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Communicating Elective Sterilization: A Feminist Perspective

Sara Davis

Iowa State University

Abby M. Dubisar

Iowa State University, dubisar@iastate.edu

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Abstract

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Keywords

contraception, tubal ligation, vasectomy, patient-physician communication, childfree

Disciplines

Family, Life Course, and Society | Feminist, Gender, and Sexuality Studies | Gender and Sexuality | Public Health Education and Promotion | Sociology of Culture | Women's Health | Women's Studies

Comments

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Abstract:

Patient-OBGYN (obstetrics and gynecology) communication about contraception and reproduction can be fraught with ideological pressures, cultural assumptions, and emotion-based claims and concerns. Specifically, the topic of elective sterilization for women often invokes preconceived notions of femininity and mothering. Based on medical pamphlets and online discussion forums, our analysis reveals how gendered discrepancies exist in medical information about elective sterilization. This persuasion brief aims to invite OBGYNs to understand how cultural and traditional views of gender inform medical decisions and oppress women's reproductive autonomy. It offers suggestions for OBGYNs, women seeking sterilization, and scholars in the rhetoric of health and medicine. **Keywords:** contraception; tubal ligation; vasectomy; patient-physician communication; childfree

Elective sterilization is a taboo topic, especially when requested by women with the profile of an “ideal” parent with a body “fit” for reproduction. Such assumptions have their roots in often unacknowledged eugenic discourses from the nineteenth and twentieth centuries, invoking beliefs that “children from the ‘fittest’ individuals and fewer from the ‘unfit’ would result in the overall improvement of the nation” (Cellio, 2011, p. 19-20). The American College of Obstetricians and Gynecologists (ACOG) acknowledges this complex historical context. ACOG (2017) states, “Sterilization practices have embodied a problematic tension, in which some women who desired fertility were sterilized without their knowledge or consent, and other women who wanted sterilization to limit their family size lacked access to it” (p. 1). Rhetoric researchers have contributed to studying the long and horrific history of forced sterilization and its relationship to eugenics in the United States (Brady, 2001; Enoch, 2005; Wellerstein, 2011) but not as much attention has been paid to the rhetorical context of requesting sterilization.

Elective sterilization enables women to permanently control their ability to be sexually active without the risk of pregnancy, a powerful assertion of autonomy that destabilizes patriarchal expectations for women to accommodate men’s sexual pleasure, be monogamous, and maintain feminine “purity.” These are all dominant cultural norms that control women and come linked with racist, classist, and ableist implications. Further, the cultural assumption that women should mother and perform other nurturing care work is powerfully embedded in our understandings of gender, which are widely reproduced, since expectations for mothers are much higher than for fathers. Many of us actively put

these stereotypes into practice when we implicitly judge mothers' actions more harshly than fathers' behaviors, when we praise men for paying the slightest attention to their children, and when we expect women to embrace no- and low-pay care work, including eldercare and other underpaying, care-based jobs, such as teaching. Reflecting on these gendered expectations and stereotypes can productively reveal how gendered ways of seeing pervade cultural practices, including medical interactions.

In this persuasion brief we directly address obstetricians and gynecologists (OBGYNs) who are able to perform elective sterilization, a unique procedure in its permanence. We ask these readers to consider elective sterilization as a social justice issue and a rhetorical problem since patients ask for it to assert autonomy over their own bodies. At the end of this brief we list recommendations for OBGYNs (Appendix A), our primary audience, as well patients seeking elective sterilization (Appendix B), and scholars in the rhetoric of health and medicine (RHM) (Appendix C). Ultimately, we hope OBGYNs and others who provide elective sterilizations for women engage in productive communication about elective sterilization that removes shame and guilt-based narratives. OBGYNs can instead ethically address patients who are interested in elective sterilization in manners consistent with informed consent and gender equity (American College of Obstetricians and Gynecologists, 2017). While reading this brief, we encourage OBGYNs to consider how to enact the ethical principles that ACOG articulates and that patients, including those seeking elective sterilization, have come to expect. The American College of Obstetricians and Gynecologists (2017) recommends such a practice since "Respect for an individual woman's reproductive autonomy should be the primary concern guiding sterilization provision and policy" (p. 1).

As women's reproductive freedom and access to contraception become increasingly limited in the United States, providers should anticipate an increased rate of requests for sterilization and be prepared to respond effectively and ethically. Scholars who conduct rhetorical research, such as ours featured here, can inform health and medical practice so that patients can access the healthcare they need and reproductive choices they require to live their lives. Our research is prompted by the questions: How does communication about elective sterilization reveal gendered stories and possible discrepancies? How are

gendered identities constructed in isolated physician-patient interaction regarding elective sterilization?

