that each case be documented, and approved by the Welfare Commission and the respective state institution involved. Permission for treatment from the patient, or his legal guardian were to be obtained as a first alternative. Failing this, or if a ward of the state, petition for treatment could be made through the local probate court. Attempts were also to be made to contact other interested parties in the following order; "husband, wife, father, mother, brother, sister, child, or

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[11]Ibid. Sterilizations from 1923-1937: 307 men, 932 women; The sterilized epileptic patients, were presumably all mentally deficient(lowIQ), as the 1923 statute hadn't provided for the sterilization of epileptics. Records for this period, 1923-1926, are not currently available.

other next of kin".[12] This was also the order of precedence, outside of the state officials delegated this responsibility, for who was allowed to petition for the sterilization of any particular individual.

Once a petition for treatment was submitted to the court, a hearing had to be scheduled within fourteen days. Within ten days of the hearing, notice had to be served personally on the interested parties listed above. The law stated:

> "Whenever at such a hearing it shall be found by the court or by a jury that such person is a mentally defective person and the court shall find that said defective person would be likely to procreate children unless he be closely confined or rendered incapable of procreation, that such children would have a tendency to mental defectiveness.....or that such children might be a menace to society or might become wards of the state, the court shall make an order requiring and specifying that such defective person shall be treated or operated upon by *X-rays or by the operation of vasectomy or salpingectomy or other treatment or operation best suited...."*[13]

Who were the "said defective persons"? The statute made no differentiation on the basis of race, gender or creed. This was also a necessary legal criteria to meet the provisions of the equal protection clause. Whatever an individual may feel about the ethical nature of the PA

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[12]Public Act 285: 1929. Public Acts of Michigan: 1929.

[13]Public Act 281:1929, Michigan Public Acts of 1929.

281:1929, its framers were acting in accordance with established legal precedent. It must be remembered that constitutional law, as regards the individual rights of citizens, was still being defined in the courts, as it is to this day. Section 2 of PA 281:1929 states:

> "The words "mentally defective person" or "defective person" in this act shall include all feebleminded, insane and epileptic persons, idiots, imbeciles, moral degenerates and sexual perverts. Where such persons are referred to in this act as of the masculine gender, the same shall be deemed to include persons of the feminine gender as well."

Several state hospitals, and institutions with hospital facilities, were the principal sites where procedures were performed, with a few exceptions. Operations performed at University Hospital in Ann Arbor(yet considered to fall within the diagnostic criterion of PA 281:1929) were covered under a seperate law, Public Act 274 of 1913.[14] Regarding individuals falling within the definition of "defective persons" in PA 281:1929; Section 4. stipulated who were to report and initiate petition for sterilization within the state bureaucracy.

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[14]Public Act 274:1913. Public Acts of Michigan: 1913, PA 274:1913 was a funding provision, for University Hospital(Ann Arbor) to perform corrective surgeries on deformed children at state expense, if the family was indigent. Sterilization was not mentioned in this statute. Another piece of 1913 eugenic legislation, Public Act 150:1913 was a statute that provided for the creation of "Commission to investigate the extent of feeble-mindedness, epilepsy, insanity and other conditions of mental Defectiveness."

> "Whenever the medical superintendent, warden, or principal officer of the Kalamzoo state hospital for the insane, the Pontiac state hospital for the insane, the Traverse City hospital for the insane,the Newberry state hospital for the insane,the Ionia state hospital for the criminal insane, the Michigan Home and training school for the feeble-minded at Lapeer,the farm colony for epileptics at Wahjamega, the state psychopathic hospital at Ann Arbor, the Michigan state prison at Jackson, the branch of the state prison at Marquette, the Michigan reformatory at Ionia or any other hospital, trainig school, farm colony, prison or public institution maintained or supported in whole or in part by the state of Michigan, shall be of the opinion that any inmate or person in the custodial care of such institution is a mentally defective person...it shall be the duty of the{aforesaid}...to bring to the attention of the {respective institution and State Welfare Commission}"[15]

Virtually every institution involved with the medical, legal or social welfare programs of the state were to participate in the implementation and maintenance of the sterilization policy.

The majority of cases were performed at the four state hospitals for the insane, the state hospital for the criminal insane, the Michigan Home and Training School for the Feeble-minded, and the Michigan Farm Colony for Epileptics at Wahjamega. A much smaller number of cases were performed in the penal institutions.

In the penal operations, castration was often the method

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[15]Public Act 281:1929. Public Acts of Michigan of 1929.

used. In all castration cases, the reasons given were therapeutic, not punitive. A 1938 memorandum from Director of Corrections Gellein reveals the awareness of public officials that compulsory sterilization as punishment was both illegal and likely unpalatable to the public.

All persons, receiving treatment, were to fall under the established categories of PA 281:1929 or PA 274:1913. Treatment to be performed by a state-paid surgeon. The statute allowed sterilization for individual cases where "such children were likely to become wards of the state". To this end, many public city and rural hospitals participated in the policy. Some state hospitals for the institutionalized also provided treatment to the general public. The Pontiac State Hospital for the Insane, also functioned as a hospital for the indigent, and performed sterilizations on indigent mothers at their request(sometimes on suggestion), as a means of birth control.

Sterilizations were performed elsewhere, that were never recorded. How many sterilizations were performed on the unsuspecting, as part of a particularly difficult delivery, will never be known. Having grown up and worked in the medical community, I have heard stories of these situations. Many nurses, attendants and other ancillary personnel employed in hospitals throughout the state, all have stories of similar situations. My father, as a chief pathologist at

two city hospitals in Michigan knew of cases where, in the attending doctor's opinion, sterilization was appropriate, and performed. These cases were legally legitimate, based on the physicians best opinion. What is ethically questionable, in light of the so-called "wild" period of euthanasia and sterilization in Nazi Germany, is the grey area where individual physicians may have used the criterion of the law(e.g. preventing the propagation of children likely to become wards of the state, or with a Tendency Towards Idiocy or Mental Deficiency, TTIMD) in the operating room, without due process. Little direct evidence for this would exist, as the records would describe the procedure as necessary. I believe the numbers of such cases to be very small, but that they happened, I believe, is undoubtable. In retrospect, we would view such doctor's actions as highly unethical, the result of class biases and elitism. Eugenics constituted the "scientific" justification for acting on these prejudices.

Euthanasia of deformed and retarded newborns was not unknown. In the hospital jargon of the times, they were "set aside". They were set aside, to live or die, while care was given to the mother. At best, this was marginally legal behavior. The medical profession's jargon, is full of seemingly, calloused descriptions of disadvantaged individuals. Deformed and retarded chidren were referred to as FLKs, funny-looking kids; their parents as FLPs. Ethically, these physicians, no doubt, felt they were acting

in the interests of their patients and/or society.

These abberations show that Michigan's eugenic path was not so dissimilar from the Germans as we might hope. At the same time, Michigan's policies did provide a legal basis for much of what the Nazis would proceed to carry out, along their path to the Holocaust.

Whether the blame for these initial eugenic policies (compulsory sterilization), in Germany, can be laid entirely at the feet of the Nazis is questionable. Many progressive movements supported eugenic sterilization. For example, in Germany as well as the United States, many socialists were at the forefront of the eugenic movements. In the United States, it was the policy of the elected governments, acting in the name of, and with the implied consent of the public. Throughout the 1920s and 30s, German and American eugenicists would point to the eugenic achievments in each other's country, and expound on the need to emulate these achievements. The two nations' eugenicists were even recognized and recieved awards for their work, from the respective foreign country's professional societies and institutions. Where along this bio-ethical "slippery-slope", Germany and the US parted company, is difficult to delineate precisely.

Certainly, the eugenic laws and their rationales, were initially based on the same criteria(the 1933 German sterilization statute did not include race as a criterion of

treament). The German law was formulated with a knowledge of the American models, and was a relative late-comer on the international eugenic scene. Similar citizens(i.e. doctors, lawyers, nurses, social-workers, judges, et.al.), within the congruent positions of the responsible German bureaucracies and institutions, performed similar tasks to their counterparts in Michigan. In totalitarian Nazi Germany, the program was carried out, supposedly "in secret"; though everyone knew about the *"Hitler Schnitt"*(the Hitler Cut). The "treatment" was the butt of many jokes.[16]

In democratic Michigan, even the pretense of secrecy was unnecessary. Perhaps in this lies part of the difference in our paths. Certainly, Germany's desperate position during the war, and Nazi philosophy were of prime importance. But if the latter two rationales are held to be most responsible for the divergence in eugenic actions, these are only relevant to the question, "Why Germany went as far as it did?". They do not answer why we, in the United States, went as far as we did. Why did we not go farther? Under situations similar to the Germans experience, would we do the same? Do not demagogues and wars exist, often side by side, in the life of a democracy? We were well along the

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[16]Weindling, Paul. Health, Race, and National Politics in Germany from Unifiication through Nazism: 1870-1945. The Nazi regime went so far as to pass legislation providing for prosecution of individuals found to have revealed the names of sterilization patients, or to have publicly insulted said patients.

path. Well meaning people, all. The same institutional framework that registered, reported and treated patients in the US, exists today. These sterilizations have continued throughout the US, until the very recent past. Many researchers were shocked to find that sterilizations, and euthanasia of deformed newborns, continued in Germany even after the war, and the Nuremburg "Doctor's trials" had ended.

In Michigan, habitual criminals were never sterilized as a class. Though these individuals were within the jurisdiction of the law, and the institutions and that implemented it, only a few, sexually-deviant criminals were sterilized. This was an effort to provide them a therapeutic solution, to what were considered psychiatric dysfunctions, with a basis in hormonal imbalance. The institutional reach of the statute was enormous, yet bounds, not specified in the law, proscribed the actual limits to which it was pursued. That is the story told in the following chapters.

## *Chapter 3-Five Years of Eugenic Sterilizations: 1933-1937*

### The Records: A Five Year Period in Michigan's Eugenic Sterilization Program, 1933-1937.

This chapter evaluates the sterilization requests that I examined and the sterilization program as outlined by them. Necessarily, the research had to be expanded as new questions arose. To some degree, this chapter will also present a historiography of my research and how my understanding of the project changed over time.

I started my research into Michigan's sterilization program by examining the "Sterilization Records" of the Department of Corrections and Charities and the Welfare Commission. I began with the first box of records in this set; these began in 1933 and ran through 1937. I decided to examine the five years from 1933-1937 because, initially, I believed they represented the beginning and heyday of the program.

In a cursory review of the records for the years 1938-1952, an effort to get an overview of the end of the program, I found two memoranda from the Director of Corrections, Hilmer Gellein, dated March 11,1938. These memoranda revealed a program of greater extent than I had ever gathered from the "Sterilization Records".

According to Mr. Gellein's figures, from 1923 through

1933, 890 sterilizations were performed under the statutes passed in 1923 and 1929. Even more startling was the assertion that by 1938, twenty castrations had been performed.[1]

I had found a total of 339 requests for sterilization, the total I thought for the period in question. Mr. Gellein's memoranda made it apparent that I had seen slightly more than a third of the requests for the total number of operations performed through 1937.

Further research among other sources, such as the national sterilzation surveys of the Human Bettermant Foundation, showed Michigan's program was much larger than I had initially presumed. Not only had the program affected a great many more people than I had thought, but it had operated for a much greater span of time, from 1923(1913 if you include the one sterilization performed under that law) apparently through to the present.

Not only was the actual size and duration of the program larger, but there were at least two types of sterilization operations performed, whose use I had not conceived of. These were sterilization by X-rays and castration. Of the former I found no direct evidence, though the method was mentioned in the 1923, 1925 and 1929 statutes. This would

[1]Gellein, Hilmer. "Memo to Mrs. Bowen", Sterilization Records. Archives of the State of Michigan, 11 March 1938.

seem to disprove the assertion that the Nazi regime was the first to contemplate sterilization by X-rays. Of castration, I found ample proof.

For the period from 1933-1937, I found requests for six castrations, all from the Ionia correctionl institutions. All of these operations were performed upon sex offenders. Certainly, sterilization was within the purview of the law, but castration is not among the listed procedures to achieve sterilization. Though unlisted, it could and was construed to be included under "other treatment or operation".[2]

I have found no direct evidence for the completion of these procedures, other than the authorizations attached to the requests. Authorizations are as much proof as we have from any of the request records, that the surgeries had actually been performed. Indeed, the records from the Ionia Reformatory are among the most incomplete records I have viewed.

Philip Reilly asserted in his 1991 book, The Surgical Solution, that only one legal castration had been performed in the United States.[3] Mr. Gellein's "Memoranda" show that

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[2]P.A. 281: 1929. In referring to the sterilization of a patient, "such defective person shall be operated upon by X-rays or by the operation of vasectomy or salpingectomy or other treatment or operation best suited to the condition of such person", Public Acts of Michigan: 1929. pg 693. (see Chapter 7 for specific discussion on castrations).

[3]Reilly, Philip. The Surgical Solution. (Baltimore: The John Hopkins University Press, 1991), pg 28-29. In 1864, "a jury in Belton, Texas convicted a Negro man of rape and recommended castration, a sentence that was carried out".

this was not the case. Dr. Reilly's castration was, while possibly the first legal castration, certainly not the last.

Mr. Gellein's "Memoranda" also demonstrated that the extent of the Michigan program was nearly three times the size I had envisaged from the records initially available to me. The "Sterilization Records" from November 1932 to December 1937 contain 339 files. The rest of the records contained within the two boxes, covering the period 1938 through 1952, record an additional three hundred thirty-three cases. The number of sterilizations derived from the Archive's sterilization records and Gellein's Memoranda, covering the years 1913 through 1952, came to a grand total one thousand seven hundred twenty-one.[4] This number turned out to be a little more than half of the actual figure of three thousand two hunderd eighty-eight.[5]

In comparison with the State of California's sterilization program(the largest program in terms of absolute numbers), Michigan has essentially the same proportion of cases, on a per capita basis.

All of the 3,288 cases have been categorized as to the sex of the patient. Figures on the number of cases per year were available for only 1933-1952. Totals, differentiated

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[4]Gellein, Hilmer. "Memo to Mrs. Bowen", pg 1-4; "Sterilization Records", Archives of the State of Michigan.

[5]Human Betterment Foundation. Table of Sterilizations Reported in the United States to January 1, 1953. (Battle Creek: Human Betterment Foundation, 1953).

only by sex, were available only as a block for the years 1923-1932.

The data in the Sterilization Records(1933-1952) generally constituted a relevant medical history of the patient, but varied in composition and completeness from institution to institution. Therefore, the data presented an incomplete picture of the selection process.

The poorest, in terms of completeness, were the files from the Ionia Reformatory and Ionia State Hospital for the Criminally Insane. This was especially frustrating, in that the individuals selected for sterilization were generally sexual offenders, but very little other than that can be ascertained from the files. Certainly, these cases do not reflect the total number of sexual offenders incarcerated during this period. In a couple of cases, the reason for the request is stipulated as "prior to parole". This would certainly be similar to the reasoning used for sterilizing many inmates from the other state institutions, particularly the State's training schools.

State institutions provided environments that were generally segregated by sex. Inmates were housed in same sex wards, and attempts were made to keep fraternization between the sexes at a minimum. Thus, there was a relatively low probability of procreation among the inmates. Potential parole or vacation of state patients was an incentive for authorities to instigate sterilization proceedings; before

the patient, beyond the restraint of the authorities, could procreate. Of 264 requests, where a reason was provided, sixty-six listed potential parole as the specific reason for the request.

The reasoning, beyond the environmental or hereditary unsuitability of the prospective parent's background, was often explicitly stated as the prevention of the procreation of additional wards of the state, and the concomitant costs of those new wards. The requests indicated this to have been the routine understanding of the law among those individuals responsible for carrying out the statute. The 1923 and 1929 Michigan statutes explicitly stated this purpose of the law. But, as Director of Corrections, Hilmer Gellein noted in 1938,

> "In *Osborn vs. Thompson*, 169, N.Y. Supp.638, which held its act(the New York statute) unconstitutional for the reason that the purpose of the statute was to save the expense in the operation of charitable institutions in the theory that if the inmates were sterilized the State would be able to turn them at large with no danger in the future from their abnormal offspring. It was held to be an improper use of "Police Power""[6]

Thus, sterilization requests for prophylactic purposes were viewed as unconstitutional in the dissenting New York

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[6]Gellein, Hilmer. "Memorandum to Mr. Bryant", Sterilization Records. Archives of the State of Michigan, 18 March 1938.

opinion, *Osborn vs. Thompson*. This restriction was obviously contrary to the intents of the Michigan statute, and those of most other states, too.[7] However, the ruling apparently was never used against Michigan's law.

The primary purpose of the Michigan statutes was always explicitly stated as the prevention of further generations of mental defectives. The vast majority of requests stated this as the primary justification. The amount of information provided in the requests as proof of these assertions varied among institutions.

The State Hospitals and Training Schools usually provided the most complete records. The hospitals had reasonably complete medical records, but often missing from diagnoses of feeblemindedness were the results of the objective testing of the day(i.e. IQ measurements and other scales of intellect). Of 264 reasons given in the sterilization requests, seventeen specifically state low IQ. An additional, yet somewhat indeterminate number of diagnoses of feeblemindedness are contained in the 156 entries of TTIMD, a *tendency towards insanity or mental deficiency*. Of 184 entries under the heading of IQ, there

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[7]Public Act 281:1929, "It is hereby declared to be the policy of the state to prevent the procreation and increase in number of feeble-minded, epileptic and insane persons, idiots; imbeciles moral degenerates, and sexual perverts, likely to become a menace to society or *wards of the state*", Public Acts of Michigan: 1929. pg 689-690. This policy, as regards the procreation of potential wards of the state, is reiterated within the law again on page 691.

were only one hundred IQ entries that had a numerical value. These ranged from 40 to 97, though twenty-two of the one hundred eighty-four total were listed as average or superior. The cohort's average IQ derived from the numerical entries was sixty-seven.

The State Training Schools provided most of the numerical IQ data. This is explained by the nature of the contemporary IQ tests. Alfred Binet had originaslly developed these tests for the French Government. The testing was an effort to quantify the abilities of France's developmentally disabled, so as to provide the most appropriate treatment and education. Henry H. Goddard, the eminent American psychologist, brought the methodology to the United States, and did pioneering work with it at the Vineland Training Schools for Feebleminded Boys and Girls, in New Jersey. In the training schools, several modifications of the original IQ test were used. These tests were and remain very effective in measuring a specific set of learning abilities; abilities, in general, that are particularly deficient in the developmentally disabled. Thus, the tests were very useful tools in determining appropriate training for the patients.

Though it is beyond the scope of this paper, it should be mentioned that the state training schools, in the Depression era, were under pressure to reduce institutional costs by re-integrating patients into general society,

"mainstreaming" as the process is known today. Ideally, the patients would be able to function with a minimum of supervision. The re-integrated patient's economic self-sufficiency was considered of prime importance. Learning a trade was considered a necessity. Domestic service, agricultural and light industrial work were considered most appropriate. The successes and failures of this policy should be compared with the state's current policy of de-institutionalization and re-integration. In many ways, the patients released in the 1930s were better prepared for their re-integration than those of today. Unfortunately, current efforts at re-integration often amount to little more than drug therapy, without the benefits of institutional supervision.

Sterilization before re-integration could be considered another facet of the state's attempt to reduce its potential costs(additional wards of the state) from this policy of de-institutionalization. On the other hand, pregnancy and childrearing were seen as excessive mental and emotional burdens on the de-institutionalized patients, and thus likely to reduce their chances for successful re-integration and self-sufficiency. This view of what was in the patient's reproductive interests appeared consistently in the requests.

The focus of de-institutionalization would remain on the Training Schools, in that their patients suffered from

mental deficiency, rather than a form of insanity. The social and economic disadvantages related to a mental deficiency could be ameliorated by education and training. Of the forty-five cases, where potential parole was indicated as the specific reason for sterilization, four were patients of the Michigan Farm Colony for Epileptics and thirty-six were inmates of the Michigan Home and Training School. The remainder were patients of the Pontiac and Newberry State Hospitals, and were also categorized as mentally deficient or epileptic. A diagnosis of mental deficiency or epilepsy was explicit in all of these cases.

If one accepts the IQ data from the requests in these parole cases, the training schools provided a good program for the re-integration of their patients. In 90% of these files a specific numerical IQ value was given. The average IQ for this cohort was 62. Thus, a cohort of patients with a median IQ of 62 was believed able to be successfully re-integrated into society, albeit with an unstipulated amount of supervision. This did not appear to be the case for the insane patients.

In the 1930s, most forms of insanity were considered progressive disease states, with continuing deterioration the prognosis. This view of mental illness is evident in the most commonly listed form of insanity in the sterilization records, Dementia Praecox. Dementia Praecox, or schizophrenia as it is now referred to, was considered a

premature or adolescent form of age-related dementia, more commonly referred to as senility. Due to the perceived, progressive nature of most insanity, and a general lack of success in treatment methods, de-institutionalization was generally not an option for these patients.[8]

A diagnosis of insanity with mental deficiency, occurs in a large number of cases in the state hospitals. As insanity was the primary reason for institutionalization in these cases, an "objective" measurement of intelligence was probably not considered necessary or particularly relevant. As the probable forecast for their form of insanity was progressive deterioration, mental age could be considered somewhat superfluous in relation to their overall prognosis.

The methodology of IQ testing had been modified and standardized by another eminent psychologist, Robert Yerkes.

Yerkes developed a test, believed to be applicable to the general population, that the Army could use to direct World War I draftees to appropriate training and assignments. By the end of the war, the tests had acquired an aura of scientific validity. The results from the draftees' tests had also suggested a much greater number of mentally deficient stock existed, than even the eugenicists had previously believed.

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[8]Berne, Eric. A Layman's Guide to Psychiatry and Psychoanalysis. (New York: Simon and Schuster, 1968), pg 190.

Though IQ testing was widely available (in as much as many people had been trained to administer the tests), it was not widely used outside the training schools. Of the 183 entries under IQ, seventy-five were subjective labels. Only two of the subjective intelligence assessments were from the training schools, the rest were from the state hospitals for the insane and the Ionia reformatories.

Of these seventy-five entries, thirty-six were given simply as "low". Though this constitutes a rather subjective assessment, it must be remembered it was the considered opinion of the staff and the staff psychiatrist of the institution. Neither the law nor the agencies responsible for its implementation required more.

Of the 260 diagnoses provided, over 150 were for various forms of insanity. Dementia Praecox, a somewhat erroneous term for schizophrenia, was the most numerous entry, with seventy-three cases. Mental deficiency was listed just over seventy times, but over a third of these latter cases were accompanied by a diagnosis of mental illness. Manic-Depression was the third most prominent category with twenty-seven cases. Ten cases of epilepsy, ten cases of venereal insanity and five cases of psycho-sexual pathology complete the list of diagnoses. It is indicative of the incompleteness of the records that only 76% include a diagnosis.

If the categories of diagnosis and reason for request

are combined, suitable medical-legal justification for the requests existed on this basis in over 90% of the requests. When the diagnosis is unavailable, but can be inferred from the requesting institution,(e.g. Michigan Farm Colony for Epileptics=Epilepsy) the ratio increases to over 95%.

In examining the sterilization records from 1933-1937, I established twenty categories specifically related to eugenic classifications. If the entries in all these categories are correlated to the eugenic stipulations within the law, then less than one percent of the files is of questionable legal merit.
This one percent is reduced even further when requests and consents are included. In my opinion, the remaining questionable cases represent incomplete recordkeeping rather than an abuse of the law.

A third of the records included information on whether consent had been given and/or a request made. There were five refusals and fourteen cases where no family was considered legally able to provide consent. Typical of this latter category, were individuals, whose closest family members had already been institutionalized. The "Swamp Dixbys" of Battle Creek were an example of this situation(See Chapter 5).

In over twenty cases, the patient provided consent. In many of these cases, the specific reason given was the prevention of additonal unwanted pregnancies. Before the

Second World War, birth control information and distribution was meager in the United States. Particularly among the indigent, sterilization provided a viable contraceptive alternative.

In several cases of breakdown and depression, childbirth or concerns over additional children were listed as either bringing on the illness directly, or as a contributing factor. These cases should probably be considered, more or less voluntary.

Particularly questionable in terms of legal consent, are five cases from the Michigan Home and Training School, where patients with IQs from 50 to 73 were allowed to provide consent for their own sterilization proceedings. Moreover, four of the five list parole as the specific reason for sterilization. These cases were instances where sterilization was explicitly given as a condition of release. These cases demonstrate a marginally legal consent, in effect, consent given by an institutionalized individual, already adjudged *non compus menti*.

