ENDING COERCED STERILIZATION IN IMMIGRATION DETENTION

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Abstract

Recent reports of coerced sterilizations at the Irwin County Detention Center sparked nationwide public outcry. Yet systemic change to prevent ongoing coerced sterilizations in the U.S. immigration detention system remains to be seen. This Article analyzes potential factors that allowed coerced sterilizations to occur at the Irwin County Detention Center, including the historical influence of eugenics on U.S. policy and issues with informed consent and oversight. In particular, this Article highlights how the use of private contractors to operate ICE detention centers prevents meaningful oversight of immigration detention centers and contributes to issues with inadequate and abusive medical care. This Article concludes by providing recommendations for reforming ICE policy to prevent future coerced sterilizations, including (1) passing federal legislation modeled after California's S.B. 1135, a recently passed law aimed at addressing coerced sterilizations in the prison system; (2) revising ICE's Performance-Based National Detention Standards; (3) ending the use of privatized of immigration detention centers; and (4) adopting legislative reforms to improve oversight mechanisms for detention facilities.

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INTRODUCTION

In September 2020, the nation awoke to a chilling account of the inner workings of the Irwin County Detention Center (ICDC), an immigration detention center in Ocilla, Georgia.[1] In a complaint filed by Project South with the Department of Homeland Security (DHS), Office of the Inspector General, Dawn Wooten, a nurse at the ICDC recounted how an unusually large number of women at the detention center received hysterectomies.[2] Wooten also raised concern that women at ICDC who had hysterectomies did not fully understand why they needed the procedure.[3]

Project South's complaint sparked national outrage and a call from legislators for further investigation.[4] For some, the complaint evoked memories of similar abuses. In an interview, Nancy Pelosi, former speaker of the U.S. House of Representatives, stated, "[t]his profoundly disturbing situation recalls some of the darkest moments of our nation's history, from the exploitation of Henrietta Lacks, to the horror of the Tuskegee Syphilis Study, to the forced sterilizations of Black women that Fannie Lou Hamer and so many others underwent and fought."[5] The

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1. *See* PROJECT SOUTH ET AL., LACK OF MEDICAL CARE, UNSAFE WORK PRACTICES, AND ABSENCE OF ADEQUATE PROTECTION AGAINST COVID-19 FOR DETAINED IMMIGRANTS AND EMPLOYEES ALIKE AT THE IRWIN COUNTY DETENTION CENTER 18–20 (2020).

2. *Id.*

3. *Id.* at 19.

4. Letter from Pramila Jayapal et al. to U.S. Department of Homeland Security Inspector General Joseph V. Cuffari (Sept. 15, 2020), https://jayapal.house.gov/wp-content/uploads/2020/09/DHS-IG-FINAL.pdf.

5. Rachel Treisman, *Whistleblower Alleges 'Medical Neglect, 'Questionable Hysterectomies of ICE Detainees*, NPR (Sept. 16, 2020, 4:43 AM), https://www.npr.org/2020/09/16/913398383/whistleblower-alleges-medical-neglect-questionable-hysterectomies-of-ice-detaine.

outcry over Project South's complaint also led DHS Secretary Alejandro Mayorkas to announce that the agency would sever its contracts with LaSalle Corrections, the private prison company running the ICDC.[6] However, it is unclear if the coerced sterilizations at ICDC are part of a larger pattern of similar abuses at immigration detention centers. Additionally, change at the federal level to prevent future coerced sterilizations from occurring at immigration detention centers remains to be seen.

This Article focuses on lack of informed consent and oversight as potential issues that led to reports of coerced sterilizations in immigration detention centers and will likely lead to further coerced sterilizations if not addressed. Ultimately, this Article concludes that inadequate oversight is likely a greater factor than lack of informed consent in creating an environment allowing for coerced sterilizations at immigration detention centers. However, this Article also provides recommendations for improving ICE's policies regarding informed consent. This Article also examines the role of privatization as a factor leading to oversight difficulties that enable ongoing coerced sterilizations. In order to address issues with inadequate informed consent and oversight, this Article argues that federal legislation is necessary and proposes (1) passing federal legislation modeled after California's S.B. 1135, a California law aimed at addressing coerced sterilizations in the prison system;[7] (2) revising ICE's Performance-Based National Detention Standards ("PBNDS"); (3) ending the privatization of immigration detention; and (4) modifying existing ICE policy to improve oversight mechanisms for immigration detention centers.

This Article proceeds in four parts. Part I provides a historical overview of coerced sterilization and immigration restrictions in the U.S. Part II discusses how reports of coerced sterilizations at the ICDC fit into a larger pattern of population control measures carried out by the U.S. government and private actors. This section also explains why the coerced sterilizations at ICDC raise questions about issues with informed consent and oversight at immigration detention centers. Part III elaborates on why lack of informed consent and oversight are factors that likely enable coerced sterilizations. In particular, this section highlights issues with oversight of privatized immigration detention centers. Part IV discusses potential legislative changes to address the issues with informed consent and oversight raised in Part III.

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6. Ben Fox & Kate Brumback, *U.S. Ends Use of 2 Immigration Jails Accused of Mistreatment*, AP (May 20, 2021, 5:43 PM), https://apnews.com/article/immigration-government-and-politics-cfa4dbb16a9db9bb25d9cd0db873a32a.

7. Phyllida Burlingame, *Stop Sterilization Abuse in California Prisons*, ACLU NOR. CAL. (Aug. 1, 2014), https://www.aclunc.org/blog/stop-sterilization-abuse-california-prisons.

I. COERCED STERILIZATION AND POPULATION CONTROL IN THE UNITED STATES

A. *History of Coerced Sterilizations*

Sterilization[8] is a popular form of permanent birth control that individuals seek for both medical and personal reasons.[9] While sterilization has many potential benefits for those who choose to undertake such procedures, the U.S. has a long history of performing coerced sterilizations.[10] Project South's complaint reflects this larger

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8. Sterilization refers to surgical procedures that leave an individual permanently unable to reproduce. Common forms of sterilization include tubal ligation and hysterectomy (most commonly for women) and vasectomy (most commonly for men). Melissa Conrad Stöppler, *Birth Control: Surgical Sterilization*, MEDICINENET https://www.medicinenet.com/surgical_sterilization/article.htm (last visited Dec. 16, 2021). Tubal ligation and vasectomy are considered permanent forms of birth control, even though the procedures may be reversible in some cases. *Tubal Ligation Reversal*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/tubal-ligation-reversal/about/pac-20395158 (last visited Dec. 16, 2021); *Vasectomy Reversal*, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/vasectomy-reversal/about/pac-20384537 (last visited Dec. 16, 2021). "Tubal ligation seals off the fallopian tubes by either clamping, snipping and sealing, or tying then cutting and sealing them." Dawn Stacey, *Tubal Ligation Surgery: Everything You Need to Know*, VERYWELL HEALTH (Dec. 13, 2021), https://www.verywellhealth.com/getting-your-tubes-tied-906939. The procedure is typically done through a laparoscopy or mini-lap. These are done by inserting a viewing instrument and surgical tools through two small incisions (laparoscopy) or one small incision (mini-lap) in the abdomen. *Tubal Ligation Surgery*, U. MICH. HEALTH, https://www.uofmhealth.org/health-library/hw7305 (last visited Dec. 18, 2021). Vasectomy is a surgical procedure that involves cutting or sealing the tubes that carry sperm to permanently prevent pregnancy. *Vasectomy,* WEBMD, https://www.webmd.com/sex/birth-control/vasectomy-overview (last visited Dec. 18, 2021). Hysterectomy, by contrast, is a far more invasive procedure that involves the complete removal of the uterus, and, in some cases, the cervix, ovaries, fallopian tubes, and other surrounding structures such as the womb. *Hysterectomy*, NAT'L. HEALTH SERV., https://www.nhs.uk/conditions/hysterectomy (last updated Oct. 11, 2022). For some, losing a womb may profoundly impact one's sense of identity in a way that a tubal ligation or vasectomy might not. *See, e.g.*, Alicia Armeli, *Who Am I Without My Uterus? The Psychological, Social, and Cultural Stigmas of Hysterectomy*, HUFFINGTON POST (Oct. 20, 2015), https://www.huffpost.com/entry/hysterectomy-stigma_b_8247954.

9. *See Key Statistics from the National Survey of Family Growth - C Listing*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nsfg/key_statistics/c.htm#currentuse (last updated June 29, 2020) (comparing rates of usage for various birth control methods); I. Cori Baili et al., *Counseling Issues in Tubal Sterilization*, 77 AM. FAM. PHYSICIAN 1287, 1288 (2003) (describing some of the advantages and disadvantages of permanent sterilization procedures).