Do gendered discrepancies exist in the presentation of options?

Method

Invested in ethical patient-OBGYN communication, we are inspired by scholars in medical rhetoric, such as Laura Pigozzi (2018), who encourage researchers to adopt the perspective of a feminist educator, as we invite readers to do. Acting as a feminist educator when interacting with patients includes “disrupt[ing] power differentials and promot[ing] understanding” (Pigozzi, 2018, p. 210) and fulfills the American College of Obstetricians and Gynecologists recommendation of prioritizing respect for an individual woman’s reproductive autonomy. To better understand how elective sterilization is communicated to patients, we analyzed medical pamphlets addressing vasectomy and tubal ligation (TL) and eighty-seven postings on three different public discussion boards that feature stories of patients seeking elective sterilization.

We ultimately use this persuasion brief to ask OBGYNs to be mindful of how communication with TL-seeking patients may reinforce stereotypes and send other problematic messages to women, especially as that communication may rely on ideological perspectives on motherhood, opinions that can obscure medical advice. We also use this brief as a way to listen to patients who tell their stories online in order to better understand patients’ perspectives. We further rely on Sara’s personal experience seeking and obtaining elective sterilization to investigate this issue.

We examined the pamphlets and online postings using rhetorical analysis, which, put simply, is the “study of persuasion in order to understand how people have been and can be persuasive” (Longaker and Walker, 2011, p. 3). In reading the pamphlets and online postings, we sought out intentionally persuasive moments and the communicative strategies that the pamphlet designers and writers used to address their audiences since many health and medical communications include “rhetorical interactions across varied and overlapping cultural spheres” (Scott & Melonçon, 2018, p. 2).

Our study follows methodological entry points for RHM. First, it aligns with Judy Segal’s idea of attending to “prior questions” (Scott & Melonçon, 2018, p. 5), aspects of health and medical discourses

that make certain meanings possible, situating patients as certain types of decision makers and subjects. For example, if some OBGYNs presuppose an assumption that all women want to be mothers, that motherhood is good for women, or that young women cannot make permanent medical decisions about their bodies, a patient-initiated conversation about elective sterilization will be affected by those prior assumptions. Further, as OBGYNs commit their careers to babies being born—since that is the focus of their training, practice, and business—investment in women getting pregnant and giving birth may obscure conversations that patients may initiate about TL. We acknowledge that OBGYNs do not intentionally want to limit women’s options, but the findings we detail below nevertheless show the consequences of the ways some physicians question patients, in some cases going so far as to refuse to sterilize women who request it.

Second, RHM scholarship focuses inquiry on the “persuasive agents and functions of health and medical discourse” (Scott & Melonçon, 2018, p. 5) to determine the means of persuasion and the audiences addressed by such discourse. As feminists, we are invested in seeing how power and gender are especially embedded in such discourses and agential opportunities, principally those that create access or barriers to women seeking control over their own bodies. By performing rhetorical analysis with a feminist lens, we work to illuminate how gender inequality is persuasively created and perpetuated in medical texts, interactions, and discourses.

By comparatively analyzing pamphlets directed to both individuals who seek vasectomy as well as those who seek TL, we can discern how gender norms are embedded in presumably objective medical information when directed differently to men and women. We came to these conclusions after collecting pamphlets from our own personal physicians as well as searching online for additional pamphlets. While we realize that we are taking such pamphlets out of context, as physicians might distribute such literature in concert with an in-person appointment or consultation, the isolated pamphlets still represent a method for communicating about elective sterilization, one meant to serve OBGYNs’ needs and answer patients’ questions. It is also possible that such pamphlets would be available in a waiting room and patients would

read them outside of the context of a conversation with a provider. One limit of our study is not being able to contextualize how these particular pamphlets are accessed and used.

Beyond pamphlets, we also analyze stories told online by patients who have sought sterilization, as well as responses to such stories from physicians. While we cannot guarantee that these writers are genuinely patients who sought sterilization or certified doctors who provide them, we nevertheless sought such stories as an attempt to compare Sara's experience with other individuals' experiences. We consulted methodological advice (De Hertogh, 2018; Opel, 2018) about online research to determine that reading and featuring such public stories fulfilled our goal of prompting more listening to and consideration of patients' experiences, reading to notice trends in stories. Another major limit to our approach is that we did not have time to enhance our study with interviews or other case study material. Instead, we have oriented our role as researchers to gather extant sterilization stories to better understand individuals' experiences with obtaining elective sterilization. Despite the multiple limitations of our study, we maintain that elective sterilization's status as taboo necessitates attention being paid to it in order to create a context for attention to this topic.