Holding parole as a reward for consent also presented a legal problem, as it constituted a coercive measure not specifically allowed by the Michigan statute. This legal quandary was a technical aspect of the law and certainly not in line with the statute's intent. Interestingly, all of these cases occurred within an eight month period from June 1935 through February 1936.

Though this constitutes a seemingly distinct period for this type of proceeding, I could find no evidence that this was a distinct phenomenon. I could find no particular evidence to explain its implementation, or prove it to be an initial instance. Neither could I find a reason to believe that the practice was halted after this, in effect, I found no evidence of legal proceedings to halt the practice. In that the 339 records I closely examined constitute less than 20% of the 1,721 reported cases up to that time, it is impossible to accurately estimate the frequency of this practice.

Though less than half of the records fail to note the outcome of consent requests, this again seems to be a problem of incomplete records. Several cases demonstrate, that the institutions' authorities went to great lengths to track down and secure consent from relatives. There is evidence that failure to attain consent did become a problem by 1937. The Director of the State Hospital Commission, Dr. Joseph Barrett stated, in a memorandum to the Medical Superintendent of the Kalamazoo State Hospital, Dr. Morter, that the new Hospital Commission had questions as to whether adequate attempts were being made to acquire the consent of patients and next of kin. Though consent was not strictly necessary, the statute required that, in Dr. Barrett's words, all "necessary persons have been notified and been

given sufficient time to file their objections".[9]

Despite Dr. Barrett's assurances to the new members of the Hospital Commission, they voted to defer action on the bloc of five male patients submitted by Dr. Morter. Of the four patients who were married, all had two or more children, and yet none of these files included consent information. Dr. Morter's requests have a particular problem in this regard, as nearly 28% of all sterilizations were upon patients in his facility, and of these ninety-seven case files, only eleven provide consent information.

Dr. Barrett's memorandum also noted among the new commission, "some feeling expressed in regard to a possible promiscuous sterilization of many cases".[10] For the requests of the five year period examined, 1937 showed a remarkable decrease in the number of sterilizations performed. The 1937 total, forty-two cases appeared to be less than half the number(95) performed in this period's most active year, 1934. The 1937 numbers of requests appeared to reflect a 45% drop in the number of cases from the previous year.

Recourse to the national statistics compiled by the Human Betterment Foundation(HBF), indeed confirmed that a drop of almost 45% had occured from one year to the next. But they also demonstrated that it had been 1935 that had

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[9]Barrett, Joseph. "Memorandum to Dr. Morter, 8 December 1937", Sterilization Records. Archives of the State of Michigan.

[10]Ibid. pg 1.

been the big year, with well over three hundred sterilizations performed. The one hundred forty-one operations of 1936 were indeed a decrease, but this figure was half again the highest per year figure, I had been able to establish from the Archives' boxes of request records. This established, what turned out to be a good rough correlation between the numbers and types(i.e. insane /feebleminded & male/female) provided in the Michigan Archives' "sterilization records" versus the HBF's national statistics (which were submitted by the states). After comparing per year data between the two sets of records, by the three criteria held in common(sex, diagnosis, total), the correlation held up. Apparently, a little more than half of each institutions records had actually been compiled(or had survived to be compiled?). There were numerous lacuna, some of which overlapped. Such is research, conditional answers posing new questions. Could there be a reason, nefarious or not, for the rather meager survival of the records?

None the less, it seemed that the effects of public pressure were working to constrict the size of the program. Subsequent years would see a progressive decline in the number of requests. Using the Michigan Archives' records and those of the HBF, only once it seems, in 1948, did the number of requests per year(131 cases) come close to equaling those prior to 1938. Excepting 1948, the post 1938

period averaged under one hundred requests per year, though there was considerable inter-year variation.

Reilly's study of compulsory sterilization, The Surgical Solution, noted that many state sterilization programs became dormant during the war years, as many of the surgeons had been called up for military service. Though the 119 request records from the war era were only a third proportionally to the number performed in the prewar period, this did not reflect a decline similar to that experienced in other states. That nearly half the total number of cases in this period were performed in 1945, does probably indicate that the decline was in some part due to a dearth of institutional physicians during the war, and an effort to remove a backlog of cases upon their return following demobilization. When the requests are examined with regard to sex of patient, and the comcomitant surgical expertise required for the operation, another facet of the program is revealed in this regard(see Chapter 6).

Following 1948, there was a steady decline in the number of reported sterilizations. Through the late 1940s the average was about a hundred cases a year. The files for the last three years(1949-1952) in the sterilization request records, contained four or less cases per year. But the HBF national statistics showed that Michigan continued its program through the 1960s, as far as the HBF records go. State-sanctioned, compulsory sterilization still occurs in

the United States.[11]

Though the records disappear and the program obviously did not, we can still get a fairly accurate image of the program in its heydey. A correlation seems to exist between total number and types of cases documented by the HBF and the surviving requests records. From this a demographic picture starts to emerge, conditional upon the presumed correlation.

The question as to racial discrimination, is complicated by the incompleteness of the files. Race is specified in only 67 of 339 cases, less than 20% of the records for this period. Twelve of these patients are specifically referred to as African-Americans. Among the files where race was stated this would have amounted to four times the proportion of African-Americans in the state's population at this time.[12] An additional nine cases listed race as "mixed". This information after sifting, provided a very different picture. First, if race wasn't stated, I think it safe to presume that the omission can be inferred to indicate a caucasian.

Due to the particular type of eugenic ideology common at this time, German-Dutch mating was included as an example of a "mixed" racial background. Therefore, persons in the

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[11]Reilly, Philip. The Surgical Solution. (Baltimore: John Hopkins University Press, 1991), pg 128-165.

[12]Census Data.

category of "mixed", cannot all be assumed to be individuals of African-American descent, though the majority no doubt were. This would indicate that African-Americans suffered at a rate four times that of their proportion in the population as a whole.

Considering that race was more likely to be stated if the patient was other than white, the ratio could be as low as 3.7%, a proportion in line with the contemporary ethnic distribution in the population. The incompleteness of the records, prevent a more definitive answer to this question at this time. Two cases list race as Indian, and one as Oriental. Statistically, the number, less than one percent of cases, is too small to draw any conclusions(See Chapter 5).

The most blatant case of a disparity, or differentiation in treatment rates between groups, is that between men and women. From 1923 through 1935, three-quarters of the 1,239 sterilization were performed upon women. It seems that this ratio was gradually shifting to a more equal distribution.

By 1933, the ratio was just below three to one, and proceeded to decline through the 1930s, with the exception of one year. According to the 1936 HBF records, 280 women and 36 men were sterilized, an eight to one ratio. The following year the proportion of males to females had dropped from that of the previous three years, with 38 men

and 103 women undergoing the procedure.

In actuality, this does not seem to reflect a trend, as much as a statistical oscillation. The records for the following fourteen years show a great variation from year to year. For this period from 1938-1952, the proportion remains two women to each man. Table D(Appendix C) shows the remarkable inter-year variation. While I did not examine these records in great detail, it would seem an area of prime research potential. Significant variations, such as the nearly nine to one ratio in 1942, could shed light on critical periods in the eugenics movement.

For the United States, 1942 was the first year of World War II; when manpower was drawn from the homefront to the battlefront, in this case surgeons from the institutions. As noted earlier, most institutions, nation-wide, recorded precipitous declines in the number of surgeries done. Michigan records indicate that five times as many sterilization were performed in 1942 as in 1941. Moreover, salpingectomy, the far more dangerous and surgically-demanding operation, predominated over vasectomy, nine to one. Were obstetricians and gynecologists, awaiting imminent draft orders, hurrying to perform surgeries they could expect would be left undone in their absence? A breakdown by age, for this period might be able to show whether a younger cohort of women were operated upon. This might indicate a prophylactic effort on the part of the institutions and

doctors. The next two years of the war do reflect a net decrease in the number of sterilizations performed, particularly those upon women.

With the end of the war in 1945, the number of sterilization again more than triples over the previous year. 1948 was the last big year, with 131 cases.

The oscillations in the data also suggested other critical junctures in the Michigan eugenics movement and its various programs. The records for 1937 showed a marked decline in the number of requests. This coincided with increasing public scrutiny on the program. This was reflected in comments in the request files and memoranda of the various institutions' doctors and administrators. The December return, unapproved, of Dr. Morter's bloc of five requests, with a note containing the embarrassed Dr. Barrett's queries about proper consent notifications and the "possible promiscuous sterilization of many cases", would seem to have indicated the effects of the growing public debate on the program.

By 1938 though, the number of sterilizations increased slightly. The program wasn't apparently encountering serious opposition, but caution seems evident. Director Gellein, in a covering letter to the Deputy Director of the State Welfare Department, responded to a request that he speak about the sterilization of inmates in state institutions, to a meeting of social workers in Ann Arbor. He stated,

> "After going into the matter and comparing the number of sterilization operations in this state with the numbers in other states, and the fact that there was some considerable opposition to sterilization....I do not feel that with the showing contained in the statement enclosed herewith(Table of Sterilizations by State up to January 1, 1935), that it would be wise to take up this matter again....I do not think we should do anything for fear that the law would be repealed, and thus prevent us from doing anything along this line at all."[13]

Indeed, after 1938 the number of cases dropped to less than half those of the previous year. The number would not increase again until the two, possibly war-related, peak years of 1942 and 1945. These two years stand out in the series, and probably indicate attempts by the surgeons, before and after their wartime service, to lessen the effects of the sterilization hiatus of the war years.

A thorough examination of the files from 1938 forward would no doubt help clear up these questions and others. I have found that for the five years of files I examined closely, the quality of the records became progressively more complete in content, and consistent between what different institutions provided. A cursory examination for the remaining files from 1938 to 1952 shows this trend continued in content, if not in the number of surviving records.

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[13]Gellein, Hilmer. "Memo to Ruth Bowen, Deputy Director State Welfare Department", Sterilization Records. Archives of the State of Michigan, 11 March 1938.

The most difficult, and perhaps most important, facet of the records to quantify, are those of heredity and environment. The records include many facts that can be considered of either a hereditary or environmental nature, depending upon the perticular philosophy applied to the analysis. This is not only a difference between modern and contemporary perspectives on the nature versus nurture argument, but upon the differences on the nature-nurture question throughout the last century. I have included five separate categories for familial related genetic defect. These are based upon the contemporary criteria used when the records were written. Much of this remains consistent with modern criteria though the hereditary perspective on strength of the predisposition has shifted away from genetic determinism.

I have, unfortunately, not included Tuberulosis in my analysis as either a hereditary or enviromnmental factor. TB had been viewed as having a genetic component, even after the tubercle bacillus had been isolated as the cause of the disease. The contemporary belief in this hereditary influence was based upon the idea of genetic variance in susceptibility and resistance factors.

This continuing belief in the genetic component of TB distribution, demonstrates the difference inherent between the two scientific methodologies used in genetics: inferred hereditary studies(pedigree studies) versus direct

examination of the genome,(DNA analysis). Direct DNA analysis has recently proven that there is a genetic component to resistance to TB.[14] At the same time, pedigree studies have been used to isolate the gene for Huntington's Chorea, something DNA homology studies had, as yet failed to do.[15] Both methodologies remain viable avenues of approach, and both suffer from deficiencies relative to practical application(See Chapter 7).

In the 1930s, pedigree analysis was the only real avenue of approach. DNA would not even be recognized as *the* genetic material until Watson and Crick's revelation in the 1950s. The shortcomings of the pedigree analysis method were already evident in the 1930s though, the problem of subjective diagnoses. The sterilization records are cluttered with subjective psychiatric notes on patient's relative's psychiatric makeup. "Nervous aunts", "odd uncles", and other "strange sisters and brothers" abound throughout the files. As insanity, or at least, a strong predisposition to it, was believed to be inheritable; almost any nervous complaint mentioned in family interviews found its way into the files as a general proof of a genetic, psychiatric taint.

The family interviews that much of the doctor's

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[14]Lanning, Dennis. Professor of Medical Microbiology, Loyola. Conversations January 1993.

[15]Science News, 1993.

analysis was based upon, were generally conducted by social workers. The variance in their abilities to gather pertinent data was not only reflective of differences in knowledge related to eugenics, social science and psychiatry, but to the class biases inherent in the distinctions social workers made among their clients(modern term- find the old one). Interviews with neigbors, local officials and the police contribute to this subjective debris of class distinctions. Letters from relatives yeild similar results.

Listed among these notations are included distinct hereditble-disease states, and these I've sought to quantify under hereditable family complaints. The criteria for this distillation of the data is based on the contemporary standard filtered through the modern criteria of recognized hereditary disease. Table E represents a modern understanding of the ethnic distribtion of some hereditary diseases. Table E lists only those diseases where a discrete biochemical abnormality can be ascertained, and connected with a particular ethnic group. Not included are hereditary diseases with more cosmopolitan, ethnic distributions. Also not included are disease states where hereditary distributions have been established, but the specific biochemical or physiologic nature of the disease remains unknown. Huntington's chorea is a specific example of a hereditary disease fitting these latter two criteria. Table F provides a summary of recent articles found in various

scientific journals and medical texts. The disease states listed in Tables E and F were used to quantitate the rate of hereditary disease among family members of those sterilized.

Less than twenty percent of cases, listing a family member of the third degree or closer, contained diagnoses of herditary disease. When cases of feeblemindedness and institutionalization, among family members(third degree or closer), were included this figure rises to over half of the cases. When congenital diseases of a non-hereditary type, such as, various types of sexually transmitted diseases(e.g. syphilis) were included the rates of congenital disesase among the 1933-1937 cohort rose to two-thirds.

If alcoholism is included as a related syndrome, either on the basis as a hereditary predisposition or as repesenting a potential environmental insult to the fetus or genetic material, the rates of "familial" disease rise to nearly three-quarters of cases in the cohort. The incompleteness of the records explains why a higher proportion of eugenic characterizations were not found in the records.

The problem of the general incompleteness of the files is compounded in this analysis by the variance in the information available to the researchers: the social workers, judges and doctors. State wards, such as, abandoned children had virually no known hereditary background at all. In all cases, nothing like a pedigree analysis of the

"Jukes" or "Kallikuks" is evident.

I have listed alcohol and drug abuse as a distinct category, though largely environmental in influence, eugeneticists believed in the 1930s, and geneticists believe today that there is a genetic component in a predisposition to severe alcoholism. About twenty percent of the cohort contain a record of familial alcoholism. Less than twenty cases of alcoholism and drug abuse were listed for the patients themselves, less than six percent of total requests.

Under the more decidedly environmental influences I have delineated abuse for children and adults. It should be rememberd that American eugenicists, though generally non-Lamarckian, believed that a degenerate environment, if not a genetic determinate, was certainly a direct social handicap to the next generation and thus a cause of further social degeneracy. It was, of course, also believed to be a reflection of some sort of inhereditable predisposition towards social inadequacy.

Ten percent of cases list child abuse in the patients' histories. An additional twenty cases report abuse of the patient as an adult. Overall, a sixth of the cohort contain reports of abuse, either as a child or adult.

Over twenty percent of the sterilization requests include a history of criminal offences. Nearly half of the offences listed were of a sexual nature. These sexual

offences ranged from indecent exposure to rape and murder. Homosexuality was also included as a deviant, illegal behavior. Though homosexuality was legally defined as a form of sodomy, cases of bestiality and worse were also extant.

The most unusual case was a poor, physically-deformed girl of 13, who had been repeatedly raped by uncles and other family members. Reportedly, she preferred intercourse with a "large hunting dog" the family owned. This file reveals the patient not so much as victim, but as a repository of social evil. Through her weakness, her inability to prevent males from taking physical advantage of her, she supposedly represented a continuing temptation towards societal immorality. Rape, incest and sodomy constituted evidence of her personal degeneracy, not society's inability to protect her from abuse.

Over twenty percent of the records listed the patients' promiscuity as a factor in the request decision. The fact that seventy percent of the cases with the assertion of promiscuity included, were women would seem to confirm the sexist nature of an appellation of "promiscuity". It is interesting that the eugenic rationale of sterilizing promiscuous "defectives" was to prevent the birth of additional wards of the state. Of the seventy cases with "promiscuity" listed, only twelve noted illegitimate children, representing a total of fifteen illegitimate

children. The total number of children born to the promiscuous group was sixty-four, less than one per patient. Only twenty-seven of the seventy were parents, less than forty percent. In reproductive terms, not a particularly successful record for the promiscuous.

While only five of the seventy "promiscuous" requests were from correctional institutions, thirty-five percent in the promiscuous category had prior criminal records. Sixty-four percent of these crimes were of a sexual nature. Of the 29 requests from the Ionia hospital and reformatories nearly sixty percent had histories of criminal sexual behaviors. As has been noted castration was the treatment recommended for six of this latter group.

The files presented a picture much different than the one I had initially envisioned. Hopefully, the following chapters convey the outline of the program and its intricacies of practice and rationale. They are sometimes convoluted, but revealing of the nature of social programs conceived in the "best interests" of society.

## *Chapter 4-Treatment Categories and Application of the Law*

### Treatment Categories: The Laws

The categories of patients to be treated under Michigan's sterilization laws changed over time. I can find no version of the proposed law of 1897 extant, and therefore can make no statement as to treatment classifications. The 1913 law(P.A. 34) called for the sterilization of those "mentally defective persons maintained wholly or in part by public expense in public institutions in this state.....who are mentally defective or insane".[1] This law had almost as little effect as the proposed law of 1897, in that only one individual was operated upon under its authority. This law was found to be unconstitutional in 1918 for a variety of reasons, principally for its failure to meet the requirements of the equal protection clause(the law referred only to patients in institutions,and thus constituted class based legislation).

The sterilization law passed in 1923(P.A. 285), authorized the sterilization of individuals both inside and outside of state institutions. While this was necessary to meet

[1]Public Acts of Michigan. P.A. 34, 1913

constitutional requirements, it also effectively broadened the reach of the law. This act further differed from the 1913 law in that it did not include the insane. The categories of the mentally defective covered by this law were "deemed to include idiots, imbeciles and the feebleminded".[2]

**Feebleminded**

According to the estimate of Dr. H.E. Randall, the President of the Michigan State Medical Society, this category(the feebleminded) would include 73,000 or more of the citizens of Michigan. Dr. Randall noted that sterilization was not a "means of entirely eradicating the 73,000 or more feebleminded in Michigan....sterilization is not a panacea. But sterilization is a valuable procedure where your patient has collateral family bearing feebleminded children".[3]

From Dr. Randall's statements we may deduce a few salient points on the intentions of the law, at least as the doctor saw them. First, the law was not intended to sterilize all of the 73,000 feebleminded in the state. Second that sterilization alone would not eliminate

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[2]Ibid. pg. 1

[3]Randall, H.E. "Sterilization of the Feebleminded in Michigan" Third Race Betterment Conference Proceedings. (Battle Creek: Race Betterment Foundation, 1928) pg. 177-179

feebleminded persons from future generations. Third, sterilization should be used where a hereditary indication of feeblemindedness existed, as evidenced by *collateral family members bearing feebleminded children*.

Dr. Randall, in his address to the 1927 Race Betterment Conference, provided a long list of hereditable defects, among which he considered some types of feeble mindedness. He stated that a "considerable number of cases" were due to severe illness(infections) changing cerebral function. While it is true that biological determinism was quite strong in the 1930s, we should not lose sight of the fact that physicians, geneticists, and eugenicists were all very aware of the effect of infectious agents. The germ theory of disease developed contemporaneously with that of eugenics.

Eugenic thought in the 1920s and 30s included a belief that resistance to infectious disease also had hereditary components, and this has since proved to be case. One need only think of the hereditary endowment of sickle cell anemia. While the trait has gained notoriety in recent years for the debilitating effects of the homozygous phenotype, the trait's real value is as a means of resisting malarial infections. The resistance trait most eugenicists seemed to have believed existed was to the *Mycoplasma* bacilli that cause tuberculosis, the great wasting disease of the ages. Human resistance factors to the *mycoplasma* species have been found to exist.

The 1923 law specified three conditions that must be in existence for a feebleminded person to qualify for operation under the statue: that the individual must manifest sexual inclinations indicating the likelihood of procreation unless closely confined or rendered incapable of procreation, that the children of the individual would have a *hereditary tendency* to inherit the defect, and no probability of the individual's condition improving such that, either his/her children would not inherit the defect, or that the individual by nature of their illness would be unable to care for their children.

The above criteria reveal that most of the feebleminded committed permanently in state institutions would not be sterilized, as they were already closely confined. Indeed, release is specified as the reason for the request in over a sixth of the records. Prevention of children with a hereditable tendency is cited in over half of the remaining records. The rest of the records do not include a specific reason for the request. The reason for request can generally be assumed from the patient's record, and with the specific exception of sexual deviants, fall into the categories of parole or pregnancy prevention.

Prevention included not only patients who were to be paroled, but additionally, the sexually active in the institutions. While segregation of inmates by sex was the rule, in many institutions this would have been practically

impossible in all situations. Some institutions such as the Michigan Farm Colony for Epileptics was intended to provide a safe setting for patients who could, when afflicted, live a fairly normal life. The Michigan Training School ran small manufacturing facilities(e.g. shoe factory) in the hopes of training inmates in a trade so that the might eventually leave the institution. Some patients at MTS were hired out daily to local farmers as farmhands. The opportunity for sexual encounters, though brief, certainly existed. It should also be remembered that feeblemindedness does not affect the individual's desire for sexual activity, though it could be argued that a person with a deficient mental capacity would be more likely prey for the sexual predators in society. This was certainly the belief of the eugenicists and caregivers in the 1930s.

Mainstreaming, as it is known today, the release of patients when they were believed able to be self-supporting, was considered the mission in treatment of the moderately feebleminded. As a condition of their release, sterilization was considered necessary not only as a benefit to society(i.e. fewer wards of the state born) but as a protection of the patient, as it was not considered a burden the patient could or should bear. Thus, over 85% of sterilizations were performed upon the feebleminded. The remaining 15% of sterilizations were performed on the insane.

**Insane**

Insanity, though a condition named in the 1913 law, did not become a part of sterilization policy again until the passage of Public Act 285 of 1929. But by 1936, 180 psychiatric patients had been sterilized under the new statute. The following year another 82 patients had undergone the surgery, but this was to change. In December of that year, Dr. Morter, Superintendent of the Kalamazoo State Hospital for the Insane, was questioned by the Hospital Commission as to "a possible promiscuous sterilization of many cases".[4] From that point on, about 10 psychiatric cases a year were recommended for sterilization. This number dropped off to five or less in the 1940s.

Dr. Morter's institution performed the largest number of sterilizations of insane patients, but this amounted to 97 cases.

As KSH had a patient population of 3000 this amounts to only 3% of the inmates. This is the total up to December 1937, when as noted, the per year numbers declined precipitously after that.

It could be that the cases of sterilization at KSH were high initially because the institution was trying to take care of what it considered a backlog of cases in need of

[4]Barrett, Joseph. "Letter to Dr. R.A. Morter from Joseph Barrett M.D. Director of State Hospital Commission", Sterilization Records, Michigan State Archives, December 1937

treatment. This would explain an initially large number followed by incremental increases.

Certainly, Dr. Barrett's letter referring to a "possible promiscuous" number of sterilizations could be seen as indicating another reason for the rapid falloff. Dr. Barrett's letter refers to questions from the State Hospital Commission, but does not give us an indication if this was a reaction to some public outcry. A cursory search through contemporary newspapers do not reveal a public outcry if there was one, but this certainly calls for further investigation. The probate judge of Kent County, Clark Higbee declared that "we are sterilizing at a greater rate in Kent County in the last two years than anywhere else in the United States, and we find no popular clamor against the sterilization law".[5]

While public feeling on sterilizations is not evident, public feeling on the commitment of the insane was. In March 1938, the Detroit Free Press carried an article claiming that over 100 mental patients in Saginaw County were being housed in county institutions waiting for admittance to state facilities. Some of these commitments were over twenty years old. Saginaw County Probate Judge John Murphy stated that two years previously cells had been established for

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[5]Higbee, Clark. "Sterilization Approved by Intelligent People of Every State", Proceeding of the Third Race Betterment Conference. (Battle Creek: Race Betterment Foundation, 1928).

mental cases, but that "this wasn't enough, so the others have had to be placed in the regular jail quarters".[6] It is ironic that the same situation exists today for a different set of reasons.

