Part II: patients' views on their sterilisation

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Summary and conclusions

As part of a study of the complications after sterilisation 485 of the 547 women who had been sterilised by a modified Pomeroy procedure in one unit over 10 years were interviewed. They were asked whether they regretted being sterilised and about the quality of their sex lives, mental health, social relationships, and marriages.

Most women were pleased to have been sterilised, only 24 regretting it. Regret was more pronounced among women who had been sterilised in association with a third caesarean section, those sterilised for medical reasons, and those whose marriages had ended in divorce. In each case where a woman regretted a sterilisation that had been performed on the recommendation of a psychiatrist, the psychiatrists were still prepared to defend their opinions.

On their sex lives, mental health, social relationships, and marriages, more women reported improvement than deterioration, and in most cases the deterioration could not be attributed to the sterilisation.

The overall benefits from sterilisation to the women in this series therefore seemed to outweigh substantially the adverse consequences experienced by a few.

Introduction

The long-term effects of sterilisation as experienced by the patient have been much studied, and several reports have discussed patients' regret at having been sterilised[1-7]; the effect of sterilisation on their sex lives[2-4]; and the influence of the operation on the woman's interpersonal relationships,[1] her mental health,[2 5] and the stability of her marriage.[4] During a study of the outcome and complications of sterilisation (see accompanying paper) the 485 women who were interviewed and examined were also asked about these more personal aspects.

Method

The methods of tracing the women are described in the accompanying paper; altogether 485 of the 547 women who were sterilised in a Dunfermline obstetric and gynaecological unit in 1965-74 were interviewed. No attempt was made to influence the women in their replies or to probe into confidential matters, though if a patient offered an explanatory comment this was noted.

Results

In response to the question: "Do you regret having been sterilised, are you pleased to have been sterilised, or have you no definite feelings one way or the other?" 445 (91·8%) women said that they were pleased to have had the operation—many of them with emphasis and enthusiasm. Only 24 regretted having been sterilised, and 16 were indifferent or had "mixed feelings."

Of the 24 who expressed regret, six had been sterilised after a third caesarean section; six had remarried after a divorce and would like to have been able to have had children by second (in 5 cases) or third (in 1 case) husband; one had been sterilised after a terminated pregnancy at the age of 44; four had had the operation on the recommendation of a psychiatrist (and a general practitioner); one had lost her only son in a road traffic accident and would like to have "tried for another boy"; one, with four children, was sterilised because of rhesus isoimmunisation; four women, one of them with 13 children, would like to have been able to add to their families, though all had originally wanted to be sterilised; and a mother of nine had suffered a loss of libido, which she attributed to the operation.

The woman who was sterilised after a termination (the only such patient in the series) had undergone the operation on the recommendation of a consultant physician because she was suffering from "nephritis grade 2." In the case of the four women sterilised on the recommendation of a psychiatrist (because of mental retardation (1 case), recurrent depression (1), and epilepsy (2)), the psychiatrists and general practitioners were unrepentant of their advice and emphasised that the women were incapable of caring for the children they already had.

The table shows the numbers of women who thought that their libido, mental health, and social relationships had improved or deteriorated after sterilisation.

Libido—Of those who believed that the quality of their sex lives had improved, almost all spontaneously attributed the improvement to the fact that sterilisation, by removing the fear of pregnancy, had enhanced the pleasure derived from sexual intercourse. On the other hand, some of the 48 women whose sex lives had deteriorated since sterilisation went out of their way to say that the deterioration was not caused by the sterilisation. Twenty-five believed that there was an association, though in some the deterioration had not occurred until several years after the sterilisation, by which time two of the patients were over 40 years of age. One woman stated that the quality of her sex life had suffered since sterilisation because there was now "no risk." Other explanations offered for the deterioration were arthritis, dyspareunia (found to be due to endometriosis), menopausal symptoms, and, in 10 cases, mental depression.

Numbers (and percentages) of women reporting improvement, deterioration, and no change in several personal factors after sterilisation

	Improved	Deteriorated	No change
Sex life	176 (36·3)	48 (10·0)	261 (53·8)
Mental health	165 (34·0)	31 (6·4)	289 (59·6)
Social relationships ..	62 (12·8)	8 (1·7)	415 (85·6)
Marriage	118 (24·3)	37 (7·6)	330 (68·0)

Mental health—Again, many of those who experienced an improvement in mental health after sterilisation spontaneously attributed the improvement to the operation. Twenty-three women attributed a deterioration to a definite cause: alcoholic husbands (4 cases), disease of the spine (1), financial troubles (1), family troubles (8), death of an only son (1), severe menopausal symptoms (1), recurrent depression (6), and physical symptoms—stress incontinence (1) and dysmenorrhoea (1). The latter patient was found, as a consequence of the study, to be suffering from endometriosis. Both patients with physical symptoms underwent surgery and both reported an improvement in their mental health afterwards. In the six cases of recurrent depression the depression had first occurred before sterilisation and the psychiatrists concerned thought that it would probably have recurred anyway. In none of the remaining nine patients did the deterioration follow soon after the sterilisation.

Social relationships—Of the eight women who believed that their social relationships had deteriorated since sterilisation, five had psychiatric histories and said that their social relationships had always been poor but that they appeared to have deteriorated still further since sterilisation. The patient who had lost her only son believed that she had become more withdrawn. One patient stated that her marriage had been unhappy for years and that her ability to enjoy the company of other people had consequently suffered. The eighth patient could not explain the deterioration but did not believe that it had anything to do with her sterilisation.