10. Philip R. Reilly, *Eugenics and Involuntary Sterilization: 1907-2015*, 16 ANN. REV. GENOMICS HUM. GENETICS 351, 354 (2015). *See infra* notes 15-57. This paper defines coerced sterilization broadly as sterilization procedures performed without informed consent. This definition encompasses sterilization procedures performed on an individual without their knowledge and instances in which an individual is pressured into undergoing a sterilization

pattern of population control measures carried out by the U.S. government and private actors directed at immigrants and Black, Latinx, and indigenous communities.[11]

Early U.S. laws authorizing coerced sterilizations coincided largely with the emergence of the eugenics movement, a pseudoscience premised on the belief that a wide range of traits—including everything from intelligence to poverty—had a genetic basis.[12] Proponents of the eugenics movement argued that coerced sterilization was necessary to curtail the reproduction of the "unfit."[13] In reflecting on the eugenics movement, some scholars say that the eugenics movement essentially became an economic movement aimed at reducing the number of Americans relying on welfare programs.[14]

In 1907, Indiana became the first state to enact a eugenic sterilization law.[15] The Indiana law allowed for the forcible sterilization of "confirmed criminals, idiots, imbeciles, and rapists" if two or more surgeons outside agreed with an institution's physician that there was no prognosis for a person's improvement.[16] Eventually, a total of thirty-two states enacted similar federally-funded sterilization programs, resulting in an estimated 70,000 coerced sterilizations during the twentieth century.[17]

The U.S. Supreme Court first upheld the practice of coerced sterilization in the 1927 case *Buck v. Bell*,[18] with Justice Oliver Wendell Holmes, Jr.'s infamous line, "Three generations of imbeciles are enough."[19] The plaintiff of the case, Carrie Buck, and her mother, Emma, were committed to the Virginia Colony for Epileptics and Feeble Minded.[20] Both were deemed "feebleminded" and promiscuous after

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procedure. *See also infra* Part III.A. (providing a more detailed definition and discussion of informed consent).

11. *See infra* notes 12–73. *See also* Reilly, *supra* note 10, at 359–60.

12. Garland E. Allen, *Eugenics and Modern Biology: Critiques of Eugenics, 1910-1945*, 75 ANNALS HUM. GENETICS 314, 314 (2011).

13. Reilly, *supra* note 10.

14. DePaul College of Law, *Sterilization Abuse: A Proposed Regulatory Scheme*, 28 DEPAUL L. REV. 731, 738–41 (1979).

15. Reilly, *supra* note 10, at 355.

16. Philip R. Reilly, *Involuntary Sterilization in the United States: A Surgical Solution*, 62 Q. REV. OF BIOLOGY 153, 158 (1987).

17. Alexandra Minna Stern, *Sterilized in the Name of Public Health: Race, Immigration, and Reproductive Control in Modern California*, 7 AM. J. PUB. HEALTH 1128, 1130 (2005); Adam Cohen & Terry Gross, *The Supreme Court Ruling that Led to 70,000 Forced Sterilizations*, NPR (Mar. 7, 2016), https://www.npr.org/sections/health-shots/2016/03/07/469478098/the-supreme-court-ruling-that-led-to-70-000-forced-sterilizations.

18. Buck v. Bell, 274 U.S. 200 (1927).

19. *Id.* at 207.

20. Hidden Brain, *Emma, Carrie, Vivian: How a Family Became a Test Case for Forced Sterilizations*, NPR (Apr. 23, 2018, 9:00 PM ET), https://www.npr.org/transcripts/604926914.

giving birth to children out of wedlock.[21] Buck's child was also judged to be "feebleminded" at the age of only seven months.[22] Hence, Justice Holmes' reference to the "three generations of imbeciles."[23] Buck challenged a Virginia statute that allowed for the sterilization of certain "defective" persons when the superintendent of certain institutions determined it was in the best interests of patients and society.[24] Ultimately, the Court rejected Carrie Buck's arguments that this practice violated the Eighth and Fourteenth Amendments.[25] In doing so, the Court stated, "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."[26]

In the 1942 case *Skinner v. Oklahoma*,[27] the U.S. Supreme Court addressed a challenge to Oklahoma's Habitual Criminal Sterilization Act of 1935 under the Eighth Amendment and the Fourteenth Amendment's Equal Protection Clause.[28] The law at issue in *Skinner* allowed for the sterilization of persons convicted two or more times for felonies involving moral turpitude and subsequently convicted of an additional felony involving moral turpitude.[29] The *Skinner* Court concluded that marriage and procreation are fundamental rights and rejected sterilization as a valid state goal.[30] When the Court decided *Skinner*, the U.S.' support for the eugenics movement began to wane following Nazi Germany's adoption of eugenics.[31] However, subsequent reports and jurisprudence indicate that private and governmental actors continued sterilizing individuals through coercive practices in the years following *Skinner*.

In *Relf v. Weinberger*,[32] a federal court in the District of Columbia addressed the federal government's widespread funding of coerced sterilizations.[33] In 1964, Congress created Community Action Programs (CAP) intending to improve the self-sufficiency of low-income families.[34] In 1973, welfare workers associated with the CAP in Montgomery, Alabama encountered the Relfs, a low-income Black

21. *Id.*
22. *Id.*
23. *Bell*, 274 U.S. at 207.
24. *Id.*
25. *Id.*
26. *Id.*
27. Skinner v. Oklahoma, 316 U.S. 535 (1942).
28. *Id.* at 536–38.
29. *Id.* at 536.
30. *Id.* at 541.
31. Daniel J. Kevles, *Eugenics and Human Rights*, 319 BRIT. MED. J. 435, 437 (1999).
32. Relf v. Wienberger, 372 F. Supp. 1196 (D.D.C.1974).
33. *Id.* at 1198.
34. 42 U.S.C. §§ 2781–2837 (1964).

family.[35] The CAP workers provided the Relfs with housing services and encouraged them to use family planning services through a federally-funded clinic.[36] The clinic eventually sterilized Minnie Relf (age twelve) and Mary Alice Relf (age fourteen).[37] Minnie and Mary Alice's mother unintentionally agreed to her daughters' sterilizations when she signed an "X" on a consent form that she could not read.[38] Upon learning of Minnie's and Mary Alice's coerced sterilizations, the Relfs filed a lawsuit challenging the constitutionality of regulations of the Department of Health, Education, and Welfare governing sterilizations.[39]

The *Relf* court concluded that the federal government did not have the authority to fund sterilization of individuals not competent to consent to the procedure in light of Congress's command "that federal family planning funds not be used to coerce indigent patients into submitting to sterilization."[40] The *Relf* court also stated that legally competent adults must give doctors their 'informed consent' to sterilization.[41] The court noted, however, that "[e]ven a fully informed individual cannot make a 'voluntary' decision concerning sterilization if he has been subjected to coercion from doctors or project officers."[42] The court then ordered the Department of Health, Education, and Welfare to promulgate new regulations requiring sterilization to be voluntary and requiring that every sterilization consent form prominently state that welfare benefits should not be withheld or withdrawn if a patient decides not to undergo sterilization.[43]

In *Madrigal v. Quilligan*,[44] a federal court in California considered a case brought by ten Mexican women who alleged that medical staff at the University of Southern California-Los Angeles County Medical Center (USC-LA Medical Center) sterilized them without obtaining proper informed consent.[45] The case arose following testimony by Dr. Bernard Rosenfield, a young physician at the county General Hospital, who acted as the whistleblower by exposing doctors' malpractice on low-income

35. RANDALL HANSEN & DESMOND KING, STERILIZED BY THE STATE 249 (Cambridge Univ. Press ed., 2013).

36. *Id.*

37. *Id.*

38. *Relf v. Weinberger*, S. POVERTY L. CTR. https://www.splcenter.org/seeking-justice/case-docket/relf-vweinberger (last visited Dec. 16, 2021).

39. *Id.*

40. Relf v. Weinberger, 372 F. Supp. 1196, 1201 (1974).

41. *Id.* at 1199.

42. *Id.* at 1203.

43. *Id.*

44. Madrigal v. Quilligan,. No. CV 75-2057-JWC (C.D. Cal., filed June 30, 1978).

45. Maya Manian, *Coerced Sterilization of Mexican-American Women: The Story of Madrigal v. Quilligan*, *in* REPRODUCTIVE RIGHTS AND JUSTICE STORIES 97 (Melissa Murray et al. ed., 2019).

and minority women.[46] The *Madrigal* plaintiffs subsequently provided testimony revealing that medical staff at USC-LA Medical Center routinely coerced women into undergoing sterilization procedures, often approaching them while they were sedated and seeking medical care for childbirth or other medical procedures.[47]

Plaintiff Jovita Rivera recounted how a doctor approached her while she was in labor and under anesthesia and told her that she should be sterilized because she was a burden to the government.[48] The doctors also falsely told Rivera that the tubal ligation procedure could be reversed.[49] Plaintiff Helena Orozco similarly recounted how doctors coerced her into agreeing to a tubal ligation without properly explaining the procedure, stating that:

> [A] doctor said that if I did not consent to the tubal ligation that the doctor repairing my hernia would use an inferior type of stitching material which would break the next time I became pregnant, but that if I consented to the tubal ligation that the stitches would hold as proper string would be used. No one ever explained what a tubal ligation operation was, I thought it was reversible.[50]

Another plaintiff, Maria Hurtado, similarly described how USC-LA Medical Center staff told her she needed the tubal ligation procedure following her third cesarean section because "the State of California did not permit a woman to undergo more than three caesarean section operations. . . ."[51] Again, no one explained the tubal ligation procedure to Maria, including the fact that it is a permanent form of birth control.[52]

