Case conference

Abortion and sterilization

The following case history relates to a 19-year-old girl who was referred to a consultant gynaecologist for the termination of pregnancy. The medical and social reasons for the termination and the gynaecologist’s decision to sterilize the girl are set out. Three questions arise: 1) Were the medical decisions taken in this correct? 2) What are the implications for current policies regarding contraceptive advice, abortion, and sterilization? 3) What are the general practitioner’s current responsibilities to this patient?

She was a West Indian girl who had come to Great Britain when she was 12 to live with an aunt following the death of both of her parents in Jamaica. Her father had been a diabetic, her mother a hypertensive who probably died of heart disease. At 14 the patient herself was admitted as an emergency to hospital in hyperglycaemic coma. A diagnosis of diabetes mellitus was sustained, but there were no other physical stigmata of the disease and she was subsequently stabilized on twice daily injections of soluble insulin. At 16 she left home to work as a shop assistant, became pregnant, and miscarried at 12 weeks. A year later she again became pregnant and during this pregnancy the diabetes was not easily controlled and she was admitted twice, once in hyperglycaemic coma and once with hypoglycaemia. The hospital records of the delivery were not available but her baby was born normally at full term weighing 9 lb. This child was taken into her aunt’s family and was being cared for mainly by the aunt, although the patient frequently visited the baby. The patient had recently come onto the general practitioner’s list, and had presented with amenorrhoea lasting for three months. On examination she was clearly pregnant and the general practitioner felt that on clinical and social grounds a termination, which she requested, was justified.

A social worker’s report revealed that she was living on her own in a single rented room and had had a number of liaisons in the previous three years. The father of her present child seemed unlikely to marry her or set up a stable home. The aunt was unable to cope with any other children and her relationship with the patient had recently been strained. There were no other relatives living in England. The patient had had a number of general practitioners, and appeared never to have had clear contraceptive advice, although she had at one time been told she could never take the pill, and she was unable to tolerate an intrauterine device. She had not used any other form of contraception, nor had her present boy friend.

The gynaecologist after seeing her wrote to the general practitioner: ‘Thank you for referring this patient. I agree to terminate the pregnancy, although at this stage it will have to be by hysterotomy. Incidentally, I have persuaded her to be sterilized.’ The latter operation was carried out at the time of the termination.

Three years later, aged 22, the patient was sent again to the gynaecological clinic complaining of dysmenorrhoea. She had severe pain, often making her stay away from work for the three days before her periods, which were heavy. There were no new gynaecological abnormalities. The diabetes was well controlled with glibenclamide, and there was no report of any further diabetic complications. She was well dressed and seemed composed but rather depressed. On discussion it emerged that she now had a steady boy friend who wished to marry her, but was unlikely to do so until she was pregnant. She was advised that a tubal reanastomosis was most unlikely to restore her fertility. She was tried for some months on the pill which did not relieve her symptoms but did not disturb her glucose tolerance. On return to the clinic the question of hysterectomy was discussed, but she was averse to it.

Discussion

SIR DUGALD BAIRD Professor Emeritus of Obstetrics and Gynaecology, University of Aberdeen

There are strong medical and social reasons for terminating the pregnancy in this case. Possibly hysterotomy was chosen because the pregnancy had advanced beyond the stage when the simpler vaginal methods could be used. In the second trimester intraamniotic saline or prostaglandin might have been used. The gynaecologist would no doubt point out to the patient that her diabetes constituted a serious risk to mother and baby but there is no evidence that the patient could not have continued successfully with the pregnancy in happier circumstances. It is strange that the gynaecologist did not discuss the problem with the general practitioner before he took the drastic step of sterilization, especially in a woman 22 years of age.
2. The social circumstances in this case are unusually complicated. The broken home, loss of both parents, and the sequence of unfortunate events thereafter may have had serious psychological consequences for this young woman. Ideally she should have had a family doctor who could give her continuous support and might even have been able to prevent the pregnancy. She obviously needed something more than advice on contraception. Contraceptive technique is probably the least of her problems. For example, what is the significance or her confidence? At what point did she make a decision to tolerate an intrauterine device? Was this due to intolerable symptoms or unfounded fear of consequences?

