Education and debate

Ethics in practice

Sterilisation of young, competent, and childless adults

Piers Benn, Martin Lupton

Is it ethical to sterilise a young woman who is determined she never wants children, even if there are no strong medical reasons to avoid pregnancy?

Case history

A 26 year old woman presented to a general gynaecology clinic requesting sterilisation. She worked as the manager of a large legal practice in central London. She had never been pregnant. She was in a relationship that had lasted five years and was using condoms for contraception. At the age of 17 she had discovered that she had a serious congenital heart defect. Neither she nor her partner had any desire to have children, and they had spoken about this at some length.

The reasons she gave for requesting sterilisation were that she did not have faith in other forms of contraception; had no desire to have children; did not wish to change her lifestyle or threaten her financial status (she saw children as a financial burden); felt that children would prohibit many important life choices, including the opportunity to travel; thought the world was already burdened with enough people; and had serious anxieties about the risk of medical complications during a pregnancy as her cardiologist had told her that pregnancy would be risky.

The gynaecologist suggested alternative and reversible methods of contraception, including the intrauterine progestogen system. He also asked whether her partner would consider vasectomy. He explained the risks of laparoscopic sterilisation, which include a small risk of death and a risk of about 1 in 300 of requiring an emergency laparotomy to repair damage done to internal organs. The patient declined the intrauterine system and refused to ask her partner to have a vasectomy as he was only 25. She explained that, should she die prematurely, he might meet a new partner who wanted to have children.

The doctor reassured her that many of the cardiac risks in pregnancy could be ameliorated by judicious medical care in a centre of excellence. He did not feel qualified to challenge the personal choices that she was making but felt uncomfortable with the permanence of her choice. He explained that the people who were most likely to regret their sterilisation were those who decided to be sterilised on medical grounds, those who were young, and those who had a change of relationship. She acknowledged that these were reasonable points but did not feel they were sufficiently powerful to alter her decision. The gynaecologist still

did not feel that he would be acting in her best interests by sterilising her and decided to seek a second opinion about whether the operation was appropriate.

The purpose of surgery

The General Medical Council has set out the duties of a doctor.¹ They include making the care of the patient the doctor's first concern, listening to patients and respecting their views, and making sure that the doctor's personal beliefs do not prejudice a patient's care. The primary principle of the Hippocratic tradition is to "above all, do no harm." Until recently, most surgery was performed to remove diseased tissue and restore the body to reasonable physical function. The modern surgical remit has, however, expanded, and patients may request operations for other reasons. An example of this is sterilisation. Surgery is increasingly seen as a tool for enhancing a patient's life and not just preserving it.

This raises important issues, the most complex of which is the judgment between the patient's view of a life enhancing surgical procedure and the Hippocratic requirement to do no harm. Although it is clearly within doctors' competence to advise on the most appropriate treatment for the amelioration of disease, it is less clear why they are competent to determine the

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reasonableness of personal, life enhancing, choices made by their patients. Inevitably occasions will arise when a doctor believes that what is being requested will do more harm than good. In such cases, are doctors justified in declining a treatment and imposing their judgment on another, autonomous person? More specifically, can a doctor refuse to perform a sterilisation on a patient because he or she thinks it is the wrong choice?

Yes or no: who should choose?

Contemporary thinking about medical ethics attaches much importance to respecting the patient's autonomy. Thus it might seem surprising that there should be any fundamental controversy about sterilising competent, properly informed adults who ask for this operation, even if they are young and have no children.

We leave on one side ethical objections to the procedure itself. A more common worry concerns the ethics of offering sterilisation to young men or women without children who, in the doctor's judgment, may regret the decision later on. Can a responsible doctor offer such a procedure?

Can you be too young for sterilisation?

