Nonsurgical aspects of female sterilization: The San Francisco General Hospital experience

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The experience of a publicly funded program of voluntary sterilization involving 817 cases performed between January, 1979, and July, 1981, is reviewed. The social and demographic characteristics of this patient population are analyzed, with special emphasis on the possibility of eventual regret among young, unmarried, and childless women requesting sterilization. The evidence to date suggests that this group appears capable of making well-considered decisions and, thus far, do not appear at high risk for regret. Age, marital status, or parenting are not justified as categorical criteria for denial of sterilization. Insightful counseling remains the keystone of sterilization care.

THERE ARE many reasons to consider the "software" of sterilization. The demographic characteristics of women seeking permanent contraception and the changing societal context in which it occurs render many earlier studies of satisfaction and regret obsolete. Hospital and physician attitudes have also changed, with more permissiveness regarding indications and yet tightening of the procedural requirements for informed consent in many cases.

In view of these changes, it is important that we avoid a narrow biomedical approach to sterilization. In 1967 the Pacific Coast Obstetrical and Gynecological Society held a panel discussion entitled "Sterilization of Women" at which both biomedical and sociocultural aspects were discussed.[1] Its cautious consensus was that contraceptive sterilization was gaining in acceptance. Little did anyone at that meeting foresee, however, that within less than 15 years, sterilization would have become the third most frequently performed gynecological operation and the method of contraception most frequently requested by married couples. In the past decade some 13 million women in the United States have chosen to be sterilized, and access to this method of birth control has been extended through public-funding mechanisms to reach all socioeconomic levels of society.

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In 1976, when Title XX funds became available to provide sterilization service for eligible low-income patients, San Francisco General Hospital (SFGH) entered into a contract with the California State Department of Health to provide this service to a clientele referred from a variety of Bay Area health agencies. It is important to recognize the social context in which this program was initiated. The decade of the 1970's was one of profound change in the character of the U.S. family. It was a decade in which fertility continued a downward trend. The "baby boom" generation was growing up and did not march to the pronatalist drum that guided its parents. It was a decade of influx of women into the work force. Motherhood as the central purpose of a woman's life changed from obligation to option and the childless began to be called "childfree." It was a decade of disenchantment with the "Pill" and the intrauterine device (IUD), which had been the contraceptive "glamour stocks" of the 1960's. Concomitantly, laparoscopy and, later, minilaparotomy had made permanent contraception safer, cheaper, more comfortable, and less dependent on hospitalization.

The evolution of this hospital-based program was also shaped by the political tenor of the times. It was profoundly influenced by the feminist movement, which found women demanding an increasingly active participatory role in their own health care. At the same time, the national concern for the protection of voluntarism and fully informed consent had resulted in federal and, in California, state regulations governing the content of counseling for contraceptive sterilizations.

The multi-ethnic, low-income character of the popu-

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Table I. Age-parity distribution of women sterilized at SFGH (1979-1981)

Age	*No. of living children*										*%*	*Total*
	0	1	2	3	4	5	6	7	8	9		
<25	34	21	42	15	1	0	0	0	0	0	15.4	113
25-20	34	47	57	31	22	9	1	2	0	0	27.6	203
30-34	35	54	59	45	26	8	5	1	1	2	32.1	236
35-39	11	21	38	19	19	9	2	4	4	2	17.2	129
40-44	5	6	12	11	8	4	2	1	1	2	7.1	52
45-49	0	0	2	0	0	0	1	0	0	0	0.4	3
Total											100%	736

NOTE: Missing data in 81 cases.

lation traditionally served by the county hospital required painstaking efforts to assure that patients would not be subjected to discriminatory or coercive influences.

To meet these challenges, feminist and consumer organizations were invited to participate in planning the service at SFGH. Bilingual counselors, who were themselves consumer advocates, were recruited from the communities represented in the patient population. Special culturally sensitive training and supervision were provided with equal emphasis on the social and medical details of sterilization. From the start, couple counseling was encouraged and vasectomy service offered along with female sterilization. But, in fact, requests for female sterilization have far outnumbered those for vasectomies. Emphasis on presterilization counseling has been on the credibility of the patient's decision, with an effort by the staff to avoid either pro- or antinatalist bias. No institutional barriers to sterilization on the basis of age, marital status, or parity have been imposed; thus the only absolute contraindication to sterilization under this program is the inability to arrive at a fully comprehended informed consent.