Requesting Sterilization Creates a Rhetorical Problem

As a result of studying the gross anatomy lab as a communication context, T. Kenny Fountain (2014) coins the term "anatomical vision" to define the ways medical students are trained to understand and respond to the human body. This term is helpful for understanding the ways OBGYNs are trained to adopt ways of considering patients' requests and communicating with them about their reproductive choices, what we could call "reproductive vision." OBGYNs deserve the benefit of the doubt that they strive to serve patients ethically and effectively, yet training and ways of seeing may privilege helping some women get pregnant over helping them prevent pregnancy. Likewise, TL may be offered to women of color or poor women repeatedly and eagerly without reflecting on how medical training influences a pattern of seeing some women as eager for TL and others as eager to become pregnant, implicitly

enacting sterilization's oppressive history. Reflecting on how they react to request for sterilization can help physicians improve their interactions with patients. We detail specific suggestions in Appendix A.

Many patients are eager to discuss these taboo issues. Recent public attention has been directed toward elective sterilization, especially physicians' lack of support for patients who seek it. Allana Weissman's 2017 op-ed published in the *New York Times*, entitled "How Doctors Fail Women Who Don't Want Children," sheds light on the medical concerns and personal decisions that lead women to seek elective sterilization, including negative side effects to hormonal birth control and their desire to be childfree. Weissman chronicles the many ways physicians attempt to persuade women that they do not know what they want or cannot access what they want, with some physicians refusing to perform the procedure. The stories Weissman features align with Sara's experience when she sought her own elective sterilization. This experience and our subsequent research show a trend of OBGYNs invoking cultural stereotypes about women's "natural" destiny to mother their own biological progeny. Writing about the challenges faced by Canadian women who seek sterilization, Carolyn Abraham (2016) quotes philosopher Christine Overall: "a lot of the tension here [regarding the choice to have children or be childfree] is rooted in the tendency to continue to define womanhood in terms of reproduction, child-bearing and motherhood. Women who want children are rarely asked to explain their decision, she says, but women who don't face an 'unfair burden of justification'" (np). Instead of expecting childfree people, especially women, to justify their status as non-parents, Overall (2012) argues that the burden of justification should rest primarily on parents themselves (p. 3).

Attitudes about sterilization have long appeared together with cultural stereotypes that are embedded in value judgments about who is fit to be a mother. Such stereotypes reveal themselves when we consider the prior questions that enact meanings of TL beyond those asserted by women seeking the procedure. These prior designations often rely on classist, racist, sexist, and ableist assumptions that invoke eugenic attitudes and slot women into categories. For example, as Jenna Vinson (2017) chronicles, during the 1960s and 1970s in the United States, "While white women had to confront panels of male physicians and endure psychiatric evaluations for approval of sterilization procedures, poor women of

color were coerced into unnecessary hysterectomies or sterilizations in order to receive medical assistance and welfare benefits” (54). In 2013, Abby Ohlheiser reported on the recent practice of California illegally sterilizing imprisoned women, showing this disturbing practice continues. Communication and rhetoric research about forced sterilization also makes apparent the racist, sexist, classist, and ableist assumptions that undergird sterilization practices (Enoch, 2005).

Stakes for Rhetoric and Reproductive Justice

OBGYNs can become more aware of any implicit bias that might lead them to assume that women want to become pregnant (if not now, then later) and bear children. To ask to be sterilized is to violate the status quo expectation of motherhood and disrupt a gendered system that reflects “prevailing beliefs about sex and sexuality, femininity and masculinity, reproduction, and children” (Buchanan, 2013, p. 116). Lack of access to TL creates high stakes for women as they increasingly face barriers to autonomy over their sexuality and reproduction. For example, in the concluding remarks to *The Rhetoric of Pregnancy*, Marika Seigel (2013) notes that “[Fetal ultrasound legislation] takes to the extreme the belief that women are not experts about their own bodies and pregnancies” (p. 152). These articulations against women’s autonomy often become law, whether limiting contraception choices or mandating ultrasounds, as with women who seek abortions. Such efforts show how women’s bodies are legislated from ideological positions. These positions entrench and mandate women’s inability to make decisions about their own bodies yet also offer opportunities to support women patients by helping them access procedures such as TL when patients request it.

