OPEN ACCESS

Why-UD? Assessing the requirement to trial an intrauterine device as a condition for elective sterilisation in female patients

Teresa Baron

Correspondence to
Dr Teresa Baron;
teresa.baron@nottingham.ac.uk

Received 11 May 2023
Accepted 16 November 2023
Published Online First
13 December 2023

ABSTRACT

Some National Health Service healthcare boards in the UK will approve a request for female sterilisation only if the patient first accepts a trial period of 1 year with an intrauterine device (IUD), a form of long-acting reversible contraception. In this article, I argue that this requirement is not justified by appeal to any of (or any combination of) promotion of informed consent, paternalistic concerns regarding patient regret in later life and health service budgetary considerations. Informed consent and patient autonomy may be promoted by a mandatory waiting period, but the concomitant imposition of an IUD trial during this period cannot be justified on these grounds. As long as elective vasectomy is offered by the healthcare system, elective female sterilisation should be accessible under reasonably similar—even if not identical—conditions.

INTRODUCTION

While all patients in the UK theoretically have the same rights to access medical care through the National Health Service (NHS), the kinds of care available and the conditions under which it can be accessed are, in reality, dependent on geography. Integrated care boards (ICBs), previously clinical commissioning groups (CCGs), are responsible for developing policies and plans to meet the health needs of those living within their area. These policies can vary across the country. For example, research by the British Pregnancy Advisory Service conducted in 2020 found significant discrepancies in fertility funding and in barriers to access to *in vitro* fertilisation, dubbed the 'IVF postcode lottery'. One key element of this geographical variation was in the number of IVF attempts provided on the NHS: 86 CCGs were found to fund only one cycle of IVF per individual/couple, while 23 funded three cycles.[1]

A different discrepancy can be found when examining ICB policies on the provision of elective sterilisation. (For male patients, this is provided in the form of vasectomy; for female patients, it is usually provided in the form of tubal ligation, in which the fallopian tubes are severed or clamped to bar the movement of eggs from the ovaries towards the uterus.) Alongside widespread discrepancy between male and female patients' access to elective sterilisation, there is further discrepancy in the conditions placed on access to elective female sterilisation between ICBs. As an issue relating to healthcare provider policy in a subset of one country's health system, this might not initially seem to demand widespread attention; however, this provides an important lens for examining broader ethical issues relating to elective medical procedures, healthcare policy and reproductive autonomy.

In short, some ICBs require that a female patient requesting sterilisation agrees to use an intrauterine device (IUD) for a minimum of 1 year first. An IUD is a long-acting method of birth control which prevents pregnancy either by preventing fertilisation or by preventing implantation of a fertilised egg. The hormonal IUD releases progestogen, which causes the cervical mucus to thicken and creating a barrier to the meeting of egg and sperm in the fallopian tubes; the copper IUD inhibits the viability and motility of sperm, and alters the lining of the uterus to prevent implantation of any fertilised egg.[2] IUDs are widely considered safe and effective, and patients who use IUDs generally report a high level of satisfaction.[3] However, insertion and removal of IUDs (especially in nulliparous women) is also associated with pain and discomfort, with 78% of nulliparous women rating the pain of insertion as moderate to severe. The (sometimes extreme) pain caused by IUD insertion has been further highlighted in public discourse and popular media in recent years.[4] These more public discussions have, in particular, drawn attention to the routine clinical practice of performing IUD insertions (as well as other common gynaecological procedures such as cervical biopsy) without analgesic or other pain relief.[5]

While some ICB policies on elective sterilisation merely state that counselling should include information on long-acting reversible contraception, or that female patients should be offered a trial of these alternatives, other ICBs require that female patients undergo a period of at least 1 year with an IUD before sterilisation will be approved. For example, Surrey Heartlands ICB's policy includes the condition, 'Sterilisation will not be available on non-medical grounds unless the woman has had at least 12 months' trial using Mirena or Implanon and found it unsuitable'.[i] Nottinghamshire ICB similarly requires that a patient requesting sterilisation 'Has tried an IUS/IUD for 12 months and found it unsuitable'. This condition can be waived if sterilisation takes place 'at the time of another clinically appropriate gynaecological procedure such as caesarean section' or where there is a clinical contraindication to the use of the IUD. The only other condition under which a patient can access sterilisation without undergoing a trial of the IUD is

[i]Mirena and Implanon are the names of a hormonal IUD and a copper IUD, respectively.