The significance of a mandatory waiting period between counseling and operation deserves further study. The state regulations call for a 2-week waiting period, which can be waived to not less than 3 days only on the initiative of the patient. It is intended as an opportunity for reflection, consultation with family or friends, or resolution of conflict over one's decision. At SFGH the interval between counseling and surgery averages 2 to 3 weeks. We have observed that as many as one third of the women seen for presterilization counseling do not proceed to sterilization. While some make known their decision not to proceed based on the content of the counseling encounter, many simply call to cancel the scheduled surgery, "postpone" (often indefinitely), or simply fail to appear and are lost to follow-up. A prospective study of this group is planned in order to ascertain the qualitative content of counseling and the role of the waiting period per se.

Results and comment

Table I gives the age distribution of those sterilized under this program. It is noted that 15% were less than 25 years of age, compared with 17% reported in the sample studied by the Sterilization Surveillance Unit of the Centers for Disease Control (CDC) for the years 1976 to 1978,[2] although our patient population differs from the CDC sample in several characteristics, which makes comparisons difficult. We are, nevertheless, interested in learning more about the motivations of young women seeking sterilization. We do not, pro forma, subject applicants who are young, unmarried, or childless to psychiatric consultation or extraordinary measures that might be construed as obstacles. They are, however, encouraged not to exercise the shortened waiting period allowed under the regulations, to return for additional counseling or consultation when indicated, and to weigh heavily the long-range implications of their decision.

Of those less than 25 years of age, 34 patients (30%) had no children, while 79 (70%) had one or more children. Fifty-eight percent of the 113 less than 25 years of age were unmarried at the time of sterilization. A total of 33 were less than 25 years of age, unmarried, and childless.

Several sources have suggested that women under age 30 years should categorically be denied sterilization.[3] Others focus on marital status, citing cases in which fertility aspirations have changed with new relationships. Our own observations are more consistent with the view that this group is to be taken seriously as representing the new "childfree" alternative that has emerged in U.S. family patterns. In a study of a small subsample of women sterilized at SFGH in 1980, Nakell[4] compared 15 childless women undergoing sterilization with 13 who had had one or two children. Demographic characteristics, family background, contraceptive his-

tory, decision process, mood and self-perception, and expectations following sterilization were studied by using a combination of interview and psychological testing. The results showed that the childless women had considered sterilization longer, were more autonomous, and were less anxious and confused at the time of decision making than the women with children. The childless group demonstrated more change in those areas of their lives that indicate nurturance and expressed less expectation of change in their personal adjustment, a finding that is perhaps not surprising since these women seek preservation of a status quo, as opposed to mothers requesting sterilization who view it as a liberation from the previously experienced burdens of childbearing and childrearing.

Although the sample used in this study is admittedly small, the results were statistically significant and suggest that the childless women studied are capable of making well-considered decisions consistent with their life-styles and goals. The results of the study are consistent with our clinical observations of those childless women who are not screened out by the counseling process and whose decision for sterilization remains resolute.

Further supporting these observations is our experience that requests for reversal of sterilization among young, childless women appear to be rare. Thus far, of a total of 1,486 women sterilized at SFGH since 1975, only four are known to have returned to request reversal, and only one of these was childless. This may, admittedly, underrepresent the true incidence of regret, since neither prospective study nor long-term follow-up has been actively pursued. Nor do we know how many may have sought reversal elsewhere. It is, nevertheless, consistent with the observations of others reporting on sterilization of both men and women who have never had children.[5–8]

In general, we subscribe to most of the guidelines emerging in the literature regarding risk factors for regret.[6, 7, 9, 10] Those whose sterilization is medically indicated, those whose decisions may be influenced by the stress of childbirth or abortion, and those in unhappy or unstable relationships are clearly at higher risk for regret and call for special counseling. We do, however, disagree with blanket exclusions that designate either age, marital status, or parity per se as categorical criteria for denial of sterilization. We must not substitute an equally irrational "rule of 30" for the old, infamous "rule of 120" that placed an arbitrary barrier in the way of many women desiring sterilization two decades ago.

