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1 Patient-Provider Conversations about Sterilization: A Qualitative Analysis

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Abstract

Objectives: Although female sterilization is the second most commonly used contraceptive method in the U.S., research suggests that providers may serve as barriers to desired sterilization.

Study Design: We conducted a modified grounded theory analysis of audio-recorded contraceptive counseling visits with 52 women who specified on a pre-visit survey that they wanted no future children, and a supplemental analysis of visits with 14 women who wanted or were unsure about future children in which sterilization was mentioned.

Results: Sterilization was discussed in only 19 of the 52 visits, primarily with patients who were older women with children. Although some framed sterilization positively, many clinicians discouraged patients from pursuing sterilization, encouraging them instead to use long-acting reversible methods and framing the permanence of sterilization as undesirable. In the 33 remaining sessions, sterilization was not mentioned, and clinicians largely failed to solicit patients' future reproductive intentions. We found no clear patterns regarding discussion of sterilization in the 14 supplemental cases.

Conclusion: Clinicians did not discuss sterilization with all patients for whom it might have been appropriate and thus missed opportunities to discuss sterilization as part of the full range of appropriate methods. When they did discuss sterilization, they only infrequently presented the method in positive ways and more commonly encouraged patients to choose a long-acting reversible method instead. Clinicians may want to reflect on their counseling

practices around sterilization to ensure that counseling is centered on patient preferences, rather than driven by their own assumptions about the desirability of reversibility.

Implications: Clinicians often fail to discuss sterilization as a contraceptive option with potentially appropriate candidates and, when they do, often discourage its selection. Clinicians should consider assessing reproductive intentions to ensure that potentially relevant methods are included in counseling.

Keywords: female sterilization; contraceptive counseling; qualitative methods; reproductive intentions

1. Introduction

Female sterilization is the second most commonly used method of contraception in the United States. Currently, 15.5% of US women of reproductive age rely on female sterilization to prevent pregnancy, and low-income women and women of color disproportionately use this method.[1] The historical context of sterilization, in which many low-income women and women of color were sterilized without their consent, coupled with contemporary statistics, raises concern that providers may be promoting this method of birth control selectively.

Simultaneously, there is evidence of unmet demand for the procedure. In addition to logistical obstacles, [2-10] available research suggests that providers may serve as barriers to desired sterilization by discouraging women from undergoing sterilization or refusing to perform the procedure, often citing the patient's young age or low parity as too highly correlated with future regret.[3,8,11] Although providers are presumably well-intentioned, women have reported feeling that these types of encounters reflect a lack of respect for their preferences and decisional capacity and ultimately undermine their reproductive autonomy.[3] The increased enthusiasm around long-acting reversible contraception (LARC) overall and specifically as an alternative to sterilization [12-14] has the potential to intensify this dynamic.

To date, studies describing provider behaviors around sterilization counseling are primarily retrospective accounts from the patient perspective. There are no studies describing the presence, content, and tone of

80 sterilization counseling using recordings of patient visits. In this study, we
81 analyzed audio-recorded contraceptive counseling sessions to examine the
82 frequency and content of conversations in which sterilization was discussed
83 or would have been appropriate to discuss.

84

85 2. Methods

86 This study draws from a body of 342 audio-recorded contraceptive
87 counseling sessions of women of reproductive age (16-53) seeking family
88 planning services at one of six San Francisco Bay Area family planning,
89 primary care, or general gynecological clinics. Because of public programs,
90 all patients at these sites had insurance coverage for contraception. All
91 counseling was conducted by health professionals, including licensed nurse
92 practitioners, physician assistants, certified nurse midwives, and physicians.
93 The study was described to patient and provider participants as an
94 investigation of communication about contraception, with the goal of
95 improving understanding of women's experience with contraception.
96 Recruitment took place between August 2009 and January 2012.
97 Patients were eligible if they wished to discuss starting or changing a birth
98 control method during their visit, spoke English, were not and did not desire
99 to become pregnant in the next year, and identified as black, Latina, or
100 white. All participating patients completed a pre-visit and a post-visit paper
101 survey, which included questions on their fertility intentions, pre-visit method
102 preference, post-visit selected method(s), planned start date, and

103 demographic characteristics. Patient participants were compensated for
104 their time with a $25 gift card. Clinicians also completed a brief demographic
105 survey. Written informed consent was obtained from both patients and
106 clinicians prior to recording.

107 The entirety of the contraceptive counseling visit was recorded by a
108 recording device left in the room; no member of the study team was present
109 for the visit. The sessions ranged in length from 10 to 45 minutes, averaging
110 about 15 minutes. Recordings were transcribed verbatim. Study protocols
111 were approved by the Committee on Human Research at the University of
112 California, San Francisco.