Existing research informs our analysis of patient-OBGYN discourse and also reveals gender bias that contributes to a number of negative outcomes and ineffective communication across a range of conditions (Daugherty et al., 2017; Hoffmann & Tarzian, 2001). Jessica Enoch’s (2005) analysis of the *Madrigal v. Quilligan* lawsuit—in which ten Chicana women who were sterilized by the USC-LA Medical Center sued because the medical center did not obtain informed consent—showcases how forced sterilization is justified with racist logics. As a result of the case, activists influenced the Department of

Health, Education, and Welfare to establish protocols for sterilization that ensure informed consent is obtained in the language spoken or read by the patient, alternatives are presented through extensive counseling, consent cannot be given at times of delivery or other times when patients are in stressful conditions, patients have access to an advocate, a thirty-day waiting period between consent and procedure is mandated, and people under 21 years old cannot be sterilized (p. 19-20). Clearly sterilization is a communication issue, one fraught with a history of ineffective and unethical circumstances.

One communication-based study, by Lyn Turney (2000), has addressed elective sterilization, brochures about the procedure, and the ways it is conveyed to women specifically. Its conclusion reveals how value-laden claims are represented as scientific fact, identified, for example, by how sterilization brochures describe women's sexual feelings as unaffected by sterilization, which will instead enhance her sex life (p. 161-62). Like ours, Turney's findings show that women's experiences are dismissed by physicians. However, unlike our findings, Turney's work leads to the conclusion that sterilization is overly promoted and that reversibility is overstated, misleading women who choose to be sterilized and not fulfilling ethical informed consent expectations. We build on Turney's work to show the multiple ways communication about elective sterilization is often not serving the very patients who seek to know more about it and choose to be sterilized.

Sterilization Procedures: A Comparative Look at Pamphlets

One noticeable difference in sterilization counseling between men and women exists in the visual design of patient education pamphlets. We want to reemphasize that the taboo nature of elective sterilization may contribute to how these pamphlets are designed and written, as well as the dearth of pamphlets available. When Sara requested information about sterilization, the only pamphlet her physician had available was *Post-Partum Sterilization* by the American College of Obstetricians and Gynecologists (2013a). The vasectomy pamphlet her husband would have received from his physician (obtained from the clinic at a later date) was *Vasectomy* by McFarland Clinic Urology (n.d.).

Pamphlet	Section	Graphics
<i>Vasectomy</i> - McFarland Clinic	-How a Vasectomy Works -Vasectomy Reversals -Remember, (You are Still Fertile)	Cover: smiling heterosexual family Inside: 1 detailed illustration of the procedure
<i>Post-Partum Sterilization</i> - The American College of Obstetrics and Gynecology	-Female Reproductive System -Making Your Decision -What if I change My Mind? -Your Doctor's Concerns -Timing of the Procedure -Risks and Discomforts -Afterward -Finally -Glossary	

Table 1.1 Comparison of Pamphlets: a summary of a vasectomy and tubal ligation pamphlet given to patients.

Table 1.1 indicates the subtle differences between the two pamphlets, including the number of sections, the topics covered, and the illustrations used. In the vasectomy pamphlet, a man and woman, accompanied by two children, gaze directly at the camera and smile in a very positive and relaxed manner. This happy white couple is cozied up under a white blanket, angling their bodies and faces to be close together, as though posing for a family portrait. The information on the inside is limited to one section that details how the procedure works, one that reminds readers about fertility post-procedure, and one that assures no effect on sexuality. The confident tone matches the proud, assured cover image. The TL pamphlet has no people on the cover, but shows a clean blue graphic design. Inside, there are significantly more sections than the vasectomy pamphlet. These sections include the doctor's potential concerns and anticipate the possibility that patients should change their minds. There are three detailed illustrations of the procedure, with cross sections of female anatomy in various views, showing where instruments would be used to perform the procedure. This approach seems to assert a clinical rather than

personal outlook on women's healthcare decision-making. It mimics the hypothetical emptiness of the sterilized woman, and creates an impersonal atmosphere surrounding the information being presented. Furthermore, because the TL pamphlet also contains a section titled "Your Doctor's Concerns," which details that the doctor, and not the patient, will make the final decision of whether or not the procedure can be performed, it maintains the doctor's authority over women's choices. The pamphlet further supports this power structure by saying that doctors will want to ensure that the requesting *couple* is making the right decision. This detail affirms traditional gender roles by implying that the only woman who should be requesting a sterilization is a woman within a relationship that can produce children.

An interesting rhetorical difference exists in these two section headings: *Vasectomy Reversals* versus *What if I Change My Mind?* While both pamphlets do indicate that patients should be sure of their sterilization decision, the vasectomy pamphlet discusses the possibility of reversal with a factual heading, while the TL pamphlet presents the idea with a question. The question in and of itself indicates a possibility of regret, which is an idea that pervades TL discourse. While the mere mention of reversal could also be assumed to indicate a possibility of regret, the smiling family on the cover of the *Vasectomy* pamphlet seems to dispel any possibility of remorse.

