

---

## REFLECTION

McGill Journal of Medicine

# Healthcare in Her Shoes

Brooke Richards<sup>1</sup>

<sup>1</sup>Dalhousie University, Halifax, NS, Canada

### Correspondence

Brooke Richards

Email: brookerichards@dal.ca

### Publication Date

October 10, 2022

MJM 2022 (21) 2

<https://doi.org/10.26443/mjm.v21i1.968>



McGill  
Journal of Medicine

[www.mjmmed.com](http://www.mjmmed.com)



This work is licensed under a Creative Commons BY-NC-SA 4.0 International License.

### ABSTRACT

Women's reproductive health has been the subject of debate for decades and the surrounding controversy does not appear to be dissipating any time soon. Thousands of articles are published annually on the topics of abortion, female sterilization, their associated ethical dilemmas, and the disparities that women face in the healthcare system. Although we have made great strides towards equitable healthcare, I would argue that women still face a disproportionate degree of stigmatization, bias, and unethical policy when it comes to their reproductive health. This essay highlights fictional but realistic examples to illustrate this ongoing discrimination, followed by an evidence-based discussion which proposes the potential roots of the discrimination and describes the harms associated with stigma and bias in this setting. Broadcasting these issues and encouraging medical professionals to think about them allows disparities to be more greatly recognized, and more readily dismantled.



### KEYWORDS

Reproductive Health, Abortion, Sterilization, Women

## 1 | EMMA & STERILIZATION

Emma is a 25-year-old graduate student from a rural community in Canada. Emma's personal interests include art, baking, and philosophy. She has many plans for her future, some of which include travelling to Europe, writing a novel, and pursuing her dream career of becoming a lawyer. Emma has two sisters and a current long-term relationship – a boyfriend of four years to whom she hopes to one day be engaged. She has always known that she does not want children. She is sexually active and takes an oral contraceptive pill daily to prevent pregnancy but finds she often forgets to take it, and

this produces a great deal of stress for her. Though she has consulted with her physician about her options, she is not open to the available contraceptive alternatives. Other contraceptive options include an intramuscular injection, an intravaginal ring, or an intrauterine device, but they all seem too invasive to Emma. Additionally, she does not feel comfortable using condoms or other barrier methods as her sole method of contraception. At this time, Emma reports being tired of the worry and fear surrounding unwanted pregnancy, and mentions she is not comfortable with the idea of having to undergo an abortion in the event she does become pregnant. Thus, following a long period of careful thought, Emma sched-

ules an appointment with her family doctor to discuss tubal ligation.

Tubal ligation is also an invasive procedure, but Emma thinks it will be worth it to not have to worry about contraceptive medications or their side effects, and to know that she will not become pregnant if she continues to have sex with her boyfriend. Emma called her doctor's office and obtained a consultation appointment for later that month. Emma's doctor, Dr. Matthews, is a general practitioner in his late 40s and has been overseeing Emma's health since she was a teenager. It is evident to Emma that Dr. Matthews cares about her well-being and she has always felt he provided her with the best possible care. Several weeks went by and the date of Emma's appointment rolled around. Emma stepped into the doctor's office and was greeted warmly by Dr. Matthews before jumping into their discussion on tubal ligation.

"Do you understand that tubal ligation is often irreversible?" Dr. Matthews inquired gently. Emma began nodding in understanding before her doctor had even finished his sentence. She responded, "I have done my research into this quite thoroughly".

Dr. Matthews hesitated before presenting his next question: "can you tell me a little bit about how you came to this decision?". Emma was prepared for this question too and promptly responded that the worry and stress of possible pregnancy often affected her ability to study and impaired her sleep.

Dr. Matthews listened intently as Emma spoke, but the confusion that remained on his face suggested that his question had not entirely been answered. "I mean, how did you come to decide that you don't want children?", he rephrased. Before Emma could counter, the doctor went on to question how thoroughly she had thought about this decision. Emma felt that it was a fair question as the procedure is potentially permanent, but admittedly did not anticipate being asked about how she came to her decision about children. She replied that she had always known. Dr. Matthews remained perplexed; he leaned toward his patient with concern in his eyes, "Emma, I don't think you understand the gravity of the decision you are trying to make here".