113 To examine the frequency and content of discussions around
114 sterilization with potentially appropriate candidates in contraceptive
115 counseling visits, we sampled from the 342 sessions all visits for those
116 patients who specified in the pre-visit survey that they wanted no future
117 children, surmising that these were patients for whom sterilization would
118 have been appropriate to discuss as a possible method. Response options
119 for the pre-visit survey question about desire for future children included
120 "yes," "no," or "I don't know," rendering the choice of "no" a non-ambivalent
121 answer. As a supplemental analysis, we created a second sample of any
122 additional visits where female sterilization was mentioned, however briefly.

123 For this study, sessions were analyzed according to grounded theory
124 analytic techniques [15] in Atlas.ti 7 (Scientific Software Development GmBH).
125 The first author read all transcripts and developed a preliminary codebook.

126 She then coded the data using this preliminary list and added new codes as
127 they emerged, simultaneously compiling brief reports and memos. As
128 themes began to emerge, she discussed her findings with the second and
129 third authors who gave feedback on patterns and perceived redundancies.
130 Disagreements were resolved through discussion until consensus. When no
131 new codes emerged and the authors agreed on the thematic patterns,
132 coding was considered complete.
133

134 **3. Results**

135 Fifty-two patients indicated in their pre-visit survey that they did not
136 want future children. Patient characteristics are reported in Table 1 and
137 method preferences, choices, and planned start dates in Table 2. Six
138 women expressed a pre-visit preference for female sterilization. However,
139 only two women left with a plan for female sterilization.

140 [Tables 1 and 2]

141 The counseling sessions spanned 30 different providers (see Table 2
142 for clinician characteristics).

143 [Table 3]

144 *3.1 Discussion of sterilization*

145 Sterilization was discussed in 19 of the 52 visits in the sample (37%).
146 Generally, the sessions in which sterilization was discussed also included the
147 patient conveying to the clinician that she did not want future children. In
148 seven cases (with seven different clinicians), the clinician introduced

149 sterilization as a possible method, in all cases after first soliciting the
150 patient's fertility intentions and then, based on patients' response that they
151 did not desire future children, suggesting sterilization. The women in these
152 seven sessions were 37-years-old or older and had a history of one or more
153 pregnancies, whereas the overall sample was more heterogeneous (Table 1),
154 suggesting a pattern for whom clinicians considered asking about future
155 pregnancy intentions and considered as potential candidates for sterilization.
156 Notably, in these seven cases, clinicians presented sterilization using
157 neutral or even positive language. For instance, a 38-year-old black patient
158 with three children and two previous abortions was seeking a new method
159 because she had been encouraged to discontinue the contraceptive injection
160 after four years of use. After they jointly ruled out the pill because of
161 adherence difficulties, the clinician entertained continuing use of the
162 contraceptive injection, but quickly segued into questions about the patient's
163 age and number of children. The patient's responses lead the clinician to
164 query about desire for future children and subsequently propose sterilization.
165 Specifically, upon learning that the patient is 38, the clinician asks how many
166 children she has and, when the patient responds that she has three, asks,
167 "And are you done with children?" The patient responded enthusiastically
168 and affirmatively, saying, "Schwow!" and the clinician then introduced
169 sterilization: "So do you want a tubal?" The patient was hesitant, and they
170 discussed her concerns about weight gain and the permanence of
171 sterilization, although she also averred her desire to avoid pregnancy,

172 saying, “Do I want another baby? No, I don’t. But if I get pregnant, will I have
173 another baby? Yes.” Speaking positively about sterilization as a method, the
174 clinician described the surgery and said, “It’s a good option. It’s a good
175 option, because you don’t need to get pregnant right now, or for a while, you
176 know.” The patient agreed with this statement, saying, “That’s true.”
177 Encouraged to consider tubal ligation in the future but not interested in
178 committing at this visit, the patient left having received another
179 contraceptive injection.

