Middle Articles

CONTEMPORARY THEMES

Sterilization of Women

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In a memorandum prepared and published by the Royal College of Obstetricians and Gynaecologists in 1966 the following sentence appears: "Sterilization has such an important part to play in the prevention of pregnancy from the standpoint of the health of the individual, of the happiness of family life and of population control that the need for new legislation to cover its performance is a far greater urgency than that for a new abortion law." Since that time the Medical Defence Union has issued a statement that in the opinion of its experts voluntary sterilization is not illegal provided that the signed consent of the patient and preferably that of her husband as well are duly obtained. In collaboration with the Simon Population Trust the R.C.O.G. decided in 1967 to carry out a survey among practising gynaecologists in order to determine (a) their own views and practice about sterilization of women, and (b) the extent to which this operation was being carried out in National Health Service Hospitals. The surveys were carried out by sending questionnaires to individual fellows and members of the College and to the heads of departments in selected hospitals.

Attitudes of Fellows and Members of the R.C.O.G.

A questionnaire was addressed to 1,401 fellows and members of the R.C.O.G. residing in the United Kingdom asking them to answer a few questions about their attitudes to sterilization. Anonymity was preserved. Replies were received from 882 fellows and members (63%). The relatively low percentage of replies may have been due to the fact that many of the younger and recently qualified members were still working at registrar level and not practising with full clinical responsibility. It was for this reason that some, at any rate, did not reply to the questionnaire. It is reasonable to assume that the replies represent a cross-section of opinion and practice among gynaecologists in this country. Of those replying, 96% said they were not debarred by any matter of principle from carrying out the operation of sterilization of women, 83% were prepared to carry out the operation at their own discretion without seeking a second opinion, and 99% made it routine practice to obtain the written consent of both husband and wife except in cases of emergency. It seemed from this questionnaire, therefore, that it was reasonable to conclude that very few gynaecologists in this country are deterred by legal fears or moral scruples from sterilizing women when they think the operation is indicated.

Questionnaire to Hospitals

It was decided to circularize hospitals in each of the 15 regional hospital board areas in England and Wales, as well as

the teaching hospitals. The hospitals in each regional board area were selected independently by the senior administrative medical officers of each region as being examples of large district hospitals. Questionnaires were sent to 21 hospitals in the four metropolitan regional hospital board areas and to 38 hospitals in the other 11 regional hospital board areas. Fifty-nine hospitals received questionnaires and 85% responded. In six of the remaining nine the figures submitted were too incomplete to use and in three the questionnaires were not returned.

Results

Out of the total of 198,218 admissions to the obstetrical and gynaecological wards during 1 January to 31 December 1966, 3,997 (2.02%) were sterilized by some form of tubal interruption. Table I shows the distribution as between obstetrical and gynaecological wards and indicates that the percentage of sterilizations carried out in the puerperium is higher than the percentage in which this operation is carried out on patients admitted to gynaecological wards.

TABLE I

Type of Ward	Total Admissions	No. of Sterilizations	Rate (%)
Obstetric	116,207	2,671	2.20
Gynaecological	82,011	1,306	1.59
Total	198,218	3,997	2.02

TABLE II

Type of Hospital	No. of Hospitals	Total Admissions	No. of Sterilizations	Rate (%)
Teaching	27	120,512	2,407	1.99
Non-teaching	23	77,706	1,570	2.02
Total	50	198,218	3,977	2.02

Table II shows the figures for teaching as compared with non-teaching hospitals and indicates that there is no apparent difference in practice with regard to this particular operation between these two groups of hospitals. Further analysis of the questionnaires, however, showed a wide difference in practice in different hospitals. The range varied from 1% up to 4%. The highest rate of sterilization was in the Liverpool Regional Hospital area and the lowest was in the Sheffield area. The rate of sterilization in the South-east Metropolitan Regional Hospital Board area was more than twice that in the North-east Metropolitan Regional Hospital Board area (3.05% against 1.43%).

Many factors may be responsible for these variations. It may be that they reflect different attitudes on the part of gynaecologists, but it is likely, too, that they reflect different

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features of the populations served by individual hospitals. Uniformity of practice in regard to this particular operation is far from being achieved.

