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Paper:

McQueen, P. (2017). Autonomy, age and sterilisation requests. *Journal of Medical Ethics*, 43(5), 310-313.
<http://dx.doi.org/10.1136/medethics-2016-103664>

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Autonomy, age and sterilisation requests

ABSTRACT

Sterilisation requests made by young, childfree adults are frequently denied by doctors, despite sterilisation being legally available to individuals over the age of 18. A commonly given reason for denied requests is that the patient will later regret their decision. In this paper I examine whether the possibility of future regret is a good reason for denying a sterilisation request. I argue that it is not and hence that decision-competent adults who have no desire to have children should have their requests approved. It is a condition of being recognised as autonomous that a person ought to be permitted to make decisions that they might later regret, provided that their decision is justified at the time that it is made. There is also evidence to suggest that sterilisation requests made by men are more likely to be approved than requests made by women, even when age and number of children are factored in. This may indicate that attitudes toward sterilisation are influenced by gender discourses that define women in terms of reproduction and mothering. If this is the case, then it is unjustified and should be addressed. There is no good reason to judge people's sterilisation requests differently in virtue of their gender.

INTRODUCTION

Many of us live in a society that is strongly structured around the family. It is typically taken for granted not only that one will marry and have children, but also that parenthood is an intrinsically valuable and rewarding experience.[1,2] This is reflected in the fact that one rarely needs to offer a justification for the decision to conceive a child. In contrast, it can strike people as unusual and even suspicious if one declares that one never wants to have children.[3–6] This is especially the case for women. As Gillespie argues, ‘Failure to become a mother is interpreted within a western biomedical framework as a physical or psychological illness’,[7] an assumption that implies that no woman would autonomously choose to forego parenthood. [1,8] Nevertheless, a growing number of women (and men) are consciously deciding to live a

childfree life.[3–7] Some of these individuals identify sterilisation¹ as their preferred form of contraception. There is evidence that many requests for sterilisation are denied by doctors, especially when the request is made by a woman without children and under the age of 30.[5,7,9] This fits with the advice to patients on the National Health Service (NHS) website, which states that ‘Surgeons are more willing to perform sterilisation when women are over 30 years old and have had children’.[10, cf. 11]

Denied sterilisation requests raise important questions about autonomy, age and the doctor-patient relationship. Autonomy is typically understood as the capacity for self-government or self-determination; in short, as being the “author” of one’s life by choosing the course that it will take.[12] This involves being able to both reflect and act upon one’s desires and preferences. To respect a person’s autonomy involves refraining from interfering with their decisions, provided that the individual meets certain standards of psychological functioning and their decisions are reached in an appropriate, autonomy-consistent manner (i.e. free from coercion, delusion, misinformation, deception, manipulation and the like). Within a health care and medical context, it is standard to expect doctors to treat their patients who are decision-competent in ways that express respect for their autonomy, such as by obtaining their informed consent for procedures and being responsive to their wishes.[13] Thus, respect for a patient’s autonomy is seen to safeguard individuals from paternalistic treatment. In light of these considerations, when, if ever, is it justifiable to deny a sterilisation request made by a decision-competent adult?

Despite the importance of this question, and the significance that the decision can have for a person’s life, there has been a dearth of philosophical discussion about the ethics of voluntary sterilisation. In particular, little attention has been paid to the role that regret should play in medical decision making and whether the possibility of future regret should count as a decisive reason to deny a person’s sterilisation request. In addressing this deficit, the paper seeks to make an important contribution to discussions about voluntary sterilisation and the relevance of regret and gender to such debates. Its central claim is that the possibility of future regret should not be treated as reason to deny a sterilisation request, so long as the request is justified at the time of asking.

¹ Due to negative associations with the word “sterilisation”, the term “female permanent contraception” is starting to be used in its place. However, the majority of authors writing on this topic continue to use “sterilisation” and I thus I follow them in this regard.

SEEKING STERILISATION

There are many reasons why a person may request to be sterilised: they may not want any (more) children; their physical health could be at risk if they become pregnant; they might find alternative forms of contraception undesirable because of their adverse side-effects. I will treat these reasons – and others like them – as good ones to offer in order to justify a sterilisation request. I assume also that the use of contraception in general is morally acceptable. Starting with these assumptions, I shall explore whether it is permissible to deny a sterilisation request made by an autonomous agent who, following appropriate deliberation, has decided that they do not want to have any (more) children.