Stability of marriage—Many of the women who reported an improvement attributed this to the sterilisation, and only seven of the 37 women whose marriages had suffered regretted having been sterilised. Six regretted it because they now wanted to remarry and would like to have been able to have had children by the next partner. None of the six believed that her sterilisation had contributed to the dissolution of her marriage. Five other women said that they had experienced some loss of libido since sterilisation, but only two

regretted being sterilised and associated the loss of libido with the deterioration of the marriage. None of the remaining 25 women thought that sterilisation had contributed to the decline of the marriage.

Discussion

The percentage of women in this series who regretted being sterilised was low (5·0%) and similar to those reported in other studies.[1–6] This study also supported the findings of others that regret is particularly strong when sterilisation has been performed for medical reasons[2] or in association with caesarean section.[7]

Four women in this series who had been sterilised on strong psychiatric recommendation also expressed regret. All were considered by their general practitioners and psychiatrists to be incapable of giving adequate care to the children they already had and all had agreed to sterilisation without argument. In these cases second thoughts may not be better.

Mowat[8] has argued that if patients are denied postpartum sterilisation and made to wait for three months many will reconsider the subject and decide against it. The underlying suggestion that interval sterilisations are less likely to be followed by regret than those carried out in the puerperium finds no support in this series. That women who already have large families (like the mother of 13 children in this series) should regret having been sterilised emphasises how highly some women value their capacity to bear children, even when medical and economic considerations indicate the need to bring their childbearing years to an end.

The possibility that an apparently happy marriage may end in divorce, and the woman, wishing to remarry, will regret her sterilisation, is one that should always be considered, especially when a young woman requests sterilisation. Six examples occurred in this series. Even with careful selection, the possibility of such a contingency is difficult to assess and is an outcome which may come as a surprise not only to the surgeon but to the couple concerned. Nevertheless, over 90% of the women in this survey, as in others,[1–6] were pleased to have been sterilised.

The findings of this study confirm those of others[1–7] that, although a few women may experience a deterioration in the quality of their sex lives, their mental health, their social relationships, and the stability of their marriage after sterilisation, they are outnumbered by those who report an improvement. Whereas any improvement was often attributed to the sterilisation, deterioration was usually ascribed by the women to other causes.

The evidence of this survey indicates that if patients considered for sterilisation are carefully selected, the benefits to the women, both socially and psychologically, outweigh overwhelmingly any possible adverse effects.

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If a doctor urges an individual to be vaccinated can he be held legally responsible for any adverse effects?

As always, it depends on the facts. Only a court can "hold" that a doctor is liable to compensate a patient for adverse effects of treatment. Far more often it is *alleged* that the doctor who recommended vaccination was negligent in forming the view (and basing his advice to the patient on it) that the balance of advantage and disadvantage made vaccination appropriate. When the legal advisers of a patient recognise, after taking expert advice, that the treatment given to their client accorded with a recognised and responsible school of thought, they can no longer maintain the allegation of negligence. It is then usual to adopt the more sophisticated allegation that in concealing from the patient the nature and extent of *known* complications of the procedure, the doctor invalidated the consent given by the patient, so that the vaccination constitutes an assault. The doctor, they allege, is therefore responsible even for the known, intrinsic hazards of the procedure and must compensate the patient. This does not mean that there is a legal duty to tell the patient in exhaustive detail of all the known complications that have ever occurred after vaccination; there is a duty in common law to give the patient a fair explanation of the balance of advantage and disadvantage, and to take competent steps (including taking a history and a physical examination) to assess this balance. The doctor may be called on to justify his actions, with hindsight, in the occasional case where the patient suffers a known complication of the vaccination.

A healthy 20-year-old girl at university has not menstruated for eight months. She is not pregnant. What, if any, investigations and treatment are advised?

It is unlikely that such a girl is accepting her amenorrhoea with true equanimity. Therefore investigations should begin, even though periods may return spontaneously. It is not good enough to assume that amenorrhoea can be just of emotional origin. Even if the proximate cause is psychological, endocrine changes may have been set in train. Clinical investigation is all important. The history must explore social, psychological, sexual, academic, and medical factors. Physical examination includes height, weight, the noting of thyroid signs, acne, hair growth, breast development, abdominal palpation, inspection of the vulva, bimanual examination of the pelvis, and inspection of the cervix and vagina through a speculum. These should all help in deciding what further investigations may be needed. Unless there are suggestions of thyroid or adrenal disorder it may be best to proceed with further examination of the pituitary-ovarian axis. This can precede examination under anaesthesia and dilatation and curettage, since with secondary amenorrhoea the uterus is prima facie normal and responsive to adequate levels of hormones produced in cyclic manner. The state of the vulva, vagina and cervix, and breasts may all show oestrogen production. It may satisfy all concerned to confirm this by estimations of this steroid in blood or urine, but is not strictly necessary if the biological signs are normal. The pituitary should certainly come under scrutiny by estimations of the stimulating gonadotrophins and serum prolactin concentrations.

It is not possible to go further in a short answer. The management of amenorrhoea may be very simple or very complex depending on what is discovered in the individual patient. This one should probably be referred to a gynaecologist with a special interest in the subject and who commands the full range of facilities for investigation and treatment.

Is there any risk in using an electronic tablet counting machine at the local pharmacy?

There should be no risk if the machine is thoroughly cleaned to avoid cross-contamination after the counting of each type of tablet. The manufacturers of the machines advise that such cleaning should be scrupulously observed as a routine. All contact parts of the machines are in material that can be wiped clean immediately and are designed to be detached without any difficulty to facilitate cleaning.