The reason such a small proportion of those actually in state facilities for the insane being sterilized has much to do with the prognoses of those patients. Psychiatric disorders were considered progressive and permanent. Very few patients were believed able to improve enough to live outside of the institutions.

We should not view all the patients in these institutions as individuals kept in segregated wards, as was the case at the Kalamazoo State Hospital, for example. Though segregated by sex in separate buildings, even the Kalamazoo State Hospital patients were allowed to attend church every Sunday, football games at the local university, and dances most Saturday evenings. Though this group of patients would be considered under close supervision, this did not mean that there were not opportunities for sexual encounters, as the staff was well aware, and constantly on guard against.[7]

Though we could assume that the small number(3%) of

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[6]"Neglect of Insane is Cited by Judge" Detroit Free Press. March 3, 1938

[7]Conversation with Miss. Virginia Hill R.N., Director of Nursing Education-Hurley Hospital, Flint, Michigan. September 1993

insane patients sterilized reflects those inmates who were considered to have ability and opportunity for procreation, this can not be stated as fact. Unfortunately, records do not seem to exist that would either confirm or deny this supposition.

What we can conclude is that the practice in the institutions correlated well with the law, in terms of who was sterilized. Six times as many feebleminded patients were sterilized as those considered insane. This reflects the belief that the former were capable of being reintegrated into society, while the latter were not.

On the other hand, if Dr. Randall's estimate of 73,000 feebleminded was correct, then the law was not very effective in that only 4% of that number were sterilized. Obviously, the state institutions were never set up to handle that number of patients. Even if we eliminate from consideration those feebleminded, whose syndrome was due to an infectious process, and additionally those who were incapable of procreation, in effect, sterility related to their condition(e.g. males afflicted with Down syndrome), this still shows the law not to have been very effective in its stated purpose.

We should also consider whether Dr. Randall's estimate of the number of feebleminded was not exaggerated. His estimate would put 3% of Michigan's population in the feebleminded category. In the 1930s this was not considered

an outrageous percentage, but would include cases of learning disabilities considered treatable today. It would be unfair to condemn those of the 1930s who acted to the best of their knowledge, in what they considered the public and patients' best interests.

# *Chapter 5-Class and Race*

## Social and Economic Class

Few inferences can be made about the class position of the patients undergoing sterilization procedures. Information relating to social economic status of patients was not included in the sterilization records other than a few anecdotal remarks that probably reveal more about the bias of the interviewers and those interviewed than about the patient. Even these were few and far between.

Most of the sterilization requests were dry and bureaucratic in tone, citing IQ scores and other measurements of intellect, disease histories, relatives with similar conditions, family conditions, prognosis, attempts at acquiring consent and final disposition. Occasionally, relatives were termed as peculiar, nervous, "had a bad background" or odd. But generally there was a specific disease cited for the relative, manic depression, dementia praecox, etc.

When remarks like "peculiar" or "nervous type" appear in the record they seem to reflect more often on the source than the interviewer who recorded the remarks. Neighbors and

family members most often provided the information contained in the requests. Their responses also probably reflect on their inability to communicate in the interviewers lexicon and their general lack of knowledge about forms of insanity and feeblemindedness. Several of those sterilized, as wards of the state, had no known family members or none competent to provide family history.

From the wording of the law, it is evident that not only the feebleminded, insane and those whose progeny were thought to have a *tendency towards insanity or mental deficiency*(TTIMD) were to be prevented from procreating. The law authorized sterilization also on the grounds that a patient, apparently regardless of the hereditability of that patient's disorder, might be unable to support his/her children and that "such children would probably become public charges by reason of his mental defectiveness".[1]

Obviously, reduction in the social costs of mental defect was always a central theme in much of eugenic ideology, but hereditable disorders were usually thought to be the cases where sterilization was most applicable. Sterilization of the poor was never the object of Michigan's policy, though cases certainly exist of individuals being sterilized at least partly on the basis of their inability to provide for their families.

The meagerness of the records and the sometimes strident

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[1]Public Acts of Michigan. P.A. 285, 1923. Section 7.2a

tones recorded in the court hearings give the impression that some people ran a foul the law because of their marginal position in society. The "Swamp Dixbys" may be a case in point.

The "Swamp Dixbys", a family from the rural Battle Creek area, lived a backwoods style of life more reminiscent of the early frontier days than of the twentieth century. At least this was the opinion of the interviewer and several of the Dixbys' more productive farming neighbors. Michigan's economy was still heavily oriented towards agriculture in the 1930s, so the Swamp Dixbys must have been a rather unusual bunch to gain such a reputation as was evident in the court hearing.

The family maintained a subsistence level by market gardening and small game hunting. Their home was rundown, a "shack" according to witnesses, and their living meager. What first brought them to the attention of authorities were incidents of petty theft. But by the age of 35, this father of five had been committed to Kalamazoo State Hospital(KSH) five times and had managed to escape three times. The patient, who we'll call Gerald, received a diagnosis of dementia praecox and manic depressive insanity compounded by a low IQ. Gerald's wife and all his sibling's were also considered to have subnormal IQs. In addition Gerald's father was an inmate at KSH.

At the court hearing, regarding the sterilization of

Gerald, his entire family came in for a general condemnation as social misfits by both the judge and social workers. There should be little doubt that the "Swamp Dixbys" probably warranted that label. They were not good productive farmers, certainly not in the minds of their farming peers. The question is whether Gerald and his family's social marginality did not contribute excessively to the decision to sterilize Gerald.

From the records, it is not evident that the Dixbys were public charges, or that any of the family was actually retarded. At least no data on Gerald's or any of his siblings' IQs were presented. The diagnosis for Gerald's father, an inmate at KSH, was not even presented, though the request for sterilization originated at KSH. The request merely mentions him as a patient there.

Indeed, though this must have been a colorful hearing, Gerald qualified for sterilization on a number of counts. Even if he hadn't received a recognized IQ score, he was committed as insane with two widely recognized diagnoses. He had managed to elope three times from KSH, a none to easy feat. That he was one of the insane likely to procreate, seems reasonable. Close confinement hadn't worked and his reproductive capacity had already been proved five times. The hereditability of his illness is inferred from his father's incarceration at KSH, but it does seem unusual that a more direct connection to the presumed inheritance pattern

was not made.

The poor would probably more likely become involved with the Welfare Commission by their reliance on the public assistance. This would put them in the "welfare system", part of which was compulsory sterilization. As shown in the second chapter almost every public official in health care, welfare and the law was commanded by the law to report individuals who fell under the qualifications of the law.

This would also have involved an enormous number of families during the Great Depression. The small numbers of people actually sterilized seem to demonstrate that no specific effort was made to sterilize on the basis of social and economic class. Though we might suspect the straitened economic circumstances the 1930s would have made the practice of sterilization policy more class based, there is no direct evidence from the requests.

The number of sterilizations did jump precipitously in the early 1930s. According to the President of the Michigan State Medical Society, only 111 patients had been sterilized through 1928.[2] In less than two years an additional 277 people had been sterilized. Almost seven hundred more would be sterilized in the following three years. In 1935, 316 sterilizations were performed in Michigan(See Appendix C,

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[2]Randall, H.E. "The Sterilization of the Feebleminded in Michigan", Proceeding of the Third Race Betterment Conference. (Battle Creek: Race Betterment Foundation, 1928) pg. 178-179

Chart 1).

In 1936 the number of operations fell by half. Through 1954, though the number would sometimes vary by 25 patients or more, approximately one hundred sterilizations were performed per year. From then through the early 1960s, the number of operations fell as a general trend. For the last year in which there is data, 1964, thirty-three sterilizations were recorded.

Though the early thirties were the heyday of Michigan's sterilization program, there are reasons outside of the economic considerations of the Great Depression that explain the upsurge in the number of operations. The 1927 Supreme Court decision in the Virginia case of *Buck vs. Bell* constituted a legal green light for the process of compulsory sterilization. Indeed, Michigan formulated a new sterilization statute in 1929 for the purpose of coming in line with the legal precedents of that case. The 1929 statute was also broader in its reach, because it now included the insane. This more than quadrupled the number of facilities whose patients would now be possible sterilization candidates. Yet the insane never constituted a majority of patients. The number of operations on the insane in the early thirties was quite high, but the numbers for all categories were elevated.

A hint exists that the number of sterilizations among the insane was considered excessive by 1936. A letter from the

Hospital Commission questioned the number of sterilizations performed at KHS in that year, and there was a substantial decline in requests after this letter.

Mental patients probably represented a wider spectrum of socio-economic classes than the hereditary feebleminded. Due to their mental defect, the latter group would probably tend towards the lower end of the socio-economic scale.

Thus, the Hospital Commission's question of "possibly promiscuous" cases of sterilization may reflect some resistance to the program when it began affecting a wider range of social classes.

On the other hand, the Commission's worries may just be a reflection on the high number of sterilizations at KSH versus the other facilities for the insane. There were no such letters to the other four facilities for the insane, though the numbers of operations performed at each of these facilities were also at their historical highs.

The one real linkage to a social class that shows up in the records, is those people who have had come to the attention of both the Welfare Commission and law enforcement agencies. Those who were adjudged incompetent and had contact with the police appear quite often in the record. The crimes cited range from petty theft to violent attacks. For the insane and feebleminded in institutions these crimes usually amounted to delinquency or petty theft.

## Criminals

Among those regarded as truly criminal were thirty inmates of the Ionia Prison system that were sterilized. The vast majority had committed sex crimes, though half of these inmates were also considered insane or feebleminded. Sterilization was thought to be therapeutic in moderating behavior in such cases. A sixth of this group were castrated, most all provided their own consent for this procedure. The castrations appear out of the blue, they were all done during a three month span of time in the winter of 1937. The prison requests, when they provide a reason, state the therapeutic nature of the operation. Punishment is never cited.

Indeed, Michigan law did not allow for sterilization as punishment, though some states did. The Washington case of *State vs. Fielen*, in which sterilization was prescribed as punishment for a statutory rape, was upheld as not being a "cruel and unusual punishment".

Though Michigan law did provide for the sterilization of those with an inherited tendency towards "sexual degeneracy", proof of the inheritable aspect is not seen in the requests. The requests records from Ionia are very light on details, and no evidence of an inheritable condition of sexual degeneracy was provided for any inmate.

An explanation for the fact that two-thirds of the

sterilizations at the Ionia facilities occurred in the winter of 1936-1937, a period in which the six castrations were also performed, remains a mystery. In only three of the twenty cases was release a factor. This would indicate that pressures to release inmates because of overcrowding, or prison budget constraints were not involved.

The small number of inmates sterilized argues against any widespread policy to sterilize the inmate population. Though figures for the population of sex criminals do not appear extant, it seems safe to assume that this category of inmate was not being sterilized in relatively large proportions either. Thus, the flurry of activity in the Ionia system in the winter of 1936-1937 seems particularly odd.

## Race

Perceptions of race in the sterilization requests present an unusual understanding of the question as seen in the light of modern standards. Dutch and German were listed as races. And the combination of the two was listed as a "mixed" race on one request. Most requests did not list race at all. Where race was mentioned, whites constituted the greatest proportion.

Eight cases out of 338 were listed as mixed. With the exception of two of these, "mixed" race can be assumed to mean people of African-American heritage. Thirteen patients were explicitly referred to as black, colored, negro or mulatto. Adding the six cases of "mixed" race to this number shows that 5.6% of the patients were African-Americans. The percentage of African-Americans in the Michigan population of 1937 was recorded as four percent.[3]

Some of the discrepancy between the percentage of race in the population and in the requests for sterilization may be due to the terms used to categorize race then and now. In the report on population cited above, the only two racial categories listed were white and black. If we except the "mixed" category and compare only the cases where African-Americans are explicitly listed, the percentage drops to

[3]Webb, John, Westefeld, Albert & Huntington, Albert. Mobility of Labor in the State of Michigan. (Lansing: State Emergency Welfare Relief Commission, 1937) pg. 8-10

3.7%, which is very much in line with the percentage in the general population(4%).

Retardation was a factor in over half the requests for the African-American group. The percentage of African-American patients that were retarded was the same as that of the among the rest of the requests. The only difference I could find among the requests was that half of the African-American population was scheduled for parole. This was a much higher rate than the seventeen percent found for all sterilization requests. Unfortunately, little more can be inferred from the surviving records that would cast more light on the reason for this difference.

Class or race discrimination can not be demonstrated from the available records. If discrimination of this type existed, I can find no evidence of it. The discrimination that apparently did exist, was based on gender. This disproportion will become evident in the next chapter.

# *Chapter 6-Sexuality, Gender and Sterilization*

## Sexual Disparity in the Ratio of Sterilizations Performed

An abiding question in my research was what biases, if any, were evident in the application of the sterilization laws. The answer would seem explicit from even a cursory viewing of the records. Throughout the 1930s, three to four times as many women as men were sterilized in Michigan. This was not the case in most other states.

National statistics for 1935, compiled by the Human Betterment Foundation(HBF), show that of the twenty-seven states reporting, in only seven were more males sterilized than females. Nationwide, 58% of cases were women. The two states most actively pusuing a sterilization policy, California and Virginia, had rates of 48% and 58% for women, respectively. In 1935, men accounted for only 22% of the sterilizations done in Michigan up to that time. While Michigan's ratio of women to men may seem quite high, at least seven other states had ratios as high or higher. The worst was New York with 1 out of 42 cases being a male. More representative of the disporportion among larger programs was Connecticut's, where among 383 sterilizations over 94% were on female patients. Kansas was the only state in which significantly more men than women were sterilized, 922 as

opposed to 587.[1]

These figures are the more remarkable in that the incidence of mental defect due to hereditary causes is four times as high among males as females.[2] Some of this disproportion reflects the different effects on the sexes of various syndromes. The first is rather obvious in that males are more often sterile as a result of genetic defect than females. All males with Down syndrome are sterile, for example. The second is not as obvious in its effects, but probably was of some importance, namely that hereditary defects are generally less severe among females than males. The only possible exception is mild mental handicap. Thus more women, particularly among the feebleminded, would qualify for parole.

The biological explanation for the sexual disparity among disorders of mental defect is that several biological factors contribute to male vulnerability. Some severe handicap is due to sex-linked recessive disorders such as Lesch-Nyhan syndrome. Some vulnerability may be due to a slower rate of fetal development among males, thus leaving

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[1] Human Betterment Foundation. "Table of Sterilizations Performed in the United States Under State Laws, Up to January 1, 1936, Segregated According to Diagnosis and Sex", Association for Voluntary Sterilization, Social Welfare History Archives, University of Minnesota, Minneapolis, Minnesota(hereafter *AVS Archives*).

[2]Rutter, Michael & Casear, Paul. Biological Risk Factors for Psychosocial Disorders. (Cambridge: Cambridge University Press, 1991) pg. 20-25

males more susceptible to factors that disrupt any particular stage of development. Some current studies suggest that sex hormones such as testosterone may be a factor in the male excess of disorders affecting speech, language and reading.[3]

This suggests that there would have been essentially equal numbers among the feebleminded, if mild retardation is included in the figures. Dr. Randall's estimate of 73,000 feebleminded in the state, undoubtedly also included this mildly affected cohort. Among the 57 sterilization requests specifying parole as reason for application, over 80% were from the Michigan Home and Training School in Lapeer.

Lapeer was a training school for the feebleminded, so this proportion of "parole" requests should first be compared to the ratios of the sterilized belonging to the categories of feebleminded and insane. Through 1936, approximately 88% of the parole requests specifically cite feeblemindedness.[4]

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[3]Rutter, Michael & Casaer, Paul. Biological Risk Factors for Psychosocial Disorders. (Canbridge: Cambridge University Press, 1991) pg. 21-28

[4]"Sterilization Records", *ASM*. 1936

## Feeblemindeness

Indeed, eighty-eight percent of all sterilizations performed in Michigan through 1935 were categorized as feebleminded. There was remarkable variation among the programs in different states as to who the primary focus of sterilization policy was to be upon, the feebleminded or the insane.

Through 1935, four of the twenty-six states with active programs sterilized only the insane. Three of the twenty-six sterilized only the feebleminded. Of the twenty-two states that sterilized the feebleminded, only three operated on more males than females. Overall, the sex ratio among these twenty-two states exceeded two to one, female to male. Michigan's ratio of roughly four to one among the feebleminded(1056:279) does not compare favorably with this national ratio. Eight states: Connecticut, Maine, Minnesota, New Hampshire, North Carolina, North Dakota, Washington and Wisconsin had female sterilization sex ratios as great or greater than Michigan's. Connecticut, Minnesota and Washington had ratios of over nine to one.[5] It would be interesting to be able to know if the states with higher ratios of female to male sterilizations, had higher parole rates for the feebleminded in general, and specifically as

[5]HBF. "Table of Sterilizations Performed", *AVS Achives*. May 1936

regards female inmates. Unfortunately, the records available leave us no clues on this score.

It can be stated that of the surviving patient records from 1933 through 1937, the sixty-six referring to parole, release, or elopement constitute one fifth of the 339 requests. Of these sixty-six "prior to release" requests, sixty-two percent were for women. This two to one ratio fits well for the projected excess of female to male parolees among the feebleminded.

The theory that many more women were sterilized than men because of the greater number of women released does not explain why a four to one(female/male) ratio existed among those feeblminded patients for whom parole is not mentioned. An obvious sexual bias against the women in this cohort would seem to exist.

The criteria for sterilization in the Michigan law(P.A. 285, 1929) explains this apparent bias. The law required sterilization of those likely to procreate if not closely confined or rendered incapable of procreation before release. In the institutions for the feebleminded, close confinement equating to total segregation of the inmates was certainly more difficult than at institutions for the insane.

Therefore, among the feebleminded not eligible for parole, we would still expect to see a greater number of women sterilized for two reasons mentioned previously.

First, a greater number of the feebleminded males would normally be sterile(e.g. Down syndrome). Second, a greater percentage of males would be profoundly retarded than females, and thus close confinement would more likely be effective among the male cohort. The male to female ratios of both sterility and profound mental defects are four to one. This ratio is exactly the inverse of the number of females sterilized but not paroled.

Taken another way, the ratio of feebleminded women not eligible for parole, but mildly retarded and fertile, would probably be at a four to one ratio of men in the same category. Thus, part of the apparent discrepancy in sex ratios in the paroled and unparoled cohorts can be explained by the fact that the greater fertility and milder retardation among the female feebleminded made them more likely targets of the law. In effect, more women fell into the two categories most likely to be sterilized, those most likely to be paroled, and those least likely to suffer close confinement.

Salpingectomy, the method of choice for female sterilization, was a far more technically difficult and dangerously invasive procedure for the patient than vasectomy. The surgical and post- operative costs for women would also have been significantly higher. Yet the greater expense and surgical difficulty of one procedure over another does not seem to have been a significant criterion.

The disaprity between the sexes in the number of operations performed on the feebleminded is most reasonably explained by the fact that women, because of their less incapacitating forms of mental defect, fell into the category of those most likely to procreate. In effect, they were more likely to have been eligible for parole or minimum supervision, and less likely to have been sterile than the feebleminded men.

The above interpretation is certainly plausible, but it is also quite hypothetical in that the incompleteness of the surviving patient records precludes a more definitive analysis. A review of the numbers for each of the above cohorts as proportions of total inmate population, not only those sterilized, would help provide a more solid conclusion.

Unfortunately, that is beyond the scope of this paper as these figures on institutional populations cannot be ascertained from the available records. Though a sexual bias in favor of sterilizing women over men does exist, the seemingly unwarranted magnitude of the ratio is not near what initial impressions might lead one to believe.

## Insanity

In Michigan, sterilizations of the insane amounted to a little more than 11% of the total number by the beginning of 1936. Thus, the ratio of feebleminded to insane sterilizations, agrees with the same diagnostic ratio in the "parole" requests. Considering the negative prognoses for psychiatric patients in general, this percentage would not be unusual. By 1956, the ratio of sterilizations performed on the feebleminded versus the insane had changed by only 1% to become 10% insane versus 90% feebleminded. This certainly reflects the continuing lack of efficacious treatments for the insane, in that a smaller proportion of the insane received a prognoses favorable for parole. Thus, they were more likely to have faced permanent institutionaliztion and consequent sexual segregation.

From 1923-29, the Michigan program did not include the insane. Therefore, it is unusual that while nearly 400 inmates had been sterilized by the end of 1929 under Public Act 285 of 1923, which excluded the insane, by 1936 the percentage of the insane sterilized had reached 13 percent of the total number of sterilizations performed under both laws. In 1936, the number of insane sterilized was 58% of the total sterilized for that year.[6] According to figures

[6]HBF. "Table of Sterilizations Performed", *AVS Archives*. May, 1937.

compiled by the HBF, of the 82 insane sterilized in 1936, 38% were males.

This would appear to reflect the possibly "promiscuous" number of sterilizations performed in the Kalamazoo State Hospital for the Insane(KSH) in that year. Indeed, 38 percent of the sterilizations for which we have patient records in that year, were performed at the KSH. Of these KSH sterilizations, 60% were reported as performed on males. This percentage drops to 55% if we compare all surviving patient sterilization records from KSH for the period 1933-1937.[7]

Because slightly more than half of all the patient records for the period have survived, we may assume that the high percentage of males in the record reflect a preferential survival of the male patient records. The higher vulnerability of the women's records is best explained by the fact that more females were paroled than males.

State law in Michigan currently requires medical facilities to maintain patient records for 50 years from their last use, and though most institutions maintain records for longer periods than required, there has always been great variation in the number of years records are kept

[7]Sterilization Records. *ASM*. 1933-1937

beyond the legal requirement.[8]

Thus, because of the presumed higher rate of female parole, the women's records would have been discarded or transferred earlier on average than the men's. This hypothesis is untestable with the data available, because the surviving patient sterilization records for KSH contain no requests for parole. If we assume that some of the sterilization requests for paroled psychiatric inmates represent the number of missing patient records(83) between surviving patient(insane) records(179) and the psychiatric totals for the period as compiled by HBF(262) this would help explain the disparity in sex ratio.

Depression and anxiety, the two most common psychiatric conditions afflicting women, are two to three times more common among young women and female adults, than among males. The sex ratio among insane disorders attains more towards the mean when one considers that personality disorders and schizophrenia occur more frequently in males.[9]

Assuming that both male and female psychiatric disorders equally affect sexual function, we would expect that the original cohort of sterilized patients, excluding those paroled, would approximate equality. Since this group does

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[8]Hodges, Jeffrey. "Conversation with Kendra Thrasher", Medical Records Director. CHC, Sept. 1993

[9]Rolf, Masten, Cichetti, Nuechterlein, & Weintrab. Risk and Protective Factors in the Develpoment of Psychopathology. (Cambridge: Cambridge University Press, 1990) pg. 323-324, 352-356

not include the paroled, the indications for sterilization would be based on the efficacy of close confinement in the prevention of procreation among this group of inmates. This equality in the sex ratio of the sterilized insane is exactly the situation observed in the first cohort of the insane sterilized at KSH(1933-1937).

The KSH sterilization requests are the most revealing of general policy as regards psychiatric cases in that this institution was the largest in terms of inmate population and number of requests for operations. The KSH committments were also almost exclusively psychiatric. In addition the most severe cases were sent to KSH.

This was not the case at the other state hospitals for the insane. The Pontiac, Newberry, and Ypsilanti state hospitals for the insane had mixed populations with twenty percent categorized as feebleminded. Mental deficiency was cited in less than ten percent of cases at KSH. The feebleminded in the former institutions likely represent not only the insane among the feebleminded, but those patients requiring closer supervision than could be provided by the Michigan Home and Training School.

Manic-depression, recognized as an often transient state, especially in women, points further to the increased likelihood of parole, and collaterally for sterilization of insane women.

The shift in sterilization authorizations was certainly

in that direction after 1936. The HBF records showed that during the sixteen years from 1944 through 1960, in fourteen of those years, among the insane only women were sterilized. HBF records of total sterilizations performed for the period between 1937 and 1944 consist of only one record for the year 1941. During those seven years 11 men were sterilized as compared to 32 women.[10] Reliable numbers of patient records do not exist for this period that would allow an accurate assessment of exactly when the sex ratio among the sterilized insane switched to favor the women.

Nonetheless it is evident that among the insane cohort, women continued to be affected by the law in far greater numbers than males. The sexual bias in favor of sterilizing women is even more evident among the insane than in the feebleminded cohort.

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[10]HBF. "Table of Sterilizations Performed", *AVS Archives*. Tables for 1930-1960.