It is also worth noting that in the TL pamphlet, the traditional "risks and benefits" statement is replaced by *Risks and Discomforts*. This, along with the other section headings, could subtly communicate that sterilization does not actually benefit women. We find the absence of a "benefits" section troubling since women anecdotally describe how TL has benefited them and fulfilled their intentions.

Sara later collected several more pamphlets from different physician's offices in her immediate area and online and noticed a trend across them. Studied together, the TL pamphlets contain more sections and more questions than the vasectomy pamphlets, and if they feature images of people, they typically portray women seeming to be pensive or uncomfortable. These women appear alone and without any visible context, which makes them seem isolated, without a community. Conversely, vasectomy patient education pamphlets often feature smiling couples enjoying various activities together, including

walking in a park or laughing with children in a domestic setting. Because it is widely accepted that women should want to be mothers, these subtle rhetorical differences may not be immediately visible to the untrained eye or to a physician who believes all women want to be mothers. Conversely, no such extreme pressure is placed on men to reproduce, nor is it asserted that their value would in any way be diminished should they choose to become sterile.

These pamphlets may inadvertently influence the way in which a physician might present sterilization information to the patient, reaffirming the gendered status quo of discourses of regret for women and liberation for men. While the lack of emotional connection through images may be an attempt to render the pamphlet as objective as possible, this objectivity is unfairly skewed towards female, and not male, reproductive health. Our findings lead us to wonder how women patients may be better served if a TL pamphlet detailed the benefits of sterilization for women or featured the same sorts of images often used on pamphlets advertising reversible contraception, such as women joyously hang-gliding, smiling while playing guitar, or practicing other more independent hobbies. The permanence of TL positions women as pensive, unsure, and unliberated. Likewise, TL pamphlets could mirror vasectomy pamphlets with portrayals of happy couples or families since many pamphlets assume that women reading them already have children. Such a portrayal would reflect reality since “Almost twice as many couples choose female over male sterilization (30 percent versus 17 percent)” (Letters, 2017).

Pamphlet	Sections	Graphics
<i>Vasectomy-</i> Positive Family Planning	<ul style="list-style-type: none"> -What is a Vasectomy? -Where is it Done? -After the Operation, How Can I Take Care of Myself? -When is the Operation Effective? -Can it Affect My Sexuality? -What are the Possible Complications? -Are there Any Long-Term Health Risks? -Why Choose Vasectomy? -Have You Considered... 	Cover: -purple graphic Inside: -1 detailed illustration of the procedure

<p><i>Female Sterilization-</i> The Couple to Couple League</p>	<ul style="list-style-type: none"> -What is Tubal Ligation? -What are Occlusion Procedures? -Is Female Sterilization 100% Effective? -What are the Risks? -Complications of Surgery -Long-Term Consequences on Menstrual Symptoms -Effects on Interest in Sex -Procedure failure -Ectopic Pregnancy -Regret -Can Female Sterilization be Reversed? -Is there an Alternative? -Is Female Sterilization Right for Me? -Where Can I Learn More About Natural Family Planning? 	<p>Cover: -pensive woman</p> <p>Inside: -1 detailed illustration of the procedure -1 image of a happy woman -Personal quotes of regret</p>
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Table 1.2 Comparison of Internet Searchable Pamphlets: a summary of pamphlets patients may find during online searches.

Sara also collected a sample of online pamphlets that a patient might encounter when doing an Internet search on sterilization. Table 1.2 features a comparison of two pamphlets, *Vasectomy* (Positive Sexual Health, 2000) and *Female Sterilization*, (CCL, 2018) that are similar in length and content. Both pamphlets organize much of their information with question headings, assuming the patient is unsure and anticipating questions and feelings about the procedure. Earlier ideas about happiness for men and discomfort around sexuality for women continue in these pamphlets. The TL pamphlet by the Couple to Couple League (CCL, a Catholic nonprofit) discusses over a substantial part of the text the possible side effects on sexuality and pleasure; a vasectomy pamphlet by Positive Sexual Health features a section to assure patients that their sexuality will not be affected. For some of the content, the vasectomy pamphlet continues with questions, while the TL pamphlet makes an assertion. For example, the vasectomy pamphlet by Positive Sexual Health asks the question, “Can it affect my sexuality?” while the TL