3. If she has at last found a doctor who can gain her confidence and direct her to the various social agencies able to give her practical help and guidance, she might make a happy marriage and possibly adopt a baby in due course. So much depends on the quality and personality of the young woman and of the family doctor. It is possible that the detailed medical history of the father and mother and their deaths at an early age might make it likely that any future pregnancy would have been hazardous and that she may not be fit to bring up children of her own. One would need much more information on the health of the parents and close relative. The prospect that a West Indian with this complicated social and medical background would make a suitable and successful marriage in Britain today seems to be rather poor. As a single woman in poor health she may have difficulty in earning a living. She might be better in Jamaica where the climate is better. I do not think, with the facts available, that there is anything to be said for attempts to reanastomose the fallopian tubes.

There is urgent need for family doctors to take more responsibility for family counselling which would include advice on how to regulate fertility and also advice on more general problems of marriage and the family.

HUGH McLAREN  
Professor of Obstetrics and Gynaecology, University of Birmingham

The decision to sterilize an unmarried Jamaican girl by the gynaecologist was clearly an error. Moreover the phrase, 'I have persuaded her to be sterilized' suggests that the gynaecologist put pressure on the girl to agree.

Secondly I suspect that the gynaecologist's decision to terminate by hysterotomy a pregnancy of 12 to 14 weeks was influenced by his desire to include sterilization in the operation. Why not give prostaglandins, allowing the girl time to recover from the effects of losing her child before deciding for or against sterilization? The method of choice for sterilization would (if used at all) be by laparoscope.

This girl is Jamaican - now in a new culture. She has diabetes but with reasonable care during pregnancy and afterwards there should be no risk to her life or future health. The social background in this case is difficult to appraise. My own view is that, especially in a young girl, the weighting given to this factor in the decision to perform an abortion was excessive. I would myself take note of her sexual activity (a number of liaisons) and, even as the social worker guessed, accept that the father of the child in the womb would not marry the girl. On the other hand, the Jamaican's love of children might have led to a postnatal marriage. Again a personal view: I should not consider promiscuity or no marriage as an indication for abortion. Nor would I ever advise sterilization simply to arrange sterile coitus. I might by such advice lead the unfortunate girl into prostitution!

The general practitioners are entitled to their opinion of course but their total experience of diabetes in pregnancy must be almost negligible so that the decision to abort rested with the obstetrician specialist. The social evasion of the decision I have discussed already, but personally I fail to see how living in a single room or sexual activity in any way would endanger the health or life of this young Jamaican. Even so the legal case for abortion was clear.

I take the view that as the patient's health was intact no real danger all our efforts should have been in the direction of 1) improving the girl's home background using all help available in the city or local charities; 2) controlling the diabetes, especially to ensure that the unborn child suffers no injury because of loss of diabetic control or by allowing the infant to suffer injury at childbirth, particularly as it might well be overweight before term; 3) by personal supervision and encouragement to ensure the girl's cooperation. Visits to her home by the medical social worker would be of great value. 4) After the birth, to offer her contraception, especially by a low-oestrone 'pill', that is, taking into account the diabetes.

Manifestly the well intentioned advice to the girl to submit to abortion although 'legal' proved not to be in her best interest. Sterilization of an unmarried girl was a grave error in medical judgment made worse by the fact that the patient was a Jamaican with the traditional regard for fertility, often seen as sine qua non to marriage.

J E ROBERTS  
Lecturer in Social Administration, University of Edinburgh

The case of a 19-year-old girl being sterilized carried with it such emotional overtones that it is difficult to consider the ethical issues rationally.