Intuitively, the sterilisation of someone in their teens seems more contentious than sterilisation of someone who is 40, but it could be argued that it is strange to raise ethical concerns even about this. After all, young people are allowed to take all kinds of risks they might later regret—say in relationships, lifestyle, or financial investments. Treating people as rational adults means letting them do things they may bitterly regret later. This applies as much to young competent adults as to older ones. If our patient, at the age of 26, can lawfully damage her health by, for instance, drinking a bottle of whisky every day, it might be reasonable to ask what is so special about voluntary sterilisation.

Cautious view

Those who advocate caution, or condemn sterilisation outright, are likely to respond in two ways. Firstly, they may assert that sterilising a patient for non-medical reasons—for example, when pregnancy would present no unusual risks to the woman's life or health—does not fall within the remit of medicine. Doctors are there to treat medical conditions alone, and sterilisation for purely lifestyle reasons cannot be considered treatment of a medical condition. Secondly, they might distinguish allowing people to make risky choices from helping them to do so. Even if a doctor does not confiscate the bottle of whisky from her drunken patient, she will feel under no obligation to buy her another bottle.

The first objection can be dealt with straightforwardly. Of course, normal fertility is not a medical condition in need of intervention. But there is no good reason why doctors should not sometimes use their skills for non-medical interventions. Indeed, they commonly do; the most obvious example of this is the dispensing of contraception.

The second objection turns on a much discussed distinction between causing and allowing some bad

thing to occur, and in many contexts this distinction bears moral weight. However, to assess this objection means asking in more detail what kind of harm doctors may be implicated in, if they grant a patient's wish for sterilisation.

Paternalism and future regrets

The main question to be discussed is whether the possibility that the patient will later regret the decision to be sterilised should be taken into account when deciding whether to offer the procedure. Although sterilisation can sometimes be reversed, the chances of success are low (below 50%), and patients seeking the operation are advised to assume that it is irreversible.

An initial response to this concern is that it is unjustified, not to say condescending, to assume that the operation is likely to be regretted. People who want this operation have usually thought about it long and hard; why then not believe them when they say they are sure they will not regret it? At the same time, many people do later regret making such irreversible decisions, and it is these cases that are ethically more interesting. Studies have shown that about a fifth of women regret their decision to be sterilised.² Furthermore, if the decision was taken when the woman was aged 18 to 24 she was four times more likely to request reversal than if she was over 30.³ Regret is also associated with failure of a relationship, but in the under 30 age group the fundamental variable seems to be age at sterilisation.⁴

Suppose a doctor has good evidence based reasons to believe that a particular patient will regret sterilisation 10 years later if the operation goes ahead. How should the doctor act? It is tempting to see this as a question about paternalism, about over-riding a patient's wishes for the sake of her best interests. Here, the idea is that it is not in a patient's best interests to be sterilised. In view of this, the doctor must decide how to balance the patient's present wishes and her best interests.

Present and future interests

Close analysis shows that this balance does not involve a straightforward conflict between paternalism and respect for autonomy. A paternalistic doctor over-rides a patient's wishes to better promote what the doctor believes to be the patient's best interests. In the case of sterilisation, we have a conflict between two different wishes, separated in time: the present wish never to have children (and to be sterilised to ensure this) and the statistically possible future wish to have children and therefore not to have been sterilised. Fulfilment of the potential later wish would not promote the patient's interests more than fulfilment of the earlier wish. And even if it would, this is not because the second wish comes later. There is no reason why later wishes should be any more conducive to best interests than earlier ones; after all, it is possible to become more foolish as life progresses, rather than wiser.

If we argue that refusing requests for sterilisation is paternalistic, we need to be more careful. We might first distinguish between those wishes that are relatively autonomous and those that are less so. And we could plausibly suggest that wishes that are well informed

and directed at the long term are more autonomous than those that are badly informed and subject to the seductions of the short term view.