Now, it was Emma's turn to be confused. "I've always known that I don't want children. I simply don't want them - what more is there to it?", she asked. Dr. Matthews leaned back in his chair and sighed in mild frustration, "but how can you know that?". At this point, Emma did not know what to say. Dr. Matthews continued, "I mean, you're so young, how could you possibly know with certainty that you don't want kids?". It was clear to Emma that this question was rhetorical. Dr. Matthews' tone continued to exemplify concern for his patient, but the nature of his questions suggested resistance to Emma's request for sterilization. Advocating for herself, Emma transitioned the conversation towards the medical consultation she had hoped for and asked if the procedure was unsafe for her to undergo. "Is there another reason I shouldn't be considering this?", she asked. At this question, the doctor sat upright in his seat and in clear exasperation, implored "have you talked to your boyfriend about what he wants? How would your future husband feel about this?".

The case of 25-year-old Emma seeking tubal ligation is representative of the experiences of many women who are denied tubal ligation by their doctors. Reasons for rejection often include age (women are judged as being too young to make a decision of this nature), fear of regret, or concern for a future partner's desire to have children. (1,2) A case series of women seeking tubal ligation conducted by two Ontario physicians found that many women were referred from their initial point of contact (abortion clinics, primary care providers, and gynaecologists) to other providers on the basis of hospital limitations or personal conscience. (3) The study patient's records documented that many women had experienced prior difficulty in obtaining the sterilization procedure. (3) If we go back in time a mere 50 years in the United States, obstetrician-gynaecologists would multiply a woman's age by her parity to determine if she could qualify for sterilization. (4) If the product was less than 120, the woman was deemed ineligible. (4) At this time, several states required spousal consent for a woman to obtain sterilization, meaning that a woman could not access any kind of tubal ligation procedure without the permission and signature of her husband (if she was

unmarried, her father's signature could have been required). (5) The double-standard seems flagrant here. To this day, the stigma surrounding male sterilization is arguably minimal compared to that of female sterilization. One might contend that this is because vasectomies are reversible procedures where tubal ligation is permanent, but this is not entirely correct. While rates of pregnancy following reversal are generally higher with vasectomies, a study assessing rates of successful pregnancy in women (mean age of 32) following tubal ligation reversal found the rate to be over half at 56%. (6) A separate study assessing rate of pregnancy in women (mean age of 31) whose partners had undergone vasectomy reversal found the rate of pregnancy to be 72.2%. (7) Evidently, successful pregnancy following tubal ligation reversal is possible, and despite the common misconception, pregnancy following vasectomy reversal is not a guarantee. That is not to say that physicians should not carefully consider the appropriateness of tubal ligation in their patients, or that it is unreasonable for a doctor to present the risks and potential for regret to their patients seeking this procedure. A discussion of this nature should certainly be had, but provided that there are no contraindications, a woman should not be denied sterilization because she is, for example, currently without children, or because her future partner(s) may object. Further, a woman's decision to become pregnant and have a child or not should be her own to make. Her partner's opinion may be of considerable value to her in making this decision, but such matters are for her to manage personally, and not the responsibility of her health-care provider. The eligibility policies mentioned above have since changed, but significant barriers to a woman obtaining sterilization still exist. Many physicians continue to be apprehensive about performing tubal ligation, and the causes for their hesitation reflect age-old ideas about a woman's value to society, and more specifically her role in childbearing.

The fictional scenario that I have presented through the character of Emma illustrates the unconscious bias at play that hinders a woman's access to sterilization. Why is the doctor hesitant to agree to Emma's wish to undergo tubal ligation? The doctor raises concern

around Emma's age and suggests she is too young to know that she does not want to have kids. Emma is 25 years old. A 25-year-old in this country does not face any age-related limitations in any setting – a 25-year-old can rent a car or a hotel room, hold more than one university degree, independently move to a new country, choose a life partner under the eyes of the law and, her health and other variables permitting, can then decide to give birth to as many children as she wishes. Why is it that when a 25-year-old declares she is ready for marriage and children that she is met with societal praise, but when she declares she is certain that a life with children is not what she wants, she is met with disbelief? The age need not be set at 25 either – people do not doubt young girls or teenagers when they claim that they are sure they will one day want kids. A double standard clearly exists here. It may be thought that the younger a woman is, the greater the risk that she may regret her decision to undergo sterilization later in life – an appropriate consideration. This segues into the ethical dilemma surrounding regret in women undergoing sterilization procedures. Research has been conducted regarding how often women are regretful of their decision to undergo tubal ligation. One study found the overall 14-year cumulative probability of a woman obtaining tubal ligation reversal to be 1.1% (8). The researchers also determined the 14-year cumulative probability of a woman requesting information on tubal ligation reversal to be 14.3%. (8) This data suggests the majority of women do not regret their decision to undergo tubal ligation. Notably, the study observed that the younger a woman was when she underwent tubal ligation, the greater the likelihood that she would later request information about reversal. (8) Therefore, it would be reasonable for clinicians to consider that the potential for regret is greater in younger women and to counsel their patients accordingly. However, a woman should not be denied the procedure based purely on age. It would make little sense to force a woman to wait until she is in her mid 30s or 40s, for example, to access sterilization, at which point her most fertile years would be behind her. On the subject of regret, consider that a similar argument surrounding a change of heart could be applied