180 Clinicians encouraging patients to consider sterilization, however, was
181 uncommon in the data. In the remaining 12 sessions with patients who did
182 not want future children during which sterilization was discussed, the
183 conversations were patient-initiated and clinicians actively discouraged
184 patients from considering sterilization, instead diverting the conversation
185 from sterilization to LARC methods—most commonly the IUD. Patients in
186 these visits ranged in age from 21 to 43; nine had one or more pregnancies
187 (Table 1). In encouraging patients to consider the IUD over a tubal ligation,
188 clinicians emphasized the reversibility of the IUD. One 35-year-old
189 nulliparous patient initiated the conversation about sterilization with, “I’m
190 35. I know I don’t want children. So I’m just wondering if there’s something
191 more permanent. So, I don’t know if getting my tubes tied is an option for me
192 or that’s too dramatic.” Her clinician acknowledged that sterilization was an
193 option for this patient, but discouraged choosing it, repeatedly referring to
194 the permanence of sterilization as a negative characteristic:

195 If you’d like to have a tubal ligation, I can certainly send you to one of
196 the surgeons who does that. But it’s permanent and there’s a 1% failure
197 rate. And if you change your mind, because you may change your mind,
198 there’s a surgery that is- It’s a reversal surgery. But it doesn’t always
199 work. And it’s not usually covered. I don’t believe so. We have an IUD if
200 you’re looking for something else.
201 Although the provider presented clinically-accurate information about the
202 permanence of sterilization and the difficulty and cost of reversal, the
203 framing of the discussion presented sterilization as unappealing because it is
204 permanent—and not because, for example, it was not immediately available.
205 Later, the patient attempted to clarify to the clinician that the permanence of
206 sterilization was not an issue for her, but she nonetheless selected the IUD,
207 saying, “The permanence doesn’t scare me, but I feel like I might as well try
208 the IUD.” The clinician endorsed her decision, saying, “Right. IUD is a good
209 choice.” The patient did not have the IUD placed during that visit; she
210 planned to commence the method in the next month.
211 In another counseling session, with a 37-year-old Latina patient with a
212 history of one abortion who articulated her desire to never have any children,
213 the clinician highlighted the ease of the clinical procedure for an IUD
214 insertion compared to a sterilization procedure, and also emphasized the
215 reversibility of an IUD. She said:
216 When people come in asking about sterilization, I also talk about IUDs
217 because that’s the way-. First of all, really good birth control, almost as

218 good as, basically, tying your tubes. No method's 100%. And it is
219 reversible—let's say something changed in your life. But also, it doesn't
220 require a procedure. So I just throw that out there.

221 Here, the clinician suggests that the patient's desire not to have children
222 could easily change and thus she discourages her from permanently ending
223 her child-bearing capacity through sterilization. Later, the clinician repeated
224 this theme: "I think the issue is it [the IUD] is reversible and in case you
225 change your mind, although I hear what you're saying that you don't think
226 you ever want to have kids." In this example, as in others, even when
227 clinicians verbally echoed a patient's expressed wish to avoid future
228 childbearing, they still put forth reversibility as a primary reason to select
229 LARC over sterilization. This patient persisted in her interest in sterilization,
230 ultimately selecting it as her method. Even then, the clinician reminded her
231 that she could change her mind and choose an IUD:

232 So we'll sign the forms [for the sterilization] and then, you can always
233 change your mind. Let's say you think about it and go, "Oh, no, I don't
234 really want it. I'm not gonna do this. I'm gonna come back and do an
235 IUD." Then just call us and make an appointment for that.

236 Although this patient and one other who expressed a preference for female
237 sterilization before the visit left with a plan for sterilization in the next month,
238 the others did not; of the four other women who had a pre-visit preference
239 for sterilization and discussed it during their counseling visit, three left with a

240 LARC method (one placed that day, two planned for in the next month), and
241 one chose the pill (started that day).

242 *3.2 No discussion of sterilization*

243 In the remaining 33 cases of women who reported no desire for future
244 children in their pre-visit survey, sterilization was not discussed. These
245 women ranged in age from 19 to 53; 22 had one or more pregnancies (Table
246 1). The omission of discussion of sterilization was a missed opportunity to
247 discuss the full range of contraceptive options for these women. Indeed, one
248 woman in this group expressed a preference for sterilization in her pre-visit
249 survey, but it did not come up in the counseling session itself. Part of the
250 oversight likely resulted from clinicians failing to solicit patient reproductive
251 intentions altogether. In 21 of the 33 cases, the patient's future reproductive
252 desires were not discussed at all; they were neither assessed nor did
253 patients volunteer this information.