We believe we are supported in this view both by our own experience and by current trends in fertility patterns in the United States. Both the Select Panel for the Promotion of Child Health[11] and the Joint Economic Committee of Congress predict that the present low levels of fertility will continue. The growing role of women in the work force, with more than 50% of women in the United States now working outside the home, is a major factor in this projection. The recently released study of trends in U.S. family life by Bloom[12] indicates childlessness, singleness, and "second-career marriages" on the rise, with divorce rates now at about 50% of the marriage rate. This study shows that whereas only 24% of ever married women 20 to 24 years of age were childless in 1960, the percentage had jumped to over 40% by 1979. The time-honored stereotype of the nuclear family—father, mother, and two children—is now seen in only 7% of U.S. households.

Commenting on a recent University of Michigan study of a "National Cross-Section of Americans on Attitudes Toward Marriage and Children," Douvan has observed that "today marriage and parenthood are rarely viewed as necessary, and people who do not choose these roles are no longer considered social deviants."[13] It now appears that we are experiencing a shift of the burden of proof from those who do not procreate to those who do!

In the face of these bewildering changes in U.S. life-styles, there is every reason to expect continuing high demand for sterilization. What should our response be as gynecologists to the changing social milieu in which we practice?

At the very least, prudence dictates that we hedge our bets against potential regret by adopting surgical techniques that minimize tubal damage. Results of tubal reconstruction are improving steadily, and experimental attempts at reversible sterilization show promise. For practical purposes, however, the operation still represents a permanent decision. Accordingly, further study on the nuances of decision making and the precursors of regret are necessary.

In the meantime, insightful counseling, whether provided by the private physician or the trained counselor in an institutional setting, remains the keystone of sterilization care.

We cannot eliminate regret entirely. But the potential for regret is but one ingredient in a risk/benefit equation in which the social context argues increasingly for the benefits of sterilization. We shall, of course, continue to exercise caution and careful selection of candidates for sterilization. We must also, however, expand our biomedical horizons to a view of the patient's total life experience if we are to do full justice to the new woman of the eighties.

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Discussion

Dr. David Pent, Phoenix, Arizona. Dr. Minkler has pointed out that past studies of satisfaction and regret concerning surgical sterilization are obsolete. The social climate that has brought about the dramatic changes in this area of gynecological practice was discussed at length, but there is a paucity of information on some important aspects of the SFGH experience. For one thing, the counselors are described as being "consumer advocates" and "recruited from the communities represented in the patient population." I'm not sure just what that means and just what the counselors' qualifications were.

Counseling consists of both an information component and a feeling component—the counselor needs to be able to assess the information coming from the patient and appreciate those subtle keys to deeper feelings that are expressed by the patient. The counselor, therefore, should have some type of formal or structured training. Furthermore, counseling the economically deprived poses special problems. Psychotherapy and counseling have traditionally been oriented to the middle and upper classes. This has changed somewhat, largely in the past decade, with the institution of various poverty programs. As Donald Blocker points out in his book *Developmental Counseling*, there are three baseline differences in counseling the economically disadvantaged. First, lower class people are generally more fatalistic. Second, they tend to polarize the masculine-feminine roles, with exaggerated stereotypes of masculinity and femininity. Third, there is a need for immediate gratification of perceived needs and thus a lack of ability to defer anticipated needs. All of these factors have special importance when counseling for surgical sterilization, and realizing this is a prerequisite for meaningful counseling of patients such as those reported on here.

Using the creditability of the patient's decision as the only criterion for performing the sterilization, without regard to age, parity, and marital status, is certainly to be commended. The general experience has indeed been that the young, single childless group rarely does regret this decision. This may be due to the fact that sterilization requests often have an element of economic and emotional coercion—the financial stress involved in clothing, feeding, and educating another child and the stress of the interpersonal relationships in marriage. The young, single woman, however, is relatively free from the coercion and can reach her decision based more on her own personal goals. One other factor is that because of our own personal biases, we may be doing a better job of screening and counseling this group of patients.