to a woman electing to undergo other irreversible surgeries (such as cosmetic surgery, for example). While sterilization cannot be equated to other surgical procedures, I propose this comparison to highlight the disproportionate fixation on the potential for regret that exists in the setting of female sterilization. If a woman is knowledgeable of the risks, understands her options, and wishes to proceed (i.e. has made an *informed* decision), to deny her sterilization on the grounds that she may regret her decision later in life is not only paternalistic, but beyond medical purview. In the setting of other irreversible medical procedures, the informed decision to follow through ultimately lies with the patient. Why should it be different in the context of female sterilization? As I have mentioned, it is important to counsel patients on the potential for regret and to possibly be prepared to offer psychological support in the event that regret occurs, but this exaggerated apprehension in providing women with access to sterilization may serve as a barrier to care.

The issue that remains in Canada is predominantly that of an unconscious bias rendering physicians reluctant to provide women with sterilization procedures. Personal physician bias should cease to play a role in a woman's access to reproductive healthcare, and a woman who otherwise qualifies should not be denied access to sterilization on the basis of perceived naivety.

## 2 | CARRIE & ABORTION

I now move to the example of Carrie, an 18-year-old woman from the city of Birmingham in Alabama, USA. Carrie recently graduated high school and will soon be attending the University of Alabama where she will be majoring in biomedical sciences. She is hoping to one day work in healthcare but is not yet decided on which profession she would like to pursue. She will be paying for her university education exclusively through a line of credit and government loans. Carrie was raised by a single mother and has one older brother. She has a large friend group that she graduated high school with which further bolster her support system, and although she is not currently in a relationship, she identifies as hetero-

sexual. In the summer, Carrie works at a coffee shop in the city. Her shifts begin quite early in the morning and over the past few weeks, Carrie has noticed that she has been feeling nauseous when she gets up to get ready for work, even vomiting a couple of times. Three weeks prior to the onset of her nausea, on the night of her prom, she had sex for the first time and did not use protection. This morning, she couldn't keep her breakfast down before work and it dawned on her that there was a real possibility that she could be pregnant. She decided to stop at the drugstore nearest her house on her way home from work to pick up a pregnancy test.

Carrie began to feel very uncomfortable as she entered the women's health section of the drugstore. A wave of anxiety washed over her as she scanned the aisle for the test that would best apply to her. She was confused by all the different boxes, labels, and time-frames for the tests, but did not feel comfortable asking the pharmacist for help. When a front store worker passed her in the aisle, she reflexively ducked her head in shame and skittered away from the area where the pregnancy tests were located; she grabbed a box of tampons off the shelf and tucked them under her arm. The worker didn't seem to notice Carrie's odd behaviour and turned the corner into another aisle. Carrie darted back down the aisle and grabbed the first pregnancy test she could find; she noted the test read "early response" and felt that was good enough. She rushed to the self-checkout and, still quite embarrassed, scanned her items and tossed them in a bag as quickly as she possibly could. When she got home, she hurried up the stairs to the bathroom without saying hello to her mother. She threw the plastic grocery bag on to the floor at her feet, and felt her heart begin to beat rapidly in her chest. Her breathing quickened as she contemplated the prospect of pregnancy, what it would mean for her future, and what her mother may think. She knew that she would not be able to afford a baby, and that her family did not have the resources to help her. She carefully followed the directions written on the pamphlet that came with the pregnancy test. The instructions stated that it may take a few minutes for her results to become clear. She lowered herself onto the cold laminate floor and

watched the analog clock in the corner of her bathroom anxiously. At the end of the wait period, she picked the test up from the bathroom counter and closed her eyes tightly before looking at the test result. After a painful 30 seconds, Carrie opened her eyes. The test result was very clearly positive. She quietly wept on her bathroom floor before slinking away to her bedroom and crawling under the covers of her bed. She went on to cry herself to sleep as she embraced what she perceived to be the beginning of her terribly bleak future.