In the UK sterilisation is, in principle, available to any decision-competent individual over the age of 18. However, Richie reports that women's accounts of denied sterilisation requests are 'ubiquitous'.^[9] Recounting her personal experiences, Holly Brockwell reveals that she first requested sterilisation at the age of 26, which was denied by her GP. She was then denied sterilisation a further four times in three years before, at the age of 30, her request was finally approved.^[14] Two reasons that are frequently given by doctors for denying a sterilisation request are that the patient is too young and that they will later regret their decision ^[5,9,15]. Are these reasons defensible?

HOW YOUNG IS TOO YOUNG?

In UK law, and barring certain psychological / mental difficulties, when a person turns 18 years of age they are recognised as an adult and hence able to act autonomously (e.g. without the consent of parents). Indeed, in many countries, including the UK, a person can legally choose to have a child and to get married from the age of 16 (although if they are under the age of 18, then they must have parental consent). In light of this, it appears questionable that Holly Brockwell would be denied sterilisation at the age of 26 because she was "too young", especially given the fact that she had subjected the decision to extensive and careful deliberation and that she had had adverse reactions to alternative forms of contraception.^[14]

It seems that the specific age of an adult making a sterilisation request cannot be normatively significant in itself. A person at, say, 26 years of age is typically capable of understanding their longer-term desires, beliefs and of formulating life plans. Thus, they are able to make autonomous decisions and are recognised as such by the law. Rather, what seems to be doing the normative work here is the assumption that a person at 26 is likely to change their mind and will later want to have children, regardless of their present beliefs and desires.[7] Thus, a person's age is relevant because it signifies the likelihood of future regret. Accordingly, a doctor is seen to be justified in denying a sterilisation request because they are preventing the individual from making a decision that they will later regret.

AUTONOMY AND FUTURE REGRET

There are two distinct issues relating to regret. The first is an empirical one: do people who choose to be sterilised later regret their decision? The second is a normative one: ought we to consider the possibility of regret as a reason to refuse a sterilisation request? These two issues interrelate. If most people do experience post-sterilisation regret, then this could support the claim that we should not sterilise people, or at least those people particularly prone to future regret. Conversely, if regret is very rare, then one may not see possible future regret as a good reason to refuse a request. However, one may also hold that possible future regret is irrelevant to deciding whether to agree to or deny a sterilisation request, regardless of the occurrence rates of post-sterilisation regret; or, at the very least, one may believe that the possibility of future regret ought not override a person's present desires.

According to Benn and Lupton's survey of the research, about a fifth of women regret their decision to be sterilised.[16] Following their own analysis of existing studies, Zite and Barrero conclude that the prevalence of regret ranges from 1-30%.[15] In Campbell's research, 22 of the 23 voluntarily sterilised women she interviewed did not regret their decision.[5] A more extensive study of 11,232 women by Hillis et al. found that 20.3% of participants between the ages of 18 and 30 at the time of sterilisation regretted their decision 14 years after the procedure was performed. Notably, the probability of regret was much *lower* for women with no children (6.3%). For women over the age of 30 the overall probability was 5.9%, with a figure of 5.4% for childfree women.[17] Finally, in a study of Slovenian women, Becner et al. report that out of 308 women only four (1.3%) reported regret about being sterilised.[18] Based on such

findings, Curtis et al. conclude that ‘most women who undergo sterilization remain satisfied with their choice of a permanent method of contraception’.[19]

As Hillis et al.’s study indicates, there is evidence that younger women are more likely to experience post-sterilisation regret than older women.[17,19] One study of 846 women who had undergone sterilization in Puerto Rico revealed a 10% increase in the risk of regret for every one year decrease in age, although not all of these sterilisations were voluntary.[20] Research conducted in the Dominican Republic found that, compared with women over the age of 30, women under the age of 30 were 2.17 times more likely to report dissatisfaction with their decision to be sterilised and 1.39 times more likely to report regret. However, it should be noted that of the women under 30 only 11.6% expressed dissatisfaction with being sterilised and 21.7% said they regretted their decision.[21]² Accordingly, the increased likelihood of younger women regretting their decision compared to older women has to be set against the overall relatively low levels of post-sterilisation regret for all ages.

One issue to note is that there is a paucity of data on post-sterilisation regret.[9] In addition, many of the existing studies do not indicate the intensity of the regret, if it was long-lasting or fleeting, and whether it was recurrent or one-off. For example, Hillis et al. determined the presence of regret in participants by asking “Do you still think tubal sterilization as a permanent method of birth control was a good choice for you?” This fails to identify the strength and persistence of regret. Indeed, it is debatable whether this question is adequate for identifying regret at all.³ Accordingly, firm conclusions about the likelihood of post-sterilisation regret and its specific nature are difficult to draw, given the lack of research into this issue.