Incidentally I have persuaded her to be sterilized carries with it an implication that the writer knew
what was best for the patient and could take the decision on her behalf. Given that the writer really does know best, this might have been the only ethical course he could follow. It raises, however, a number of points. The first is probably, How do I assess when I 'know?', followed by, What professional authority does the patient invest in me, and do the reasons for my 'knowledge' fall within the bounds of that authority? There is also the question, always to be asked when giving advice, If I persuade someone of a course of action, but do not persuade them that they really want it, what will flow from such a course of action?

It seems in this case that, although there were likely to be medical complications to any further pregnancy, the consultant gynaecologist's decision to persuade the girl to be sterilized was not based solely on medical factors. Social, moral, and emotional factors must surely affect anybody's judgment, and consideration must be given to possible unborn children, the present child, the aunt, and no doubt in some degree to various medical and nursing staff, as well as to the girl herself. I would suspect, however, that in these circumstances the consultant would use the weight of his professional (medical) authority even when his own opinion (conviction) was based on other factors. But his professional training as such would not prepare him any better than a layman for considering the questions, What does sterilization mean for this particular girl? Will it constitute a barrier to marriage? Nor does his training usually assist him to approach his patient in such a way that he is likely to find the answers from her attitudes.

It is perhaps worth noting here that views about the connexion between pregnancy and marriage, apparently held by the girl and her boy friend, need not be personal idiosyncrasies. In many parts of the West Indies having children is a symbol of virility and prowess in the man and femininity and strength in the woman. A woman unable to bear children would be seen and would consider herself to be only half a woman, as it were. Proof therefore of a woman's fertility becomes vital as it reflects the man's virility. Such attitudes persist among West Indians in Britain, and, as this girl did not leave Jamaica until the age of 14, she is even more likely to be influenced by these strongly held views. (It should be noted in passing that this attitude is also determined by class and becomes progressively less explicit the higher the socio-economic ladder is climbed.)

The consultant gynaecologist did have the report of another professional worker whose training and experience should have enabled her to be sensitive to the importance of cultural attitudes but the evidence we have does not indicate that the social worker tried to discover the meaning of sterilization for the girl. Further, beyond a factual statement that neither the girl nor her boy friend used contraceptives, no attempt was made to discover what emotional and cultural factors might have been involved in their not using contraceptives. Neither did there appear to be any medical investigation of the patient's statement that she had been told that she could not take the pill and was unable to tolerate an intrauterine device. On the one hand this girl was seen as being socially irresponsible and, on the other, responsible enough for her statement on medical matters to be accepted. Later evidence showed that the pill did not disturb her glucose tolerance.

The decision then, seems to have been precipitate to terminate a West Indian girl's ability to have children. It may in some senses have been a 'right' decision, but could never be truly so unless, within the decision-making process, the girl had a chance to look at, think about, and explore the various implications and make a true choice of her own. If she had chosen not to be sterilized, it would certainly have caused us (her professional advisers and helpers) anxiety. We might have had very good reasons for anxiety and genuine concern. But however realistic our anxiety, its relief should never take priority when trying to help the patient or client reach a decision which is valid for her.

The task now for this girl is far from easy. From the moment she came to Britain her situation was difficult: at 14, in the turmoil of adolescence, she had lost both parents, her friends, close relatives, a known environment, school system, culture, and climate. She was required to adapt to new people and unfamiliar expectations and patterns of language. Now she must also come to terms with herself as someone feminine and of worth when she has lost her ability to have children. There is also the pressing problem of dysmenorrhoea. It may be tempting to see depression and dysmenorrhoea as separate problems but they may be interconnected and thus it is vital that those whose task it is to assist the girl should work together in a way that both doctor and social worker use the skills of both professions to best advantage.

RAYMOND PLANT  Senior Lecturer in Philosophy, University of Manchester

As a philosopher I am neither equipped nor competent to take a line on the more technical medical aspects of the case: whether, for example, the medical reasons for abortion were as strong as the girl's general practitioner, the consultant gynaecologist, and Sir Dugald Baird think, or whether these were overemphasized as Professor McLaren insists. This difference of judgment is quite crucial to the case but it is not an issue which I can take up. However, the case does raise an interesting issue in moral philosophy concerning the notion of professional authority and its relation-
ship to professional knowledge.