The *Human Life Protection Act* was enacted in 2019 in the state of Alabama, USA. (9) This bill was passed in both chambers of the Alabama Legislature, and states that any physician who performs an abortion could be subject to life in prison. (9) The bill bans abortions at any stage of pregnancy and fails to recognize its necessity under even extreme circumstances. (9) A preliminary injunction has delayed its implementation, but were it to be implemented, women like Carrie would not be able to access abortion at all and would be forced to carry out their pregnancies. (10) States like Alabama are not alone in their pursuit to ban abortion access. Extreme abortion bans are being proposed all over the United States of America, among other countries around the globe. (11) The leak of a draft decision by the supreme court of the United States which occurred just this past month serves as concrete evidence of this very fact. (12) The draft outlines the supreme court's intention to overturn the landmark *Roe v. Wade* – a law that has protected a woman's right to an abortion since 1973. Evidently, an extreme abortion ban is on the horizon in Canada's neighbouring country. This is a reality that cannot be ignored by Canadians; American policies are not without influence in our country and conceivably set a precedent within Canada. (12) What could a lack of access to abortion mean? Limiting access to abortion may actually lead to a rise in unsafe abortions. One study from 2009 found an association between restrictive abortion laws and the rate of unsafe abortions. Researchers observed that abortion related deaths are much higher in countries with laws that restrict access to abortion, and that when abortion laws are relaxed, the rate of unsafe abortions drops dramatically. (13) For example, in South

Africa, following legalization of abortion in 1998, the abortion mortality ratio dropped by 91% in just 3 years. The study reports that similar trends were observed in other countries. (13) The evidence suggests that restricting access to safe abortion creates an increase in abortions which are associated with greater physical harm. Of note, the methods through which women complete unsafe abortions involve the ingestion of toxins, infliction of abdominal injury, or direct trauma to the vagina, while the most common causes of death related to unsafe abortion were found to be genital trauma, sepsis, hemorrhage, infection, and necrotic bowel. (13)

Carrie represents one of many different types of women who may reasonably seek an abortion. She is 18 years old with desires to pursue a higher education and, while she may one day want a family, strongly feels that now is not the time for her to raise a child. Financial stressors mean that it is not feasible for Carrie to follow through with her current pregnancy. A 2013 study which sampled nearly 1000 women from 30 abortion facilities in the United States found that the two most common reasons to seek an abortion were financial stressors and timing. (14) Thus, I chose to share the story of Carrie because I feel it is representative of a realistic and prevalent case in which a person could want to terminate a pregnancy. However, it is important to acknowledge that there are many different circumstances that may lead a woman to seek an abortion. Consider the case of a young girl who is molested and raped by a relative, only to become pregnant with his child. Under the US laws proposed in 2019, any doctor who agrees to conduct an abortion for the victim of rape and incest could be subject to life imprisonment. (9)

Abortion is certainly a controversial subject, and there understandably exists a spectrum of opinions surrounding when it is reasonable to access abortion. The safety of these procedures at various time points throughout pregnancy should be considered, and the decision to undergo abortion should involve some contemplation. However, provided that a woman has discussed the benefits and risks with her healthcare team, deliberated the decision carefully, and decided to move forward with abortion, provider bias and politics should

not stand in the way of her right to this form of health-care. This is an issue of bodily autonomy; when it can safely be avoided, women must not be forced to follow through with unwanted pregnancies. I would argue it is unethical for our governments to restrict which health-care is and is not accessible to women when we have the professional and financial resources to provide this care.

If nothing else, the stigma surrounding abortion must end. Despite being a commonly sought procedure – around 73 million induced abortions are performed every year worldwide – abortions are a clandestine topic. (15) Women who undergo abortions are pitied, and judged, and the air of controversy that surrounds the procedure likely contributes to some of the misinformed perspectives of the public and our policy makers. For many women, the decision to get an abortion is not cut and dry. For some, it is a very stressful experience requiring days and weeks of contemplation. To add insult to injury, abortion clinics are notoriously riddled with protestors, making a potentially overwhelming appointment almost unbearable. What other medical procedure is so heavily stigmatized? This stigma likely contributes to unconscious bias among the public and the health-care community which creates a barrier to abortion access.