Dr. Minkler states that their experience shows requests for reversal of sterilization among young, childless women appear to be rare. I do not find a basis for this in the figures he presents; in fact, it appears to me that his nulliparous patients have a higher rate of reversal requests. These figures, however, have no statistical significance, since they only involve four patients, and as Dr. Minkler points out, complete follow-up is needed to establish more meaningful data. In fact, there are really no data from this study to show any objective assessment of the success of the sterilization program at SFGH with regard to "satisfaction and regret." This is especially unfortunate in the one third of the patients who decided not to be sterilized. Kahil Gibran said that if you would understand a man, listen not to what he says, but to what he does not say. Similarly, if we are to understand our patients and their requests and needs for sterilization, we should look not to those who are sterilized, but to those who have not been sterilized.

Dr. Keith P. Russell, Los Angeles, California. As I recall, I was a member of that panel 15 or so years ago referred to in Dr. Minkler's opening remarks. I was struck by his use of the word *infamous* for the "rule of 120" which was considered acceptable and, in fact, was being utilized at that time. And yet, where have we gone in that 15 years? He implies that we were very backward then. But the same rules still apply, from a professional application, without making them categorical written rules. His largest number of patients are those of greater parity and older age groups. In other words, age 30 and para 4. There were only 35%, despite removing all these categorical restrictive guides, out of 700 cases in which the rules have not been applied. I don't wish to sound as if I am against sterilization when indicated, but I think that most obstetricians still exercise a certain amount of professional integrity and do a professional evaluation; what has been removed, essentially, are the legal restrictions. We still are motivated by the desire to preserve fertility, and properly so, except in those cases in which continued fertility would be detrimental to the mother's health, medical or social. I simply wanted to point out that it appears as though the "infamous" rules are still at work without being written down, if you look at the numbers.

Dr. Simon Henderson, San Francisco, California. I think the young woman who wants to be sterilized really has to have special attention. Although the presentation is an excellent subject, I think that 5 years is perhaps too short a time to really evaluate the data. After all, when patients were sterilized at 18 years, and some of these patients in this presentation were that age, they are really still not old enough at 23 years to have changed their minds. In my infertility practice, I generally am seeing a lot more women in their thirties, usually 35 or 36 years, who are often career women that have suddenly realized that their reproductive life is running out and have decided to have children. I wonder if the young patients who are sterilized will have the same response when they are in their thirties. If they do, I hope they were sterilized by a method that damages only the midisthmus of the tube.

Dr. John Miller, Sacramento, California. There is an issue addressed in Dr. Minkler's paper that is significant in terms of his attempt to find counselors from the community. I would suggest that you reflect back on the reason we have sterilization regulations. The case of *Relfs vs. Weinberger* involved two black girls who were sterilized under a federal program. To the public there is still the implication that we are sterilizing people inappropriately. The case that was used as a very effective tool in California to fulfill sterilization requests with informed consent was *Madrigal vs. Quilligan.* It is interesting to note that this case is still cited even though the federal court found Quilligan and his group at the University of Southern California not guilty of improperly informing patients of the consequences of sterilization. I understand that the Federal Appeals Court has reversed the *Relfs vs. Weinberger* decision, yet we still have the federal regulations in their present form. The feeling persists that patients are not properly informed.

Dr. J. Oppie McCall, Portland, Oregon. Regarding the 17% of women sterilized at SFGH who were classified as childless, I would like Dr. Minkler to explain that this probably does not tell the whole story. There are a number of so-called childless women who have had multiple abortions and seek the end to their problems by sterilization. I think it would make some of us much more comfortable about sterilizing a childless woman if we knew the gravida rather than the parity.

Dr. Robert Israel, Los Angeles, California. Since we deal with a low-income, low-educated population at Los Angeles County Hospital, I would like to ask Dr. Minkler about what his counselors do for the *education* of these patients. He talked about freedom of choice, advocates, etc. In our East Los Angeles population, we have not seen the "new women of the 1980's" that he mentioned. I wonder, for instance, does he do any pretesting of these patients, as we do in our counseling sessions? Does he do any posttesting? For the younger patients, those under 25 years and with less than three living children, we have elected to have them see two members of our full-time faculty, as well as the counselors. In addition, would Dr. Minkler comment on the education of these people before they undergo sterilization. We find that we have to teach them about reproduction before we can really go ahead with the sterilization.