The way in which the case report was written with its explicit emphasis upon the fact that the gynaecologist persuaded the patient to be sterilized implies that the impetus for sterilization did not come from the patient but was rather the result of pressure from the consultant. The same impression from the case report was also gained by Professor McLaren and Miss Roberts. The exercise of such pressure by the consultant would presumably be justified by a claim that he was, in some sense, in a position to know what was in the best interests of his patient, that is to say, pressure would be exercised as the result of a clinical judgment which in turn would be based upon professional knowledge. Another way of putting the point would be that the consultant exercised his professional authority to persuade the girl to take a course of action which she might not otherwise have contemplated. This authority would be based upon and made legitimate by the consultant's medical knowledge. The assumption here is that in this case the issue of sterilization was a matter entirely for professional knowledge and professional judgment. Both Sir Dugald Baird and Professor McLaren would also seem to subscribe to this assumption. Indeed Professor McLaren goes so far as to say that the decision to sterilize the girl was a grave error of medical judgment.

The question which I should like to raise is whether the issue of sterilization in this particular case was entirely a medical one, and if it was not and could not have been, then the use of professional authority, backed up also no doubt by status, to persuade the girl to be sterilized was misplaced just because that authority could not be underpinned by an appeal to entirely medical factors and was thus not a matter of purely medical expertise.

Usually people who are in authority or exercise authority do so if and only if they have expertise in some body of knowledge relating to the sphere within which that authority is exercised. For example, the umpire in a cricket match is in authority over the game but it is a necessary condition for his being in authority that he should have a good knowledge of the rules of cricket. There is an intimate connexion between knowledge and authority, and in a good many cases authority disappears when a claim to be expert in the relevant body of knowledge cannot be vindicated. The exercise of professional authority necessarily requires that it should be supported by the relevant area of knowledge. In this particular case the exercise of authority by the consultant in persuading the girl to be sterilized, as opposed to pointing it out as one possible course of action, would be justified only if the issue of sterilization in her case could be construed as falling entirely within the sphere of medical expertise or knowledge. However, as Miss Roberts points out, this is not so. Social, moral, and emotional factors are central in this case. In the context of West Indian culture there is a very close connexion between the ability to bear children and a woman's image of herself as being fully a woman and a man's conception of her as desirable. The ability to bear children is not seen as being merely a biological condition but enters into the ways in which people form estimates of their own value and status. For a girl within this sort of cultural and value context the inability to bear children will have a special meaning which will involve a revision of her own estimate of her own femininity and in the way in which her lovers see her. This is already demonstrated, as her current lover will not marry her unless she can become pregnant. If the ability to have children is so closely and centrally woven into a woman's value system, as it clearly is in this context, then the question of sterilization must transcend purely medical factors (the force of which are in any event disputed in this case). As Miss Roberts says, 'His professional training as such, however, would not prepare him any better than the man in the street for considering the questions.' If the question of sterilization in this sort of context is not purely a matter of professional knowledge and expertise then it is arguable that the exercise of professional authority in persuading the girl to be sterilized involved not just a mistake in medical judgment but was rather a misuse of that authority just because it involved issues of value and morality which necessarily were outside the doctor's professional competence. In this sort of case where 'professional' knowledge is of necessity circumscribed professional 'authority' has to be similarly truncated.

The obvious way out of this kind of dilemma would be to train doctors through the use of sociological work, and, indeed in some cases of an acquaintance with comparative religion, to be more sensitive to the ways in which birth, copulation, death - 'Sweeney Agonistes' basic facts about human life - are coloured by the different moral and religious perspectives which can be found in a pluralistic society such as Britain. However, it is important to remember that it is a case of making people sensitive rather than adding one more piece of knowledge to the doctors body of expertise. There can be no moral experts, and to realize that moral issues may enter into the very definition of medical problems must require that the doctor's professional authority should be used more sensitively and circumspectly than appears to have been the case here.