## Sexual Degeneracy

The problem of criminal sexuality has been dealt with in Chapter 4. These inmates constitute a distinct group, very different from the feebleminded and insane. Though homosexuality was a crime and considered an indication of, if not outright sexual degeneracy, only one homosexual man was sterilized, and his homosexuality was not the reason for his sterilization.

Among other terms for sexual deviancy commonly assigned to the non-criminal group was promiscuity. A good 20% of all cases cited this explicitly, or hinted at the potentiality. One young girl was condemned as being of "low IQ, irresponsible and attractive". Women were more likely to be cited as promiscuous than the men. This probably indicates a serious sexual bias on the part of the staff, that is a reflection of the general bias shown in the preference for selecting female patients.

# *Chapter 7-Insanity and Mental Defects: Changing Perspectives*

Over the last sixty years, public and professional views regarding mental deviations have changed drastically. Many new subdivisions of contemporary categories have been recognized as regards both feeblemindedness and insanity. Most importantly, modern therapies have appeared that at least provide amelioration of the disorders' symptoms.

## Feeblemindedness

Feeblemindedness(low IQ) or mental deficiencies, as they were generally called in the thirties, included a wide variety of psychiatric categories and learning disabilities. These ranged from profound mental retardation to dyslexia. It is now recognized that many cases of what was called feeblemindedness were actually types of learning disabilities. Dyslexia and attention deficit syndrome (ADS) are only two examples of learning disorders that were unrecognized in the 1930s. This is not to say that all feeblemindedness was considered to be the product of heredity. As Dr. H.E. Randall M.D., president of the Michigan State Medical Society said in a paper delivered

before the 1928 Race Betterment Conference, "There is a considerable number of feebleminded who are the result of severe sickness damaging the brain cells".[1]

Most American eugenics philosophy in the 1930s held that insanity and feeblemindedness were inherited disorders of the recessive type. It was realized that if this was true it would take several generations of eugenic sterilization to clear the traits from the carriers, and even then there would be the occasional point mutation that would reintroduce the defect into the gene pool.

Among the diseases Dr. Randall enumerated as due to a hereditary cause were "deaf mutism, color blindness, astigmatism fragile bones, cases of phalangeal ankylosis (7 generations, Harvey Cushing-14, Drinkwater), food idiosyncrasies, polydactylism, blood groupings, hemophilia, familial hemolytic jaundice or familial jaundice, hereditary ataxia, Huntington's chorea (10 generations)".[2] Most of the diseases in Randall's list are still considered to be of a hereditary nature, though some diagnostic cohorts include cases of a non-hereditary nature, ,brought on by infectious illness or environmental effects.

The most significant change, in terms of categorizing

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[1]Randall, H.E. "The Sterilization of the Feebleminded in Michigan", Proceedings from the Third Race Betterment Conference. (Battle Creek: Race Betterment Foundation, 1928) pg 177.

[2]Ibid. pg. 177

symptomology has been in the delineating the etiologies of mental defects. Several types of mental impairedness have been linked to environmental causes. The effect of lead poisoning is an example of knowledge gained in the last sixty years.

Lead poisoning in children is associated with mental retardation that is essentially irreversible. In adults, lead can cause profound psychotic and depressive states. Lead poisoning of the environment can be ascribed exclusively to human activity. As one of the first ores mined, its effects as a toxic agent are now more fully appreciated as a contaminant of our own environment but also of past civilizations. Some paleo-pathologists studying human remains from the Roman era, have linked lead plumbing materials to the decline of Roman civilization. The cooking of tinned food in cans with leaded seams has been blamed for the disaster that overtook a failed expedition in search of the Northwest passage.

Generally, lead poisoning is an example of a background toxin whose effects are chronic, not only in the sense of exposure but in the effects of the toxin. Lead is not cleared quickly by the body, thus the effects are cumulative and chronic. On the other hand, the *sclerotia* fungus, which parasitizes various cereal plants is an example of an episodic toxin. The fungus produces various ergot alkaloids structurally similar to various human neurotransmitters.

Ingestion of these alkaloids, usually by consumption of contaminated cereal products, causes profound psychotic episodes.[3]

Both the exposure and effects thereof are episodic in this example. The psychotic reactions diminish with the clearance of the ergot toxin from the body. In terms of historical revision, ergot poisoning has found its way into explanations of the Salem witch hunts and the Terror of revolutionary France.[4]

Some toxins have long been recognized as contributory to mental illness and defect. Alcohol is the prime example. Though many of the mental problems associated with chronic alcoholism had been known for centuries, the direct effects on a developing fetus have only been well described in the last thirty years. It is now clear that alcohol consumption by pregnant women in their first trimester can lead to profound mental and physical defects. These defects are due to the effect of alcohol on the developing fetus' genetic material. The effects are not just congenital, in that they effect prenatal development of the individual, but that they also can be detrimental to the individual's germ plasm, and

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[3]Rutter, Michael & Casaer, Paul. Biological Risk Factors for Psychosocial Disorders. (New York: Cambridge University Press, 1991) pg. 201-214. Davidsohn, Israel & Henry, J.B. Clinical Diagnosis by Laboratory Methods. (Philadelphia: W.B.Saunders, 1974) pg.680-681.

[4]Siegel, Ronald. Intoxication. (New York: E.P. Dutton, 1989), pg 70-71, 210.

thus the hereditiy of the next generation.[5]

While environmental effects can be overdrawn, the new and varied subspecialties of archealogy(e.g. paleo-pathologists)and anthropology are revealing that the collapse of many past civilizations was due in large measure to the environmental consequences of developing human societies. Our knowledge of environmental toxins has increased in the number of toxins identified, but has also provided us with a greater ability to understand the etiology and the prognoses of the syndromes they cause.[6]

The importance of ecological toxins on mental health has been complemented by an increased awareness of the detrimental effects of negative social environments. Many syndromes previously thought to be hereditary in their propagation are now believed to be the passed through the social environment, at either domestic or societal levels.

This changed perspective on the causes for mental deficiencies contributed to the founding of Federal programs to improve the physical and mental health of the populace in the 1960s. Some programs(AFDC and WIC) dealt with improving the nutrition of children and mothers. Nutritional deficiencies had at last been associated with mental retardation.

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[5]Rutter, Michael & Casaer, Paul. Biological Risk Factors for Psychosocial Disorders. (Cambridge: Cambridge University Press, 1991) pg. 214-217

[6]Ibid. pg. 199-230

The Headstart program was a response to the realization that the educational environment of young children also contributed to their future performance as mentally and physically adequate citizens.

These programs have shown great promise in helping people avoid the mental consequences of negative material and social environments. But they have also demonstrated by their lack of results in some cases that the balance in the nature/nurture dichotomy often does not weigh principally with environmental effects. Geneticists are continually revealing hereditary predispositions and causes of mental defect.

Today, genetic studies of mental illness and defect, are not based merely on better statistical analysis of familial trait studies, but increasingly depend on direct relations of disease to the hereditary material, DNA. Defective loci in DNA have been characterized at the molecular level. The genetic coding of individual proteins, and their relation to mental function are being elucidated evermore frequently.

Geneticists and social scientists are now aware of a wider range of influences on mental health and understand to a much greater degree the linkages between cause and effect, both environmental and genetic. In this sense, the nature/nurture dichotomy has expanded both in its breadth and depth of complexity.

In particular, modern views on the complexity of

inheritance demonstrate the Mendelian perspectives of the 1930s to have been very simplistic. Many of the Mendelian inheritance patterns of some syndromes have been born out, but the recessiveness of traits was used very often as a catch all for those inheritance patterns that could not otherwise be explained.

Today we understand that there are great many modes of inheritance that lie outside of the simple Mendelian patterns. Genetic amplification is one such very important inheritance pattern unknown up until just a few years ago.

This genetic amplification, know as genetic anticipation, does not usually result in greater proportions of progeny affected, but rather an increasing severity and earlier onset of symptoms in subsequent generations. Though in some common mental conditions both increased frequency and severity of symptoms are now noted.

Genetic amplification, known as the *Sherman paradox*, is involved in the *Fragile X Syndrome*, the second most common cause of mental retardation(feeblemindedness) after Down syndrome, and the most common cause of familial mental retardation. The incidence of this condition in the general public is one in 1250 males and one in 2500 females. With the Sherman paradox, we have a situation in which each subsequent generation inherits a higher incidence and greater severity of disease. In both genetic anticipation and the Sherman paradox the mode of action at the genetic

level is the addition each generation a single codon to the affected gene loci.

Only 30% of female carriers of the *Fragile X* exhibit retardation, but those who do have a 50% probability of bearing mentally handicapped sons. Among the apparently unaffected sons
will be a cohort, known as *normal transmitting males*(NTMs) that constitutes 20% of the male carrier population. Brothers of NTMs are at low risk(9%) of intellectual handicap, while grandsons and great-grandsons are at greatly increased risk(40% and 50% respectively). Thus even though the numbers affected in the general population are quite low, the incidence in a family line becomes progressively greater.[7]

Other hereditable impairments of a physical versus a mental condition that follow this situation of increased severity and incidence in subsequent generations are also well demonstrated.
Muscular dystrophy, especially the Duchenne form, is an example of a hereditary disease where the malfunctioning of a particular protein(dystrophin) causes the effects of the disease. The elucidation of the defective protein and the gene loci responsible for the defect have provided us with a

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[7]Tsongalis, Gregory & Dilverman, Lawrence. "Molecular Pathology of the Fragile X Syndrome", Archives of Pathology and Laboratory Medicine. (Washington:ASCP, Nov. 1993), Vol. 117.

possible mode of treatment.[8]

With muscular dystrophy, there is currently hope that a DNA insertion of a corrected portion of the affected region might be able to reverse the progress of the disease. The insertion of a functional gene into the MD patients somatic cells would bring
about production of the necessary protein, thus a cure at the cellular and permanent level for the individual.

While gene insertion of this type is known today for somatic (body) cells, it does not exist for the germ(reproductive) cells. The technology for a cure of this latter type is recognized to be decades in the future. This presents a dilemma in that while we may be able to effect individual cures that make for a person to lead a life unaffected by the trait, each subsequent generation has a greater probability of inheriting the trait. In the case of MD, where the genetic consequences to muscle tissue may be reversible, it would seem easy to decide that even though there may be a net increase in the affected and carrier cohorts, the efficacy of the individual cure would balance out the this increase while waiting for a genetic technology for correcting the germ plasm.[9]

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[8]Partridge, Terrence. Molecular and Cell Biology of Muscular Dystrophy. (London: Chapman and Hall, 1993)pg. 3-31, 38

[9]Ibid. pg. 283-297

Often in mental disease, as with the Fragile X syndrome for example, the damage is irreversible. Often the damage occurs early in life, *in utero*. Thus the chances for intervention before permanent damage is done are quite low. Table 7.1 shows the chronology of some abnormalities of prenatal development.

Table 7.1 Normal and pathological structural events during brain development.

| **Cytogenesis-histogenesis** | (0-20 weeks) |
|---|---|
| Normal Events | Pathology |
| Neuronogenesis | Early developmental microcephalies |
| Neuronal migration | Disorders of Neuronal migration |
| Regional development | Disorders of telencephalic and commissural development |
| **Growth and Maturation** | (20-40 weeks) |
| Neuronal Growth, dendritic development, synaptogenesis | Inhibition of neuronal and glial growth,and maturation |
| Gliogenesis,periventricular and local; myelination | Late developmental microcephaly |
| Cerebral angiogenesis | Disorders of microvasculature |
| Modulation of neuronal circuitry: axonal elimination, synaptic redistribution, neuronal death, development of neurotransmitters and trophic factors | Disorders of secondary modulation of neuronal circuitry<br>Encephaloclastic brain damage |

Table 7.2 reveals the pathogolies associated with the developmental abnormalities listed in Table 7.1. Most of these abnormalities result in mental retardation though not all. Where possible the mode of inheritance has been included.

*Table 7.1 Main structural abnormalities of brain development.*

**Abnormalities of telencephalic division and formation of cerebral commissures**

*Arhinencephaly-holoprosencephaly*

Characterized by absence of the interhemispheric commissure, undivided or fused ventricular cavities, absence of olfactory tracts (which may be detected on MRI). Various degrees.

Frequent, possibly familial (autosomal recessive or dominant) or associated with 13/15 trisomy.

Except for major lethal forms, moderate or severe mental retardation and evident to mild facial malformations: hypotelorism (on skull x-rays), cleft palate, choanal atresia, fused maxillary central incisors ...Formes frustes in parents.

*Agenesis of the corpus callosum*

Frequent, rarely familial, possibly related to metabolic disorders. No specific clinical syndrome.

**Insufficiency in neuronogenesis**

*Early developmental microcephalies*

Mostly familial, generally autosomal recessive. Usually severe mental retardation.

**Disorders of neuronal migration**

Rare, frequently familial, autosomal recessive or with chromosomal anomaly. Some are rapidly lethal (type II lissencephaly) or part of a progressive metabolic disorder (Zellweger's disease). Others are constantly associated with severe mental retardation. Type I lissencephaly is associated in 50% of cases with a deletion of chromosome 17.

**Disorders involving excessive or insufficient cell death (!) or excessive axonal elimination**

Familial hypoplasia of corpus callosum, central white matter and pyramidal
tracts.

**Disorders of cell growth and maturation**

*Late developmental microcephalies*

Cause frequently unknown. Mild to moderate mental retardation, various
disorders of behavior.

*Megalencephalies*

Usually familial, various degrees of mental retardation.

**Abnormalities of the cerebellar cortex**

*Cerebellar atrophy*

Practically always associated with mental retardation, although usually no structural abnormality of the telencephalon

-Acquired: as in fetal alcohol syndrome, hypothyroidism

-Familial(? autosomal recessive), vermian atrophy with mental retardation and speech disorders. Normal telencephalon at autopsy.

*Segmental hypoplasla of vermis in autistic children (!)*

*Complex fusion of molecular layers: "cerebellar microgyria"*

*Heterotopias of fetal granule cells (as in 13/15 or 18*

*trisomy) always with severe mental retardation even if no strtlctural anomaly of the telencephalon.*
**Encephaloclastic brain disorders in the second half of pregnancy**
Causes:ischemia, hemorrhage, infection
Polymicrogyria
Porencephalies and hydranencephalies

As one can see from Table 7.2, most causes of mental retardation are due to genetic anomalies that make their appearance early in developmental life. Though the process of inheritance is not the simple recessive pattern thought to be the case in the 1930s, the mode of inheritance, as currently understood, would still qualify under the letter and spirit of the sterilization laws.
Feeblemindedness, if the definition is restricted to mental retardation, is the product of genetic inheritance.

## Psychiatric Disorders

Among the psychiatric disorders, many categories remain current as regards their clinical descriptions of symptomology. For example, the varieties of manic-depressives and psychotics (e.g. schizophrenics) remain the most numerous of the mentally ill. This is not to say that new diagnostic categories have not been recognized. Autism was not described until the 1950s, and the etiology of the disorder was not recognized until the 1980s. In the case of autism there again is a genetic component that had not become apparent until 1988. Previous work on autism had initially seemed to indicate an environmental component, such as rubella infection.[10] The linkages between genetic and environmental effects are still not clearly demonstrated in autism, and this is the case for most psychiatric disorders.

The unknown etiologies of many psychiatric disorders have made it very difficult to provide efficacious treatments for these patients, let alone provide reasonable genetic

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[10]Biological Risk Factors. pg 113, 51, 82-84, 247

counseling for them. In the first part of this century, the emphasis on heredity was the natural outcome of the determinism prevalent in medicine.

The modes of treatment available througout the first third of this century had increased greatly in diversity. Some such as electroshock therapy, insulin and metrasol shock enjoyed a relative heyday in usage and expectation of result, but ultimately showed little promise of permanent amelioration of mental disturbances for most ptients. While most therapies made patients more manageable for the institutions, they did little to improve the social functioning of individuals. The prognosis for most mental patients in the first half of the century remained quite negative. Mental illnesses were viewed as progressive syndromes, not subject to lasting interventions. In many cases this remains true today.

Progressive deterioration due to infectious agents such as in tertiary syphilis were well known. Likewise, organic deterioration due to genetic abnormality as in Huntington's Chorea was also well demonstrated. Though the complexity of the disease processes were not well understood, the consequences were self evident, progressive deterioration. This prognosis of progressive and permanent deterioration were in large measure responsible for recommendations for sterilization. All Michigan law related to compulsory sterilization contained the proviso that the patient's

condition was not likely to improve. Fortunately, the negative progression of many mental illnesses was to be ameliorated in the post war years.

The most significant change in treatment modalities came with the advent of new drug therapies in the 1950s. Though these treatments initially aimed at making patients more manageable for institutional personnel, by the 1960s a few drugs had been developed that promised true remission of symptoms. The most effective drugs worked on disease states caused by chemical imbalances in neurotransmitters.

This remains the case today. These disease states are generally related to a genetic anomaly. It is ironic that some of the mental illnesses associated with unalterable hereditary factors, chronic depression for example, are those most amenable to drug therapies, while those due to preventable environmental factors(e.g. heavy metal toxicity and nutritional deficiency) remain the most unresponsive to treatment.

As with all disease states, remission of symptoms does not equate with a cure if the underlying causes of the condition have not been corrected. In conditions due to genetic anomalies, this is especially true, particularly as regards propagation of the disease state to the next generation.

One aspect of hereditity that has become clearer in the last three decades is the fact that many hereditary

influences are of a predisposing nature as opposed to the more deterministic views of the geneticists and eugenicists of the 1930s. Yet geneticists have discovered several hereditary defects that show genetic amplification of the disease trait.

Another perennial problem in dealing with psychopathologic phenomena has been the difference in the two components of these syndromes, the biological source versus the psychosocial aspect. In the 1970s, as German Berrios M.D. has described it, there was an "overemphasis on the social aspects of psychopathology(which) generated works that read like political mainfestos" and created the impression that the "internal evolution of symptoms didn't matter any more".[11] As Dr. Berrios points out, the cultural variation responsible for presenting a seeming variety of symptoms in no way should be taken to deny the validity of a biological basis for the phenomena. In effect, though the specific delusion(e.g. blue, green or purple monsters) is conditioned by societal values, the underlying cause of the delusion is biological.

The focus in the 1970s was on the New Dynamic Psychology, which seemed to stray from the more deterministic view of a biological basis of the 1930s. "Descriptively, however,

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[11]Berrios, German. "The History of Descriptive Psychopathology", Psychiatric Epidemiology: Assessment Concepts and Methods. (Baltimore: John Hopkins University Press, 1994) pg. 47-49

psychodynamic theories remained suprisingly close to 19th century psychopathology".[12] Thus, while the focus of causation changed from one of deterministic hereditary influence, the essential descriptions of psychopathologies remained generally intact. The DSM III diagnostic standards were developed as an attempt to standardize diagnoses throughout the world and to eliminate cultural bias in diagnosis.

By the beginning of the 1980s, the determinism of heredity factors had again gained preeminence as causative factors.[13] The elucidation of these hereditary factors is ongoing and will owe much of its success to the molecular biologists working on the Human Genome Project.

As the biological foundations for psychiatric conditions are found, they may lead to treatments that ameliorate symptomology, yet this will not equate with a cure. Just as insulin is not a cure for diabetes, lithium is not a cure for chronic depression. Where genetic components of psychiatric disease can be determined they may in the distant future allow for intervention, and hence correction of these hereditary defects in the DNA. As in the case of mental retardation this ability to correct DNA of future generations lies in the distant, if not unforseeable future.

Though great progress has been made in the treatment of

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[12]Ibid. pg. 53

[13]Ibid. pg 53-62

psychiatric disorders, the ability to preclude these disorders from our citizenry still rests with intervention in the reproduction of defective offspring. Whether modes of intervention such as genetic counseling or compulsory sterilization are employed depends upon the willingness of society to intervene in the sexual autonomy of its citizens. The Supreme Court of the United States has consistently maintained the right of society to these types of intervention from the 1930s to the present.

## *Chapter 8-Conclusions*

Michigan's policy for the compulsory sterilization of the "socially unfit" has revealed some of the worst and best traits in American society. This policy, the product of over thirty years of legislation, epitomized much that was common to Progressive Era reform. The Progressive Era encompassed a time of truly awe inspiring change in the human condition. In the United States, the advances in the sciences seemed to portend a future technological Eden, the product of modern Western rationalism.

This philosophy found its self-justification in the technological products attributed to its method. New technologies in almost every field of human endeavor had revolutionized the productivity of the individual. This phenomena enveloped the world leaving virtually no society unchanged.

A technologically modern nation like the United States found itself able to feed its people with a fraction of the number of farmers necessary only a generation earlier. The nation's factories produced a plethora of useful and inexpensive labor saving devices that presaged a future free of life's more onerous tasks. Edward Bellamy's Looking Backward:2000-1887(1888) reflected the utopian vision that many Americans held as they entered the Progressive Era. The worst abuses of competitive capitalism would have ended and

a new "cooperative commonwealth" arisen to replace it. All made possible by the rationalization of human effort and interaction, and of course, continual scientific advancement and its concomitant, technological progress. Marxism held that scientific and social rationalism when finally applied to human society would introduce a slightly different version of Utopia. There lurked one major obstacle to attaining these modern Edens, human nature.

Profound social change, largely the product of technological and scientific progress, caused American society to exacerbate that age old paradox of human social development. In effect, that trends towards greater freedom for the individual led conversely to a greater individual dependence on increasingly complex and interdependent social structures. These social structures marginalized those people who could not or would not fit into increasingly complex social roles. The "socially unfit" were defined by behaviors that society had come to feel were threatening to the evolving social order. Criminality, poverty, insanity and other social ills were attributed to the inability of some individuals to be able to participate productively.

Scientific rationalism and the related perspective of Social-Darwinism provided a somewhat self-justifying explanation for the existence of the "socially unfit." Darwinian evolution had been coopted into the philosophy of Social-Darwinism, wherein more highly evolved types of

mankind formed more highly evolved societies. The Western societies, considering themselves far more advanced than the rest of the world's social orders, maintained that their philosophy of scientific rationalism(and the society it supposedly produced) made them *ipso facto* the measure of social progress.

Thus these societies, particularly the two modern republics of Germany and America, perceived themselves sophisticated and knowledgeable enough in the field of social evolution to take somewhat radical measures to supposedly control a genetic aspect of this evolution, eugenically. But how radical were the policies of compulsory sterilization? They had broad professional and public support in both nations. I would suggest that policies for compulsory sterilization represent a progressive agenda, and were comparable with other morally and ethically coercive measures considered by contemporaries as reforms.

Michigan's policy of compulsory sterilization should be viewed in this context of reform. The Progressive Era witnessed broad reforms and extensions of rights and opportunities for many people. The State Hospitals, Farms Colonies and Training Schools were certainly a reform of the previous system of poor houses and lunatic asylums. The insane and feebleminded received a level of care that was previously unknown. Likewise the state's penal institutions tried new methods of reforming criminals. The goal was to

reintegrate the "socially unfit" into society as productive members if possible. This perspective symbolized the Reform-Darwinists attitude towards social progress. Even programs like Kelloggs' euthenics were variations on a theme of biological determinism and moral rectitude for the masses.

In this world view, the laws governing the evolution of social organizations were subject to comprehension and therefore of use in the formulation of public policies that would construct a new idealized social order. Governments and social reform groups would be the agents for these rational interventions to correct the wasteful outcomes of trial and error inherent in the process of natural selection. The quandary about whether the socially unfit were the cause of various social evils, or were merely the products of these evils was solved. Social evils arose from the failure of modern society to select out its anti-social members. The latter's "unfitness" was inherent in themselves, in their entire genetic make-up.

The "sciences" of phrenology and even Lombardo's criminology held that mental and psychological character could be ascertained from physical appearance. Binet's method of determining "intellectual" ability, devised as a method of selecting the appropriate level of training for mentally retarded children, became also a proof for the malignant spread of the "socially unfit." The results of Yerkes' Army IQ tests during World War I showed that a much

greater proportion of the general population was intellectually inferior than even the most pessimistic had forecast.