Dr. Minkler (Closing). Dr. Pent asked us to define the qualifications that we sought in our counselors. A very appropriate question, because as he reminded us, counseling needs not only an information component, but a feeling component, and these counselors need some formal structured kind of preparation. We have received some guidance from a principle enunciated by Everett Rogers in his writings on "homophily" in communication. Drawing these counselors from the communities that are representative of the population that we are serving ensures a certain amount of linguistic and cultural homophily with the population with whom they are dealing. It is often the social and educational distance between the doctor and the patient that makes for misunderstanding of the contents of informed consent. We have taken a page from the history of abortion counseling in this country in which lay counselors often are not formally trained in a traditional professional sense, but trained on the job in a very detailed and structured way to provide the kind of counseling that is appropriate to the needs of the client. This is the kind of counselor that we have recruited. They are all women with a college education but they do not have formal degrees in counseling or related disciplines. They are under the direction and supervision of a full-time director of counseling who has a Ph.D. in psy-

chology; this director conducts regular in-service training as well as close supervision. The counselors are, in most cases, bilingual. They reflect the communities that refer patients to this program and they, therefore, have a high degree of "homophily" with their clients.

The reference in this article to requests by childless women for reversal being rare was raised by Dr. Pent and also by Dr. Henderson. I agree with each of them. I by no means assume that we have answered the question of how many young people being sterilized at the present time are going to regret their decisions in the future. None of us has a higher order of prophecy, and I certainly don't. All we can say is that with the accumulated experience thus far, and this corresponds with the published experience of a number of sources reported since the middle 1970's, at least we have some reason to take seriously the young women requesting sterilization when we consider the changing social values of the society in which they live. I fully agree that we need further information on follow-up, and prospective studies that we are now planning are designed to answer that question.

Dr. Russell is correct in saying that we have not abandoned the "rule of 120," and perhaps the term "infamous" was too strong. As I recall, the American College of Obstetricians and Gynecologists never intended this to be a hard and fast rule. Rather, it was meant as a recommendation or a guideline, but many physicians—particularly in small hospitals—came to accept it as something of a "rule" and there was a certain rigidity in some hospital committees held responsible for passing judgment on applicants for sterilization. That is what led to my designation of this rule as "infamous." It is absolutely true, of course, that the majority of voluntary sterilizations being done today are still for women who have completed their families and are about 30 years of age, as our series shows. The primary message, however, was for physicians to recognize the changing social context and at least take with some seriousness the requests of those who deviate from what was once considered, by many hospitals, as a hard and fast rule.

Drs. Miller and Israel talked about the problem of alleged sterilization abuse and particularly the adoption of regulations in order to minimize this. I agree that the regulations under which we now work leave much to be desired. In fact, one of the reasons that the California Office of Family Planning has elected to continue to pay for some Title XX eligible sterilizations with state rather than federal funds is because the federal regulations are regarded as too rigid. My personal view of this (and I chaired the Committee on Public Affairs of the Association of Planned Parenthood Physicians that scrutinized these regulations intensely) is that they pay far too much attention to the procedural details and cognitive content of the informed consent procedure and give too little time and attention to the effective communication between the patient and counselor. To answer Dr. Israel, however, about educating the patient, we do spend a great deal of time in this effort. The sequence of events is the patient first attends a group session that includes videotapes, group discussions, explanations of the risks and benefits, the sterilization procedures, as well as contraceptive alternatives, and some review of the reproductive physiology to correct any misconceptions. As Dr. Israel observed, the young, childless women interested in sterilization tend to have a higher education and to have an interest in a professional or artistic career. Each woman is seen by a member of the faculty, to answer Dr. Israel's other question. After the group sessions, there is one-to-one counseling on a separate occasion by one of our trained counselors, and then the woman is seen by a member of the faculty who conducts the preoperative, preanesthetic physical evaluation and reviews the counseling procedure.

Dr. McCall, the term "childfree" is one that was coined in 1972 by Ellen Peck, one of the most vocal exponents of the feminist movement of the early 1970's. What she was referring to has been examined in subsequent studies on the motivation of women, both married and unmarried, who are opting for childlessness. One of the best of these studies came out of Great Britain and shows that it is not only the career minded or the business women, but a large number of women who are not employed, are happily married, and who simply do not want to experience the long-term responsibility for bearing and raising children. The modest study at SFGH seems to bear out that there is a group of women who no longer feel that motherhood is the central purpose of a woman's life, as was claimed particularly by the Freudian school of psychology one or two decades ago.