One also needs to consider the normative significance of regret. How is it relevant to the assessment of a sterilisation request? Benn and Lupton argue that there is no reason to assume that we should give priority to a person’s possible future wishes over and above their actual present ones.[16] Thus, even if it is the case that a person’s preferences do change in the future, with the result that they experience regret, this does not itself count as a sufficient reason for these future preferences to override the preferences that the person currently holds: ‘after all, it is possible to become more foolish as life progresses, rather than wiser’.[16] Furthermore,

² The discrepancy between these two figures raises questions about how “regret” was understood by participants.

³ The difficulty of how one can and should identify post-sterilisation regret applies to all research in this area.[4]

there is no guarantee that a person will change their mind. As the above research findings suggest, it is entirely possible (likely, even) that the person's beliefs and desires will remain fairly constant and that they will not regret their decision.

It can also be argued that future regret is a risk that an autonomous agent takes when making a decision. Such a risk is unavoidable because one does not, and cannot, know for sure how one will change as a person over time and one cannot foresee with any certainty how one will later feel about one's decisions. Thus, it is a condition of being respected as autonomous that we are permitted to make decisions that we might later regret, so long as we can justify our decisions at the time they are made. As Richie argues, 'regret is the competent woman's burden, not the doctor's'.^[9] Similarly, Denbow declares that autonomy 'entails living with the consequences of decisions instead of being relentlessly protected from potential adverse outcomes'.^[8]

Within a medical context, many elective surgeries are typically approved, such as breast enlargement or kidney removal for donation, despite the possibility that the individual will later regret their decision. Similarly, medical procedures such as blood transfusions can be refused by the patient irrespective of their future assessment of this decision. The ability to undergo or to refuse treatment is grounded in respect for the patient's capacity for making autonomous decisions. It is unclear why sterilisation requests warrant differential treatment when they are made by decision-competent adults who are certain that they do not want children.

It is also important to note that some individuals regret *having* children,^[2] and yet this possibility is rarely raised as a reason to prevent someone becoming pregnant. In the UK, for example, the eligibility criteria for IVF treatment make no reference to the possibility of regretting one's decision as a reason against offering it.⁴ It is unclear why the burden of justification lies with the person who does *not* want to have children, especially given the impact that having a child has on the individual, their family and wider society. This indicates a questionable asymmetry based upon a pronatalist discourse in which parenthood is the normative position and refusing to have a child is treated as deviant.^[2–4,6,7] One woman described her experiences as follows:

⁴ See <http://www.nhs.uk/Conditions/IVF/Pages/Availability.aspx> and <https://www.nice.org.uk/guidance/cg156/chapter/Recommendations#access-criteria-for-ivf>.

I have made all kinds of noises, with my GP, with the Clinic and all over the place to say that I want to be sterilised. But they just won't have it, because I'm too young... I am too young to know what I want, if what I want is not to be a mother. It would be different if I wanted to be a mother. I would not be too young then.[7]

Finally, more needs to be said as to why the experience of regret is normatively undesirable. Why is it that we should be protected from the possibility of regretting a decision, if the decision can be justified at the time it is made? If the motivation is to improve the future well-being of the individual by preventing regret, then it is important to acknowledge that the denial of sterilisation can have a negative impact upon the requester.[5,9] As Dworkin notes, 'because my body *is* me, failure to respect my wishes concerning my body is a particularly insulting denial of autonomy'.[12] Furthermore, contrary to popular assumptions, it is not clear that having children will improve one's well-being and it may actually lower it.[22,23] In a recent overview of research findings, Simon concludes that 'parents of grown children have no better well-being than adults who never had children'. Jeffries and Connert report that, of 72 female participants, those who had chosen to be childless had higher overall levels of well-being and fewer regrets than mothers.[24]

In conclusion, if a decision-competent woman (or man) has good reasons to want to be sterilised – reasons that accurately reflect her (or his) desires and life-plans – then the possibility of regret should not be taken as sufficient justification to deny the request. When a patient requests sterilisation, the focus should be on whether they have good reasons for their decision *now*, rather than how they might change as a person in the future.⁵ Furthermore, the claim that the denial of their request is justified because it is for their own (future) good can be challenged for being paternalistic and also because it is not supported by the experiences of those who are voluntarily sterilised. The large majority of these individuals do not regret their decision and the lives of childfree individuals are not, on average, less happy or fulfilling ones than the lives of parents.

AUTONOMY, AGE AND GENDER

⁵ Note that if a person currently plans to have children of their own in the future, then they do not have a good reason to be sterilised and hence denying their request would be justified.