But this was self-evident to the commentators of the time. Rates of criminality, poverty, divorce and other dissolute social behaviors seemed constantly on the rise. It seemed evident to many that increasing numbers of defective social members were the cause. This made it seem imperative that action be taken before society was undermined by a tide of socially unfit individuals. The Progressive Era manifested a faith in the ability of government to intervene positively in the affairs of society, specifically in the lives of individuals. For many Progressive reformers, the precepts of Reform-Darwinism, showed the path to be taken. Government would provide the laws and some funds for an expansive reform agenda. Electoral reform, workplace reform, women's suffrage, food and drug regulation, prohibition, sexual-disease monitoring, and redistribution of wealth via a Federal Income Tax were all typical of this era's reforms. These reforms also had a necessarily coercive side. Enforcement often led to what many would perceive as intrusions into the private sphere, especially as regards the sexual autonomy of individuals.[1] These encroachments

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[1]Boyer, Paul(Ed.), The Enduring Vision. (Lexington: D.C. Heath and Company, 1995) pg.469-493. The following are examples of Progressive Era Federal reform legislation: 1906 Hepburn Act, empowered ICC to regulate railroads; 1906 Pure Food And Drug Act and Meat Inspection Act, set up Federal

into people's personal affairs were meant to improve society as a whole by direct intervention against "antisocial" elements. Some legislation was against rapacious capitalists, others against socially undesirable "aliens" and the homegrown "deviants".

Yet the paradox of Social-Darwinism, for people like Shallmayer, Laughlin and the other eugenicists, was that a social-reformist society harbored the very seeds of its potential destruction or in their terms, devolution. Modern societies' ability to provide better care and control of the "socially unfit" constituted a drain on the productive resources of the society and contributed to further debilitation of the body politic through the maintenance of their progeny.

To the people who formulated compulsory sterilization

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regulation of food and drug producers and distributors; 1910 Mann Act made the transportation of women over state lines "for immoral purposes" a federal crime. (1914)Federal Trade Commission Act, establishes FTC; 1916 Adamson Act, provides 8 hour workday for railroad workers; 1915 Clayton Act, exempted strikes, boycotts, and peaceful picketing from "restraint of trade"; Federal Farm Loan Act and Federal Warehouse Act, protected farmers from bankruptcy; 1916 Owen-Keating Act, barred products of child-labor from interstate commerce; 1916 Workmen's Compensation Act, provided accident and injury insurance for workers; (1913)16th Amendment, established a federal income tax; (1913)17th Amendment, provided for the direct election of Senators; (1919)18th Amendment, established prohibition, (1920)19th Amendment, provides women's suffrage. Even Supreme Court decisions reflected the pervasive view of the Progressive Era, e.g. 1908 *Muller vs. Oregon*, upheld Oregon law setting maximum working hours for female laundry workers at 8 hours, supported by the Brandeis Brief. 1924 National Origins Act, limited net immigration and set 2% rule for immigration quotas based on the 1890 Census.

laws in Michigan, a certitude existed that the propagation of defective progeny resulted from the inherited characters of their forebears. Sterilization constituted a net benefit both to the individual and to society as a whole. The "defective" individual would not be burdened with a task beyond their abilities to perform and society would decrease its direct costs for maintenance and incarceration. There would also be a collateral reduction in other social costs. The reduction in the numbers of feebleminded and insane would conceivably result in fewer people for the criminal element to prey upon. The former were not generally considered of evil temperament, rather they were susceptible to the machinations of the latter.

The wording of the Michigan laws shows a due regard for the direct and indirect reduction in costs to society. But as Dr. Randall, the President of the Michigan State Medical Society, stated "sterilization is not a panacea, but a valuable procedure" in some cases. Dr. Randall calculated the potential number of cases in the feebleminded category alone at seventy-three thousand. Less than three percent of this potential number were actually sterilized, though far more of the feebleminded were sterilized than people listed as insane or sexual-criminals.

This indicates that the policy of compulsory sterilization was rare in practice. Less than one tenth of a percent of the population was actually affected. I think

that it is a fair assumption that this fraction could be considered pretty well marginalized from the general population. Yet the laws provided due process with at least two direct oversight committees composed of elected and appointed officials. These officials had a clear set of three criteria to use in rendering a judgement in these cases.[2]

There was also a provision for the notification of family of the first degree, guardians, and other interested parties of upcoming hearings. Permission for the operation was also requested. It seems that most requests received no response. Yet the majority of requests to the requests was affirmative. Indeed many of the requests had originated from family members. An open hearing was held and evidence given from at least two state agencies, the Hospital Board and the Department of Corrections and Charities(requests passed through two additional committee reviews within these agencies). Individuals throughout the state bureaucracies, charities and institutions were made responsible for

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[2]*See Chapter 4:* The 1923 law specified three conditions that must be in existence for a feebleminded person to qualify for operation under the statue: that the individual must manifest sexual inclinations indicating the likelihood of procreation unless closely confined or rendered incapable of procreation, that the children of the individual would have a *hereditary tendency* to inherit the defect, and no probability of the individual's condition improving such that, either his/her children would not inherit the defect, or that the individual by nature of their illness would be unable to care for their children.

initiating requests, a situation closely resembling German practice. Though the legal procedures bear a remarkable resemblance to the German legislation and legal practice, all certainly qualify as due process.[3] Some recent revisionism has tried to portray sterilization programs as operating with little due process, this was certainly not the case in Michigan.

Overall, the law seems to have been applied as it was intended, though there are four specific instances or trends that appear atypical. The first and most significant in terms of bias and numbers, was the disparately larger proportion of women sterilized than men. A partial explanation for this phenomenon is that the women constituted a larger proportion of those potentially able to procreate. The women, because of higher rates of parole and a lower incidence of congenital sterility than like populations of men, were more likely to have been selected by the laws' criteria.

There was also another explanation for part of this disproportion. There was a paternalistic view in the United States that women in general were in need of protection from unscrupulous males. Insane and feebleminded women were believed to be especially vulnerable. These women were believed to lack the capacity to comprehend the results of their sexual activities. Sterilization was thought of as a

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[3]See Chapter 2. pg, 27.

way to reduce the potential burden(their potential children) to themselves and society. It was also believed by many eugenicists and doctors that sterilization reduced the sexual drive in women. Thus the women were the more likely targets of a paternalistically biased selection process.

The second irregular trend was the castration of twenty inmates in the prisons and reformatories. All of these incidents occurred before 1938. Of the six records located, all were performed at the Ionia Reformatory, and all in the winter of 1937. Very little information exists on these cases, but the brief span of time in which they occurred seems unusual.

None of the castrations were performed as punishment, which was indeed proscribed by Michigan law, though not that of other states. The reasons given were therapeutic, an amelioration of symptoms of criminal sexual behavior. As the law did provide for the sterilization of those convicted of criminal sexuality, the total number sterilized was quite low in proportion to their numbers in the prison population.

While castration seems by modern standards to be the most radical of the procedures used to create sterility, we must remember that the law also specifically provided for sterilization by x-rays. A method general believed to have been used only in Nazi Germany. While the procedure as a means of sterilization is certainly radical, the stated goal in these operations was primarily a behavior modification

not sterilization.

The third, fortunately uncommon practice was certainly unethical by contemporary standards and most probably illegal. This was the practice of obtaining consent for these surgeries from patients already adjudged *non compus menti*, particularly when sterilization was held as a condition of parole. While five cases equates to less than two percent of the records available, it seems an unusual coincidence that all these operations took place in a six month span from June 1935 to February 1936, and all occurred at the Michigan Home and Training School. It is impossible to determine from the available records what significance, if any, this coincidence of time and place has.

The fourth atypical trend in the records, was the increased frequency of sterilization of the insane in the mid 1930s, particularly at the Kalamazoo State Hospital for the Insane. This practice was the only instance found where state officials questioned the number of sterilizations performed. Considering that the prognoses(at least regarding parole) for the insane were if anything worse than those for the feebleminded, it would seem that the insane would have been less likely to be selected for sterilization as their release would also be less likely. Another likely explanation for this tendency was that in practice the insane were more strictly segregated by sex than those in other institutions, according to state law this would have

obviated the need for their sterilization.

Discrimination on the basis of race or creed does not seem to have been a factor in selection. Interestingly, the stipulation against discrimination of this type was also part of the German sterilization legislation, though the Germans later changed their practice. Many authors have drawn attention to the similarities between the various American and German sterilization programs. The similarities exist and are certainly not coincidental.

Most recently, Stefan Kühl's The Nazi Connection: Eugenics, American Racism, and German National Socialism documents the variety of connections between American and German scientists, philanthropists, and eugenicists.[4] In Health, Race and Politics Between National Unification and Nazism, Paul Weindling has detailed many of the same connections and showed that the process of professionalization in the fields of medicine, social welfare, law, and even the scholarly arts such as history underwent essentially the same processes in both countries at about the same time. Certainly the number of scholars and professionals that studied in each other's universities made for a certain common world view among these professions and the people influenced by them. Both nations were of relatively recent political creation, and had similar

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[4]Kühl, Stefan. The Nazi Connection: Eugenics, American Racism, and German National Socialism, (New York: Oxford University Press, 1994). pg 13-36, 53-64, 85-96.

patterns of modernization.

Ian Kershaw, in The Nazi Dictatorship, noted that "though Nazism contained obviously archaic and atavistic elements, they often served as propagandistic symbols or ideological cover for wholly 'modern' types of appeal."[5] Germany's sterilization proceedings were initially as open as those of the Americans, but this changed after the Nazi seizure of power. There was a rapid increase in the number of German sterilizations immediately before the outbreak of the Second World War. Indeed, introduction of euthanasia for the "useless eaters" was a war time measure specifically backdated to the beginning of the Polish campaign.

The nature of the divergence in the paths of the two nations in the application of their laws against the "socially unfit" was caused by several different factors. First and foremost is the difference in time spans between the two countries programs, and also in the pace of operations. By the outbreak of hostilities with the United States, when virtually all communication between the corresponding German and American professional groups had come to an end,[6] American programs had been in operation for

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[5]Kershaw, Ian. The Nazi Dictatorship: Problems and Perspectives of Interpretation. (New York: Routledge, 1990). pg 148

[6]Proctor, Robert. Racial Hygiene: Medicine Under the Nazis (Cambridge: Harvard University Press, 1988). By late 1941, the German program had virtually come to a halt. On September 1, 1939 an order from the government went into

over forty years. The German program lasted less than six years, yet a much greater proportion of its population had been sterilized in this short interval than had been in the America in period more than six times as long. As is often seen in German correspondence to American compatriots, German eugenicists and other concerned professionals felt that they were far behind Americans and in imminent genetic peril.

Certainly, the American eugenics movement had its share of members with ethnic or racial biases. Madison Grant was typical of the influential and more virulent racist types. Even Laughlin, director of the Eugenics Record Office, often displayed racist and ethnic biases. Their major accomplishment as regards their agenda was the immigration restrictions that came with the passage of the National Origins Act. In Michigan's program there was apparently no discrimination, but in the nation as a whole it is difficult to say with the research available. Michigan had historically had better race relations than the majority of states, it was after all the birthplace of the Black Republican Party, as Stephen Douglas called it, a veritable

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effect asking that genetic health courts accept no further application for sterilization unless there was an "exceptionally great danger"(pg 117). Many doctors had been mobilized, leaving few to perform the operations, and most of the potential population(slightly over 100,000) that could have been sterilized according to the law had been(well over 90,000). This date also marks the beginning of the euthanasia program that would eventually kill many of the people in those categories to be sterilized.

den of abolitionists. Michigan might not be indicative of practice in the deep South, though the deep South states tended to perform few sterilizations. Virginia, more a Border state, had a program similar in size and scope to that of Michigan. A comparison between the two would be helpful in determining whether there was a regional difference regarding proportions by race.

Unlike Germany, in the United States sterilization laws were mandated by the states, not the federal government. There was a great deal of variation in size and type of program, and in whether a state even had a program. Almost forty percent of the states never had sterilization laws, so it is difficult to construe the American programs as national in scope.

Most opposition to the German programs arose from the Catholic and Protestant church groups. Regional variation in the effect of this opposition on the scope of local programs varied essentially with the strength of these religious groups in the particular area. Other than opposition from the Catholic church, large American religious orders were either relatively supportive or uninvolved.

Undoubtedly, by caring for some of the Catholics patients who would have been deemed "socially unfit" if they had come to the attention of public institutions, Catholic charities and hospitals protected some from falling under the purview of the law. This could have had the effect of

dulling opposition by removing the question of sterilization for people likely to have been the cause of a stronger response from the Catholic church, namely its parishioners and wards.

No doubt the much faster pace of the German sterilization program would have seemed much more pervasive in its effects than those of the US. Thus, German programs were likely to appear as more radical than their slower paced American counterparts and also more likely to garner attention, and consequently opposition.

The often radical nature of the Nazi regime brought rapid German legislative reforms in a range very similar to what had been accomplished in the United States over a longer period of time. These reforms echoed much of Progressive Era American legislation, examples would be German national regulation and certification of doctors, social welfare and medical and disability insurance programs, federal regulation of working conditions and federal aid to farmers. In Nazi terms, there had even been electoral reform, albeit very perverse in democratic terms.

Perhaps we should not focus principally on the actions of government in assessing accountability in either the German or American cases. Arthur Caplan's <u>When Medicine Went Mad</u> records that even in the case of the euthanasia program, "No doctor was ever ordered to participate in the euthanasia

program; they came of their own volition."[7] If we consider that a much greater proportion of doctors were needed to accomplish the rapid pace of the Nazi sterilization policy and that there was no apparent shortage of volunteers, it should not be surprising that the smaller proportion of American doctors dealing with a much smaller number of cases would not have been as desensitized to their patients welfare as some German physicians had become by the advent of the euthanasia program. It does seem ironic that Michigan law, through the actions of Dr. Jack Kevorkian, has become the current focus of public debate on a form of euthanasia, physician assisted suicide.

The President of the German Medical Society stated that he was proud that his opinion had prevailed in the sterilization and euthanasia programs. "Keep the scalpel in the hands of the doctor" was his metaphor for the primacy of physician opinion in the decision making process. Yet, in both the US and Germany, many other people in and out of bureaucracies were involved in the process. Ultimately, the electorates that put politicians in power to legislate these program should also be held accountable. Nazi era atrocities have often been cast in purely racial terms and

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[7]Caplan, Arthur(Ed.). When Medicine Went Mad: Bioethics and the Holocaust. (Totowa: Humana Press, 1992):Proctor, Robert. "Nazi Biomedical Policies". pg 23-41; Caplan, Arthur. "How Did Medicine Go Wrong" pg. 53-92. Caplan provides a concise timeline of events on the "slippery slope" of Nazi era bioethics.

there certainly exists a prevalent racist component, but the victims also included large numbers of political enemies, homosexuals, and non-Aryan ethnic minorities. Nazi policies on sterilization, euthanasia, punishment brigades, and death camps took a much greater toll in human suffering than did the American sterilization programs, but this legacy should not preclude our making a general comparison between the two nations' histories of compulsory sterilization.

Obviously, the scope(in terms of the numbers sterilized) of the two nations' policies were of quite different magnitudes. If we extract the German sterilization program from its somewhat deservedly, if not overly teleological connection to the subsequent atrocities, it would seem that the essential difference was the slower pace of American legislative and judicial processes and their variety of outcomes compared to those of the federated Nazi state.

In fairness to the Germans, we should remember that the United States had not suffered as radically as Germany in the World Wars and the intervening depression years. Fears for the social and genetic health(believed to be interdependent) of the population were certainly exacerbated to a greater degree in Germany than the US. The US had suffered far fewer casualties in the first war (a minuscule proportion of population as compared to the German losses).

The social disruptions of the Great Depression, as bad as they were in the US, never approached those of Germany.

Currency failure, the weight of reparations payments, and the national embarrassment of lost territories and Empire contributed to the establishment of a radical regime, whose forte was expediency.

Indeed, I believe that compulsory sterilization in general can most accurately be characterized as an expedient solution to a complicated and morally vexing problem, the nature of society's responsibility for the care and rights of its most vulnerable members.

That proposition posed, I conclude by asking a counterfactual; if Americans had been faced with more radical social conditions, similar to those of the Germans, can we be sure that we would have behaved much differently than them?

## Appendix A

Michigan Public Act 281. 1929.

AN ACT to prevent the procreation of feeble-minded, insane and epileptic persons, moral degenerates, and sexual perverts; to authorize and provide for the sterilization of such persons and payment of the expenses thereof; and to repeal act numher two hundred eighty-five, public acts of nineteen hundred twenty-three, and amendmcnts thereto.

*The People of the State of Michigan enact:*

SECTION 1. It is hereby declared to be the policy of the state to prevent the procreation and increase in number of state
feeble-minded, insane and epileptic persons, idiots; imbeciles,
moral degenerates, and sexual perverts, likely to become a menace to society or wards of the state. The provisions of this act are to be liberally construed to accomplish this purpose.

SEC. 2. The words "mentally defective person" or "defective person" in this act shall include all feeble-minded, insane and epileptic persons. idiots, imbeciles moral degenerates and sexual perverts. Where shall persons are referred to in this act as of the masculine gender, the same shall be deemed to include persons of the feminine gender as well.

SEC. 3. The several probate courts within the state of Michigan shall have power to receive petitions, hold hearings and make orders for the purpose of carrying out the provisions of this act and perform all necessary acts in connection therewith. For that purpose the general provisions of law applicable to the jurisdiction of probate courts and particularly the laws and procedure governing the holdings of hearings and making orders of admission of mentally diseased persons to the several hospitals of the state, shall be construed as a part of this act insofar as the same are not inconsistent herewith.

SEC. 4. Whenever the medical superintendent, warden, or principal officer of the Kalamazoo state hospital for the insane, the Pontiac state hospital for the insane, the

Traverse City hospital for the insane, the Newberry state hospital for the insane, the Ionia state hospital for the criminal insane, the Michigan home and training school for feeble-minded at Lapeer, the farm colony for epileptics at Wahjamega, the state psychopathic hospital at Ann Arbor, the Michigan state prison at Jackson, the branch of the state prison at Marquette, the Michigan reformatory at Ionia, or any other hospital, training school, farm colony, prison or public institution maintained and supported in whole or in part by the state of Michigan, shall be of the opinion that any inmate or person under the custodial care of such institution is a mentally defective person who would be likely to procreate children unless closely confined or rendered incapable of procreation; that such children would have a tendency to mental defectiveness and that there is no probability that the condition of said defective person will improve and that it is for the best interest of such person and of society that such mentally defective person should be sexually sterilized, it shall be the duty of such medical superintendent, warden, or Principal officer to bring to the attention of the governing board or body of such institution and to the state welfare commission, the facts, records, family history, traits, and mental and physical condition of such person so far as the same can be ascertained. It shall be the duty of the governing board or body of such institution and the state welfare commission to cause an investigation, and examination to be made to determine whether such mentally defective person would be likely, if allowed to mingle in society, to procreate children having an inherited tendency to feeble-mindedness insanity, idiocy, imbecility, epilepsy or sexual degeneracy and who would be likely to become a social menace or a ward of the state, and whether there is no probability that the condition of such person would improve to such an extent as to avoid such consequences. It shall be the duty of such governing board or body and the state welfare commission to keep a record with reference to each such person embodying its findings and conclusions in said respects, and either to obtain the consent hereinafter referred to or to cause to be filed a petition in the probate court of that county in which such mentally defective person was a resident at the time of commitment or admission, or in the probate court of the county in which such institution may be situated, for the purpose of carring out the provisions of this act, and procure an order directing the sterilization of such defective person. Nothing in this act contained shall be considered to require a court order when consent is given as hereinafter referred to. Whenever the defective person is of the age of sixteen years or more and not otherwise incapable of giving consent, such operation or treatment may be performed upon obtaining a consent thereto in writing, signed by such defective person, together with a similar

consent in writing signed by his or her legal guardian, if any, and also by one or more of the following persons, in the order named; husband, wife, father, mother, brother, sister, child or next of kin. If such a defective person is in the custodial care of a state institution said written consent shall be filed and kept a part of the records of such institution; otherwise, the same shall be obtained and kept by the surgeon performing such operation. Upon complying with the foregoing provisions, it shall htereupon be lawful to perform such operation.

SEC. 5. The father, mother, husband, wife, brother, sister, child or guardian of a mentally defective person, the medical superintendent, director or principal officer of any state institution, the state welfare commission, any sheriff or superintendent of the poor or supervisor of any township, may petition the probate court of any county in which a mentally defective person resides or in which may be located any institution having the custodial care of a mentally defective person, for an order directing such treatment or operation of vasectomy, salpingectomy or other operation or treatment as may be least dangerous to life, to effectively render said defective person incapable of procreation. Upon receiving such petition the court shall fix a day for hearing thereof, which shall be not less than fourteen days after the date of filing such a petition. Notice of such hearing shall be personally served at least ten days before the date thereof as follows: (1) Upon such defective person, if above the age of ten years; (2) Upon the father, mother, husband, wife, brother, sister, child or next of kin who may be of full age, os such defective person, other than the petitioner, if there be any such known to be residing within the county (3) If such defective person has no father, mother, husband, wife, brother, sister, child or other next of kin who may be of full age, known to be residing within the county, such service shall be made either personally or by registered mail on one or more of said relatives who may be residing outside of the county, and within this state if there be any such known to the petitioner or to said court (4) Upon the legal guardian of such defective person if a legal guardian has been appointed; if not, the court shall at the time of receiving such petition appoint a guardian ad litem upon whom such notice shall be served and who shall represent said defective person at the hearing; (5) If such defective person shall be residing with or in the custodial care of some person or institution other than the petitioner, such notice shall also be personally served upon the person, or principal officer of the institution having the custodial care of such defective person, if within the

county of jurisdiction; if without said county, said service shall be made either personally or by registered mail upon the prosecuting attorney of the county in which such hearing is to be held; (7) Upon such other persons, if any, as the court may, in its discretion, determine to be proper persons who should have notice of such hearing. Due proof of such service shall be filed with the court at or before such hearing.

SEC. 6. The court shall appoint two reputable physicians who shall make an investigation and examination of the mental and physical condition, and personal and family history of such defective and report the same to the court with the opinion of said physicians as to whether said person is a defective person within the meaning and intent of this act who should be rendered incapable of procreation. The certificates of said physicians shall be filed with said court before an order shall be made for such operation or treatment. The court shall at such hearing take testimony in writing as to the mental and physical condition of such defective person and the history of his case and shall, if no jury is required, determine whether he is a mentally defective person subject to be rendered incapable of procreation in order to prevent the production of children who may be mentally defective or a menace to society or become wards of the state.

SEC. 7. If the court shall deem it necessary or if such defective person or any relative or the legal guardian or guardian ad litem of such person shall so demand a jury shall be summoned in accordance with the rules and practice of summoning juries in probate court to determine the questions of fact as to whether such person is a mentally defective and should be rendered incapable of procreation, under the provisions of this act. Such defective person shall have the right to be represented by counsel at such hearing and to be present in person unless it shall be made to appear to the court by certificate of two reputable physicians that his condition is such as to render his removal for that purpose or his appearing at such hearing improper and unsafe.

SEC. 8. Whenever at such hearing it shall be found by the court or by a jury that such person is a mentally defective person and the court shall find that said defective person would be likely to procreate children unless he be closely confined or rendered incapable of procreation, that such children would have a tendency to mental defectiveness and that there is no probability that the condition of said defective person would improve, and the court shall find that such children might be a menace to society or might

become ward of the state, the court shall make an order requiring and specifying that such defective person shall be treated or operated upon by X-rays or by the operation of vasectomy or salpingectomy or other treatment or operation best suited to the condition of such person, and most likely to produce the beneficial results intended by this act and which will effectively render such defective person incapable of procreation. The court may in said order direct that such defective person be admitted at the university hospital at Ann Arbor for such operation or treatment whenever the mental and physical condition of such person is such that he may be admitted and cared for in said hospital; or may direct that such operation or treatment be performed by a reputable surgeon whose duty it shall be to perform such operation or treatment in accordance with said order. The expense of such operation or treatment together with physician's fees and all other expenses incurred in connection with such proceeding shall be a proper charge against the state of Michigan: *Provided*, That such operations or treatment shall be performed or provided by the legal surgeon of the state institution whenever possible, without fees therefor and when not so performed, the liability of the state for surgeon's fees and other expenses, including care, etc., shall in no one case exceed the sum of fifty dollars; that when such person be admitted to the university hospital at Ann Arbor the provisions of act number two hundred seventy-four, public acts of nineteen hundred thirteen, shall be considered to apply to such case insofar as the same are not contrary to the provisiona of this act. The (auditor general of the state of Michigan is hereby required to reimburse the county or other claimant for all said expenses upon receipt of a certified copy of such order and a proper certificate of the court that such expenses are reasonable and proper, accompanied by an itemized statement thereof from the treasurer of said county, or other claimant. If on investigation it shall appear that such defective person has means or property sufficient for the payment of such expense or if those persons legally liable for the care and support of such defective person as an indigent person under the laws of this state have sufficient means for that purpose, the court shall require that payment or reimbursemcnt for such cspense shall be made by him or them. The provisions of law regarding the care and maintenance of insane persons, as well as indigent persons, are hereby expressly made applicable to the provisions of this section so far as the same are not inconsistent with this act.