To cite: Baron T. *J Med Ethics* 2024;**50**:708–711.

where 'there is an absolute clinical contraindication to pregnancy'.

Other ICBs, however, do not make access to sterilisation contingent on acceptance of the IUD. For example, Gloucestershire ICB's policy requires that, 'The patient has received counselling about all other forms of contraceptives. Long-acting reversible contraception has been discussed, tried, refused or deemed unsuitable'. Likewise, Cambridgeshire and Peterborough ICB require that: '[Patients] have received counselling about the availability of alternative, long-term and highly effective, contraceptive methods and females have been offered a trial of long-acting reversible contraception'.

In the British Pregnancy Advisory Service's report on IVF (mentioned above), local policies on IVF provision were critically evaluated against the National Institute for Health and Care Excellence (NICE) guidelines. The NICE guidelines recommend that three IVF cycles should be offered to women aged under 40 years, and one cycle to women aged 40–42. We may begin with a similar comparison, and note that the NICE guidelines for considering elective sterilisation requests recommend that—in line with promoting fully informed consent—patients are fully aware of, and understand the risks and benefits of, all possible forms of contraception. However, they do not recommend that trying an alternative method of contraceptive be required as a condition for approving sterilisation.

In examining what I will hereafter refer to as the IUD requirement, I am interested in whether this is a justifiable condition on access to sterilisation. Since this policy pertains to *conditional* access to sterilisation, rather than denial of sterilisation requests, the question of whether sterilisation is itself medically necessary or justified is not relevant. I am also not interested in justifying access to elective sterilisation per se, or addressing the sexism that particularly underpins denial of sterilisation requests by young and childless women; these discussions have been given detailed consideration elsewhere in recent years. I take it as read that both men and women have an equal right to control of their reproductive autonomy, and that sterilisation and contraception (including long-acting contraception) are not equivalent in their nature or value for the patient. If the NHS offers vasectomy to male patients, it should also offer tubal ligation or other forms of female sterilisation.

GENDER NORMS, REGRET AND FRUSTRATION

No ICB in the UK requires that male patients seeking vasectomy undergo a 1-year trial of another form of contraceptive. But of course, this is explained rather straightforwardly by the lack of long-lasting reversible contraceptives available to men. It is also important to note that while vasectomy and tubal ligation both bring about sterilisation, the two are different procedures with different kinds of associated risks. In particular, vasectomy is performed under local anaesthetic, while tubal ligation is performed under general anaesthetic. When procedures are not themselves directly comparable, we cannot assume that it is necessarily a matter of discrimination to offer them on different conditions. Whether the IUD requirement is justified depends on the reasons for some ICBs having this specific policy. Why an IUD, and why the requirement of a 1-year trial, rather than merely offering the patient this or other alternatives (as is the case in other ICBs)?

It may be that the reason for approving sterilisation only on condition of a 1-year trial of an IUD is in order to enforce a 'cooling off period'—while still providing adequate birth control—to ensure that the patient gives the matter sufficient thought. Buturovic, for example, argues for such a time period: 'We should not want sterilisation to be available at the press of a button. To the contrary, obstacles to sterilisation for young women are precisely the process needed to weed out the confused and uncommitted'.[6] However, this reasoning would only justify the imposition of a waiting period, and not insistence on a specific method of contraception. Further, counselling regarding alternatives and explaining the ramifications of sterilisation is considered sufficient for male patients, for whom no set time period for 'cooling off' is mandated.

