Tubal Sterilization in Women Under 30: Case Series and Ethical Implications

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Abstract

Objective: According to the SOGC Contraception Consensus, it is recommended that permanent contraception be offered to women regardless of age or parity. Many women who desire sterilization at a young age experience barriers from physicians who decline to facilitate the request.

Methods: As part of a quality assurance project, we performed a review of cases where tubal sterilization was performed in women under 30 over a 42-month period (September 2013–March 2017). We also performed a literature review on the ethical and clinical considerations with respect to young women requesting permanent contraception.

Results: We identified 29 women under 30 who had consented for tubal sterilization; 27.5% of women were nulliparous, and 27.5% had a medical condition for which unintended pregnancy is associated with an increased risk of adverse event. As documented in the patients' records, many women expressed prior difficulty in obtaining the procedure. Despite being informed of the risk of regret, most women proceed with the surgical procedure. Three additional women had consented and subsequently cancelled their surgical procedure.

Conclusion: Women who are well-informed and desire permanent contraception should be offered the procedure, regardless of age or parity. Declining such requests is a form of conscientious refusal and is not a clinical decision.

Résumé

Objectif : Dans son consensus sur la contraception, la SOGC recommande d'offrir la contraception permanente aux femmes, peu importe leur âge et leur parité. Or, bon nombre de femmes désirant être stérilisées à un jeune âge sont confrontées à des médecins qui refusent de répondre à cette demande.

Méthodologie : Dans le cadre d'un projet d'assurance de la qualité, nous avons examiné des cas de stérilisation tubaire chez des femmes de moins de 30 ans, réalisées sur une période de 42 mois (de septembre 2013 à mars 2017). Nous avons également mené une revue de la littérature sur les considérations éthiques et cliniques relatives aux demandes de contraception permanente par des jeunes femmes.

Résultats : Nous avons recensé 29 femmes de moins de 30 ans ayant consenti à une stérilisation tubaire. Parmi celles-ci, 27,5 % étaient nullipares et 27,5 % étaient atteintes d'un trouble médical entraînant une augmentation du risque d'événement indésirable en cas de grossesse imprévue. Plusieurs des patientes ont rapporté avoir eu de la difficulté à obtenir la chirurgie, comme en témoignent leurs dossiers médicaux. Bien qu'elles aient été avisées qu'elles risquaient de regretter leur décision, la plupart des patientes ont décidé d'aller de l'avant. Trois autres femmes avaient d'abord donné leur consentement, mais l'ont retiré avant la chirurgie.

Conclusion : Les femmes bien renseignées désirant une contraception permanente devraient se voir offrir la chirurgie, peu importe leur âge ou leur parité. Le refus de répondre à leur demande est une forme d'objection de conscience et ne constitue pas une décision clinique.

Key Words: Family planning, tubal ligation, permanent contraception, autonomy, reproductive ethics

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INTRODUCTION

Tubal sterilization is the fourth most common form of contraception among Canadian women; however, it is uncommon in women under the age of 30.[1] There is published and anecdotal evidence that this situation is partly the result of barriers for young and/or nulliparous women.[2] Sterilization should be considered permanent because tubal reanastomosis or IVF may not result in pregnancy. Additionally, coercive sterilization practices and paternalistic beliefs about the necessity of motherhood require a considered and unbiased approach to requests for permanent contraception.

A detailed discussion on permanent contraception is available in the SOGC Canadian Contraception Consensus guidelines.[3] Most commonly, sterilization is chosen when a woman has completed her family.[2,3] Other women choose

this option because of a medical or genetic condition for which an unintended pregnancy would pose significant risk. Some women desire to be child-free. Regardless of the reason, women may experience barriers to obtaining sterilization; 23% of women in a study exploring sterilization at the time of repeat CS would have accepted concurrent tubal ligation but were not offered it.[4]

Historical Perspective

Female surgical sterilization has a complex history. In much of the 20th century, providers engaged in coercive sterilization of women from certain social locations, including indigenous women, racialized women (women of colour), and women with disabilities.[5] In the 1960s, professional bodies attempted to address this situation by recommending restricting sterilization to older, multiparous women. Although these well-intentioned but paternalistic restrictions have relaxed over time, there remains a hesitation to perform sterilization in young and/or nulliparous women.[3]

METHODS

As part of a quality assurance project, we reviewed the cases of a single tertiary-care family planning provider who offers permanent contraception regardless of age or parity. Charts were reviewed over a 42-month period between September 2013 and March 2017. Cases where another method was selected were not included in the analysis. Because this was a quality assurance study, institutional ethics was not required.

RESULTS

An overview of our patients is provided in Table 1. Tubal sterilization has been performed in 26 women under 30, and three additional women are currently on the waitlist for surgery. Referrals came from three sources: abortion clinics, primary care providers, and gynaecologists declining on the basis of hospital restriction or conscience. Of these women, 27.5% were nulliparous, and 27.5% had medical conditions for which unintended pregnancy poses an increased risk of adverse health outcome, according to the US Medical Eligibility Criteria for Contraceptive Use (Table 2).[6] In 83% of cases, laparoscopic sterilization with titanium clips was performed, and the remaining procedures were performed through salpingectomy. No major complications occurred.

DISCUSSION

For any elective procedure, clinicians must consider clinical appropriateness, clinical competence, and conscience when faced with a request for sterilization. Any woman who wishes to prevent pregnancy permanently and who has no contraindications would be clinically appropriate. In Canada, all surgical gynaecologists would be competent to perform tubal sterilization, but they may not offer all methods (e.g., postpartum minilaparotomy).

Table 1. Characteristics of younger women obtaining tubal sterilization (n = 29)

Age	Mean 25.5	
	Median 26	
	Range 20–29	
Parity	8 nulliparous (27.5%)	
	21 parous (73.5%)	Range 2–6
Gravidity	5 nulligravid (17.2%)	
	24 ever pregnant	Range 1–8
Medical conditions	8 risk of adverse event if unintended pregnancy, by MEC (27.5%)	
	2 minor medical (6.9%)	
	19 none (65.5%)	

MEC: US Medical Eligibility Criteria for Contraceptive Use.

Table 2. Medical conditions for which an unintended pregnancy portends increased risk of adverse health outcome

Bariatric surgery within 2 years
Breast cancer
Cardiovascular disease
Hypertension
Ischaemic heart disease
Peripartum cardiomyopathy
Valvular heart disease
Stroke
Diabetes mellitus with:
vascular involvement concomitant vascular disease, or duration greater than 20 years
Epilepsy
Gynaecological cancer
Uterine/endometrial
Ovarian
Malignant gestational trophoblastic neoplasia
HIV/AIDS
Liver disease
Malignant liver tumours
Schistosomiasis with liver fibrosis
Severe cirrhosis
Sickle cell disease
Solid organ transplantation within 2 years
Systemic lupus erythematosus
History of venous thromboembolism or thrombophilia
Tuberculosis

AIDS: acquired immunodeficiency syndrome.

Adapted from World Health Organization (WHO). Medical Eligibility Criteria for Contraceptive Use. Geneva: WHO; 2015. Available at: http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/. Accessed on May 24, 2017.