Despite this apparent pattern of coerced sterilizations perpetrated by USC-LA medical center staff, the court found the doctors named in the complaint not liable.[53] The court accepted the doctors' argument that they acted in good faith.[54] Also, the court characterized what occurred to the plaintiffs as the result of a communication breakdown due to the hospital environment's busy nature and the plaintiffs' limited English skills.[55] Each of the *Madrigal* plaintiffs primarily spoke Spanish and had limited English proficiency but only received consent forms for the sterilization

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46. *Id.* at 100.
47. *Id.* at 101.
48. *Id.* at 104.
49. *Id.*
50. Jessica Enoch, *Survival Stories: Feminist Historiographic Approaches to Chicana Rhetoric of Sterilization Abuse*, 35 RHETORIC SOC'Y Q. 5, 11 (2005).
51. *Id.*
52. *Id.*
53. Manian, *supra* note 45, at 110.
54. *Id.* at 110–11.
55. *Id.* at 111.

procedures in English.[56]

State sterilization laws have been repealed today, and some legal protections have emerged, including laws requiring informed consent before sterilization.[57] However, there are ongoing debates regarding the appropriateness of sterilization for certain populations, such as incarcerated adults.[58] Reports of coerced sterilization also continue despite current legal protections.[59] For example, from 2006 to 2010, "nearly 150 women were sterilized in California's prisons without the state's approval."[60] Moreover, despite widespread condemnation of the eugenics movement, the U.S. Supreme Court has yet to overturn its decision in *Buck v. Bell*.[61]

B. *Immigration Restrictions as Population Control Measures*

Restrictive immigration policies served a similar purpose to the practice of coerced sterilization: to limit the population of individuals deemed unfit.[62] Like early U.S. laws authorizing sterilization, early immigration control measures emerged around the same time as the eugenics movement and reflected its racist and xenophobic underpinnings.[63] Congress passed one of the first major laws restricting U.S. immigration, the Chinese Exclusion Act of 1882,[64] in response to an influx of Chinese immigrants to the U.S.[65] Politicians labeled early Chinese immigrants as diseased and immoral—characteristics

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56. *Id.* at 102.

57. *See, e.g.*, GA. CODE ANN. § 31-20-2 (West 2021); Alexandra Minna Stern, *Eugenics, Sterilization, and Historical Memory in the United States*, 23 HISTÓRIA, CIÊNCIAS, SAÚDE 196 (2016).

58. Leita Powers, *Could Forced Sterilization Still be Legal in the U.S.?*, SYRACUSE L. REV. LEGAL PULSE, https://lawreview.syr.edu/could-forced-sterilization-still-be-legal-in-the-us/.

59. *See, e.g.*, Bill Chappell, *California's Prison Sterilizations Reportedly Echo Eugenics Era*, NPR (July 9, 2013, 3:06 PM), https://www.npr.org/sections/thetwo-way/2013/07/09/200444613/californias-prison-sterilizations-reportedly-echoes-eugenics-era.

60. *Id.*

61. *The Right to Self-Determination: Freedom from Involuntary Sterilization*, DISABILITY JUST., https://disabilityjustice.org/right-to-self-determination-freedom-from-involuntary-sterilization/.

62. NANCY ORDOVER, AMERICAN EUGENICS: RACE, QUEER ANATOMY, & THE SCIENCE OF NATIONALISM xiv (Univ. of Minn. Press ed., 2003).

63. Kenneth Ludmerer, *Genetics, Eugenics, and the Immigration Restriction Act of 1924*, 46 BULLETIN HIST. MED. 59, 60–70 (1972).

64. Chinese Exclusion Act of 1882, Pub. L. No. 47-126, 22 Stat. 58 (repealed 1943).

65. Prior to the Chinese Exclusion Act, Congress sought to exclude certain "undesirable" Chinese immigrant women. Page Act of 1875*,* 18 Stat. 477 (repealed 1974); *see also* George Anthony Peffer, *Forbidden Families: Emigration Experiences of Chinese Women Under the Page Law*, 1875–1882, 6 J. AM. ETHNIC HIST. 28, 28 (1996). At the time, Chinese women were stereotyped as prostitutes and accused of spreading sexually-transmitted diseases. *See id.*

eugenicists argued had a genetic basis.[66] The Chinese Exclusion Act sought to address Chinese immigration by suspending the immigration of Chinese laborers and prohibiting the naturalization of Chinese immigrants.[67]

Just months after the passage of the Chinese Exclusion Act, Congress passed sweeping immigration restrictions with the Immigration Act of 1882.[68] The law deemed excludable "any convict, lunatic, idiot, or any person unable to take care of himself or herself without becoming a public charge."[69] The public charge provision notably provided for the exclusion of immigrants found likely to rely on certain types of public assistance, such as long-term care at the government's expense.[70] That provision reflected eugenicists' preoccupation with excluding undesirable immigrants, including impoverished people and people with disabilities.[71] In practice, examiners at Ellis Island tasked with implementing tests to weed out immigrants in accordance with restrictive immigration policies used the public charge ground of exclusion as a sort of catch-all provision due to its vagueness.[72] They routinely listed "likely to become a public charge" as a secondary or alternate reason for exclusion along with other, often more difficult to establish, reasons.[73] As a result, roughly two-thirds of exclusions in the twentieth century were of people likely to become a public charge.[74]

Subsequent immigration laws passed in the late nineteenth and early twentieth centuries further restricted the immigration of individuals with traits eugenicists labeled as undesirable and inheritable. For example, categories of excludable immigrants included "persons suffering from a loathsome or a dangerous, contagious disease," people with epilepsy, the "feeble-minded," and "persons of constitutional psychopathic

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66. Erika Lee, *The Chinese Exclusion Example: Race, Immigration, and American Gatekeeping*, 21 J. AM. ETHNIC HIST. 36, 41 (2002).

67. 22 Stat. 58, 59.

68. Immigration Act of 1882, Pub. L. No. 47-376, 22 Stat. 214.

69. *Id.*

70. Mehda D. Makhlouf, *The Public Charge Rule as Public Health Policy*, 16 IND. HEALTH L. REV. 177, 184–85 (2019).

71. JAMES R. EDWARDS JR., CTR. FOR IMMIGR. STUDIES, PUBLIC CHARGE DOCTRINE: A FUNDAMENTAL PRINCIPLE OF AMERICAN IMMIGRATION POLICY 2–3 (2001), https://cis.org/Report/Public-Charge-Doctrine-Fundamental-Principle-American-Immigration-Policy.

72. *Public Charge Provisions of Immigration Law: A Brief Historical Background*, U.S. CITIZENSHIP & IMMIGR. SERVS., https://www.uscis.gov/about-us/our-history/history-office-and-library/featured-stories-from-the-uscis-history-office-and-library/public-charge-provisions-of-immigration-law-a-brief-historical-background (last updated Aug. 14, 2019).

73. *Id.*

74. *Id.*

inferiority," a category used to exclude LGBTQ immigrants.[75]

Despite numerous changes to immigration law and policy during the twentieth and twenty-first centuries, modern immigration law and policy continue to reflect a legacy of eugenic thinking. For example, current grounds of inadmissibility allow excluding immigrants likely to become a public charge and those with certain mental or physical disorders if associated with harmful behavior.[76] Recent waves of immigrants from Latin America are described similarly to immigrants during the Chinese Exclusion Act era as criminals, undesirables, and a drain on public resources.[77]

II. ICDC AND THE U.S. LEGACY OF COERCED STERILIZATIONS

Project South's complaint reporting of coerced hysterectomies can be viewed as a continuation of the U.S. legacy of implementing eugenic policies to limit the nation's population of "undesirables." Many issues raised in the complaint closely resemble the claims brought in *Madrigal* and other twentieth-century cases challenging coercive sterilization practices. For example, Wooten, like Dr. Rosenfield, the whistleblower who prompted the *Madrigal* case, raised concerns about the high number of detained women at ICDC undergoing sterilization procedures.[78] Wooten stated, "Everybody [the outside gynecologist] sees has a hysterectomy—just about everybody. He's even taken out the wrong ovary on a young lady."[79] Like the *Madrigal* plaintiffs, Wooten also indicated issues with a lack of informed consent.[80] She stated, "These immigrant women, I don't think they really, totally, all the way understand this is what's going to happen depending on who explains it to them."[81]

Relatedly, one woman detained at ICDC reported that the doctor's office she went to failed to explain the hysterectomy procedure properly.[82] When asked what was being done to her body, she received

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75. Act of Mar. 3, 1891, ch. 551, § 1, 26 Stat. 1084, 1084-86; Act of Mar. 3, 1903, ch. 1012, § 2, 32 Stat. 1213, 1214; Act of Feb. 20, 1907, ch. 1134, § 2, 34 Stat. 898, 898-99; Act of Feb. 5, 1917, ch. 29, § 9, 39 Stat. 874, 880 (repealed 1952).