pamphlet by the CCL includes the heading, “Effect on interest in sex.” This latter heading and accompanying section communicate to female patients that effects on sexuality, which can compromise current and future romantic relationships, are to be expected. Because the CCL is a Catholic organization, and thus against any form of contraception, its brochure ultimately encourages women to choose Natural Family Planning over TL. However, within the section on regret, the pamphlet cites an American College of Obstetricians and Gynecologists article (Hillis, Marchbanks, Tylor, & Peterson, 1999) indicating that, “Over the long term, about 13 percent of women who have been sterilized will express regret for permanently ending their ability to have children. The younger a woman is at the time of her tubal ligation, the higher the likelihood she will regret it later on; 20 percent of women who had their tubal ligation before age 30 express regret within 14 years following the procedure” (CCL, 2018, p. 2). Disclosing those statistics helps inform women’s decision, as the vast majority of women are satisfied with becoming sterilized. In spite of those ACOG findings, the pamphlet nevertheless describes TL as a “drastic and serious choice” (CCL, 2018, p. 2).

This TL brochure also features two photographs of women. On the cover a white woman wears a dark green turtleneck and looks pensively at the camera as she stands and faces forward. One arm crosses her midsection while the other reaches up to lean a hand against her chin in a thoughtful position. This depiction of a woman as puzzling over or thinking through her TL decision parallels the other pamphlets we have studied. Within the pamphlet, a woman of color with light brown skin is depicted within a section entitled “Are their alternatives?” that touts the benefits of Natural Family Planning. She appears happy and satisfied as she faces what appears to be a provider in a white coat with his back to the camera, thus displaying a positive patient-physician interaction and maintaining that women should trust their doctors, possibly encouraging women to take their physician’s advice against TL without complaint. The woman is wearing a visible wedding ring, so this image also reinforces the institution of marriage. In these ways it matches the tone of other TL pamphlets that emphasize doctors’ perspectives, negative framing of TL, and women as unsure and in need of expert guidance.

In addition to looking for information about sterilization online, women seeking an elective sterilization may also use the Internet to seek, find, and write about patient-physician interactions. Below, we analyze online social media posts in order to understand the experiences of female patients who seek elective sterilization. We amplify patient's perspectives, as well as acknowledge physician's concerns, so as to better recognize the discourse that takes place during pre-sterilization procedure counseling.

Elective Sterilization Discussions on Twitter and Reddit

To obtain stories written by individuals seeking elective sterilization, Sara conducted a number of keyword searches. Due to the amount of information readily available on the Internet, many patients will conduct their own research into medical procedures in order to be more informed and knowledgeable when speaking to their physicians; this is not limited to information seeking, but also includes information sharing (Tan & Goonawardene, 2017). Based on her own personal experience in researching various medical procedures and advice, Sara knew Twitter and Reddit were places individuals might post their stories of seeking sterilization. (See Appendix D for Sara's search terms and dates.)

Popular blogs (Bland, 2018; Brolley, 2017; Dubofsky, 2017; Grant, 2018) and articles, such as those featured in the *New York Times* (Weissman, 2017) and *Chicago Tribune* (Deardorff, 2014), detail women's negative experiences with physicians when trying to obtain an elective sterilization. Such texts also include a breakdown of women's interactions with physicians, such as arguments about potential regret and affected sexuality, subjective moral stances against being childfree, and patients' assertions of a woman's right to determine her own reproductive path. Women find their options limited when it comes to reproductive health, with much of the resistance, ironically, coming from their physicians (Abraham, 2016; Bland, 2018). One woman indicated that she felt pressure to create an imaginary abusive situation in order to get a doctor to consent to perform a TL, and such interactions raise questions about "whether a medical professional has any business worrying about a patient's hypothetical future feelings in the first place" (Lowder, 2012). Even some women who require a sterilization-causing procedure for their overall health (such as can be the case with endometriosis) report that their physicians attempt to dissuade them

(Weissman, 2017). Some blog authors refuted the idea of regret by reminding readers that there are multiple ways to be a parent, affirming that sterilization does not end a person's ability to parent a child (Wayne, 2015).

Women who participated in social media sharing about sterilization often report feeling marginalized, believing physicians do not trust them, needing to meet with multiple physicians, and feeling that doctors think they do not know their own bodies (Opinionatedness, 2008). They expressed that doctors believe women are incapable of making such a permanent decision. Some doctors likewise indicate feeling a need to make sure patients are well informed of multiple options, due to the permanence of the decision (Espinoza, 2014). The Reddit thread "Ladies of Reddit who have undergone a sterilization procedure: why? (and other questions)" (u/ohyeoflitlefaith, 2015) featured 60% of participants reporting a negative experience in requesting sterilization—either being denied, questioned, or given "the runaround"—with only 28% indicating a positive experience. Two common factors were present in the positive and negative experiences: the age of the woman and her life situation: Doctors were less likely to sterilize a woman under 30 years old and if she had no previous children. Patients reported common responses to their inquiry as "you'll change your mind, what if your husband wants kids, you're young, you never know what will happen, etc." (u/Sadnsassy, 2015) relating that they felt "talked down to" (u/Abqkat, 2015).