Alternatively, the IUD requirement may be based on the premise that (1) women are more likely to regret their choice to be sterilised, and (2) that healthcare policy may justifiably constrain access to choices that individuals may regret. But discrepancies in the ease with which male and female patients can access elective sterilisation have been widely criticised in recent years; and in large part, these discrepancies seem to reflect gendered differences in normative expectations when assessing a patient's request.[7] The presupposition that a patient will change her mind about motherhood (or feel the call of a maternal instinct) and regret the procedure later in life seems to play a significant role in healthcare provider denials of female sterilisation requests. As has been noted elsewhere, denial of a competent patient's request on this basis constitutes unjustified paternalism; it is also not supported by empirical evidence.[8] A 1999 US study of women sterilised between the ages of 18–30 found that only 6.3% of those with no children regretted their decision to be sterilised; in a 2015 Slovenian study, only 1.3% of women regretted this decision.[9 10]

There are many things that we may elect in life which, despite making our decisions fully autonomously, we later come to regret: a tattoo reminding one of a former lover, a marriage to someone who later cheats and indeed *becoming* a parent. Expressing regret about parenthood is widely considered far more taboo than the converse.[11] Nonetheless, as Mertes notes, 'there is a discrepancy between the level of scrutiny to which a request for sterilisation is subjected as opposed to a request for fertility treatment'. This aside, we do not generally consider it to be the role of healthcare providers to protect us from regret, but rather to promote and respect patient autonomy and best interests. The greater risks associated with female sterilisation (eg, the health risks that come with general anaesthetic) might warrant particularly thorough counselling with regard to benefits and disadvantages of different forms of birth control in order to promote informed consent, but the possibility of regret pertains to *outcome*, which is near-identical for male and female sterilisation. I say *near*-identical because motherhood, as has been argued elsewhere, is often taken as more strongly intrinsic to womanhood/femininity than fatherhood is to masculinity.[12] Gestation in itself, independent of genetic parenthood, also carries a particular value to many women, and sterilisation might thus be considered the loss of this particular value in addition to the loss of reproductive opportunity more generally. However, sterilisation does not represent a complete loss of this opportunity, as it will not necessarily prevent a donated embryo being carried to term. It is also worth noting that gestation carries significant risks to health and well-being, which present a counter-argument to appeals to the special value of gestation as justifying extra conditions on female sterilisation.

PERSUASION

As noted above, the requirement to trial of any specific form of contraceptive is not justified if the aim is only to enforce a

period of reflection to ensure genuinely informed consent to sterilisation. So why an IUD? Here, we may compare the IUD requirement with a different genre of healthcare policy. A number of US states (including Alabama, Texas, Virginia, Illinois and North Carolina) have introduced legislation in recent years that mandates an ultrasound prior to abortion. On a similar note, 15 US states have a two-trip mandate, which requires a patient to receive counselling in person before they receive an abortion, *and* to have a waiting period beginning after the counselling has taken place, thus necessitating two trips to the relevant facility.[13] The mandatory waiting period itself, as in the case of sterilisation, would be enough to ensure appropriate reflection. Insistence on an IUD, like the insistence on an ultrasound (and in some states, insistence on transvaginal ultrasound) is not necessary for 'cooling off', but rather, seems intended to put the patient off their elected procedure. It might be hoped that the mandated intervention will change the patient's mind, or that the prospect is sufficiently unpleasant or cumbersome to put the patient off pursuing sterilisation, even if her mind remains unchanged. One 2022 article reports waiting periods of up to a year for IUD removal appointments in England and Northern Ireland.[14] The pain associated with IUD insertion and removal can thus be combined with the expected difficulty of scheduling and attending the relevant appointments (as well as the later appointment for sterilisation) as 'putting off' rather than 'cooling off' factors. Alternatively (to take a more charitable view) the insistence on an IUD may be an attempt to change the patient's mind by demonstrating the *superiority* of the IUD vis-à-vis the patient's values, health and goals. Either way, the answer to 'why an IUD?' (as opposed to 'why a 1 year wait?') would therefore be, 'to curb female sterilisation'.