Indications for Sterilization

In the questionnaire on indications returns were asked for under the following five headings: (a) physical diseases or defects making further pregnancy dangerous to health; (b) psychiatric indication; (c) domestic and family problems, including high parity, marital stress, etc.; (d) in association with repeat caesarean section; and (e) in association with therapeutic termination of pregnancy.

In 48.7% the indication was given as domestic and family problems (c). In 27.7% of the cases sterilization was carried out in association with either repeat caesarean section or termination of pregnancy. In 16% there was a physical disease or defect, and in only 7% was the primary indication a psychiatric one. As many of the sterilizations carried out in association with caesarean section and even therapeutic termination may have been carried out for broadly social reasons, it is clear that this is the main indication for this operation. The figures suggest that there is less hesitation than might have been thought among gynaecologists in carrying out sterilization for broadly social as opposed to strictly medical reasons.

Difficulties.—The questionnaire included a question about waiting-lists. Gynaecologists were asked if there was a difficulty in admitting patients for operation, with consequent lengthening of waiting-lists, either because of shortage of beds or for any other reasons. Seventy-seven per cent. replied that there were no limiting factors in their capacity to carry out an operation of sterilization where it was indicated. Replies from 23%, however, indicated that there was such a difficulty because of the attitudes of the gynaecologists, objections on the part of

patients, or because of shortage of beds. In several instances the replies gave an indication that it was expected that there would be a considerable increase in the number of sterilizations carried out in future years which might create a difficulty for the departments from the point of view of accommodation.

Conclusions and Discussion

The purpose of this questionnaire was to obtain facts about the current situation in regard to sterilization. The purpose of this short communication is to make known these facts rather than to discuss all the many and varied implications and problems concerned with sterilization. From the point of view of limiting family size, for either medical or personal reasons, sterilization can make a valuable contribution. It obviously cannot solve all the problems associated with unwanted pregnancies. The fact that there are such wide differences of practice between different parts of the country suggests that perhaps not sufficient thought has been given to the use of this valuable preventive measure and it is clearly necessary to carry out further investigations in greater detail, perhaps more extensively over the whole country.

We would like to record our thanks to all those fellows and members of the College who filled in questionnaires and so participated in this inquiry. We would also like to thank the senior hospital administrative medical officers who advised us about the hospitals to whom we should direct our questionnaire and to the chiefs and their staff who filled in the questionnaires and made the collection of these data possible.

Many more details have been obtained from the data collected from the questionnaires returned than are reported in this brief communication. These are available at the Royal College of Obstetricians and Gynaecologists if any readers are interested to see them, and some will be published later.

AROUND EUROPE

Compensatory Leave for Doctors in Sweden

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Compensatory leave for junior hospital doctors working beyond usual working hours was adopted in Sweden two years ago, and later it was extended to include the consultants and senior registrars. The leave is intended to give doctors adequate rest, and rules to work the scheme have been agreed on between the regional administrative medical boards and the medical association. It is intended that clinics at the same hospital and near-by hospitals should combine to provide emergency services and so prevent overlap and use manpower economically.

The leave is given: (a) as direct compensation for hours worked attending emergencies, (b) to make up any loss in the number of minimum free days each month, and (c) as special leave for seniors who provide prolonged supervision and back cover. The guaranteed minimum of four free days, usually Sundays or public holidays, each four-week period was extended to junior doctors after it had been granted to employees in public services.

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Compensation Scheme

Compensation is worked differently for junior and senior doctors and will be described separately. Previously strong emphasis has been on compensation for the younger doctors, and more experience has been obtained in making it work for them.

Junior Doctors

Leave to Compensate for Broken Free Days.—Four free days are allowed each calendar month worked and should be taken on Sundays or public holidays whenever possible. A free day is considered broken if the doctor is on call at the hospital, or if he is obliged to come into the hospital from home when on call. Telephone interruptions do not break a free day.

Direct Compensation for Emergencies.—A minimum of four hours' and a maximum of 12 hours' compensation is given for call on each duty period (see below) and the doctor keeps a record of hours worked.