76. Immigration and Nationality Act, § 212(a)(4 § 212(a)(1)(A)(iii), 8 U.S.C. § 1182.

77. *See* Gretchen Frazee, *4 Myths About How Immigrants Affect the U.S. Economy*, PBS (Nov. 2, 2018, 6:48 PM), https://www.pbs.org/newshour/economy/making-sense/4-myths-about-how-immigrants-affect-the-u-s-economy; Kate Reilly, *Here Are All the Times Donald Trump Insulted Mexico*, TIME (Aug. 31, 2016, 11:35 AM), https://time.com/4473972/donald-trump-mexico-meeting-insult/.

78. PROJECT SOUTH ET AL., *supra* note 1, at 19.

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.* at 20.

three different responses from three different individuals.[83] Additionally, like the *Madrigal* plaintiffs, Wooten's statements indicated that issues with lack of informed consent were partly due to a language barrier.[84] Wooten explained that the nurse who tried to communicate with the women detained at ICDC tried to speak Spanish by googling or asking other women detained at the facility to help interpret.[85]

The targeting of immigrant women detained at the ICDC is also considerably less surprising when viewed in the historical context of U.S. population control measures. Historically, immigrant women, like the *Madrigal* plaintiffs, and other women of color, like the Relfs, were targeted for sterilization procedures due to public perception that they were a drain on public resources.[86] Modern rhetoric similarly focuses on immigrants as a drain on public resources and otherwise undesirable members of society.[87]

Additionally, many individuals sterilized in the twentieth century resided in prisons, mental hospitals, and other institutions.[88] Individuals residing in these facilities are vulnerable to coercive medical procedures for several reasons. First, individuals in these facilities may feel pressured to consent to medical procedures due to constraints on their liberty and fear of retaliation by the government and staff at the facilities where they reside.[89] Second, individuals in prisons and mental hospitals are largely shielded from the general public and have limited recourse if their rights are violated.[90] Individuals residing in immigration detention centers encounter the same or similar challenges.[91] For example, women who spoke out against Dr. Mahendra Amin, the gynecologist accused of

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83. *Id.*

84. PROJECT SOUTH ET AL., *supra* note 1, at 19–20.

85. *Id.*

86. *See* Manian, *supra* note 45, at 104; HANSEN & KING, *supra* note **Error! Bookmark not defined.**.

87. *See* Frazee, *supra* note 77 (discussing widespread myths about how immigrants affect the U.S. economy and specific claims by President Trump regarding the impact of immigration on the U.S.).

88. *See, e.g.*, Hidden Brain, *supra* note 20 (discussing the evolution of the eugenics movement and the case of *Buck v. Bell*); Chappell, *supra* note 59 ("Doctors performed tubal ligation surgeries on at least 148 female inmates at two facilities.").

89. *See, e.g.*, Diana Brahams, *Is a Prisoner Capable of Giving Consent to Treatment?*, 31 LANCET 746 (1984) ("Sir John Donaldson agreed with the trial judge's approach, which was that where in a prison setting a doctor had power to influence a prisoner's situation.").

90. *See, e.g.*, *The Challenge of Prison Oversight*, 47 AM. CRIM. L. REV. 1453 (2010) ("[T]he United States became the only country in the world in which national legislation singles out prisoners for a unique set of barriers to vindicating their legal rights in court.").

91. *See, e.g.*, Jennifer Solis, *ICE, Prison Targeted Immigrants Seeking Medical Care, Complaint Says*, NEVADA CURRENT (Mar. 1, 2023, 5:30 AM), https://nevadacurrent.com/2023/03/01/ice-prison-targeted-immigrants-seeking-medical-care-complaint-says/ (discussing incidents of retaliation against detained immigrants who sought medical care).

performing unnecessary hysterectomies on women at ICDC, were allegedly threatened with placement in solitary confinement.[92]

In the case of the ICDC, the exact motives of Dr. Amin and other individuals who aided in the performance of the hysterectomies are unclear. To date, Dr. Amin denies any wrongdoing and claims he received approval from ICDC before performing all sterilization procedures.[93] Assuming that the procedures were not medically justified and Dr. Amin had other motives for performing them, it is interesting to consider why he performed hysterectomies instead of tubal ligation or other less invasive procedures. One possible explanation is that the procedure was viewed as more punitive, as a significant way to punish individuals for coming to the U.S. and prevent them from becoming greater "burdens" on the U.S. government. Another possibility is that hysterectomies were easier to justify as treatment than other medical procedures. Some support for this explanation exists in allegations by women sterilized by Dr. Amin, who stated they originally sought treatment for ovarian cysts.[94] One additional possibility is that Dr. Amin had an economic motive. This theory is supported by findings in an investigation conducted by the House Homeland Security Committee and House Oversight and Reform Committee.[95] A doctor, who asked to review Dr. Amin's files as part of a joint investigation by the two committees, expressed concern that "[Dr. Amin] was not competent and simply did the same evaluation and treatment on most patients because that is what he knew how to do, and/or he did tests and treatments that generated a significant amount of reimbursement without benefiting most patients."[96] Regardless of the motives of those involved in performing hysterectomies on women at the ICDC, Project South's complaint and the U.S. history of performing coercive sterilization procedures on vulnerable populations point to a need for governmental intervention to prevent further coerced sterilizations.

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92. Teo Armus, *Immigration Detainees File for Class-Action Lawsuit Against ICE and Georgia Gynecologist, Alleging Misconduct*, WASH. POST. (Dec. 22, 2020), https://www.washingtonpost.com/nation/2020/12/22/ice-gynecologist-georgia-doctor-lawsuit/.

93. AB Wire, *Indian American Doctor Performed Unneeded Surgeries on Immigrants: NYT*, THE AM. BAZAAR (Sept. 30, 2020, 2:58 PM), https://www.americanbazaaronline.com/2020/09/30/indian-american-doctor-mahendra-amin-performed-unneeded-surgeries-on-immigrants-nyt-442580/.

94. *See* Lauren A. Varga, *Does Fear of Immigration Trump Love for Fetal Life? How Trump's Policies Quietly Endanger Migrant Fetuses in Spite of the Adminstration's Pro-Life Agenda*, 35 GEO. IMMIGR. L.J. 631, 652–53 (2021) (detailing the complaint filed in a class action against Dr. Amin).

95. Rebecca Beitsch, *ICE Doctor May Have Performed Unwanted Hysterectomies to Defraud DHS*, THE HILL (Dec. 6, 2021, 11:53 AM), https://thehill.com/policy/national-security/department-of-homeland-security/584486-review-finds-ice-doctor-who/.

96. *Id.*

III. INFORMED CONSENT, OVERSIGHT, AND COERCED STERILIZATION IN IMMIGRATION DETENTION

Project South's complaint demonstrates that the U.S. does not have adequate safeguards to prevent ongoing coerced sterilizations. Further, the complaint shows that medical providers for women detained at ICDC failed to obtain proper informed consent for the sterilization procedures.[97] Additionally, given that medical services at immigration detention centers are typically provided and overseen by a complex network of private and governmental actors,[98] it is important to examine inadequate oversight of these actors as a potential cause of coerced sterilizations in immigration detention centers. Ultimately, these issues must be addressed to prevent coerced sterilizations.

Project South's complaint raises several questions regarding the adequacy of current Immigration and Customs Enforcement (ICE) policies governing informed consent and oversight. Regarding informed consent, the complaint suggests that the current ICE policy is deficient in that medical providers willfully disregarded ICE policy, or perhaps both.[99] Regarding oversight, immigration detention centers, especially those run by private contractors, are frequently criticized for human rights abuses and a general lack of transparency, suggesting problematic oversight of these facilities.[100] Examining ICE policies and practices regarding informed consent and oversight is necessary to determine how to prevent future coerced sterilization in immigration detention centers. First, however, it is important to consider what constitutes informed consent.

A. *Informed Consent*

Informed consent is a process involving communication between a patient and physician that results in a patient's authorization or agreement to undergo a specific medical intervention.[101] In seeking a patient's

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97. PROJECT SOUTH ET AL., *supra* note 1, at 19–20.

98. *See* U.S. GOV'T ACCOUNTABILITY OFF., GAO-16-231, IMMIGRATION DETENTION: ADDITIONAL ACTION NEEDED TO STRENGTHEN MANAGEMENT AND OVERSIGHT OF DETAINEE MEDICAL CARE 10 (2016) (discussing the various entities that provide for detention facilities).

99. *See generally* PROJECT SOUTH ET AL., *supra* note 1 (discussing incidents of women detained at the ICDC receiving unwanted hysterectomies).

100. *See, e.g.*, CLARA LONG & GRACE MENG, SYSTEMIC INDIFFERENCE: DANGEROUS & SUBSTANDARD MEDICAL CARE IN US IMMIGRATION DETENTION 105 (2017) (examining lapses in healthcare that have led to suffering and death at immigration detention, including those run by private contractors).