SEC. 9. Said mentally defective person or any one in his behalf shall have the same right of appeal from such order as is provided by statute for appeals from orders of probate court; and any such appeal may be taken in accordance with

such statutes and the rules and practice of said court. It shall be unlawful to perform any such treatment operation during the period of five days next following the date of such order unless the court in said order shall find that such operation or treatment is immediately necessary and imperative in order to protect the physical health and well-being of such defective person; nor shall any action be taken to carry out such order during the pendency of an appeal therefrom or until such appeal, if any, shall be determined or dismissed.

SEC. 10. No Surgeon performing an operation or providing treatment under the provisions of this act shall be held liable either criminally or civilly on account thereof, except only in case of negligence in the performance of such operation.

SEC. 11. This act is hereby declared severable in its provisions and the invalidity of any part, section or provision of the same shall not be construed to affect the validity of any other part which may be given practical operation and effect without the invalid part, section or provisions.

SEC. 12. Act number two hundred eighty-five, public acts of nineteen hundred twenty-three, entitled "An act to authorize the sterilization of mentally defective persons", and amendments thereto are hereby repealed.

Approved May 32, 1929.

## Appendix B

*Prior relevant Michigan Laws.*

PUBLIC ACTS, 1925-No 71

[No. 71.]

AN ACT to amend section two of act number two hundred eighty-five of the public acts of nineteen hundred twenty three, entitled "An act to authorize the sterilization of mentally defective persons."

*The People of the State of Michigan enact:*

SECTION 1. Section two of act number two hundred eighty-five of the public acts of nineteen hundred twenty-three, entitled "An act to authorize the sterilization of mentally defective persons, is hereby amended to read as follows:
SEC. 2. Whenever a person is adjudged defective by a court of competent jurisdiction, either such court or if the patient
has been confined in some state institution, the probate court of the county in which such institution is situated may after hearing, as herein provided, order such treatment by X-rays
or the operation of vasectomy or salpingectomy or other treatment, as may be least dangerous to life, to render said defective incapable of procreation.

Approved April 23, 1925

PUBLIC ACTS, 1923-NO. 285

[No. 285.]

AN ACT to authorize the sterilization of mentally deficient persons.

*The People of the State of Michigan enact*:

SECTION 1. The words "mentally defective person or defective" in this act shall he deemed to include idiots, imbeciles and the feeble-minded, but not insane persons. Throughout this act the words "adjudged defective" shall mean any mentally defective person who has been found and adjudged to be defective by a court of competent jurisdiction according to the laws and the statutes of this state. Through out this act where words or pronouns of masculine gender are used, said words shall be deemed to include female persons ar well as male persons.

SEC. 2. Whenever a person is adjudged defective by a court of competent jurisdiction, said court may, after hearing as herein provided, order such treatment by X-rays or the operation of vasectomy or salpingectomy or other treatment as may be least dangerous to life to render said defective incapable of procreation.

SEC. 3. The court may make an order as aforesaid on the application of:

1. The father, the mother, husband, wife, brother, sister, child or next of kin of the adjudged defective;

2. Any of the following persons resident in the county in which the adjudication was made:

(a) The prosecuting attorney, sheriff or any peace officer; (b) Any director, superintendent or supervisor of the poor; (c) The board of control, board of guardians or trustees or other governing board of any state penal, corrective or charitable institution if such institution be wholly under control of the state;

(d) Any other person whom the judge of probate upon examination into the facts and circumstances of any particular case, shall determine to be a proper person to make such application.

Said order may be made at the time when the person is adjudged defective or at any later time.

SEC. 4. When an application is made as aforesaid the court shall fix a day for the hearing thereof, and notice of the time and place of said hearing shall be served personally at least ten days before said hearing:

1. Upon the person adjudged to be defective if above the age of ten years;

2. Upon the prosecuting attorney of the county in which

the hearing is to held; and

3. Upon the husband or wife, father or mother, or child of full age of said defective, or the person with whom said defective resides, or in whose house he may be, and if none of the relatives named in this subdivision can be found; also

4. Upon his guardian ad litem who shall be appointed by the court to receive said notice and represent said defective at the hearing.

In its discretion the court may cause notice to be served in any part of the state upon any relative of the defective or upon any interested person.

SEC. 5. The court shall cause the defective to be examined by three reputable physicians in the manner now provided by law for the examination into the mental condition of persons alleged to be defective (feeble-minded) with a view to obtaining the opinion of said physicians on the question of whether the adjudged defective should be dealt with under the terms of this act.

SEC. 6. The court shall take full evidence in writing at the hearing as to the mental and physical condition of the adjudged defective and the history of his case and shall, if no jury is required, determine whether he is a person subject to be dealt with under this act for his own welfare or the welfare of the community.

If the court shall deem it necessary, or if such defective, or any other relative or the guardian ad litem shall so demand, a jury of six freeholders having the qualifications of jurors in courts of record shall be summoned to determine the question of whether such person is subject to be dealt with under this act; such jury to be selected in the same manner as is provided for the selection of a jury for the condemnation of land for railroad purposes.

The jurors shall receive the same fees for attendance and mileage as are allowed by law to jurors in the circuit court.

The alleged defective shall have the right to be present at such hearing, unless it shall be made to appear to the court by certificate of two reputable physicians that his condition is such as to render his removal for that purpose or his appearing at such hearing improper and unsafe.

SEC. 7. The court may order treatment or operation to render an adjudged defective incapable of procreation whenever at the hearing aforesaid it shall be found:

1. (a) That the said defective manifests sexual inclinations which make it probable that he will procreate children unless he is closely confined, or be rendered incapable of procreation;

(b) That children procreated by said adjudged defective will have an inherited tendency to mental defectiveness; and

(c) That there is no probability that the condition of said person will improve so that his or her children will not have the inherited tendency aforesaid; or

2. (a) That said defective manifests sexual inclinations which make it probable that he will procreate children unless he be closely confined, or be rendered incapable of procreation; and

(b) That he would not be able to support and care for his children if any, and such children would probably become public charges by reason of his own mental defectiveness.

SEC. 8. The court may with the consent of the parents or guardian of an adjudged defective order treatment or operation to render such defective incapable of procreation whenever at such hearing it shall be found that the mental or physical condition of said defective would be substantially improved by such operation or treatment, or that such operation or treatment is otherwise for the welfare of such defective.

SEC. 9. Any defective shall have the right to appeal from an order directing treatment or operation to render him incapable of procreation, in the same manner and upon the same terms, and persons found and adjudged defective (feebleminded) may appeal, and while said appeal is pending and undetermined the execution of the order shall be suspended, and the court may make any necessary or proper order for the care and custody of the defective pending the final determination of said appeal.

SEC. 10. Whenever the court shall order treatment or operation as provided in this act, it shall direct a competent physician or surgeon with proper assistance to perform said operation or give said treatment. The said physician or surgeon shall receive the sum of twenty-five dollars for every such operation or treatment.

SEC. 11. The invalidity of any part, section or provision of this act shall not be construed to affect the validity of any other part capable of having practical operation and effect without the invalid part, section or provision.

Approved May 25, 1923

PUBLIC ACTS, 1913-No. 34

[No. 34.]

AN ACT to authorize the sterilization of mentally defective persons maintained wholly or in part by public expense in public institutions in this State, and to provide a penalty for the unauthorized use of the operations provided for.

*The People of the State of Michigan enact:*

SECTION 1. Authority is given to the management of any institution maintained wholly or in part by public expense in whose custody may be held individuals who have been by a court of competent jurisdiction adjudged to be and who are mentally defective or insane, to render incapable of procreation by vasectomy or salpingectomy or by the improvement of said surgical operation which is least dangerous to life and will best accomplish the purpose, any person who is mentally defective or insane.

SEC. 2. The boards of the aforesaid institutions and the physicians or surgeons in charge of each of said institutions shall for each of their respective institutions constitute board, the duty of which shall be to examine such inmates of said institutions as are reported to them by the warden or medical superintendent to be persons by whom procreation would be inadvisable. Such board shall receive the report of insanity experts hereinafter mentioned, examine the physical and mental condition of such persons and their record and family history so far as the same can be ascertained, and if in the judgement of n majority of said board, procreation by any such Person would produce children with an inherited tendency to insanity, feeble-mindedness, idiocy or imbecility and there is no probability that the condition of such person so examined will improve to such an extent as to render procreation by such person inadvisable, or if the physical or mental condition of any such person will be substantially improved thereby, then said board shall direct a competent physician or surgeon with such other assistants as may be necessary to perform the operation of vasectomy or salpingectomy or any other operation or improvement on vasectomy or salpingectomy recognized by the medical profession, as the case may be, upon such person. Such operation shall be performed in a safe and humane manner, and the board making such examination, and the institution physician or surgeon shall receive compensation therefor: *Provided,* That at least thirty days notice shall be given to the parents or guardian of such person before the performing of such operation said notice to specify the purpose, time and place of such examination: *Provided further,* That when said parents or guardian object to the performance of such operation. then

the question of the sanity of such person shall be referred to the probate court of the county in which the institution is located where the question of the sanity and the necessity for this operation shall be determined as in other insane cases before such courts.

SEC. 3. In case an institution has no physician at its head authority is given to the board of managers to cause such operation to be performed, to hire expert physicians to examine and report on the condition of the subject, and to perform the operation with such other assistants as may be necessary: *Provided,* Before said operation is ordered there shall first be secured from two physicians having qualifications prescribed by law for examiners in insanity, a written statement or report that such operation is desirable in the interests of the patient or the good of the community: and *Provided further,* That these physicians shall be allowed for their services the compensation fixed by statutes for the examination and certification of an insane person. The several sums necessary to carry out the provisions of this act shall be certified to be correct by the respective boards and shall be paid out of the general fund of the State upon the warrant of the Auditor General.

SEC. 4. In relation to each individual person sterilized under the provisions of this act, the board of control of the institution in which said person is an inmate shall file with the State Board of Public Health of Michigan, a written record setting forth the name, age, sex, nationality, type or class of mental defectiveness of said person, the nature of the operation performed, the subsequent mental and physical condition as affected by said operation: *Provided,* That said records shall not be for public inspection, but may be open to inspection of the members of the board of control of aforesaid institutions and of the members of the immediate family of the person operated upon, or any physician or surgeon designated by them.

SEC. 5. Except as authorized by this act, every person shall perform, encourage, assist in or otherwise promote the performance of either of the operations described in section one of this act, for the purpose of destroying the power to procreate the human species, or any persons who shall knowingly permit either of such operations to be performed upon such person, unless the same shall be a medical necessity shall be guilty of a felony, and upon conviction thereof shall be fined not more than one thousand dollars or imprisoned in the State Prison not more than five years, or both the discretion of the court before whom the said person or persons were so convicted.

Approved April 1, 1913.

[No. 150.]

AN ACT to create a commission to investigate the extent of feeble-mindedness, epilepsy, insanity and other conditions of mental defectiveness, and to appropriate the necessary moneys for the expense to be incurred by said commission in the performance of its duties.

*The People of the State of Michigan enact:*

SECTION 1. There shall be a commission created to investigate the extent of feeble-mindedness, epilepsy, insanity, and other conditions of mental defectiveness prevalent in the State of Michigan, and to make a study of the causes productive of these conditions.

Sec. 2. This commission shall be composed of the following members: The medical director of the State Psychopathic Hospital at the University of Michigan, the Superintendent of Public Instruction, the secretary of the State Board of Health and the secretary of the State Board of Corrections and Chairities. The medical director of the State Psychopathic Hospital is herewith made the executive officer of the commission.

SEC. 3. It shall be the duty of any and all officials in charge of any public, private, religious, charitable, penal or correctionary institution in whose custody are held individuals whose mental condition comes within the scope of investigation of this commission to furnish such information as may be desired by the commission and to keep during the existence of this commission sush records as it may prescribe.

SEC. 4. This commission shall present to the Legislature of nineteen hundred fifteen a printed report embodying the results of its work, together with such recommendations for the treatment and prevention of these conditions as are suggested by their investigation.

SEC. 5. The commission is authorized to appoint such officials and employees as it may regard as necessary to carry on the purposes of this act, and such persons shall be pnid such salaries as may be recommended by the commission and approved by the Board of State Auditors. These salaries and all expenses of the commission, after being duly certified by the chairman or some authorized member of the commission, shall be paid from the general fund of the State. The members of this commission shall receive no compensation for their services, but their actual and reasonable expenses incurred in the performance of their

duties shall after approval by the commission, be paid by the State Treasurer on the warrant of the Anditor General, on the rendering of their accounts out of any moneys to the credit of the general fund not otherwise appropriated. The above payments to be made in accordance with the general accounting laws of the State.

Approved May 2, 1913

Sterilization Requests: Archives of the State of Michigan-Chart A
Appendix C

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 1 | DATE | CASE # | SEX | FACILITY | AGE AT REQUEST | Age of Commission | Reason for Request | Reason for Comm |
| 2 | 11/30/32 | 1990 | F | MFCE | | | | |
| 3 | 11/30/32 | 1965 | F | MFCE | | | | |
| 4 | 1/10/33 | 1929 | M | MFCE | | | | |
| 5 | 1/30/33 | 13523 | F | TCSH | 33 | 31 | | |
| 6 | 1/30/33 | Erminia12 | F | PSH | 31 | 29 | | Preg/NoSp |
| 7 | 1/30/33 | 21594 | M | KSH | 26 | 25 | TTIMD | Violent |
| 8 | 1/30/33 | 1334 | F | YSH | 36 | | TTIMD | |
| 9 | 2/9/33 | Frances2/' | F | PSH | 37 | | ChronicC | PublicChr |
| 10 | 2/9/33 | 13804 | F | TCSH | 30 | | | |
| 11 | 2/9/33 | 1886 | M | ISH | 17 | | | |
| 12 | 2/21/33 | 25621 | F | KSH | 26 | 26 | TTIMD | |
| 13 | 2/21/33 | 1668 | F | YSH | 25 | | TTIMD | ChldNglct |
| 14 | 2/21/33 | Annie120 | F | PSH | 37 | 28 | | |
| 15 | 3/1/33 | Mary3/1/3 | F | YSH | 32 | 28 | TTIMD | Psychosis |
| 16 | 3/1/33 | 24588 | M | KSH | 19 | 19 | TTIMD | |
| 17 | 3/3/33 | Nettie3/3/ | F | YSH | 21 | 21 | TTIMD | |
| 18 | 3/3/33 | 6064 | F | NSH | 21 | 20 | | |
| 19 | 3/3/33 | Gloria3/3/ | F | YSH | 31 | 31 | TTIMD | Insanity |
| 20 | 3/3/33 | 1100 | F | YSH | 16 | | FthRequest | |
| 21 | 3/3/33 | 7969 | F | MHTS | 18 | 17 | Elopement | |
| 22 | 3/3/33 | 7949 | F | MHTS | | | Elopemen | Elopemen |
| 23 | 3/3/33 | 3725 | F | MHTS | 16 | | Prophylaxsis | |
| 24 | 3/29/33 | 25775 | M | KSH | 34 | | TTIMD | |
| 25 | 3/29/33 | 25671 | F | KSH | 27 | 26 | TTIMD | |
| 26 | 3/29/33 | 1463 | F | YSH | 16 | 15 | TTIMD | |
| 27 | 3/29/33 | 7912 | F | MHTS | 18 | 3 | | FblmndHy |
| 28 | 3/29/33 | 6622 | M | MHTS | 19 | 15 | Prophylaxsis | |
| 29 | 3/29/33 | 22008 | F | KSH | 26 | | TTIMD | |
| 30 | 4/22/33 | 225525 | F | KSH | 20 | | TTIMD | Insane |
| 31 | 4/22/33 | 13555 | F | TCSH | 28 | | | Psychosis |
| 32 | 4/22/33 | 24510 | M | ISH | 45 | | | SexualOff |
| 33 | 4/28/33 | 25824 | F | KSH | 30 | | TTIMD | |
| 34 | 4/29/33 | Arthur429 | M | YSH | | | FollowUpLetter | |
| 35 | 4/29/33 | Henrietta | F | YSH | 27 | 26 | TTIMD | |
| 36 | 4/29/33 | L4/29/33 | F | KSH | 36 | 36 | TTIMD | Insanity |
| 37 | 5/8/33 | 24325 | M | 'eform Ioni | 38 | | PtReqCastrt | |
| 38 | 5/19/33 | 4257 | F | MHTS | 20 | 11 | TTIMD | |
| 39 | 5/19/33 | 25000 | F | KSH | 41 | 39 | TTIMD | |
| 40 | 5/19/33 | Clarence | M | PSH | 31 | | PrvntPreg | |
| 41 | 5/22/33 | 24924 | F | KSH | 26 | 24 | TTIMD | Psychotic |
| 42 | 5/22/33 | 25692 | F | KSH | 24 | 23 | TTIMD | |
| 43 | 5/22/33 | John5233 | M | YSH | 30 | 30 | TTIMD | |
| 44 | 5/22/33 | 24454 | M | Reform Ionic | 41 | | | |
| 45 | 5/22/33 | 25834 | F | KSH | 26 | | TTIMD | Hallucinat |
| 46 | 5/23/33 | 25774 | M | KSH | 20 | 20 | TTIMD | Epil/Delusi |
| 47 | 5/23/33 | 13867 | F | TCSH | 32 | 29 | TTIMD | |
| 48 | 5/23/33 | 13240 | M | TCSH | 27 | 25 | See Note? | BrkdwnOv |

| | I | J | K | L |
|---|---|---|---|---|
| 1 | Diagnosis | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | VDGenParalysis | | | |
| 6 | pprt | | | |
| 7 | | | | |
| 8 | Hallucinated | | | |
| 9 | g | | | |
| 10 | Psychoneurosis | | | |
| 11 | Feebleminded | | | |
| 12 | PsychoneurosisHys | | | |
| 13 | DP | | | |
| 14 | DP | | | |
| 15 | DP:Psychoneurosis | | | |
| 16 | DP:HEBE | | | |
| 17 | ManicDeprs | | | |
| 18 | MD | | | |
| 19 | MD | | | |
| 20 | Psych/MthDfcncy | | | |
| 21 | Moron | | | |
| 22 | Moron | | | |
| 23 | | | | |
| 24 | DP | | | |
| 25 | DP:CATA | | | |
| 26 | Psych/MtlDfcncy | | | |
| 27 | sParalys | | | |
| 28 | Moron | | | |
| 29 | PschosisMtlDfcncy | | | |
| 30 | DP:HEBE | | | |
| 31 | MD:Manic | | | |
| 32 | NotInsane | | | |
| 33 | DP:HEBE | | | |
| 34 | Phobic:Insane | | | |
| 35 | Schizophrenia | | | |
| 36 | NerBrkdwnPsychoneurosis | | | |
| 37 | Homosexual | | | |
| 38 | Moron | | | |
| 39 | Psych/MntlDfct | | | |
| 40 | Epilepsy | | | |
| 41 | DP:Hebe | | | |
| 42 | | | | |
| 43 | MD3-3PrevAttk | | | |
| 44 | NoAcutePsychopathSym | | | |
| 45 | DP | | | |
| 46 | Rtrd | | | |
| 47 | MD:Circular | | | |
| 48 | rWoman | | | |

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 49 | 5/23/33 | 6247 | F | MHTS | 18 | 18 | TTIMD | |
| 50 | 5/25/33 | 1721 | F | YSH | 19 | | TTIMD | PossSocM |
| 51 | 5/25/33 | 25800 | M | KSH | 18 | 18 | TTIMD | |
| 52 | 6/15/33 | 1990 | F | YSH | 25 | | TTIMD | Insane |
| 53 | 6/17/33 | Meter617 | F | YSH | 36 | 36 | TTIMD | |
| 54 | 6/23/33 | 1904 | F | YSH | 22 | | TTIMD | Insane |
| 55 | 6/23/33 | Meta0617 | F | YSH | 36 | | TTIMD | Insane/MI |
| 56 | 6/27/33 | 8039 | M | MHTS | 16 | | Eloper | SocMalaju |
| 57 | 6/27/33 | 1877 | F | YSH | 29 | | TTIMD | Insane/Sp |
| 58 | 6/27/33 | 25563 | M | KSH | 45 | | TTIMD | InsaneOd |
| 59 | 6/27/33 | 6656(2sis) | F | MHTS | | | ProbDelnqnt | |
| 60 | 6/27/33 | 7607 | M | MHTS | 19 | | Eloper | |
| 61 | 6/27/33 | 8043 | M | MHTS | 15 | | EloperParole | |
| 62 | 6/27/33 | 6684 | F | MHTS | 16 | | PrtctHer&S | Unmanag |
| 63 | 6/27/33 | 8024 | M | MHTS | 20 | | Parole | ChrncSoc |
| 64 | 6/28/33 | 2306 | F | MFCE | 17 | | TTIMD | GrdMals |
| 65 | 8/14/33 | 25932 | F | KSH | 20 | 20 | TTIMD | |
| 66 | 10/6/33 | 8070 | M | MHTS | 21 | | Parole | |
| 67 | 10/6/33 | 6405 | F | MHTS | 14 | 6 | TTIMD | PrntsUnab |
| 68 | 10/9/33 | Clara7193 | F | YSH | 25 | | TTIMD | PscyhW/M |
| 69 | 10/10/33 | 8033 | M | MHTS | 15 | | Parole | |
| 70 | 10/10/33 | | F | MHTS | 20 | 19 | Parole | |
| 71 | 10/10/33 | Frances72 | F | YSH | 24 | | TTIMD | Hyperacti |
| 72 | 10/10/33 | Susie7193 | F | YSH | 22 | | TTIMD | Para/Psyc |
| 73 | 10/10/33 | 6706 | M | MHTS | 18 | | Low | Unmanag |
| 74 | 10/10/33 | 2021 | F | YSH | 30 | | TTIMD | Paranoia/ |
| 75 | 10/10/33 | 2036 | F | YSH | 31 | | TTIMD | Hallucinat |
| 76 | 10/10/33 | 8008 | F | MHTS | 19 | | PriorRelea | SexDlnqnt |
| 77 | 10/10/33 | 25972 | F | KSH | 24 | | TTIMD | TrnsStPsyc |
| 78 | 10/10/33 | 25987 | F | KSH | 19 | 19 | TTIMD | ER Order |
| 79 | 10/10/33 | Catherine | F | MFCE | 17 | 16 | TTIMD | |
| 80 | 10/10/33 | 2036 | F | YSH | 31 | | TTIMD | ParanoidI |
| 81 | 11/2/33 | 26091 | F | KSH | 24 | | TTIMD | Insane |
| 82 | 11/2/33 | 1632 | F | YSH | 41 | 40 | TTIMD | |
| 83 | 11/3/33 | 1634 | F | YSH | 30 | 29 | TTIMD | |
| 84 | 11/3/33 | 1906 | F | YSH | 18 | | TTIMD | Insane |
| 85 | 11/6/33 | 2176 | F | YSH | 17 | | TTIMD | |
| 86 | 11/6/33 | 3034 | M | MHTS | 31 | 14 | TTIMD | |
| 87 | 11/6/33 | 2890 | F | MHTS | 27 | 18 | TTIMD/Par | Retarded |
| 88 | 11/6/33 | 8089 | F | MHTS | 15 | | TTIMD | Abandon |
| 89 | 11/6/33 | 5172 | F | MHTS | 24 | 15 | TTIMD | |
| 90 | 11/6/33 | 1649 | F | YSH | 32 | 31 | TTIMD | Hallucinat |
| 91 | 11/7/33 | 0A | F | MHTS | 15 | | TTIMD | |
| 92 | 11/8/33 | 7564 | F | MHTS | 19 | | | |
| 93 | 11/10/33 | 14206 | M | TCSH | 34 | 33 | Can'tSpprtMore | |
| 94 | 11/10/33 | 25871 | F | KSH | 30 | 30 | TTIMD | |
| 95 | 12/8/33 | 25257 | M | KSH | 49 | 48 | TTIMD | |
| 96 | 12/8/33 | 6217 | F | NSH | 29 | 25 | | |

| | I | J | K | L |
|---|---|---|---|---|
| 49 | Retarded | | | |
| 50 | RtrdDlnqntPsych | | | |
| 51 | DP | | | |
| 52 | MD:Manic | | | |
| 53 | PsychW/MDfcy | | | |
| 54 | DP:Cata | | | |
| 55 | PsychW/MDfcy | | | |
| 56 | stPrsnlttyRx | | | |
| 57 | PsychW/MDfcy | | | |
| 58 | SexPervPsychopath | | | |
| 59 | Low IQ | | | |
| 60 | | | | |
| 61 | | | | |
| 62 | Low IQ | | | |
| 63 | Malajst | | | |
| 64 | | | | |
| 65 | MD:Manic | | | |
| 66 | Parole | | | |
| 67 | MDfct | | | |
| 68 | Dfcy | | | |
| 69 | | | | |
| 70 | Retarded | | | |
| 71 | PsychW/MDfcy | | | |
| 72 | n | | | |
| 73 | eable | | | |
| 74 | DP | | | |
| 75 | DP | | | |
| 76 | LowIQ | | | |
| 77 | DP:Cata | | | |
| 78 | DP | | | |
| 79 | MDfcyEpilpSexDlq | | | |
| 80 | DP | | | |
| 81 | DP | | | |
| 82 | MD:Manic | | | |
| 83 | DP:Hebe | | | |
| 84 | Rtrd/DP:HebeMDfct | | | |
| 85 | MD:Elated | | | |
| 86 | Retarded | | | |
| 87 | Retarded | | | |
| 88 | ed | | | |
| 89 | | | | |
| 90 | PsychW/MDfcy | | | |
| 91 | | | | |
| 92 | | | | |
| 93 | VDGenParesis | | | |
| 94 | DP | | | |
| 95 | DP:MDfcyPsych | | | |
| 96 | MD:Depress | | | |