254 In the 12 cases where reproductive intentions were discussed, it was
255 generally because the patient volunteered that she did not want to become
256 pregnant ever (again). Some already had children, such as a 35-year-old
257 white patient with one child, who explained "We never wanted to have more
258 than one and we're very happy with her. And just want to make sure we
259 don't have another one." Others did not have children, such as a 31-year-old
260 white patient with a history of one abortion who said, "I don't really plan on
261 having kids. It's not something I want to do anytime that I know of."
262 Another, a 22-year-old white patient, explained to her clinician: "I'd like to

263 have birth control, because I'd feel safer, and I don't want to be pregnant. I
264 don't want no children." Later, the clinician said, “So, you sound like you're
265 pretty far away from wanting to have a kid.” And the patient responded,
266 “Yeah, I don't.” Sometimes the clinician solicited the patient’s pregnancy
267 intentions and learned that she did not want children, but it was not always
268 clear from the patients’ response whether this was a short-term or long-term
269 desire. For example, when her clinician asked, “you don’t want to become
270 pregnant?” a 42-year-old Latina patient with one child responded simply,
271 “No.” Although the pre-visit survey established that none of these women
272 desired future children, in their counseling sessions, clinicians who asked
273 about pregnancy desires did not always probe to clarify whether women did
274 not desire pregnancy now versus ever. Seven of these women chose a
275 combined hormonal contraceptive (two started that day, three planned to
276 start in the next week, and two planned to start in the next month), three
277 chose an IUD (one placed that day, one planned for in the next month, and
278 one unsure of a start date), one planned to start the contraceptive injection
279 (although she was unsure when she would start), and one chose a progestin-
280 only pill (starting that day).

281 *3.4 Other discussions of sterilization*

282 [Table 4 about here]

283 Clinicians discussed sterilization in 14 other counseling sessions
284 (among women who either desired or were unsure whether they desired
285 future children on the pre-visit survey). They ranged in age from 19 to 42;

286 eight had one or more pregnancies (Table 4). In four cases, the clinician
287 mentioned sterilization and then immediately dismissed it—without input
288 from the patient—as an inappropriate option, often with reference to the
289 patient's young age. In six visits, the clinician introduced sterilization as a
290 legitimate option, but either the patient failed to respond to the idea—in
291 effect, passively dismissing sterilization as an option—or further discussion of
292 the patient's reproductive desires clarified that sterilization was
293 inappropriate at this time.

294 In the four remaining cases, patients initiated discussion of
295 sterilization. Two of these patients expressed ambivalence about
296 sterilization and ultimately sought non-permanent methods. The other two
297 were interested in sterilization but their clinicians discouraged them, citing
298 the patient's young age (26) in one case and the patient's less than 95%
299 certainty that she was done childbearing in the other.

300

301 **4. Discussion**

302 In the majority of contraceptive counseling sessions with women who
303 did not desire future children, clinicians did not discuss sterilization as a
304 contraceptive choice, potentially because they failed to solicit patient fertility
305 intentions and desires. As a result, they missed opportunities to talk with
306 patients about a potentially appropriate contraceptive method. Patients with
307 whom clinicians did initiate discussion of sterilization were uniformly over
308 age 35 and had previous pregnancies. This suggests there may be provider

309 bias in terms of who is expected to be done with childbearing, consistent
310 with existing research,[16] although it bears noting that, outside of this focal
311 group of women who desired no future children, clinicians mentioned
312 sterilization to patients representing a broader age range, many of whom
313 had not been pregnant.

314 The few clinician-initiated conversations about sterilization among
315 women who did not desire future children were almost always preceded by
316 inquiry about reproductive intentions, but such inquiries did not take place
317 with all patients. Providers may want to consider the value of assessing
318 desire for future fertility with all patients, while being sensitive to the fact
319 that not all women will have clear intentions about future reproduction, to
320 ensure that potentially relevant contraceptive methods are not left out of the
321 conversation. By making this a standard component of a contraceptive
322 counseling visit, providers can reduce or eliminate the effect of this bias on
323 their counseling.

324 With respect to how sterilization was discussed in contraceptive
325 counseling visits, we found that sterilization was often framed as a less-
326 desirable option. Some providers actively discouraged women from
327 choosing the method, instead encouraging them to choose a LARC method,
328 usually an IUD. This is consistent with focus group findings from women's
329 experience.[3] There are clinical reasons for preferring an IUD over a
330 sterilization procedure, including lower upfront cost, the possibility of
331 immediate availability, potential non-contraceptive health benefits, and

332 overall safety. In addition, given that an IUD is equally effective at
333 preventing pregnancy as sterilization, it may be that clinicians consider these
334 methods equivalent in terms of pregnancy prevention. Their emphasis in the
335 contraceptive counseling sessions on the reversibility of LARC methods,
336 however, suggests that the provider's opinions about the potential for
337 women's fertility intentions to change served to tip the scales in favor of
338 LARC over sterilization. This focus on method reversibility, however, could
339 distract counseling away from women's preferences for method
340 characteristics, which may be based on their articulated fertility desires and/
341 or other preferences, such as the convenience of a one-time procedure or
342 objections to the side effect profiles of reversible methods, including
343 menstrual changes, or the physical presence of a device.