101. *Informed Consent*, AMA, https://www.ama-assn.org/delivering-care/ethics/informed-consent (last visited Dec. 17, 2021).

informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), the American Medical Association (AMA) Code of Medical Ethics Opinion 2.1.1. states that physicians should take the following steps:

> (a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
>
> (b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
>
> (i) The diagnosis (when known)
>
> (ii) The nature and purpose of recommended interventions
>
> (iii) The burdens, risks, and expected benefits of all options, including forgoing treatment.
>
> (c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.[102]

Physicians and other medical staff should take each of these steps in the immigration detention context. Importantly, to comply with subsection (b), medical providers for individuals in immigration detention who need to undergo sterilization procedures should ensure that patients are aware of (1) why they need the procedure and (2) the permanency of sterilization. Moreover, although not directly addressed by the AMA's guidance regarding informed consent, medical staff should ensure that they provide patients with any information regarding medical procedures in a language the patient understands. Otherwise, a patient cannot properly understand the nature of the procedure and provide informed consent.

1. ICE Policies and Procedures Regarding Informed Consent

ICE policies and procedures regarding informed consent to medical care for individuals in detention are laid out in each detention facility's contract.[103] Immigration detention centers use one of four standards: the 2007 Family Residential Standards, the 2008 Performance-Based

102. *Id.*
103. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 98, at 8–9.

National Detention Standards (PBNDS), the 2011 PBNDS, or the 2019 National Detention Standards for Non-Dedicated Facilities.[104] This Article focuses on the 2011 PBNDS because these standards apply to a significant percentage of individuals in ICE detention (approximately sixty percent of the average daily population, based on data from fiscal year 2015).[105] The 2011 PBNDS also governed the ICDC.[106] However, it is noteworthy that standards across ICE detention facilities are inconsistent, leading some facilities to apply outdated policies that may not reflect the best practices regarding informed consent.

The 2011 PBNDS define informed consent as "[a]n agreement by a patient to a treatment, examination, or procedure after the patient receives the material facts about the nature, consequences, and risks of the proposed treatment, examination or procedure; the alternatives to it; and the prognosis if the proposed action is not undertaken."[107] Detention standard 4.3 of the 2011 PBNDS further provide, "[i]nformed consent standards shall be observed and adequately documented. Staff shall make reasonable efforts to ensure that detainees understand their medical condition and care."[108] Additionally, the PBNDS require that medical staff explain the medical risks if treatment is declined.[109] They must also document treatment efforts, including refusals of treatment, in detainees' medical records.[110] In the case of refusals, ICE policy requires detainees to sign a translated form indicating that they refused treatment.[111] The 2011 PBNDS also incorporate state and local law by reference, stating, "[a]ll examinations, treatments, and procedures are governed by informed consent practices applicable in the jurisdiction."[112]

The 2011 PBNDS also laid out requirements regarding the availability of materials in a detainee's native language.[113] Specifically, the 2011 PBNDS require that written materials provided to detainees "shall generally be translated into Spanish."[114] For detainees who speak neither English nor Spanish, the 2011 PBNDS state, "[w]here practicable,

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104. *Id.* at 8; *ICE Detention Standards*, U.S. IMMIGR. & CUSTOMS ENF'T, https://www.ice.gov/factsheets/ice-detention-standards (last visited February 19, 2024).

105. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 98, at 9.

106. Letter from Daniel A. Kronefield, Human Rights Counselor, to Felipe González Morales et al., Special Rapporteur on Human Rights of Migrants (May 10, 2021), https://spcommreports.ohchr.org/TMResultsBase/DownLoadFile?gId=36224.

107. U.S. IMMIGR. & CUSTOMS ENF'T, PERFORMANCE-BASED NAT'L DET. STANDARDS 2011 469–70 (2016).

108. *Id.* at 259.

109. *Id*. at 255.

110. *Id.* at 253, 276.

111. *Id.* at 276.

112. *Id.*

113. *See* U.S. IMMIGR. & CUSTOMS ENF'T*, supra* note 107, at 1.

114. *Id.*

provisions for written translation shall be made for other significant segments of the population with limited English proficiency."[115] In addition, "[o]ral interpretation or assistance shall be provided to any detainee who speaks another language in which written material has not been translated or who is illiterate."[116] Regarding consent forms, the 2011 PBNDS provide, "[i]f a consent form is not available in a language the detainee understands, professional interpretation services will be provided as described in Section E . . . and documented on the form."[117] Section E elaborates that facilities shall use "appropriate interpretation and language services" for medical and mental healthcare.[118] Facilities are to also use professional interpretation services if staff interpretation is unavailable.[119] Additionally, detainees are not to be used for interpretation services during the provision of medical or mental health services "except in emergency situations."[120]

2. The Adequacy of ICE Policies and Procedures Regarding Informed Consent

Compared with AMA guidance, the provisions of the 2011 PBNDS concerning informed consent are partly consistent. Specifically, the 2011 PBNDS guidelines require medical care providers to explain patients' medical conditions and any proposed course of treatment, including the potential risks and benefits.[121] Staff are also required to document conversations regarding informed consent as well as patients' refusal to undertake a medical procedure.[122]

However, some aspects of the 2011 PBNDS regarding informed consent for medical care are ambiguous. One unclear aspect is how medical providers for ICE detainees are meant to assess, consistent with subsection (a) of the AMA Code of Medical Ethics Opinion 2.1.1, the patient's ability to understand medical information and the implications of treatment alternatives.[123] Moreover, the 2011 PBNDS do not state what actions staff are permitted to take when a patient does not appear capable of understanding a proposed course of treatment.[124] For example,

115. *Id.*
116. *Id.*
117. *Id.* at 276.
118. *Id.* at 264.
119. U.S. IMMIGR. & CUSTOMS ENF'T, *supra* note 107, at 264.
120. *Id.*
121. *Id.* at 276.
122. *Id.* at 253, 276.
123. *Informed Consent*, *supra* note 101.
124. *See* Tom Jawetz & Scott Shuchart, *Language Access Has Life-or-Death Consequences for Migrants*, CAP (Feb. 20, 2019), https://www.americanprogress.org/article/language-access-life-death-consequences-migrants/

what medical providers are to do if a patient appears to have diminished capacity or speaks a language for which no interpreter is available.[125] Additionally, the 2011 PBNDS set no clear guidance for how staff are to document the informed consent process. For example, there is no indication as to whether staff may simply check a box indicating that a patient consented to a particular medical procedure or if staff are required to make more detailed notes.[126]

While these policy deficiencies should be addressed,[127] in analyzing the 2011 PBNDS, it does not appear that ICE's informed consent policy deficiencies are the primary reason for reports of coerced hysterectomies at the ICDC. For women who underwent hysterectomies at ICDC, the 2011 PBNDS, at a minimum, required medical staff to explain why a hysterectomy was necessary, the nature of the procedure, and its potential risks and benefits.[128] The 2011 PBNDS also required medical staff to use competent interpreters in the informed consent process.[129] Applicable Georgia law, which is binding on immigration detention centers subject to the 2011 PBNDS, also provides that sterilization procedures may only be performed after an individual has made a written request and a physician has provided "a full and reasonable medical explanation . . . as to the meaning and consequence of such operation."[130] Thus, if taken as true, Project South's allegations show that a more likely cause of coerced sterilizations at the ICDC was the medical staff's failure to follow ICE policy and applicable law rather than deficiencies with ICE policy itself.

3. Immigration Detention Privatization

Given that deficiencies with 2011 PBNDS standards do not appear to be the primary cause of the coerced sterilizations at ICDC, it is important to look beyond informed consent requirements to understand other

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(discussing proactive medical assessments which "do not depend on a detainees' ability to identify or communicate their own medical needs"); *see also* Karen S. Lucas et al., *Family Detention – Challenges Faced by Indigenous Language Speakers*, CARA 1–9 (Dec. 10, 2015), https://www.aila.org/File/DownloadEmbeddedFile/66618 ("Indigenous women and children have sometimes had difficulty communicating their symptoms to medical personnel and understanding prescriptions or medical instructions.").

125. Issues with access to adequate interpretation services for individuals in ICE detention are well-documented. *See* Jawetz & Shuchart, *supra* note 124 ("[I]nterpreters for little-spoken indigenous languages may not be available without several hours' advance notice."); Lucas et al., *supra* 124 ("These challenges include . . . (2) a lack of interpreting assistance for other interactions with government officials, subcontractors (including medical staff) and service providers.").

126. *See generally* U.S. IMMIGR. & CUSTOMS ENF'T, *supra* note 107 (describing ICE's 2011 PBNDS).

127. *See infra* Part IV.C. (discussing potential methods for addressing deficiencies with the PBNDS).

128. U.S. IMMIGR. & CUSTOMS ENF'T, *supra* note 107, at 276.

129. *Id.* at 264.