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 97 | 12/8/33 | 6222 | F | NSH | | | | |
| 98 | 12/9/33 | 24069 | M | KSH | 39 | 36 | TTIMD | |
| 99 | 1/18/34 | 1721 | F | YSH | 26 | 24 | TTIMD | Insane orc |
| 100 | 1/18/34 | 7181 | F | MHTS | 20 | | Parole | |
| 101 | 1/18/34 | 6246 | M | MHTS | 16 | 9 | Parole | |
| 102 | 1/18/34 | 1883 | M | YSH | 31 | 29 | TTIMD | Insane Or |
| 103 | 1/18/34 | Hazell-8-3 | F | PSH | | | Parole | |
| 104 | 1/18/34 | 13759 | F | TCSH | 17 | | | Public Pt. |
| 105 | 1/18/34 | Laverne1/ | F | NSH | | | | |
| 106 | 1/18/34 | 26126 | F | KSH | 26 | | TTIMD | Insane Or |
| 107 | 1/18/34 | 25257 | M | KSH | 49 | 47 | TTIMD | Insane Or |
| 108 | 1/18/34 | 6222 | F | NSH | 21 | | | |
| 109 | 1/18/34 | 26130 | F | KSH | 23 | | TTIMD | |
| 110 | 2/19/34 | 2068 | F | YSH | 37 | | TTIMD | Actively h |
| 111 | 3/1/34 | 24654 | M | MRI | | | TTIMD | |
| 112 | 3/1/34 | 8189 | F | MHTS | 18 | 13 | Parole | DepChldF |
| 113 | 3/1/34 | 7925 | F | MHTS | 17 | 15 | | Parents De |
| 114 | 3/1/34 | 25617 | M | KSH | 19 | 17 | TTIMD | |
| 115 | 3/1/34 | 3/1/34 | F | PSH | 31 | 27 | | |
| 116 | 3/21/34 | 26125 | F | KSH | 20 | | TTIMD | Insane Or |
| 117 | 3/22/34 | 14301 | F | TCSH | 37 | | Delusional | Delusiona |
| 118 | 4/20/34 | 1596 | F | YSH | 37 | 35 | TTIMD | Hallucinat |
| 119 | 4/20/34 | 15883 | M | MRI | | | Parole | |
| 120 | 4/20/34 | 26198 | M | KSH | 28 | 25 | TTIMD | Insane Or |
| 121 | 4/20/34 | 25819 | M | KSH | 21 | 20 | TTIMD | NervousAl |
| 122 | 4/20/34 | 18620 | M | KSH | 27 | 15 | TTIMD | Raving Sp |
| 123 | 4/20/34 | 26032 | F | KSH | 30 | 29 | TTIMD | Insane Or |
| 124 | 4/20/34 | 6177 | F | NHTS | 24 | 17 | Parole | |
| 125 | 5/23/34 | 2452 | F | YSH | 28 | | TTIMD | Delusiona |
| 126 | 5/24/34 | 1173 | F | YSH | 31 | 29 | TTIMD | FthReq |
| 127 | 5/28/34 | 13005 | F | TCSH | 24 | 20 | | Hallucinat |
| 128 | 5/28/34 | 2306 | F | YSH | 31 | 30 | TTIMD | Depressed |
| 129 | 5/28/34 | 26288 | M | KSH | 24 | | TTIMD | Insane Or |
| 130 | 5/28/34 | 6925 | F | MHTS | 19 | 17 | Parole | |
| 131 | 5/28/34 | 26180 | F | KSH | 22 | 22 | TTIMD | Insane Or |
| 132 | 5/28/34 | 7728 | F | MHTS | 17 | 14 | Parole | Orphan |
| 133 | 6/12/34 | 14298 | F | TCSH | 32 | | N/A | |
| 134 | 6/12/34 | 14173 | F | TCSH | 23 | | Apathy/Su | AttckRltdC |
| 135 | 6/12/34 | 26329 | M | KSH | 37 | | TTIMD | Insane Or |
| 136 | 6/14/34 | 2607 | M | ISH | 39 | | | DrgUse&E |
| 137 | 6/18/34 | 26349 | F | KSH | 28 | 23 | TTIMD | Insane Or |
| 138 | 6/18/34 | 26148 | M | KSH | 21 | | TTIMD | JbLoss/Brk |
| 139 | 7/9/34 | 2318 | F | YSH | 12 | | TTIMD | Insane |
| 140 | 7/14/34 | 26369 | F | KSH | 32 | | TTIMD | Insane Or |
| 141 | 8/16/34 | 14463 | F | TCSH | 30 | | | Delusion-R |
| 142 | 8/29/34 | 2220 | F | MFCE | 14 | | | |
| 143 | 8/31/34 | 2544 | F | YSH | 32 | | TTIMD | AttckSp/P |
| 144 | 9/8/34 | 14403 | F | TCSH | 24 | | | MntlImblSu |

| | I | J | K | L |
|---|---|---|---|---|
| 97 | | | | |
| 98 | GenParesisInsane | | | |
| 99 | General Paresis/bld&csf+ | | | |
| 100 | Low IQ-irresponsible and attractive | | | |
| 101 | Feebleminded | | | |
| 102 | MD 2nd attack | | | |
| 103 | Epileptic Insanity | | | |
| 104 | Mental Breackdown MDorDP | | | |
| 105 | | | | |
| 106 | Psych w/MDfcy | | | |
| 107 | DP w/MDfcy | | | |
| 108 | | | | |
| 109 | MDfcyMicroceph | | | |
| 110 | Suicidal Psych w/MDfcy | | | |
| 111 | Mental Defective | | | |
| 112 | eeMnd | | | |
| 113 | ead Dpndt Pt | | | |
| 114 | DP:Hebe | | | |
| 115 | | | | |
| 116 | DP w/ Dfct Basis | | | |
| 117 | MDw/schiz | | | |
| 118 | Psych w/MDfcy | | | |
| 119 | Feebleminded | | | |
| 120 | DP:Hebe | | | |
| 121 | DP:Hebe | | | |
| 122 | Psych w/MDfcy | | | |
| 123 | DP:Cata | | | |
| 124 | Mtl Dfcy | | | |
| 125 | | | | |
| 126 | EndcrnDysMDfcyPsynrHys | | | |
| 127 | Psych w/MDfcy | | | |
| 128 | Psychoneurosis | | | |
| 129 | Psych W/MDfcy | | | |
| 130 | | | | |
| 131 | Psych w/MDfcy | | | |
| 132 | MentalDfcy | | | |
| 133 | DP:Cata | | | |
| 134 | DP:Cata | | | |
| 135 | DP:Hebe | | | |
| 136 | IdiopathicEpilepsy | | | |
| 137 | Fblmnd/Apathy | | | |
| 138 | DP:Hebe | | | |
| 139 | PsychopathPrsnlty?MD | | | |
| 140 | DP | | | |
| 141 | DP:CataPreg | | | |
| 142 | | | | |
| 143 | PsychW/MDfcy | | | |
| 144 | PsychoneurosisHys | | | |

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 145 | 9/20/34 | Virginia08: | F | PSH | 17 | 17 | PrvntlllgtC | FundmntlD |
| 146 | 10/20/34 | 26171 | M | KSH | 27 | | TTIMD | Insane Or |
| 147 | 10/23/34 | Eunice102 | F | YSH | 27 | | TTIMD | Insane |
| 148 | 11/5/34 | 26281 | F | KSH | 22 | | TTIMD | Insane Or |
| 149 | 12/13/34 | Perorey12 | F | PSH | 28 | | PrvntPreg | |
| 150 | 12/13/34 | 26423 | M | KSH | 26 | | TTIMD | Insane Or |
| 151 | 12/24/34 | 26380 | F | KSH | 37 | | TTIMD | Insane Or |
| 152 | 2/14/35 | 1237 | F | YSH | 36 | | TTIMD | Hallucinat |
| 153 | 2/14/35 | Dorothy1/ | F | PSH | 23 | 21 | Parole | |
| 154 | 2/14/35 | Phyllis1/8/: | F | MHTS | 17 | 16 | Parole | |
| 155 | 2/14/35 | Stella1/8/: | F | MHTS | 20 | 18 | Parole | |
| 156 | 2/15/35 | 12493 | F | TCSH | 32 | | NtSuitRepr | NrvsBrkdw |
| 157 | 2/20/35 | 4981 | F | MHTS | 25 | 15 | Parole | RtrdDelinq |
| 158 | 2/22/35 | 26558 | F | KSH | 33 | | TTIMD | Insane |
| 159 | 2/22/35 | 6411 | F | MHTS | 21 | 13 | Parole | |
| 160 | 2/22/35 | 14415 | F | TCSH | 25 | | Insane | Insane/Pre |
| 161 | 2/22/35 | 14024 | M | TCSH | 37 | | BayCityReq | |
| 162 | 2/22/35 | 14394 | F | TCSH | 24 | 23 | | |
| 163 | 3/12/35 | Virginia3/ | F | MFCE | | | | |
| 164 | 3/12/35 | 261222 | M | KSH | 35 | 34 | TTIMD | Insane |
| 165 | 3/20/35 | 26374 | M | KSH | 37 | 36 | TTIMD | Insane |
| 166 | 3/20/35 | 2702 | F | MFCE | 19 | | Parole | |
| 167 | 3/28/35 | 8918 | F | MHTS | 17 | | Parole | RapeBadH |
| 168 | 3/28/35 | 25194 | M | KSH | 39 | 36 | TTIMD | Insane |
| 169 | 4/2/35 | 26528 | M | KSH | 44 | | TTIMD | Insane |
| 170 | 4/26/35 | Ethel T | F | PSH | | | Delinquer | Psychosis |
| 171 | 4/26/35 | 13811 | F | TCSH | 36 | | Insane | ReligiousF |
| 172 | 4/26/35 | 26528 | M | KSH | 44 | 43 | TTIMD | Insane |
| 173 | 4/26/35 | 2564 | F | YSH | 28 | 28 | TTIMD | AttmptMu |
| 174 | 4/26/35 | 2427 | F | YSH | 32 | | TTIMD | Depressed |
| 175 | 4/26/35 | 2571 | F | MFCE | 21 | | Parole | Epileptic |
| 176 | 4/26/35 | 2702 | F | MFCE | 19 | | Epilepsy | Epileptic |
| 177 | 4/26/35 | 22928 | M | KSH | 42 | | TTIMD | Insane |
| 178 | 4/30/35 | 26539 | M | KSH | 29 | 28 | TTIMD | Insane |
| 179 | 5/10/35 | 26142 | F | KSH | 24 | | TTIMD | Insane |
| 180 | 6/6/35 | Berniece5 | F | TCSH | 23 | | | Hallucinat |
| 181 | 6/6/35 | 8615 | F | MHTS | 18 | | PriorRelease | |
| 182 | 6/6/35 | 14732 | F | TCSH | 36 | 29 | Insane | Childbirth |
| 183 | 6/6/35 | 7519 | F | MHTS | 19 | | Parole | RecOfStA |
| 184 | 6/6/35 | 8285 | F | MHTS | 17 | 15 | Parole | Low IQ |
| 185 | 6/6/35 | 14099 | M | TCSH | 29 | 15 | | Hallucinat |
| 186 | 6/6/35 | 7275 | F | MHTS | 18 | 14 | Parole | DfctSocDv |
| 187 | 6/6/35 | 8243 | F | MHTS | 17 | | Promiscuc | TheftImmo |
| 188 | 7/13/35 | 26399 | M | KSH | 42 | | TTIMD | Insane |
| 189 | 7/20/35 | 26287 | M | KSH | 20 | | TTIMD | Insane |
| 190 | 7/30/35 | 25862 | F | KSH | 27 | 25 | TTIMD | |
| 191 | 7/30/35 | 26603 | F | KSH | 17 | | TTIMD | Insane |
| 192 | 8/3/35 | Myrtle C | F | MHTS | | | | |

| | I | J | K | L |
|---|---|---|---|---|
| 145 | )fct | | | |
| 146 | SchizParanoidSuicidal | | | |
| 147 | PsychoneurosisHys | | | |
| 148 | DP | | | |
| 149 | | | | |
| 150 | Psychotic&Paranoid | | | |
| 151 | ShizoDelusional | | | |
| 152 | DP:HEBE | | | |
| 153 | MD | | | |
| 154 | | | | |
| 155 | | | | |
| 156 | DP:HEBE:ExhPsy | | | |
| 157 | | | | |
| 158 | DP | | | |
| 159 | Moron | | | |
| 160 | DP:Cataleptic | | | |
| 161 | | | | |
| 162 | DP:MD:ExhPsych | | | |
| 163 | | | | |
| 164 | SchizoParanoid | | | |
| 165 | DP:Psychopath | | | |
| 166 | | | | |
| 167 | Home | | | |
| 168 | GenParalysis | | | |
| 169 | | | | |
| 170 | Psychosis | | | |
| 171 | DP:CATA | | | |
| 172 | SexPathology | | | |
| 173 | MD:DP | | | |
| 174 | MD:Depress | | | |
| 175 | Depressive | | | |
| 176 | HysPsychoneurosis | | | |
| 177 | MD:Manic | | | |
| 178 | MD | | | |
| 179 | DP:CATA | | | |
| 180 | Psychosis | | | |
| 181 | | | | |
| 182 | DP:MD | | | |
| 183 | Low IQ | | | |
| 184 | Low IQ | | | |
| 185 | MD:Mixed | | | |
| 186 | Ipmnt | | | |
| 187 | )ral | | | |
| 188 | ParanoidMtlDfct | | | |
| 189 | Psycopathic | | | |
| 190 | DP:CATA | | | |
| 191 | DP:CATA | | | |
| 192 | | | | |

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 193 | 8/3/35 | Eunice C | F | MHTS | | | | |
| 194 | 8/6/35 | 26542 | F | KSH | 22 | | TTIMD | Insane |
| 195 | 8/14/35 | 14385 | F | TCSH | | 30 | Hallucinat | ReligiousF |
| 196 | 8/14/35 | 7924 | F | MHTS | 19 | | Delinquent | |
| 197 | 8/14/35 | 2752 | M | ISH | 30 | | MtlDfcncy | w/Psycho |
| 198 | 8/14/35 | 8/14/35 | F | PSH | 25 | | | |
| 199 | 8/24/35 | 26614 | F | KSH | 23 | | TTIMD | |
| 200 | 8/27/35 | 8137 | F | MHTS | 19 | 16 | Parole | Unmanag |
| 201 | 9/3/35 | 26476 | M | KSH | 35 | 34 | TTIMD | Insane |
| 202 | 9/23/35 | 26667 | M | KSH | 16 | | TTIMD | Insane |
| 203 | 10/1/35 | 25794 | M | KSH | 29 | | TTIMD | Insane |
| 204 | 10/1/35 | 14502 | F | TCSH | 30 | | BrkdwnPre | Delusiona |
| 205 | 10/1/35 | 8716 | M | MHTS | 19 | | Parole | |
| 206 | 10/3/35 | 10/3/35 | F | PSH | 29 | | PrvntPreg | |
| 207 | 10/10/35 | 26672 | F | KSH | 26 | | TTIMD | Insane |
| 208 | 11/4/35 | 2813 | M | ISH | 37 | | Rape | Rape |
| 209 | 11/4/35 | 2697 | M | ISH | 26 | | SexOff | MtlDfncy |
| 210 | 11/18/35 | 8187 | F | MHTS | 22 | | PoorHrd | |
| 211 | 11/27/35 | Floyd11/2: | M | PSH | 40 | | Parole | |
| 212 | 12/4/35 | 8705 | F | MHTS | 19 | 18 | Parole | |
| 213 | 12/4/35 | 26782 | M | KSH | 30 | | TTIMD | Insane |
| 214 | 12/12/35 | 7265 | F | MHTS | 16 | 16 | Low IQ | |
| 215 | 12/12/35 | 7144 | F | MHTS | 16 | 11 | Parole | |
| 216 | 12/12/35 | 2745 | F | MFCE | 25 | | HrmFuture | Generatio |
| 217 | 12/23/35 | Michael11 | M | YSH | 42 | 41 | TTIMD | WifePetitic |
| 218 | 12/23/35 | 6087 | F | NSH | 34 | 28 | Feeblemnd | |
| 219 | 1/18/36 | Susie1/18/ | F | PSH | 46 | 31 | Brckdwn | |
| 220 | 1/21/36 | 26788 | M | KSH | 20 | | TTIMD | Insane |
| 221 | 1/27/36 | 26678 | M | KSH | 32 | | TTIMD | Insane |
| 222 | 1/27/36 | Mary12/1( | F | YSH | 26 | 24 | TTIMD | SisPetition |
| 223 | 1/27/36 | 26883 | F | KSH | | | TTIMD | Insane |
| 224 | 1/27/36 | Eva1/2/36 | F | PSH | 37 | | DprssChldbrth | |
| 225 | 1/27/36 | Angelina1 | F | PSH | 44 | | DprssChldbrth | |
| 226 | 1/28/36 | 26785 | M | KSH | 28 | | TTIMD | Insane |
| 227 | 1/31/36 | 2893 | F | MHTS | 18 | | Parole | |
| 228 | 1/31/36 | 4127 | M | MHTS | 26 | 20 | BadBckgrı | Abadone |
| 229 | 1/31/36 | 14856 | F | TCSH | 66 | | | Epilepsy |
| 230 | 2/1/36 | Zremont2/ | F | PSH | 40 | | 3MtlAttck | |
| 231 | 2/4/36 | 26383 | F | KSH | 23 | | TTIMD | Insane |
| 232 | 2/14/36 | 9070 | F | MHTS | 21 | | LowIQ | |
| 233 | 2/14/36 | 8161 | F | MHTS | 18 | | | |
| 234 | 2/14/36 | 7943 | M | MHTS | 18 | | Parole | |
| 235 | 2/18/36 | 26925 | F | KSH | 27 | | TTIMD | Insane |
| 236 | 3/2/36 | 26803 | M | KSH | 26 | | TTIMD | Insane |
| 237 | 3/10/36 | 26129 | M | KSH | 27 | 25 | TTIMD | Insane |
| 238 | 3/12/36 | 26768 | M | KSH | 26 | | TTIMD | Insane |
| 239 | 3/25/36 | 26604 | M | KSH | 21 | | TTIMD | Insane |
| 240 | 3/31/36 | 14909 | F | TCSH | 39 | | TriedGasC | MD:Depre |

| | I | J | K | L |
|---|---|---|---|---|
| 193 | | | | |
| 194 | MD:Manic | | | |
| 195 | DP:CATA | | | |
| 196 | | | | |
| 197 | CerebralLues | | | |
| 198 | MD:Manic | | | |
| 199 | Insane | | | |
| 200 | Retarded | | | |
| 201 | Psycopathic | | | |
| 202 | DP:HEBE | | | |
| 203 | EpilepticPsych | | | |
| 204 | DP:Psychoneurotic | | | |
| 205 | Low Moron | | | |
| 206 | MD | | | |
| 207 | PsychosisPreg | | | |
| 208 | SexPsychopath | | | |
| 209 | AuditoryHalluc | | | |
| 210 | | | | |
| 211 | Imbecility | | | |
| 212 | Retarded | | | |
| 213 | Hallucinated | | | |
| 214 | Retarded | | | |
| 215 | Retarded | | | |
| 216 | EpilepticHallucinated | | | |
| 217 | GenParesis | | | |
| 218 | | | | |
| 219 | | | | |
| 220 | DP:CATA | | | |
| 221 | Schizoid | | | |
| 222 | DP:HEBE | | | |
| 223 | DP:CATA | | | |
| 224 | | | | |
| 225 | | | | |
| 226 | Parkinson's | | | |
| 227 | | | | |
| 228 | Feeblemnd | | | |
| 229 | EpilepticPsychosis | | | |
| 230 | MD:Paranoid | | | |
| 231 | SchizCata | | | |
| 232 | MtlDfcnt | | | |
| 233 | MtlDfctv | | | |
| 234 | MtlDfctv | | | |
| 235 | DP:Autisitic | | | |
| 236 | DP:Paranoid | | | |
| 237 | Schiz:CataExctmnt | | | |
| 238 | DP | | | |
| 239 | Epilepsy | | | |
| 240 | ss | | | |