344 While these findings are robust in drawing from unique data on actual
345 patient-clinician contraceptive counseling visits, we do not know what other
346 factors may have contributed to clinicians' counseling, including their failure
347 to mention sterilization and efforts to discourage patients from choosing
348 sterilization when it was discussed. They may, for example, have had
349 additional knowledge of the patient's medical history that makes sterilization
350 an inappropriate method or have wished to avoid referring patients to
351 another provider if they did not themselves offer sterilization. They may also
352 have been influenced by knowledge of the fraught history of coerced
353 sterilization, especially among vulnerable populations. [17] Knowing how
354 sterilization has been abused as a contraceptive method, clinicians may be

355 exceedingly cautious about recommending it. Too much caution, however,
356 risks replicating the same practice of devaluing women's reproductive
357 decision-making that characterized forced sterilization practices. We also
358 encourage caution in interpreting out data on whether the patient or the
359 clinician initiated discussion of sterilization; initiation by the patient does not
360 mean the clinician would not have mentioned sterilization otherwise.
361 An emphasis on attending to women's preferences when providing
362 counseling about sterilization is consistent with the broader movement to
363 improve patient-centered care in the health care system in general and in
364 family planning specifically.[18] In order to best meet women's needs,
365 clinicians should reflect on how their own biases may contribute to their
366 counseling practices around sterilization to ensure that they present the
367 method as an option when appropriate and center their counseling on
368 individual patient's preferences, desires, and needs.
369

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421

422 **Table 1: Characteristics of Patients Who Desired No Future Children, by**
423 **initiation of discussion of sterilization**

	Clinician initiated (n=7)	Patient initiated (n=12)	No discussion (n=33)	**Total** (n=52)
Age (in years)				
19-25	0	2	13	**15**
26-35	0	3	9	**12**
>35	7	7	11	**25**
Race				
African-American	2	1	9	**11**
Latina	1	5	10	**16**
White	4	6	15	**25**
Educational Attainment	0	0	1	**1**
Some High school	1	5	8	**14**
High school or equivalent	2	1	13	**16**
Some college/2-yr degree	2	3	4	**9**
4-yr college	2	3	7	**12**
More than 4-yr college				
Annual household income (in $)				
<25,000	2	3	23	**28**
25,001-50,000	1	2	2	**5**
50,001-85,000	1	2	6	**9**

>85,000	3	5	2	**10**
Pregnancies				
0	0	3	11	**14**
1	1	1	10	**12**
2 or more	6	8	12	**26**
Births				
0	1	5	20	**25**
1	1	0	10	**11**
2 or more	5	7	4	**16**

Table 2: Patient Method Preferences, Chosen Methods, and Planned Start Dates

	Pre-visit Method Preference	Post-visit Chosen Method
Pill/Patch/Ring	15	24*
		Planned start: today (13); in the
		next week (5); in the next month
LARC	13	*(4); unsure (2)*
		18
		Planned start: today (6); in the
Female	6	*next week (1); in the next month*
Sterilization		*(8); unsure (3)*
	5	2
Depo		*Planned start: in the next month*
	2	*(2)*
Condoms		4
	1	*Planned start: today (3); unsure*

Vasectomy		*(1)*
	1	2**
Withdrawal		*Planned start: today (2)*
	9	1
No preference		*Planned start: in the next month*
		(1)
		1
		Planned start: in the next month
		(1)
		--

427 * includes progestin-only pills

428 ** Two women reported using condoms in addition to a method with higher efficacy

429 (the Paragard and the pill, respectively). We consider that condom use a secondary

430 method and do not include those two cases in this count.

431

432 **Table 3: Clinician Characteristics**

	Clinicians (n=30)
Age (in years)	
35-45	10
46-55	10
>55	10
Race	
Latina/o	2
White	21
Asian/Pacific Islander	6
Multiracial	1
Provider Type	

Nurse Practitioner	18
MD/DO	8
Physician Assistant	2
Certified Nurse Midwife	2

433

434 **Table 4: Characteristics of Other Patients for visits where sterilization was**
435 **mentioned**

	Clinician Initiated (n=10)	Patient Initiated (n=4)
Age (in years)		
19-25	4	0
26-35	5	3
>35	1	1
Race		
African-American	3	0
Latina	3	4
White	4	0
Pregnancies		
0	6	0
1	1	0
2 or more	3	4
Births		
0	7	0
1	0	1
2 or more	3	3

436