If female sterilisation represents a significantly greater strain on health service resources, it might be argued that it is justifiable for ICBs with fewer resources to try and redirect women towards cheaper alternative forms of birth control. In a healthcare system with limited resources, such as the NHS, justice-based considerations may justify constraints on the types of healthcare offered to different patients. The cost of a procedure needed to achieve an end in one patient may be far greater than the cost of a procedure needed to achieve the same (or similar) end in a different patient. Due to the differences in male and female reproductive anatomy, sterilisation procedures for male and female patients carry different financial costs (as well as different recovery times and so on). For example, according to the costings published by the East and North Hertfordshire CCG in April 2017, the estimated cost per patient over 15 years for the IUD, vasectomy, combined contraceptive pill and female sterilisation were £31, £260, £303 and £1161, respectively. These figures taken in isolation suggest that female sterilisation was roughly 4.5 times more expensive to the NHS as vasectomy during this year.

However, it must be noted that the costs for providing a specific form of birth control over a given period is not the only relevant NHS cost to consider. Users of hormonal contraceptives, including the hormonal IUD, can expect to experience any of a number of common side effects, including nausea, headaches, breast soreness, depression, weight gain and acne; the copper IUD commonly causes heavier periods and more cramping (particularly during the first 3–6 months after insertion). At best, an incorrectly inserted IUD will cause pain and will have to be re-fitted, and in worse cases may cause uterine perforation. Finally, we may also compare the contraception costs above to Public Health England's 2018 estimate of the cost of maternity care: £5505 per live birth, and £1982 per pregnancy (including those ending in abortion or miscarriage).[15] If the IUD requirement is motivated by the aim to reduce patient sterilisation numbers in order to save budget, it is far from clear that this is a financially efficient strategy.

However, more importantly, it is not a morally legitimate exercise of an ICB's decision-making power. Appealing to budgetary considerations to justify the IUD requirement strongly implies that this policy is expected to change the minds of a significant number of patients, so that they will *no longer pursue* sterilisation. If the IUD requirement is only a proxy for a 'cooling off' period, it makes no sense as a money-saving mechanism: the cost of the IUD insertion and removal is simply added to the cost of the sterilisation procedure. Thus, if designed to conserve resources, the IUD requirement must be expected to work in (at least) one of three ways:

a. By persuading enough patients that the IUD is equal or superior to sterilisation (with regards to their motivations for seeking sterilisation) that they do not continue to pursue sterilisation;
b. By presenting an obstacle to sterilisation sufficient to persuade enough patients change their minds about sterilisation entirely; and/or
c. By presenting an obstacle to sterilisation sufficient to persuade enough patients to seek sterilisation privately, rather than using NHS resources.

Both (b) and (c) straightforwardly undermine equity in male and female patient treatment, and verge toward punitive treatment of female patients who seek sterilisation. This is further underpinned by the pain associated with IUD insertion for many, particularly nulliparous, women (as noted in section 1). It might be argued, however, that (a) does not undermine equity in the health service: women who have sought a reliable method of birth control are still provided with this, and they still retain the option to pursue sterilisation later if they are not satisfied with the IUD. Nonetheless, I would argue that women seeking sterilisation are not *merely* seeking reliable birth control; they are pursuing something more specific, and it would be disingenuous to claim that their request would therefore be genuinely fulfilled by the provision of the IUD. As McQueen notes, for example, 'Sterilisation can provide these women with a sense of control, satisfaction, independence, relief and/or finality, allowing them to commit fully to their preferred lifestyle and freeing them from worries of pregnancy'.[8]

