in that case

Helen is a 23-year-old woman referred to a gynaecologist (Dr Gregg) by her GP. Helen has decided that she does not wish to have children, and has requested that she be sterilised by tubal ligation surgery.

Helen has a history of depression, although she is currently well on medication. Helen has a significant family history of mental illness, with her mother, two aunts, and grandmother being affected. Helen does not want to be responsible for passing on a genetic predisposition to mental illness to a future generation.

Helen is currently in a stable relationship with her boyfriend Josh, who is 25. They have been together for two years, and use condoms for contraception. Helen is reluctant to use any form of hormonal contraception as she is afraid that this may exacerbate her depression. She is unable to tolerate an intrauterine device, including Mirena.

Dr Gregg is unwilling to perform the surgery as he considers sterilisation is a measure that is too extreme at Helen's age, and Helen may regret her decision.

response

Dr Lynn Gillam
Centre for Study of Health and Society
University of Melbourne

Dr Gregg is right to feel some initial reluctance to proceed with a tubal ligation for Helen. This is a significant surgical procedure with far-reaching consequences. However, in my view, he would be wrong to make a categorical decision at this stage not to agree to Helen's request. His two concerns, that the procedure is 'too extreme' and that Helen might later come to regret it, do not constitute good grounds for denying a patient's autonomous decision (if that is what it turns out to be) to use a particular form of contraception.

The first issue for Dr Gregg to address is whether this request for a tubal ligation does represent an autonomous decision. There is a simple and straightforward way to assess this rather technical concept. Dr Gregg needs to engage Helen in an open, non-judgemental discussion about her reasons for wanting a tubal ligation. This will reveal a number of important factors, including what Helen understands about tubal ligation, and what values, beliefs or concerns have led her to decide that she wants to have one. This is crucial in coming to an assessment of whether her decision is substantially autonomous. However, there is no need for the discussion to become either an interrogation or a formal assessment. One of the vital skills needed by doctors is to be able to engage in open, friendly discussion of important issues with their patients, and at the same time interpret what is being said in the light of what they need to find out about.

One major issue for Dr Gregg to be alert for is Helen's degree of mental competence; that is, her ability to think through possible courses of action and compare them, and to base her judgements on her own enduring values. Given Helen's depression, even though it is being treated, it would be worth considering whether her outlook and view of the future are in some way 'blacker' or more limited than they would otherwise be. Of course, if Dr Gregg has not met Helen before, it will be harder to do this, but he can enquire about when she made her decision, whether she had a different view in the past, and why she has changed her mind, and so on. It is very unlikely

that the depression is affecting her actual reasoning processes.

Another major issue is whether Helen has an accurate understanding of all the information relevant to her decision. She would need to know about the risks of tubal ligation, including risks of surgery and risk that the procedure may fail or spontaneously reverse, as well as the alternatives to tubal ligation, and the risks and benefits of each. It is easy to see how a more complete understanding of the range of alternatives, for example, might change her decision.

Finally, Dr Gregg does need to be alert to the possibility that Helen may be experiencing pressure from someone else, and that the decision is not truly and freely her own. Again, an open and honest discussion will reveal this, provided that Dr Gregg has the people skills and attitude to make a supportive space available for Helen.

In the course of the discussion, it may turn out the Helen did not know some key pieces of information, and she may change her mind. This is easy to deal with. Or Dr Gregg may form the view that Helen's value system is being distorted by the depression, though he would need to very well aware of the role of his own values and biases in this judgement, and not stick to it too dogmatically. This would be harder to deal with, since telling a patient that she is too depressed to make her own decision is not conducive to a good on-going relationship. Dr Gregg's people skills would really need to be finely tuned here. The best sort of outcome in this sort of scenario would probably be a mutual decision to wait for some agreed amount of time, then re-visit the issue.

But it is also quite likely that Helen will actually turn out to be making an autonomous decision to have a tubal ligation, fully aware of its 'extreme' (to Dr Gregg) nature and implications, and with well articulated and understandable reasons for her decisions. Then what? Dr Gregg may still think she might regret her decision later, but it is important to consider the ethical significance of this. Later regret does not mean that the decision was not autonomous. Helen might later regret having a tubal ligation, but she might equally later regret not having it. If the possibility of later regret were a valid reason not to perform tubal ligations, then probably no woman should have one. A woman in her late 30s with four children may also come to regret having a tubal ligation. To think otherwise involves some pretty baseless assumptions that all women want children, but after they reach a certain age or number, they don't want any more at all. Such assumptions are more likely to be based on Dr Gregg's own preferred lifestyle and outlook than any knowledge he has of what women in general want (if that idea even makes sense).

Dr Gregg might be on safer ground if he were to cast his concern in terms of protecting Helen's long-term (dispositional) autonomy, rather than respecting her current wishes (occurrent autonomy). Although this distinction makes sense, and gives a sound rationale for some public policy measures (such as compulsory education up to a certain age, enforced 'cooling off' periods for some contracts, and so on), I would suggest that it is not the relevant consideration here. Certainly, undergoing a surgical sterilisation procedure at 23 will cut off some of her options in the future, but it will also open up others. Having a child would do the same. In view of this, the only form of autonomy that it makes sense to value in this context is occurrent autonomy.

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response

Dr Bertram Young
Retired GP, Hamilton

Dr Gregg is entitled to have scruples but is not entitled to inflict these on unwilling patients. He should advise that Helen can see another doctor able and willing to perform her request, just as he would if she had come to request a termination of pregnancy.

She is entitled to request tubal ligation in this case, just as she could if she had large heavy breasts causing her discomfort. Not all surgery has to be life saving.

Although her request looks a bit like Eugenics, it is not being applied to her, she is asking for it herself.

We don't know how long she has been taking antidepressives, but it is reasonable for her to fear worsening of her depression if she should become pregnant, and with that the possibility of suicide, even under care. She appears to be a well-informed person who has thought for herself.

In summary, Dr Gregg should refer her.

response

Judi Strid
Consumer Advocate, Auckland

It is perfectly understandable that Helen may feel reluctant to have children when there is a possibility that her illness could affect her parenting ability if she is depressed and that her children could also be affected by mental illness. However, this is the implied rather than the stated reason for her request to have a tubal ligation. It could be useful for Dr Gregg to discuss with Helen the option of a referral to a psychologist or counsellor to discuss any fears and concerns she has in relation to having children as there is no indication that she has had the opportunity to discuss these matters in any detail. Dr Gregg also has a responsibility to clearly outline the implications of having a tubal ligation with Helen, as it is considered a permanent method of sterilisation. Although Helen does not want children at the moment, he needs to discuss with her the possibility of changed circumstances where Helen may find herself wanting a child at a later stage. He should spell out the cost of a reversal of the tubal ligation, that this is generally only carried out in the private sector and that there can be no guarantees of a successful reversal of any sterilisation procedure.

Dr Gregg should also discuss contraceptive options for preventing pregnancy with Helen, particularly methods with a low failure rate that would be most likely to be effective in her situation. If Helen is currently in a sexual relationship it could be helpful to discuss a backup plan in the unlikely but possible event of contraception failure.

If these steps are taken, Helen is likely to be better informed about her options, feel more in control of her personal situation and may be more confident about taking a different course of action (other than a tubal ligation) in the first instance.