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 241 | 3/31/36 | 26948 | F | KSH | 28 | | TTIMD | Insane |
| 242 | 3/31/36 | 14327 | F | TCSH | 32 | | | OvrActvty |
| 243 | 3/31/36 | 6065 | M | MHTS | 19 | 11 | Parole | |
| 244 | 3/31/36 | 25823 | M | KSH | 32 | | TTIMD | Insane |
| 245 | 4/8/36 | 26960 | M | KSH | 41 | | TTIMD | Insane |
| 246 | 4/10/36 | 26886 | M | KSH | 33 | | TTIMD | Insane |
| 247 | 4/27/36 | 24517 | M | KSH | 23 | 21 | TTIMD | Insane |
| 248 | 5/25/36 | 2869 | F | YSH | 27 | 24 | TTIMD | Suicidal |
| 249 | 5/25/36 | GeorgeT | M | PSH | | | | Insane |
| 250 | 5/25/36 | 6935 | M | MHTS | 19 | 14 | PrvBhvr/Pc | fromStSch |
| 251 | 5/25/36 | 8996 | M | MHTS | 18 | 16 | Parole | |
| 252 | 7/10/36 | 25883 | M | ISH | 20 | | | |
| 253 | 7/13/36 | 26788 | M | KSH | 20 | | TTIMD | Insane |
| 254 | 7/14/36 | 26233 | M | KSH | 32 | | TTIMD | Insane |
| 255 | 7/14/36 | Ina J | F | NSH | 32 | | No Preg | |
| 256 | 7/28/36 | Mabel5/1 | F | PSH | 34 | 32 | UnfitParent | |
| 257 | 8/10/36 | 26898 | F | KSH | 28 | | TTIMD | InsaneSuic |
| 258 | 8/14/36 | Ina7/13/3( | F | NSH | 33 | | | Cata:Suic |
| 259 | 8/14/36 | 8763 | F | MHTS | 17 | 15 | Parole | |
| 260 | 8/14/36 | 6538 | F | NSH | 22 | | | Hallucinat |
| 261 | 8/14/36 | 26874 | M | KSH | 20 | | TTIMD | Insane |
| 262 | 8/20/36 | 14831 | F | TCSH | 32 | 32 | | Suicidal |
| 263 | 9/9/36 | Mabel E | F | PSH | 21 | | | Insane |
| 264 | 9/22/36 | 9283 | M | MHTS | 16 | | Parole | |
| 265 | 9/22/36 | 26991 | F | KSH | 23 | | TTIMD | InsaneSuic |
| 266 | 9/22/36 | 27071 | F | KSH | 27 | | TTIMD | Insane |
| 267 | 10/21/36 | 26951 | M | KSH | 18 | | TTIMD | Insane |
| 268 | 10/21/36 | 26993 | M | KSH | 24 | | TTIMD | Insane |
| 269 | 10/23/36 | 25063 | M | R&WelfCor | | | | |
| 270 | 11/5/36 | Laverne S | M | IR | | | | |
| 271 | 12/5/36 | 25876 | M | :Shiawasee | 23 | | | |
| 272 | 12/7/36 | 27563 | M | R&WelCon | 23 | | | |
| 273 | 12/12/36 | 2820 | F | MFCE | 23 | | | |
| 274 | 12/16/36 | 8670 | M | MHTS | 16 | 14 | Parole | CourtOrdr |
| 275 | 12/17/36 | 26316 | M | R&WelfCor | 21 | | | |
| 276 | 12/18/36 | 14533 | M | TCSH | 58 | | Parole | IndcntLibC |
| 277 | 12/18/36 | 2870 | F | MFCE | 23 | | Parole | |
| 278 | 12/18/36 | 26924 | F | KSH | 31 | | TTIMD | Insane |
| 279 | 12/18/36 | 26893 | F | KSH | 31 | | TTIMD | Insane |
| 280 | 12/18/36 | Leo11/3/3 | M | PSH | 22 | | ReduceMasturbatior | |
| 281 | 12/18/36 | 27194 | F | KSH | 28 | 28 | TTIMD | Insane |
| 282 | 12/18/36 | 13955 | F | TCSH | 20 | 16 | | Pyromanic |
| 283 | 12/18/36 | 7036 | M | MHTS | 19 | 13 | Parole | |
| 284 | 12/18/36 | 26983 | M | KSH | 26 | | TTIMD | Insane |
| 285 | 12/18/36 | 2792 | F | MFCE | 16 | | Parole | Epilepsy |
| 286 | 12/21/36 | 2926 | M | ISH | 34 | 34 | Pervert | |
| 287 | 12/21/36 | 2878 | F | ISH | 27 | 27 | PrvntFeeb | Feeblemn |
| 288 | 12/21/36 | 3156 | F | YSH | 38 | | TTIMD | Insane |

| | I | J | K | L |
|---|---|---|---|---|
| 241 | DP | | | |
| 242 | MD:Manic | | | |
| 243 | MtlDfctv | | | |
| 244 | MtlDfcncy | | | |
| 245 | DP | | | |
| 246 | MtlDfctPathDetr | | | |
| 247 | MD:DP | | | |
| 248 | MD:Endocrine | | | |
| 249 | ParanoidAlc | | | |
| 250 | MtlDfcnt | | | |
| 251 | | | | |
| 252 | | | | |
| 253 | DP:CATA | | | |
| 254 | GenParalysis | | | |
| 255 | Depression | | | |
| 256 | DP | | | |
| 257 | DP:PsychStupor | | | |
| 258 | dal | | | |
| 259 | Low IQ | | | |
| 260 | DP:2ndAdmit | | | |
| 261 | DP:CATA | | | |
| 262 | DP:Paranoid | | | |
| 263 | | | | |
| 264 | | | | |
| 265 | DP:MD | | | |
| 266 | MD:Depress | | | |
| 267 | Psych/MtlDfcncy | | | |
| 268 | DP:Delusional | | | |
| 269 | | | | |
| 270 | | | | |
| 271 | | | | |
| 272 | | | | |
| 273 | Epilepsy | | | |
| 274 | Feeblemnd | | | |
| 275 | | | | |
| 276 | MtlDfcncy | | | |
| 277 | Epileptic | | | |
| 278 | SyphilisCNS | | | |
| 279 | Syph/Psychosis | | | |
| 280 | ChronicSchiz | | | |
| 281 | DP | | | |
| 282 | Psych/MtlDfcnt | | | |
| 283 | Feeblemnd | | | |
| 284 | DP:CATA | | | |
| 285 | Idiopathic | | | |
| 286 | MtlDfcncy | | | |
| 287 | PstPartumPsych | | | |
| 288 | MD:Manic | | | |

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 289 | 12/21/36 | 8500 | F | MHTS | 19 | 17 | Parole | Delinquer |
| 290 | 12/23/36 | Floyd11/2. | M | PSH | 40 | 22 | | Asocial |
| 291 | 12/28/36 | 2659 | M | MHTS | 25 | | Parole | |
| 292 | 1/22/37 | 8670 | M | MHTS | 16 | | Parole | |
| 293 | 1/29/37 | 22304 | M | IR | | | | |
| 294 | 1/29/37 | 28353 | M | IR | | | | |
| 295 | 1/29/37 | 25876 | M | IR | | | | |
| 296 | 1/29/37 | 26316 | M | IR | | | | |
| 297 | 1/29/37 | 26799 | M | IR | | | | |
| 298 | 1/29/37 | 23915 | M | IR | | | | |
| 299 | 1/29/37 | 27563 | M | IR | | | | |
| 300 | 1/29/37 | 26934 | M | IR | | | | |
| 301 | 2/12/37 | 2833 | F | MFCE | 26 | | | |
| 302 | 2/15/37 | 26934 | M | IR | | | PriorToRelease | |
| 303 | 2/18/37 | 15130 | F | TCSH | 30 | | | InsaneVio |
| 304 | 2/18/37 | 13063 | F | TCSH | 28 | | | Insane |
| 305 | 2/18/37 | 14998 | F | TCSH | 25 | | | |
| 306 | 2/18/37 | 2826 | F | MFCE | 23 | | | |
| 307 | 2/25/37 | 6270 | M | MHTS | 21 | 11 | Parole | |
| 308 | 2/25/37 | Nellie1/20. | F | NSH | 38 | | | |
| 309 | 2/25/37 | 9283 | M | MHTS | 17 | 16 | | |
| 310 | 3/17/37 | 2833 | F | MFCE | 26 | | TTIMD | Violence^ |
| 311 | 3/18/37 | 26893 | M | IR | | | AllowRelease | |
| 312 | 3/18/37 | 26801 | M | IR | | | AllowRelease | |
| 313 | 3/18/37 | 24478 | M | IR | | | | |
| 314 | 4/26/37 | 9230 | M | MHTS | | 20 | Parole | Dependei |
| 315 | 4/26/37 | 7288 | F | MHTS | 20 | 14 | Parole | Dependei |
| 316 | 4/26/37 | 14709 | M | TCSH | 26 | | | Delusiona |
| 317 | 4/26/37 | 15304 | F | TCSH | 24 | | | Confused |
| 318 | 5/28/37 | 1799 | M | YSH | 46 | 42 | TTIMD | Insane |
| 319 | 5/28/37 | 27274 | F | KSH | 30 | | TTIMD | Insane |
| 320 | 5/28/37 | 14661 | F | TCSH | 21 | | | |
| 321 | 5/28/37 | 15367 | M | TCSH | 40 | | | |
| 322 | 5/28/37 | 5325 | M | MHTS | 32 | 20 | Parole | Dependei |
| 323 | 6/7/37 | 27777 | M | IR | 22 | | | |
| 324 | 7/20/37 | 3430 | F | YSH | 39 | | TTIMD | Insane |
| 325 | 7/22/37 | 8487 | M | MHTS | 19 | 15 | Parole | Delinquer |
| 326 | 7/22/37 | 3358 | F | YSH | 25 | | TTIMD | Insane |
| 327 | 7/22/37 | 2710 | M | ISH | 29 | | | |
| 328 | 7/22/37 | 7/22/37 | F | PSH | 28 | | | |
| 329 | 12/8/37 | 27512 | M | KSH | 31 | | TTIMD | Insane |
| 330 | 12/8/37 | 27401 | M | KSH | 49 | | TTIMD | Insane |
| 331 | 12/8/37 | 27322 | M | KSH | 28 | | TTIMD | Insane |
| 332 | 12/8/37 | 27578 | M | KSH | 35 | | TTIMD | Insane |
| 333 | 12/8/37 | 27412 | M | KSH | 38 | | TTIMD | InsaneVio |
| 334 | 6/27/46 | 25057 | F | KSH | 24 | 18 | TTIMD | Insane |
| 335 | 3//1/34 | 26118 | M | KSH | 32 | | TTIMD | |
| 336 | 3//22/34 | 25135 | F | KSH | 24 | | TTIMD | |

| | I | J | K | L |
|---|---|---|---|---|
| 289 | Feeblemnd | | | |
| 290 | Imbelicity | | | |
| 291 | MtlDfctv | | | |
| 292 | | | | |
| 293 | MtlDfcncySxPsypth | | | |
| 294 | FblmndHyprSx | | | |
| 295 | | | | |
| 296 | BordrlnDfctv | | | |
| 297 | FeeblmndSxPsyPth | | | |
| 298 | DfctvSxAct | | | |
| 299 | MtlDfctSxPsypth | | | |
| 300 | MtlDfcncy | | | |
| 301 | | | | |
| 302 | | | | |
| 303 | DP:HEBE | | | |
| 304 | DP:CATA | | | |
| 305 | OnsetChldbrth | | | |
| 306 | Epilepsy | | | |
| 307 | | | | |
| 308 | Huntington's | | | |
| 309 | | | | |
| 310 | EpilepsyAge11 | | | |
| 311 | | | | |
| 312 | | | | |
| 313 | SexDevntFblmnd | | | |
| 314 | Retarded | | | |
| 315 | ht | | | |
| 316 | DP:Paranoid | | | |
| 317 | DP:CATA | | | |
| 318 | EpilepticViolent | | | |
| 319 | PsychoneurosisHys | | | |
| 320 | MtlDfctv | | | |
| 321 | DP | | | |
| 322 | Retarded | | | |
| 323 | SxPrvrtPsypth | | | |
| 324 | DP | | | |
| 325 | t | | | |
| 326 | Psych/MtlDfcncy | | | |
| 327 | MtlDfcncySchiz | | | |
| 328 | | | | |
| 329 | GenParesisVD | | | |
| 330 | MthDfcntPsych | | | |
| 331 | | | | |
| 332 | DP:MD | | | |
| 333 | SchizParanoid | | | |
| 334 | PsychMtlDfcncy | | | |
| 335 | DP:Hebe | | | |
| 336 | PsychoneurosisHysType | | | |

Appendix C
Chart B

Sterilizations by State through January 1, 1936
As Compiled by the Human Betterment Foundation

| | A | B | C | D | E | F | G | H | I | J | K | L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | State | Diagnosis | | | | | | | | | Sex | |
| 2 | | Insane | | | Feebleminded | | | Others | | | | |
| 3 | | Male | Female | Total | Male | Female | Total | Male | Female | Total | Male | Female |
| 4 | Alabama | | | | 129 | 95 | 224 | | | | 129 | 95 |
| 5 | Arizona | 10 | 10 | 20 | | | | | | | 10 | 10 |
| 6 | California | 4208 | 3222 | 7430 | 1397 | 1974 | 3371 | | | | 5605 | 5196 |
| 7 | Connecticut | 18 | 316 | 334 | 4 | 45 | 49 | | | | 22 | 361 |
| 8 | Delaware | 178 | 57 | 235 | 65 | 139 | 204 | | 13 | 13 | 245 | 209 |
| 9 | Idaho | 2 | 10 | 12 | 2 | | 2 | | | | 4 | 10 |
| 10 | Indiana | 5 | 30 | 35 | 260 | 143 | 403 | | | | 265 | 173 |
| 11 | Iowa | 56 | 38 | 94 | 4 | | 4 | | | | 60 | 38 |
| 12 | Kansas | 662 | 460 | 1122 | 245 | 101 | 346 | 15 | 26 | 41 | 922 | 587 |
| 13 | Maine | | 4 | 4 | 13 | 78 | 91 | | 21 | 21 | 13 | 103 |
| 14 | Michigan | 29 | 151 | 180 | 279 | 1056 | 1335 | 23 | 5 | 40 | 345 | 1,212 |
| 15 | Minnesota | 83 | 239 | 322 | 89 | 743 | 832 | | | | 172 | 982 |
| 16 | Mississippi | 87 | 216 | 303 | | | | | | | 87 | 216 |
| 17 | Montana | 12 | 13 | 25 | 22 | 45 | 67 | | | | 34 | 58 |
| 18 | Nebraska | 53 | 90 | 143 | 66 | 88 | 154 | | | | 119 | 178 |
| 19 | New Hampshire | 22 | 133 | 155 | 22 | 84 | 106 | | 49 | 49 | 44 | 266 |
| 20 | New York | | 41 | 41 | | | | 1 | | 1 | 1 | 41 |
| 21 | North Carolina | 24 | 47 | 71 | 17 | 138 | 155 | 12 | 54 | 66 | 53 | 239 |
| 22 | North Dakota | 61 | 95 | 156 | 17 | 99 | 116 | | | | 78 | 194 |
| 23 | Oklahoma | 38 | 26 | 64 | | 4 | 4 | | | | 38 | 30 |
| 24 | Oregon | 185 | 240 | 425 | 152 | 397 | 549 | 13 | 60 | 73 | 350 | 697 |
| 25 | South Carolina | | | | | | | | | | | |
| 26 | South Dakota | | 3 | 3 | 93 | 180 | 273 | | | | 93 | 183 |
| 27 | Utah | 44 | 41 | 85 | | 1 | 3 | 4 | | | 45 | 44 |
| 28 | Vermont | | | | 36 | 78 | 114 | | | | 36 | 78 |
| 29 | Virginia | 622 | 826 | 1,448 | 367 | 571 | 938 | | | | 989 | 1,397 |
| 30 | Washington | 14 | 39 | 53 | 1 | 26 | 27 | | | | 15 | 65 |
| 31 | West Virginia | | 10 | 10 | | | | | | | | 10 |
| 32 | Wisconsin | | | | 87 | 637 | 724 | | | | 87 | 637 |
| 33 | Total | 6,413 | 6,357 | 12,770 | 3,368 | 6,724 | 10,092 | 76 | 228 | 304 | 9,857 | 13,309 |

The figures by diagnosis from Michigan, Iowa and Indiana are to a very small degree the result of careful

estimate, as accurate statistics were lacking in regard to a few of the operations; but are substantially correct.

Chart C: Appendix C: Sterilizations In Michigan as reported to the Human Betterment Foundation

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 1 | YEAR | MALE | FEMALE | TOTAL | MALE INSANE | FEMALE INSANE | TOTAL INSANE | MALE FEEBLE |
| 2 | 1930 | 62 | 326 | 388 | | | | |
| 3 | 1931 | | | | | | | |
| 4 | 1932 | | | | | | | |
| 5 | 1933 | 264 | 819 | 1083 | | | | |
| 6 | 1934 | | | | | | | |
| 7 | 1935 | 307 | 932 | 1239 | | | | |
| 8 | YearTotal | 36 | 280 | 316 | | | | |
| 9 | 1936 | 343 | 1212 | 1555 | 29 | 151 | 180 | 279 |
| 10 | YearTotal | 38 | 103 | 141 | 31 | 51 | 82 | 33 |
| 11 | 1937 | 381 | 1315 | 1696 | 60 | 202 | 262 | 312 |
| 12 | 1938 | | | | | | | |
| 13 | 1939 | | | | | | | |
| 14 | 1940 | | | | | | | |
| 15 | 1941 | 513 | 1632 | 2145 | 71 | 234 | 305 | 417 |
| 16 | 1942 | | | | | | | |
| 17 | 1943 | | | | | | | |
| 18 | 1944 | 606 | 1860 | 2466 | 72 | 253 | 325 | 495 |
| 19 | YearTotal | 30 | 77 | 107 | 0 | 8 | 8 | 30 |
| 20 | 1945 | 636 | 1937 | 2573 | 72 | 261 | 333 | 525 |
| 21 | YearTotal | 24 | 62 | 84 | 0 | 6 | 6 | 23 |
| 22 | 1946 | 660 | 1999 | 2659 | 72 | 267 | 339 | 548 |
| 23 | YearTotal | 19 | 56 | 75 | 0 | 12 | 12 | 22 |
| 24 | 1947 | 679 | 2055 | 2734 | 72 | 279 | 351 | 566 |
| 25 | YearTotal | 52 | 65 | 117 | 0 | 12 | 12 | 49 |
| 26 | 1948 | 731 | 2120 | 2851 | 72 | 291 | 363 | 615 |
| 27 | YearTotal | 64 | 67 | 131 | 0 | 0 | 0 | 64 |
| 28 | 1949 | 795 | 2187 | 2982 | 72 | 291 | 363 | 679 |
| 29 | YearTotal | 31 | 57 | 88 | 4 | 3 | 7 | 27 |
| 30 | 1950 | 826 | 2244 | 3070 | 76 | 294 | 370 | 706 |
| 31 | YearTotal | 19 | 53 | 72 | 0 | 1 | 1 | 19 |
| 32 | 1951 | 845 | 2297 | 3142 | 76 | 295 | 371 | 725 |
| 33 | YearTotal | 0 | 65 | 65 | 0 | 30 | 30 | 0 |
| 34 | 1952 | 845 | 2362 | 3207 | 76 | 325 | 401 | 725 |
| 35 | YearTotal | 22 | 59 | 81 | 0 | 4 | 4 | 21 |
| 36 | 1953 | 867 | 2421 | 3288 | 76 | 329 | 405 | 746 |
| 37 | YearTotal | 31 | 72 | 103 | 0 | 6 | 6 | 25 |
| 38 | 1954 | 898 | 2493 | 3391 | 76 | 335 | 411 | 771 |
| 39 | YearTotal | 11 | 60 | 71 | 0 | 6 | 6 | 11 |
| 40 | 1955 | 909 | 2553 | 3462 | 76 | 341 | 417 | 782 |
| 41 | YearTotal | 22 | 39 | 61 | 0 | 5 | 5 | 16 |
| 42 | 1956 | 931 | 2592 | 3523 | 76 | 346 | 422 | 798 |
| 43 | YearTotal | 2 | 25 | 27 | 0 | 5 | 5 | 0 |
| 44 | 1957 | 933 | 2617 | 3550 | 76 | 351 | 427 | 798 |
| 45 | Year Total | 25 | 22 | 47 | 0 | 2 | 2 | 13 |
| 46 | 1958 | 958 | 2639 | 3597 | 76 | 353 | 429 | 811 |
| 47 | YearTotal | 11 | 28 | 39 | 0 | 1 | 1 | 3 |
| 48 | 1959 | 969 | 2667 | 3636 | 76 | 354 | 430 | 814 |

Chart C: Appendix C: Sterilizations In Michigan as reported to the Human Betterment Foundation

| | A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|---|
| 49 | YearTotal | 5 | 22 | 27 | 0 | 2 | 2 | 2 |
| 50 | 1960 | 974 | 2689 | 3663 | 76 | 356 | 432 | 816 |
| 51 | | | | | | | | |
| 52 | 1961 | | | | | | | |
| 53 | 1962 | 985 | 2742 | 3727 | 77 | 359 | 436 | 818 |
| 54 | YearTotal | 3 | 23 | 26 | 0 | 3 | 3 | 1 |
| 55 | 1963 | 988 | 2765 | 3753 | 77 | 362 | 439 | 819 |
| 56 | YearTotal | 3 | 30 | 33 | 0 | 1 | 1 | 2 |
| 57 | 1964 | 991 | 2795 | 3786 | 77 | 363 | 440 | 821 |

Chart C: Appendix C: Sterilizations In Michigan as reported to the Human Betterment Foundation

| | I | J | K | L | M |
|---|---|---|---|---|---|
| 1 | FEMALE FEEBLE | TOTAL FEEBLE | MALE OTHER | FEMALE OTHER | TOTAL OTHER |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |
| 6 | | | | | |
| 7 | | | | | |
| 8 | | | | | |
| 9 | 1056 | 1335 | 35 | 5 | 40 |
| 10 | 36 | 39 | | | |
| 11 | 1092 | 1404 | 9 | 21 | 30 |
| 12 | | | | | |
| 13 | | | | | |
| 14 | | | | | |
| 15 | 1324 | 1741 | 25 | 74 | 99 |
| 16 | | | | | |
| 17 | | | | | |
| 18 | 1467 | 1962 | 39 | 140 | 179 |
| 19 | 65 | 95 | 0 | 4 | 4 |
| 20 | 1532 | 2057 | 39 | 144 | 183 |
| 21 | 53 | 76 | 1 | 3 | 4 |
| 22 | 1585 | 2133 | 40 | 147 | 187 |
| 23 | 39 | 61 | 1 | 5 | 6 |
| 24 | 1624 | 2190 | 41 | 152 | 193 |
| 25 | 51 | 100 | 3 | 2 | 5 |
| 26 | 1675 | 2290 | 44 | 154 | 198 |
| 27 | 62 | 124 | 0 | 5 | 5 |
| 28 | 1737 | 2416 | 44 | 159 | 203 |
| 29 | 44 | 71 | 0 | 10 | 10 |
| 30 | 1781 | 2487 | 44 | 169 | 213 |
| 31 | 47 | 66 | 0 | 5 | 5 |
| 32 | 1828 | 2553 | 44 | 174 | 218 |
| 33 | 33 | 33 | 0 | 2 | 2 |
| 34 | 1861 | 2586 | 44 | 176 | 220 |
| 35 | 51 | 72 | 1 | 4 | 5 |
| 36 | 1912 | 2658 | 45 | 180 | 225 |
| 37 | 52 | 77 | 6 | 14 | 20 |
| 38 | 1964 | 2735 | 51 | 194 | 245 |
| 39 | 36 | 47 | 0 | 18 | 18 |
| 40 | 2000 | 2782 | 51 | 212 | 263 |
| 41 | 34 | 50 | 6 | 0 | 6 |
| 42 | 2034 | 2832 | 57 | 212 | 269 |
| 43 | 11 | 11 | 2 | 9 | 11 |
| 44 | 2045 | 2843 | 59 | 221 | 280 |
| 45 | 8 | 21 | 12 | 12 | 24 |
| 46 | 2053 | 2864 | 71 | 233 | 304 |
| 47 | 13 | 16 | 8 | 14 | 22 |
| 48 | 2066 | 2880 | 79 | 247 | 326 |

Chart C: Appendix C: Sterilizations In Michigan as reported to the Human Betterment Foundation

| | I | J | K | L | M |
|---|---|---|---|---|---|
| **49** | 8 | 10 | 3 | 12 | 15 |
| **50** | 2074 | 2890 | 82 | 259 | 341 |
| **51** | | | | | |
| **52** | | | | | |
| **53** | 2090 | 2908 | 90 | 293 | 383 |
| **54** | 8 | 9 | 2 | 12 | 14 |
| **55** | 2098 | 2917 | 92 | 305 | 397 |
| **56** | 8 | 10 | 1 | 21 | 22 |
| **57** | 2106 | 2927 | 93 | 326 | 419 |

Sterilizations performed at the University of Michigan Hospital, 1925-1935
Chart D Appendix C

| YEAR | MALE | FEMALE | YEAR TOTAL | TOTAL |
|---|---|---|---|---|
| 1925 | 0 | 3 | 3 | 3 |
| 1926 | 1 | 2 | 3 | 6 |
| 1927 | 0 | 3 | 3 | 9 |
| 1928 | 0 | 7 | 7 | 16 |
| 1929 | 2 | 14 | 16 | 32 |
| 1930 | 4 | 48 | 52 | 84 |
| 1931 | 10 | 69 | 79 | 163 |
| 1932 | 15 | 95 | 110 | 273 |
| 1933 | 3 | 24 | 27 | 300 |
| 1934 | 1 | 14 | 15 | 315 |
| 1935 | 0 | 1 | 1 | 316 |
| 10YR TOTAL | 36 | 280 | 316 | |

Chart E
Appendix C
1936:Sterilizations by Diagnosis in Michigan

| | A | B |
|---|---|---|
| 1 | Diagnosis | Patients |
| 2 | Schizophrenia | 49 |
| 3 | ManicDepression | 38 |
| 4 | ToxicOrganicSomatic | 12 |
| 5 | Paresis | 7 |
| 6 | Epilepsy/Psychosis | 12 |
| 7 | Epilepsy w/o Psych | 8 |
| 8 | MentalDef. w/Psych | 42 |
| 9 | MentalDef. w/o Psych | 37 |
| 10 | Psychoneurosis | 11 |
| 11 | Psychopathic Pesonality | 11 |
| 12 | Psychic inferioirity | 1 |
| 13 | Sex Perversion | 4 |
| 14 | Undiagnosed Psychosis | 8 |
| 15 | Unknown | 8 |

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