The idea of the Ulysses contract was formulated to capture this thought.^{5,6} Suppose I know today, while not craving a harmful drug, that tomorrow I shall crave it and give in to the desire, against my better judgment. So today I ask a friend not to allow me access to the drug tomorrow. But tomorrow, of course, I shall regret today's request and ask the friend to ignore what I said. What should the friend do? One obvious answer is that the friend should keep me from the drug, simply because it is bad for me; this would be straightforwardly paternalistic. But a more interesting answer is that the friend should stop me taking the drug, not because it is bad for me, but because today's request to be kept from the drug is more autonomous than tomorrow's request to be given it. Actions driven by extreme cravings may be less autonomous than actions undertaken more coolly.

Can anything similar be said about the sterilisation case? If autonomy is the issue, the idea to explore is that the putative later wish to be able to have children is more autonomous than the earlier wish never to have any, perhaps because we get more experienced and mature as we get older. Although this may sometimes be true, it will not always be. The fact that one wish comes later than another one does not make its fulfilment better for me, nor does it make it more autonomous. Rather, we simply face a judgment call based on the facts of the particular situation.

How should the doctor respond?

The case described at the beginning of the article gives rise to three main considerations:

- Doctors should not be forced to perform a sterilisation if they believe that it is not in the best interests of the patient.
- To make the judgment that sterilisation is not in the patient's best interests, doctors:
 - Must be honest about their philosophical position. If the doctor is opposed to sterilisation in any circumstance then this should be explained to the patient and the patient should be referred to another doctor.
 - Must be able to explain why they believe the request for sterilisation is not in the patient's best interests (setting aside the possibility of regret).

Summary points

Young childless women are most likely to regret the decision to be sterilised

Rational considerations taken when young are not necessarily less good than those made when older

Later regret should not be a factor in a doctor's decision about whether sterilisation is in a patient's best interest

Sterilisation of young, childless adults for non-medical reasons is ethical if they are properly informed of all the risks, including regret

- If a competent adult patient voluntarily requests sterilisation they must be informed of the risks and benefits of the procedure, including the chance that he or she may regret it later.
- If these conditions are followed, and if the doctor agrees to the procedure, it is morally defensible, even if the patient is young and childless.

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- 1 General Medical Council. *The duties of a doctor registered with the GMC*. www.gmc-uk.org/standards/default.htm (accessed 5 April 2005).
- 2 Marcil-Gratton N. Premature recourse to tubal ligation in Quebec: some undesirable consequences? *Sociol Soc* 1987;19:83-95.
- 3 Schmidt JE, Hillis SD, Marchbanks PA, Jeng G, Peterson HB. Requesting information about and obtaining reversal after tubal sterilisation: findings from the US collaborative review of sterilisation. *Fertil Steril* 2000;74:892-8.
- 4 Jamieson DJ, Kaufman SC, Costello C, Hillis SD, Marchbanks PA, Peterson HB. A comparison of women's regret after vasectomy versus tubal sterilisation. *Obstet Gynecol* 2002;99:1073-9.
- 5 Lavin M. Ulysses contracts. *J Appl Philosophy* 1986;3:89-101.
- 6 Pennings G. The validity of contracts to dispose of frozen embryos. *J Med Ethics* 2002;28:295-8.

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A helpful patient

We were impressed recently at the lengths a patient will go to in order to assist his doctors.

A man attended the dermatology clinic, having been referred with a troublesome, red, itchy rash on his hands. Concerned that the rash might improve before he could show it at his appointment, he had taken photographs of each hand so that a retrospective diagnosis might be possible. The rash deteriorated, however, and so more photographs were required to document the progression accurately.

The patient was a keen amateur photographer who developed his own pictures, and so every few days he took further photographs, each set worse than those before. These he mounted in a small album and proudly presented at his first

appointment as photographic evidence of his ordeal, and in the hope of assisting with the diagnosis.

A lichenoid reaction was seen histologically on skin biopsy. Patch testing confirmed allergic contact dermatitis to hydroquinone, a chemical present in colour photographic developer, which is recognised as producing an allergic lichenoid reaction.

Unfortunately, the patient's eagerness to assist his doctors had not been in his own best interest.

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