We want to note the important power differential of physician-patient communication on this issue, especially when patients approach OBGYNs seeking a surgery that a doctor did not advise, destabilizing the doctor-patient power structure. It is true, in general, that elective surgeries are not medically necessary. Requesting one complicates the doctor-patient power dynamic. Adding to that complication a *woman* patient being the one requesting sterilization can further compromise the traditional top down path of physician to patient advice. However, virtually all non-emergency surgery is elective, meaning any patient can refuse any treatment of any kind. There are also physicians who rely on elective surgeries to generate their income, such as plastic surgeons who we generally do not see trying to dissuade patients from having a breast augmentation ("have you considered trying a padded bra?"). While

we agree that physicians have a right to refuse service to medically unnecessary procedures or those that they feel will endanger the patient's life or health, perhaps they should ask why there is a need to refuse a request of TL and whether or not resistance stems from personal gender biases.

Doctors themselves also contribute to online discussions supporting patients' requests for sterilization. Some of their apparent ideas were found in the Reddit thread "I went to the source and I figured out why the doctors are so hesitant to sterilize women. Guess what, they're probably wrong" (u/rainbow_killer_bunny, 2018; My_open_stomach., 2018). This thread included doctors and patients discussing elective sterilization, and of the participants, 95% supported elective sterilization. Most of the patients' responses described negative experiences with sterilization counseling. Participating physicians discussed how women should have a right to determine the course of their reproduction, including pointing out that any patient should be able to decide if she is finished having children (u/Dr_Bogart, 2018). While beyond the scope of this persuasion brief, it is important to note that members of the LGBTQ community may also face difficulty in obtaining an elective sterilization, and that transmen who do not undergo a gender affirming surgery, in particular, could benefit from sterilization through either tubal ligation or complete hysterectomy (Tourjée, 2016).

Conclusion

Earlier in this brief we described Alanna Weismann's 2017 op-ed. Following the publication of her article on how doctors fail women who seek elective sterilization, the *New York Times* published four letters it elicited (Letters, 2017). The first letter is written by an OBGYN who describes her own regret at choosing sterilization too young, closing her letter by writing, "Because as mature as you may think you are in your 20s, you're a relative babe in the woods, and I refuse to accommodate your premature wish to be sterilized without a good medical reason." This response infantilizes women and asserts that one person's regret, however legitimate, should dissuade another person from accessing a medical procedure. This response aligns with many physicians' reactions to young women who request TL. The second letter-writer describes a scenario in which she asked for TL and her doctor responded by asking her if she

wanted to be sterilized, a term that took her aback and led her to deeper reflection. She did choose to be sterilized, but her description of how that term contributed to her decision-making emphasizes the significance and effects of an OBGYN's reaction to a patient. The third letter-writer describes litigation as a reason doctors hesitate to sterilize women. In this writer's view, doctors' support of women is not to be questioned, but instead TL's inaccessibility should be blamed on the legal system in which doctors are entrenched. Finally, the last letter-writer, Avner Hershlag, chief of Northwell Health Fertility, sums up the high stakes for women and quotes ACOG:

Women's right to be the sole authors of their reproductive destiny is now the accepted standard of care. The American College of Obstetrics and Gynecology's Committee on Ethics declares that "respect for an individual woman's reproductive autonomy should be the primary concern." The guidelines suggest that "it is ethically permissible to perform a requested sterilization in nulliparous [never pregnant] women and young women who do not wish to have children."

We appreciate Dr. Hershlag's letter since it re-centers women's sovereignty over their bodies and the professional organization's policy of supporting women's decisions. Viewing women as autonomous individuals, without procreation as quintessential to their identity, can begin to erode sexist attitudes that prevent women from experiencing gender equity and sexual freedom.

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Biographies

Sara Davis is a student of English Education at Iowa State University. She recently returned to academia to complete her bachelor's degree and has a particular interest in social justice. In addition to research, Sara enjoys creative writing and visual arts, and hopes to incorporate them into her future classroom.

Abby M. Dubisar, Associate Professor in the Department of English at Iowa State University, teaches courses in gender and communication, popular culture analysis, feminist rhetorics, and activist rhetorics. Her publications address feminist rhetorics in historical and contemporary contexts, including students' remix videos, political cookbooks, and anti-gun violence activism.