CONCLUSIONS

I have argued that, despite the practical differences in male and female sterilisation procedures, the IUD requirement enforced by some ICBs as a condition of female sterilisation is an unjustified discrepancy in healthcare provision. I have argued that the IUD requirement cannot be justified as a proxy for a reflection period. Mandatory counselling with regard to alternative forms of birth control is already a condition for obtaining sterilisation; if the IUD requirement were truly necessary in order to demonstrate the benefits of this form of birth control, this would rather seem to indicate that counselling needs improvement. The criticisms of paternalism and sexism levelled at routine denial of female sterilisation likewise apply to a policy based on the expectation that women seeking sterilisation will discover that they were mistaken in their judgements all along, regardless of counselling about the risks and benefits of the available options. Further, the inequity in patient care represented by the IUD requirement is not justified by an appeal to efficiency savings, whether we compare the treatment of female patients with male patients or with other female patients. Rather, this requirement

seems pointless at best, and punitive at worst. This policy discrepancy between ICBs can therefore neither be justified by consideration of funding differences (this being one reason given to explain the 'IVF postcode lottery'). However, it also cannot be dismissed as a morally neutral difference in local approaches to elective sterilisation.

Contributors TB is the sole author and guarantor of this work.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data sharing not applicable as no data sets generated and/or analysed for this study. No data are available.

ORCID iD

Teresa Baron http://orcid.org/0000-0001-9930-209X

REFERENCES

1 BPAS fertility. BPAS investigation into the IVF Postcode lottery: an examination of CCG policy for the provision of fertility services. 2020. Available: https://www.bpas.org/media/3369/bpas-fertility-ivf-postcode-lottery-report.pdf
2 McNicholas C, Peipert JF. Long-acting reversible contraception (LARC) for adolescent. *Curr Opin Obstet Gynecol* 2012;24:293–8. 10.1097/GCO.0b013e32835686d5 Available: https://doi.org/10.1097/GCO.0b013e32835686d5
3 Hall AM, Kutler BA. Intrauterine contraception in nulliparous women: A prospective survey. *J Fam Plann Reprod Health Care* 2016;42:36–42. 10.1136/jfprhc-2014-101046 Available: https://doi.org/10.1136/jfprhc-2014-101046
4 Christina Cauterucci. 'pain on a cosmic level', slate. 2015. Available: https://slate.com/human-interest/2015/11/getting-an-iud-can-be-insanely-painful-is-there-a-better-way.html; Jamie Peck, 'Getting an IUD Doesn't Have to Hurt Like Hell', Elemental (blog), 17 April 2019
5 Victoria Vouloumanos. Women are sharing medical procedures they've had without anesthetics or pain Meds, and why is this so normal. BuzzFeed; 2021. Available: https://www.buzzfeed.com/victoriavouloumanos/gynecological-procedures-without-anesthetics-or-pain-meds
6 Buturovic Z. Voluntary sterilisation of young childless women: not so fast. *J Med Ethics* 2022;48:46–9.
7 Lalonde D. Regret, shame, and denials of women's voluntary sterilization. *Bioethics* 2018;32:281–8.
8 McQueen P. Autonomy, age and Sterilisation requests. *J Med Ethics* 2017;43:310–3.
9 Hillis SD, Marchbanks PA, Tylor LR, *et al*. Poststerilization regret: findings from the United States collaborative review of sterilization. *Obstet Gynecol* 1999;93:889–95.
10 Becner A, Turkanović AB, But I. Regret following female sterilization in Slovenia. *Int J Gynaecol Obstet* 2015;130:45–8.
11 Mertes H. The role of anticipated decision regret and the patient's best interest in Sterilisation and medically assisted reproduction. *J Med Ethics* 2017;43:314–8.
12 Baron T. The philosopher's guide to Parenthood. In: *The Philosopher's Guide to Parenthood: Storks, Surrogates and Stereotypes*. Cambridge: Cambridge University Press, 31 March 2023.
13 Counseling and waiting periods for abortion. *Guttmacher Institute* March 14, 2016. Available: https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion
14 Spratt. The cost of COVID & cuts: "I'll have to wait A year to have my coil removed. *Refinery29* March 28, 2022. Available: https://www.refinery29.com/en-gb/2022/03/10916385/contraceptive-coil-removal-waiting-times-nhs
15 Public Health. Contraception: economic analysis estimation of the return on investment (ROI) for publicly funded contraception in England. *Wellington House* June 2018. Available: https://assets.publishing.service.gov.uk/media/5b5ee5b1ed915d0b66bc375d/contraception_return_on_investment_report.pdf