If women over the age of 18 are formally recognised to be capable of making autonomous decisions, then why do many of them, especially those under the age of 30, struggle to find a doctor willing to agree to their sterilisation request? It is possible that certain problematic assumptions about gender and female identity inform attitudes toward the autonomy and self-knowledge of individuals seeking sterilisation.[3,6] This is suggested by the apparent fact that men rarely have any difficulty in receiving a vasectomy. Although there is an absence of research into male sterilisation requests, Richie reports that, from what anecdotal evidence she can gather, men's requests for sterilisation are typically agreed to.[9] Holly Brockwell revealed in a radio interview that, although her sterilisation request had been denied, her doctor suggested that Brockwell's boyfriend, who was 24 at the time, should have a vasectomy instead. This recommendation could have been based on the fact that vasectomies are more easily reversed than female sterilisations⁶ – and without speaking with the doctor we cannot know – but Richie nevertheless attributes the apparent ease with which men obtain vasectomies to 'the view that men are less bound by cultural norms of parenthood and more competent to make decisions'.[9]

This suggests a worrying gender difference, which could reflect a problematic discourse that defines all women as wanting to raise children. Even if a woman does not desire to have children now, it is assumed that she will do in later life – especially once her “biological clock” starts ticking. Thus, for a woman to choose to be sterilised is for her to go against her fundamental nature as a woman.[2–4,6] There could be a lingering suspicion that a woman who requests sterilisation is not making a properly informed, autonomous decision because no rational woman would want to forego parenthood.[7]⁷ Denbow and Richie each argue that this gender difference in approved/denied sterilisation requests indicates that men are considered to be more autonomous than women and hence better able to make decisions about their lives.[8,9] It may also reflect the assumption that women are more in need of protection than men, and hence should be shielded from regret.

It is not possible to assert with any degree of confidence that doctors are being guided by questionable, essentialising assumptions about female identity when they respond to a

⁶ I am grateful to an anonymous reviewer for this point.

⁷ Although it is important to note that being sterilised does not necessarily prevent one from becoming a parent, provided that options such as adoption are available to individuals.

sterilisation request. However, the difficulties many women appear to face when seeking sterilisation, coupled with the apparent ease with which men are able to be sterilised, suggest the need for further research into this issue. There can be no defensible justification for treating men and women differently when it comes to sterilisation requests. The moral dictum to “treat like cases alike” is applicable here, for there is no relevant difference between men and women that would vindicate differential treatment. One’s gender should be irrelevant to the assessment of a sterilisation request.

ARE ALTERNATIVE CONTRACEPTIVE METHODS PREFERABLE?

Even if one accepts that sterilisation is a viable option for individuals, including young, childfree women (and men), then one might still argue that alternative contraceptive methods should be favoured. Thus, one could deem sterilisation to be a “last resort” form of contraception, to be considered only when all other options have been rejected. In particular, there are an increasing number of intrauterine devices (IUDs) and subcutaneous implants that represent a long-term form of contraception, which avoids many of the difficulties associated with condoms and the pill. Although not permanent, some can be effective for up to ten years and are removed with relative ease. Thus, IUDs may be seen as offering the benefits of sterilisation whilst avoiding the danger of future regret because they are not permanent.

Perhaps, then, one should only be offered sterilisation if one is unable to use IUDs (e.g. if one has a copper allergy). However, even if one could use an IUD, there seems no good reason why this should *necessarily* be offered instead of sterilisation if the individual is certain that they never want to have children. Assuming, as I argued above, that the possibility of regret is not a decisive reason to withhold sterilisation, why should an IUD be preferable to sterilisation? Given that some IUDs last for five years, an individual who does not want children will have to have it replaced numerous times over the course of their life. Perhaps a doctor should inform their patient about IUDs, but it seems ethically unwarranted to only offer sterilisation when an IUD is not a viable option.

CONCLUSION

There is evidence that many women, especially those without children and under the age of 30, have great difficulty in being sterilised. A commonly reported reason for this is concern that they will later regret their decision. However, empirical research does not show high levels of post-sterilisation regret, even for women with no children. Furthermore, even though post-sterilisation regret is possible, I have argued that it does not carry much normative weight. If an individual is capable of making autonomous choices and has good reasons for requesting sterilisation, then it should be offered to them. The possibility that they may later regret is a risk that they ought to be allowed to take. There also appears to be a worrying gender asymmetry with regard to approved sterilisation requests. Concerns about voluntary sterilisation might be grounded in questionable gender discourses that essentialise women in terms of child-bearing and parenthood. If this is the case, then it should be challenged. One's gender is irrelevant to whether a sterilisation request should be approved and there is no reason to think that women are less capable of autonomous decision making when it comes to choices about reproduction.

Funding: X is an Irish Research Council Government of Ireland Postdoctoral Research Fellow

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