### 3 | IN CONCLUSION

There are many other disparities that exist between men and women in the context of healthcare. Though they may not be immediately apparent, the issues exist and have real consequences for women in Canada, USA, and other countries around the world. Access to sterilization and abortion are only two examples, which I have selected to highlight because they are a major part of modern public debates and effectively demonstrate the issues of stigmatization, unethical law making, and unconscious bias that exist in our medical systems today. Understandably, these subjects are complex and difficult to navigate. My aim is to validate the frustrations of the real women who, like the fictional characters of

Emma and Carrie, have struggled to navigate the health-care system, and to raise awareness of these issues to health providers so that they may recognize their own biases in their pursuit to provide the best possible care. Women should experience a healthcare system that is as ethical, unbiased, and unprejudiced as is realistically possible.

### REFERENCES

1. Richie C. Voluntary sterilization for childfree women: understanding patient profiles, evaluating accessibility, examining legislation. *Hastings Cent Rep* [Internet]. 2013 Nov-Dec [cited 2022 Apr 22];43(6):36-44. Available from Pubmed: <https://pubmed.ncbi.nlm.nih.gov/24132925>
2. Deardorff J. Doctors reluctant to give young women permanent birth control. *Chicago Tribune* [Internet]. 2014 May 13 [cited 2022 Apr 22]: People. Available from: <https://www.chicagotribune.com/lifestyles/ct-xpm-2014-05-13-ct-met-sterilization-denied-20140513-story.html>
3. Ehman D, Costescu D. Tubal Sterilization in Women Under 30: Case Series and Ethical Implications. *J Obstet Gynaecol Can* [Internet]. 2018 Jan [cited 2022 Jun 4];40(1):36-40. Available from Pubmed: <https://pubmed.ncbi.nlm.nih.gov/28870724/>
4. The American College of Obstetricians and Gynecologists [Internet]. Washington (USA): ACOG Clinical; [date unknown]. Sterilization of Women; 2017 April [cited 2022 Feb 11]. Available from: [tinyurl.com/3p9mktxk](http://tinyurl.com/3p9mktxk)
5. Simonaitis J. Spouse's Consent to Sterilization. *JAMA* [Internet]. 1974 Jun [cited 2022 Feb 11];228(11):1453. Available from Pubmed: <https://pubmed.ncbi.nlm.nih.gov/12257282/>
6. Karayalcin R, Ozcan S, Tokmak A, et al. Pregnancy outcome of laparoscopic tubal reanastomosis: retrospective results from a single clinical centre. *J Int Med Res* [Internet]. 2017 Jun [cited 2022 Apr 22];45(3):1245-1252. Available from Pubmed: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5536424/>
7. Hinz S, Rais-Bahrami S, Kempkensteffen C, et al. A. Fertility rates following vasectomy reversal: importance of age of the female partner. *Urol Int* [Internet]. 2008 Dec [cited 2022 Apr 22];81(4):416-20. Available from Pubmed: <https://pubmed.ncbi.nlm.nih.gov/19077402/>
8. Schmidt J, Hillis S, Marchbanks P, Jeng G, Peterson H. Requesting information about and obtaining reversal after tubal Sterility [Internet]. *Fert Ster* [Internet]. 2000 Nov [cited 2022 Feb 11];74(5):892-898. Available from Pubmed: <https://pubmed.ncbi.nlm.nih.gov/11056229/>
9. Human Life Protection Act 2019 (AL) s 4-10.
10. *Robinson v Marshall* (2019) 68 F.3d 1.
11. Thomson Reuters Foundation News [Internet]. London (UK): Thomson Reuters Foundation News; c2020. U.S. states

making 2021 moves on abortion rights and access; 2021 Oct 07 [cited 2022 Feb 11]; [about 5 screens]. Available from: <https://news.trust.org/item/20201231112641-qfynt/>

12. Vogel L, Duong D. What the U.S. overturning Roe v. Wade means for Canada. *CMAJ* [Internet]. 2022 May [cited 2022 Jun 4];194(20):E711-E712. Available from PubMed: <https://pubmed.ncbi.nlm.nih.gov/35609915/>

13. Haddad LB, Nour NM. Unsafe abortion: unnecessary maternal mortality. *Rev Obstet Gynecol* [Internet]. 2009 Spring [cited 2022 Apr 22];2(2):122-6. Available from Pubmed: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2709326/>

14. Biggs MA, Gould H, Foster DG. Understanding why women seek abortions in the US. *BMC Womens Health* [Internet]. 2013 Jul 5 [cited 2022 Jun 4];13:29. Available from PubMed: <https://pubmed.ncbi.nlm.nih.gov/23829590/>

15. Fact sheet: Abortion [Internet]. World Health Organization; 2021 Nov 25 [cited 2022 Jun 4]. Available from: <https://www.who.int/news-room/fact-sheets/detail/abortion>