130. GA. CODE ANN. § 31-20-2 (West 2023).

factors driving coerced sterilizations in immigration detention centers. And, as the *Relf* court pointed out, "[e]ven a fully informed individual cannot make a 'voluntary' decision concerning sterilization if he has been subjected to coercion . . . ."[131] Another factor to consider in addressing ongoing coerced sterilizations is the role of private contractors. Privately run immigration detention centers are often cited for human rights abuses and criticized for lack of oversight.[132] Additionally, one can argue that the government's decision to end its contract with LaSalle Corrections, the private company that operated the ICDC, impliedly demonstrates the government's recognition of privatization as a potential cause of coerced sterilizations.[133]

Currently, more than seventy percent of detained immigrants are held in privately run facilities.[134] Opponents of privatization criticize privatively run immigration detention centers as "immoral and rights-depriving."[135] One reason for this criticism is that private contractors are profit-motivated and thus incentivized to provide inferior services or hold detainees for longer periods to garner greater profit.[136] Additionally, critics point out that the immigration detention contracting process is convoluted and obscure, shielding many ICE detention centers from public scrutiny.[137] Despite mounting criticism of privatized immigration detention, the government's use of privatized immigration detention facilities has expanded in recent years, particularly under the Trump administration.[138]

The Biden administration also continues to allow for the use of private contractors to run immigration detention centers despite campaign

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131. Relf v. Weinberger, 372 F. Supp. 1196, 1203 (1974).

132. *See* LONG & MENG, *supra* note 100, at 2 ("Medical care in the US immigration detention system, and the poor system of oversight that allows substandard care, has long been the target of criticism by investigative journalists and human rights advocates.").

133. *See* Fox & Brumback, *supra* note **Error! Bookmark not defined.** ("The Department of Homeland Security said it would terminate contracts with the local government agency that runs the detention center in North Dartmouth, Massachusetts, and with the private operator of the Irwin County Detention Center in Georgia.").

134. David S. Rubenstein & Pratheepan Gulasekaram, *Privatized Detention & Immigration Federalism*, 71 STAN. L. REV. 224, 225 (2019), https://review.law.stanford.edu/wp-content/uploads/sites/3/2019/03/71-Stan.-L.-Review-Rubenstein-Gulasekaram.pdf.

135. *Id.* at 226.

136. JESSE FRANZBLAU, NAT'L IMMIGRANT JUST. CTR., CUT THE CONTRACTS: IT'S TIME TO END ICE'S CORRUPT DETENTION MANAGEMENT SYSTEM 1 (2021), https://immigrantjustice.org/sites/default/files/content-type/research-item/documents/2021-03/Policy-Brief_Cut-the-Contracts_March-2021_Final.pdf.

137. NAT'L IMMIGRANT JUST. CTR., FREEDOM OF INFORMATION ACT LITIGATION REVEALS SYSTEMIC LACK OF ACCOUNTABILITY IN IMMIGRATION DETENTION CONTRACTING 3 (2015), https://immigrantjustice.org/immigration-detention-transparency-and-human-rights-project-august-2015-report.

138. John Burnett, *Big Money as Private Immigrant Jails Boom*, NPR (Nov. 21, 2017, 5:00 AM), https://www.npr.org/2017/11/21/565318778/big-money-as-private-immigrant-jails-boom.

promises to put an end to the practice.[139] The current administration's apparent indifference to the frequently cited issues with privately run immigration detention centers is particularly notable given President Biden's recent executive order (EO). The EO calls for an end to the use of privately run criminal detention facilities.[140] The EO notes that "privately operated criminal detention facilities consistently underperform Federal facilities with respect to correctional services, programs, and resources."[141] Yet privately run immigration detention centers are excluded from the EO.[142] And this is true even though the same two companies responsible for operating the largest number of privatized immigration detention centers, CoreCivic and GEO Group, Inc., also operated privatized criminal detention facilities.[143]

4. Immigration Detention Privatization and Healthcare

Because the coerced sterilizations at ICDC occurred in the context of healthcare, it is also necessary to consider the role privatization plays in the administration of healthcare services at immigration detention centers. A patchwork delivers healthcare in immigration detention centers of providers whose contract terms vary from facility to facility.[144] The government's ICE Health Services Corps (IHSC) provides care in slightly less than half of all detention centers and oversees care administered by all non-IHSC providers at the remaining facilities.[145]

Private contractors are also involved in the administration of medical services in facilities where IHSC directly provides medical services.[146] In response to a report criticizing the substandard medical

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139. Joel Rose*, Biden Wants to End For-Profit Immigration Detention. His Administration Isn't So Sure*, NPR (June 15, 2021, 5:54 PM), https://www.npr.org/2021/06/15/1006728924/biden-wants-to-end-for-profit-immigrant-detention-his-administration-isnt-so-sur.

140. Exec. Order No. 14,006, 86 Fed. Reg. 7483 (Jan. 26, 2021).

141. *Id.*

142. *See id.*

143. Eunice Cho, *More of the Same: Private Prison Corporations and Immigration Detention Under the Biden Administration*, ACLU (Oct. 5, 2021), https://www.aclu.org/news/immigrants-rights/more-of-the-same-private-prison-corporations-and-immigration-detention-under-the-biden-administration; Jamiles Lartey, *Think Private Prison Companies Are Going Away Under Biden? They Have Other Plans*, THE MARSHALL PROJECT (Nov. 17, 2020, 6:00 AM), https://www.themarshallproject.org/2020/11/17/think-private-prison-companies-are-going-away-under-biden-they-have-other-plans.

144. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 98, at 2.

145. *Id.*

146. *See, e.g.*, Letter from Steve Owen, Managing Director of Communications for CCA to Human Rights Watch (July 6, 2016), https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_responseletters.pdf (detailing IHSC's responsibility at specific detention centers).

care at detention centers run by private contractor CoreCivic (formerly Corrections Corporation of America), a company representative stated that CoreCivic works "closely with our government partners to ensure detainees have access to medical care."[147] Additionally, a report by the American Civil Liberties Union (ACLU) of San Diego and Imperial Counties documents the role of private contractors in providing medical care at the Otay Mesa Detention Center (OMDC).[148] From 2002 to 2020, IHSC operated the in-house medical clinic at OMDC.[149] In September 2020, IHSC transferred responsibility for operating the clinic to CoreCivic.[150] However, the report notes that "whether IHSC or CoreCivic medical staff run the clinic, CoreCivic guards have always been the daily points of contact for people in detention managing both formal requests for medical assistance and informal observation of living conditions."[151] The report further notes that CoreCivic guards are typically responsible for facilitating visits with a doctor and responding to verbal requests and referrals based on observed health difficulties.[152] These observations suggest that private contractors play an active role in the administration of medical care at immigration detention centers, even at detention centers where IHSC is directly responsible for providing healthcare services.

Additionally, immigration detention centers run by private contractors, regardless of whether medical services are directly provided through IHSC, are frequently criticized for providing inadequate medical care.[153] For example, a 2020 report published by the ACLU notes issues with medical care at multiple privately run immigration detention centers, including six detention centers run by LaSalle Corrections, the same private contractor that operated the ICDC.[154] In its efforts to expand the immigration detention system, the Trump administration reopened several detention facilities with notable medical neglect and abuse histories.[155] For example, the Trump administration reopened the privately run Adams County Detention Center (Adams) in Natchez, Mississippi.[156] In 2012, a riot at Adams

147. *Id.*

148. MONIKA Y. LANGARICA ET AL., CORECIVIC'S DECADES OF ABUSE: OTAY MESA DETENTION CENTER 15 (2021).

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.* at 15–16

153. EUNICE CHO, *JUSTICE FREE ZONES: U.S. IMMIGRATION DETENTION UNDER THE TRUMP* 4 (2020), https://www.aclu.org/sites/default/files/field_document/justice-free_zones_immigrant_detention_report_aclu_hrw_nijc_0.pdf.

154. *Id.* at 15.

155. *Id.* at 19.

156. *Id.*

associated with concerns about inadequate medical care led to the death of a prison officer and the injury of at least twenty detainees.[157] In 2013, at least five detainees died at Adams due to inadequate medical care.[158] A subsequent facility audit revealed that private contractor CoreCivic "failed to maintain adequate staffing levels and provide a safe and secure environment at the facility."[159]

The 2020 ACLU report also notes issues with medical care at the Winn Correctional Center (Winn), an immigration detention center run by LaSalle Corporation.[160] In 2014, after spending four months at the facility as an undercover officer, reporter Shane Bauer published an exposé highlighting widespread medical abuse of detainees at Winn.[161] At the time, private contractor CoreCivic ran the facility.[162] However, issues with medical abuse at Winn persist today, along with the employment of personnel with dubious backgrounds.[163] In 2014, the Louisiana State Board of Medical Examiners placed Dr. Mark Singleton on probation after receiving information that his privileges at a healthcare facility in another state were revoked due to concerns regarding his failure to meet the standard of care in his treatment of patients.[164] At the time, Dr. Singleton provided medical care to detainees at Winn.[165] Today, Dr. Singleton is the sole physician responsible for overseeing care for individuals detained at Winn.[166]

At a minimum, the widespread issues with medical abuse in ICE detention centers run by private contractors raise serious concerns about the ability of private contractors to provide appropriate medical care for individuals in immigration detention centers. And, as noted, the Biden administration recognized that the same private contractors providing medical services at some immigration detention centers provided inferior services in the criminal justice system.[167] The lengthy history of inadequate medical care at privately run immigration detention centers, along with Project South's complaint, suggests that ending immigration detention privatization is a necessary response to reports of coerced sterilization in immigration detention.

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157. *Id.*
158. *Id.*
159. CHO, *supra* note 153, at 19.
160. *Id.* at 44–47.
161. *Id.* at 44.
162. *Id.*
163. *Id.* at 45.
164. *Id.*
165. CHO, *supra* note 153, at 45.
166. *Id.*
167. *See* Exec. Order No. 14,006, 86 Fed. Reg. 7483 (Jan. 26, 2021).

5. Oversight and Accountability

Issues with inadequate oversight of contractors running immigration detention also support the argument that privatized immigration detention leads to inadequate medical care. Although private contractors are involved in the administration of medical services at immigration detention centers, ICE bears the ultimate responsibility for overseeing medical care at these facilities.[168] A 2016 Government Accountability Office (GAO) report describes the oversight mechanisms currently used by ICE:

> ICE uses seven oversight mechanisms to monitor facilities' compliance with medical care detention standards, such as facility inspections and on-site detention monitors. The combined use of these oversight mechanisms resulted in more than 99 percent of ICE's average daily population (ADP) of approximately 28,000 detainees being covered by two or more mechanisms in fiscal year 2015.[169]

The 2016 GAO report also raised specific concerns about inadequate oversight of detainee medical care at immigration detention centers despite current ICE oversight mechanisms.[170] Specifically, the report highlighted ICE's failure to track and analyze data across facilities and over time.[171] The report concluded that ICE tends to focus on facility-specific issues to the exclusion of systemic issues.[172]

The GAO report also identified gaps in how ICE receives and tracks complaints from detainees.[173] Detainees can submit complaints regarding medical care directly to facilities or one of various DHS entities, such as the Office of the Inspector General and the Office of Civil Rights and Civil Liberties (CRCL).[174] However, only CRCL is required to review and track medical complaints.[175] Entities other than CRCL may decline to review a complaint and lack a straightforward system for reviewing aggregate data regarding complaints about medical care at immigration detention centers.[176] As a result, there is no consistent system for tracking medical care-related complaints across facilities.[177]

Additionally, one of the oversight mechanisms used by ICE, investigations, is highly criticized by both governmental and non-

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168. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 98, at 2.
169. *Id.*
170. *Id.* at 26.
171. *Id.* at 37.
172. *Id.* at 27.
173. *Id.* at 33–36.
174. U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 98, at 33.
175. *Id.* at 33–34.
176. *Id.* at 34.
177. *Id.* at 35.

governmental entities for largely giving a "free pass" to facilities whose conditions warrant a failing inspection grade.[178] A 2015 report by the National Immigrant Justice Center and Detention Watch Network highlights how ICE maintains a "culture of secrecy" surrounding its inspection process.[179] The report notes that this culture of secrecy persists because (1) information about ICE's inspection process is not readily available and (2) "there is a lack of independent oversight because both entities that conduct investigations are paid and vetted —either through contracts or as direct employees—by ICE."[180] While organizations like the National Immigrant Justice Center are able to obtain certain information through Freedom of Information Act (FOIA) requests, these requests frequently lead to years of litigation.[181] And certain information held by private contractors operating immigration detention facilities may be difficult to obtain through FOIA requests, as private companies have repeatedly argued that they are not subject to FOIA.[182]

Among the potential political and economic incentives leading to inadequate oversight, advocates point to the influence of the private-prison industry.[183] In the past ten years, the for-profit prison industry responsible for overseeing privately run immigration detention centers "spent more than $25 million lobbying lawmakers and federal agencies . . . including $3.8 million just in 2018."[184] It seems inevitable that issues with governmental and private actors' noncompliance with the PBNDS and other applicable laws will continue when there is no meaningful way to hold them accountable. As noted, private contractors are not subject to legal checks that would otherwise apply to federal officials doing the same work.[185] Moreover, "political incentives, operational dependence on private detention space, and lack of transparency" blunts "the government's oversight."[186] Consequently, human rights abuses at

178. *See* DETENTION WATCH NETWORK & HEARTLAND ALL.'S NAT'L IMMIGRANT JUST. CTR., LIVES IN PERIL: HOW INEFFECTIVE INSPECTIONS MAKE ICE COMPLICIT IN IMMIGRATION DETENTION ABUSE 15 (2015), https://immigrantjustice.org/lives-peril-how-ineffective-inspections-make-ice-complicit-detention-center-abuse ("Even where human rights violations have been publicly documented, facilities rarely fail ERO inspections.").

179. *Id.* at 4.

180. *Id.*

181. *Id.* at 3 ("The inspections released with this report were not made available voluntarily by DHS, but as the result of FOIA requests by the National Immigrant Justice Center (NIJC) and a federal court order following three years of litigation.").

182. *See* LONG & MENG, *supra* note 100, at 19.

183. Jesse Franzblau, *Phase Out of Private Prisons Must Extend to Immigration Detention System*, NAT'L IMMIGRANT JUST. CTR. (Jan. 28, 2021), https://immigrantjustice.org/staff/blog/phase-out-private-prisons-must-extend-immigration-detention-system.

184. *Id.*

185. Rubenstein & Gulasekaram, *supra* note 134, at 226.

186. *Id*. at 227.

privately run immigration detention centers, such as grossly inadequate medical care, go largely unaddressed.

IV. Solutions

Although it is unclear if the reports of coerced sterilizations at ICDC are part of a larger pattern of similar medical abuse in immigration detention centers, Project South's report demonstrates a need for a comprehensive federal response to prevent ongoing coerced sterilizations. Deficiencies with ICE policy regarding informed consent and issues with inadequate oversight of privately run immigration detention centers provide additional evidence of the need for federal legislation. Given the issues highlighted by Project's South complaint, the proposed legislation must address issues with informed consent, oversight, and the role of private contractors.

A. *The Necessity of Federal Legislation*

Federal legislation is necessary to address the issues of oversight leading to coerced sterilizations in immigration detention centers for several reasons. First, the immigration detention system is federal in nature.[187] As a result, state laws that are inconsistent with federal law may be preempted or struck down on other grounds.[188] Second, state and local laws applicable to ICE detention are inconsistent and may contribute to confusion regarding applicable policies. Third, immigrants in detention are frequently transferred between different facilities in different jurisdictions.[189] Consequently, ICE can exploit differences in state and local laws to engage in practices that are permissible in one jurisdiction but impermissible in another.

B. *S.B. 1135: A Model for Federal Legislation*

California's S.B. 1135[190] is a promising response to coerced sterilizations. Passed in 2014, S.B. 1135 emerged following decades of

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187. *See* Emily Ryo & Ian Peacock, *The Landscape of Immigration Detention in the United States*, AM. IMMIGR. COUNCIL (Dec. 5, 2018), https://www.americanimmigrationcouncil.org/research/landscape-immigration-detention-united-states (presenting findings from an analysis of immigration detention centers across the U.S.).

188. Rubenstein & Gulasekaram, *supra* note 134, at 230–33*; see also* GEO Grp., Inc. v. Newsom, 50 F.4th 745, 750–51 (9th Cir. 2022) ("The Supreme Court has interpreted the Supremacy Clause 'as prohibiting States from interfering with or controlling the operations of the Federal Government.'").

189. Lisa Riordan Seville & Hannah Rappleye, *ICE Keeps Transferring Detainees Around the Country, Leading to COVID-19 Outbreaks*, NBC NEWS (May 31, 2020, 6:08 AM), https://www.nbcnews.com/politics/immigration/ice-keeps-transferring-detainees-around-country-leading-covid-19-outbreaks-n1212856#.

190. H.R. 1135, 2013-2014 Leg., Reg. Sess. (Cal. 2014).

coerced sterilizations, including those described in the *Madrigal* complaint.[191] Notably, about one-third of the roughly 70,000 coerced sterilizations performed in the U.S. between the 1910s and the 1960s occurred in California.[192]

Although written to address coerced sterilizations within the California prison system,[193] S.B. 1135 can serve as a model for similar federal legislation to address coerced sterilizations in immigration detention. S.B. 1135 explicitly prohibits sterilization for the purpose of birth control on individuals residing at facilities under the control of the Department of Rehabilitation or U.S. correctional facilities.[194] One could argue that this policy unfairly denies individuals who want to be sterilized access to sterilization procedures. However, this prohibition is arguably less problematic in the immigration detention context, given that individuals spend an average of fifty-five days in immigration detention centers.[195]

S.B. 1135 also provides two exceptions to the general prohibition on sterilization.[196] First, sterilization is permitted if "[t]he procedure is required for the immediate preservation of an individual's life in an emergency medical situation."[197] Second, the procedure is permitted if "medically necessary, as determined by contemporary standards of evidence-based medicine to treat a diagnosed condition," if certain requirements are met.[198] These requirements further specify that:

> (A) less invasive measures to address the medical need are nonexistent . . . ; (B) [a] second physician independent of, and not employed by, but authorized to provide services to individuals in the custody of . . . the county or department overseeing the confinement of the individual . . . confirms the need for medical intervention resulting in sterilization . . . ; (C) [p]atient consent is obtained after the individual is made aware of the full and permanent impact the procedure will have on his or her reproductive capacity . . . .[199]

These procedures are reasonable and adequately robust to prevent

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191. Burlingame, *supra* note 7; Manian, *supra* note 45.

192. Alexandra Minna Stern et al., *California's Sterilization Survivors: An Estimate and Call for Redress*, 107 AM. J. PUB. HEALTH 50 (2017); Cohen & Gross, *supra* note 17.

193. Burlingame, *supra* note 7.

194. H.R. 1135 § 2(a), 2013-2014 Leg., Reg. Sess. (Cal. 2014).

195. AM. IMMIGR. COUNCIL, IMMIGRATION DETENTION IN THE UNITED STATES BY AGENCY 4 (2020), https://www.americanimmigrationcouncil.org/sites/default/files/research/immigration_detention_in_the_united_states_by_agency.pdf.

196. H.R. 1135 § 2(b), 2013-2014 Leg., Reg. Sess. (Cal. 2014).

197. *Id.*

198. *Id.*

199. *Id.*

unnecessary sterilizations. The same requirements should be included in federal legislation to address sterilization in immigration detention. The language of the legislation could be largely identical except for the references to the "department" and "county," which could be modified in subparts (b) and (c) to say "Department of Homeland Security."

S.B. 1135 also includes requirements related to data tracking regarding individuals who undergo sterilization procedures.[200] Specifically, the law provides that the department and county jails or other institutions of confinement shall "[p]ublish an annual report of sterilizations performed, disaggregated by race, age, medical justification, and method of sterilization."[201] The law also requires that the department and county and other jails subject to the requirements of the law notify "all individuals under their custody and . . . employees who are involved in providing health care services of their rights and responsibilities under" the law.[202]

This provision should also be modified and included in federal legislation to address coerced sterilizations in immigration detention centers. Modifications could require the same information cited above, including the statistics for each ICE detention facility and aggregate data concerning the overall population in immigration detention facilities nationwide, to be published on ice.gov. This data requirement would help ensure public accountability and allow for identifying trends regarding sterilization practices. The data tracking requirement would also directly address some of the issues with oversight highlighted by the 2016 GAO report regarding a lack of comprehensive data about medical issues in immigration detention centers.[203]

C. *Addressing Deficiencies in ICE's PBNDS*

Although the 2011 PBNDS are partly consistent with the AMA's definition of informed consent and the ethical guidelines laid out in the AMA Code of Medical Ethics Opinion 2.1.1, the deficiencies in ICE's current policy should be addressed to ensure that they do not result in future coerced sterilizations. First, ICE policy should be clarified to provide particular steps a medical provider must take in order to assess the patient's ability to understand medical information and the implications of treatment alternatives. ICE policy should also provide specific guidance regarding addressing the medical needs of patients who

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200. *Id.* at § 2(d)(1).
201. H.R. 1135 § 2(d)(1), 2013-2014 Leg., Reg. Sess. (Cal. 2014).
202. *Id.* at § 2(d)(2).
203. *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 98, at 26–36.

appear to have diminished capacity[204] or speak a language for which no interpreter is available.

Additionally, ICE policy needs clear guidelines regarding how staff should document the informed consent process, including requiring medical providers to detail each step they take to obtain a patient's informed consent. ICE's current practice of allowing individual facilities to dictate by contract which performance standards they use must also end.[205] Any policy regarding informed consent and medical care at immigration detention centers must be uniformly applied in order to promote transparency and ensure that medical providers at all ICE facilities observe best practices.

D. *Ending the Use of Privatization and Improving Oversight*

Consistent reports of inadequate medical care and other human rights abuses at privately run immigration detention centers demonstrate a need to end immigration detention privatization to protect individuals' health and safety in immigration detention.[206] As noted, ICE consistently fails to provide adequate oversight over immigration detention centers operated by private contractors, likely due to a combination of political and economic incentives.[207] Moreover, oversight of private contractors by the public is particularly difficult given that they have repeatedly argued that they are not subject to FOIA.[208] Ending the use of privatized immigration detention centers is an action the executive branch can take by using its authority to terminate contracts with private prison companies and local governments that operate the facilities through intergovernmental service agreements.[209] DHS can also promulgate

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204. For individuals in ICE custody who appear to have diminished capacity, ICE should adopt a policy consistent with the American Medical Association's Code of Medical Ethics Opinion 2.1.2. *See Decisions for Adult Patients Who Lack Capacity*, AMA, https://code-medical-ethics.ama-assn.org/ethics-opinions/decisions-adult-patients-who-lack-capacity (last visited Oct. 1, 2023) (providing ethical requirements for physicians to follow when a patient has diminished capacity).

205. *See* U.S. GOV'T ACCOUNTABILITY OFF., *supra* note 98, at 8–9 ("Facilities of the same type, therefore, may follow different sets of detention standards depending on the applicable set of standards specified in the facility's contract or agreement.").

206. *See* CHO, *supra* note 153 (discussing the mistreatment and abuse at detention centers which are "largely operated by private prison corporations").

207. Rubenstein & Gulasekaram, *supra* note 134, at 226–27.

208. CHO, *supra* note 153, at 11.

209. *Roadmap to Dismantle the U.S. Immigration Detention System*, NAT'L IMMIGRANT JUST. CTR. (July 28, 2021), https://immigrantjustice.org/research-items/white-paper-roadmap-dismantle-us-immigration-detention-system; *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-21-149, IMMIGRATION DETENTION: ACTIONS NEEDED TO IMPROVE PLANNING, DOCUMENTATION, AND OVERSIGHT OF DETENTION FACILITY CONTRACTS 7 (2021) (explaining that one method ICE uses to acquire detention space is intergovernmental service agreements entered into with state or local authorities).

regulations prohibiting it from contracting or subcontracting its detention authority to private prison companies.[210] Alternatively, Congress could pass legislation banning government entities from contracting with private prison companies.[211]

A recent attempt to end immigration detention privatization in California also underscores the importance of passing legislation or taking other actions to end the use of privatized immigration detention centers at the federal level.[212] In 2019, California Governor Gavin Newsom signed into law A.B. 32, a state law banning privatized immigration centers.[213] The Trump administration and GEO Group Inc., one of the largest private immigration detention center operators, brought a lawsuit challenging the rule.[214] In September 2022, the U.S. Court of Appeals for the Ninth Circuit found that the Trump administration and GEO Group, Inc., were likely to prevail on their claims and remanded the matter to allow the District Court to decide whether to issue a preliminary injunction.[215] Specifically, the court held that A.B. 32 conflicted with federal law and could not stand under the Supremacy Clause.[216] Thus, by all indications, an end to privatized immigration detention will require a federal response.

While ending privatization will address some issues with inadequate oversight of immigration detention centers, additional steps must be taken to ensure greater transparency and accountability. Organizations, such as the ACLU, have provided detailed recommendations for improving oversight of immigration detention centers.[217] Some of these recommendations include removing "restrictions on the public release of information held by state and local governments that hold individuals in ICE custody"; "institut[ing] meaningful consequences for failed inspections assessing compliance with detention standards"; and ensuring that complete facility investigations into deaths in custody or related to in-custody treatment are made public, among other recommendations.[218]

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210. *Id.*

211. *See* Scott Grammer, *Senator Warren Has Plan to Ban Private Prison Contracts*, PRISON LEGAL NEWS (Mar. 4, 2020), https://www.prisonlegalnews.org/news/2020/mar/4/senator-warren-has-plan-ban-private-prison-contracts/.

212. OFF. OF GOVERNOR GAVIN NEWSOM, *Governor Newsom Signs AB 32 to Halt Private, For-Profit Prisons and Immigration Detention Facilities in California* (Oct. 11, 2019), https://www.gov.ca.gov/2019/10/11/governor-newsom-signs-ab-32-to-halt-private-for-profit-prisons-and-immigration-detention-facilities-in-california/.

213. *Id.*

214. Liam Dillon, *Trump Administration Sues California Over Private Prison Ban*, L.A. TIMES (Jan. 25, 2020, 11:05 AM), https://www.latimes.com/california/story/2020-01-25/trump-administration-sues-california-over-private-prison-ban.

215. GEO Grp., Inc. v. Newsom, 50 F.4th 745, 763 (9th Cir. 2022).

216. *Id.* at 751.

217. CHO, *supra* note 153, at 9–13.

218. *Id.* at 11.

Implementing these additional measures will help prevent ongoing coerced sterilizations by ensuring adequate oversight and accountability of ICE facilities.

CONCLUSION

The conditions allowing for coerced sterilizations in immigration detention centers are complex and multifaceted, and adequately addressing them will take an ongoing and concerted effort. The issues with informed consent and oversight raised by Project South's complaint indicate a need for federal legislation to address deficiencies with ICE's informed consent policy and improve oversight mechanisms. California's S.B. 1135 provides a promising model for federal legislation to address many of the issues raised by Project South's complaint. S.B. 1135 strictly limits the situations in which a sterilization procedure can be performed and establishes a tracking and monitoring system that enables public oversight and accountability.

Deficiencies with ICE's current informed consent policy should be addressed through modifications to its PBNDS. Additionally, ending the use of private contractors to run immigration detention centers and modifying ICE's current procedures for monitoring compliance with the PBNDS is necessary to address issues with inadequate oversight of immigration detention centers. Without a federal response that addresses these issues, the U.S. legacy of coerced sterilizations will likely continue unchecked.