Appendix A: Advice for OBGYNs

1. Rethink risk: When the topic of TL arises, many bring up its status as risky. Contextualize such risk in comparison to the conditions TL prevents. Consider the following example:

A female patient approaches her physician and confides in them a desire to become pregnant. The patient then requests information about becoming pregnant, and the physician hands her a patient education pamphlet. The physician details the various risks associated with pregnancy, and the potential long-term complications that may arise during pregnancy, childbirth, and childrearing. The physician then proceeds to offer alternatives to the patient (have you considered a new career? or perhaps getting a dog?) as a way to help the patient understand that pregnancy is not her only option to have a fulfilling life (for example: you may regret your choice to have children later, and it cannot be reversed).

This may sound far-fetched, but consider that physicians essentially follow the same rhetorical pattern when counseling patients about sterilization. It is also worth noting that the United States has the highest maternal mortality rate of the developed world (24 per 100,000 live births) (Martin, 2017), and the CDC indicates that at least 60% of these deaths are preventable (MacDorman et al., 2016). These are staggering statistics for a society that places so much value on the role of motherhood. One such example of this elevated value, the perceived "angel mother," is a mother of five in Utah who died in childbirth, and was heralded as a "selfless" woman who was a "blessing" to her children (Iyamba, 2013). Further, it can be difficult for women to refuse the role of mother, even if they have previous children, when physicians impose their own personal ideologies on women seeking sterilization. One example was recently highlighted by a viral Twitter thread in which a woman shared the story of her own mother's experience asking for TL

and her physician responding by asking her to consider her husband's feelings (Strangelove, 2018).

While writing this brief we could not identify an article published in a medical journal that compared the risk of permanent sterilization to pregnancy and childbirth. We welcome such a study.

2. Review and follow the ACOG guidelines, committee opinion number 695 (2017), on the sterilization of women. Make it available to your staff and patients. Additionally, the 13-page ACOG Practice Bulletin 133 (2013b) can assuage your concern about risk. Page 395 includes the question, "How Safe is Laparoscopic Sterilization?" The answer reads: "Tubal occlusion via laparoscopy is a safe and effective method of permanent contraception. Overall complication rates are low, and procedure-related death is a rare event."
3. Resist making assumptions about her relationship status, interest in discussing sterilization with her partners, and other non-medical factors. Do not suggest that women speak to their husbands about getting a vasectomy as an alternative to TL. This is paternalistic, dismissive, and also violates the patient's privacy since she may not want her husband or other partners to know that she is requesting a TL. This suggestion also assumes the requesting patient is monogamous.
4. Normalize elective sterilization when patients ask for it. Position yourself simply as an informant rather than counselors guided by "hypothetical future feelings." For example, when a patient approaches you requesting information about sterilization, you could respond by focusing on these aspects:
 - a. it is a permanent form of contraception,
 - b. it is performed by these methods,
 - c. these are the risks with surgery,
 - d. what other questions can I answer?

With this sequence you would leave out assertions of regret or uncertainty as well as alternative methods of contraception, allowing the patient to inquire about them if she desires. We agree that it is your prerogative to perform a non-emergent elective procedure as you find it appropriate, but we contend that personal biases have no place within physician and patient discourse.

Appendix B: Advice to Individuals Seeking Sterilization

1. Research the laws regarding elective sterilization in your state before talking to your physician,
2. Read the ACOG guidelines, committee opinion number 695, on the sterilization of women, to better understand the professional recommendations issued to physicians. It is available for free online via any search engine. Consider taking it to your appointment when you speak with your physician.
3. Read the 13-page ACOG Practice Bulletin 133 (2013b). On p. 395 there is an answer to the question "How Safe is Laparoscopic Sterilization?" It reads: "Tubal occlusion via laparoscopy is a safe and effective method of permanent contraception. Overall complication rates are low, and procedure-related death is a rare event." This detail may be important in your conversations with your OBGYN if they describe the procedure as risky.
4. Realize that because efforts have been made to prevent forced sterilization, you may have to complete procedures to fulfill regulations around this practice. While they may seem

inconvenient or unnecessary to you, their intentions are justice-oriented to prevent women from being sterilized against their will.

Appendix C: Advice to Scholars in Rhetoric of Health and Medicine

1. Study taboo topics. For us, especially, creating contexts to discuss women's reproductive freedom is an obligation as reproductive rights increasingly come under fire. Movements such as "shout your abortion," which reject the shame and secrecy around women's reproductive autonomy, provide rich and important communication contexts from which rhetoric scholars can learn.
2. Work with technical communicators to revise pamphlets so they are respectful of patients and promote gender equity. Identifying how pamphlets and other patient-facing texts norm gender, race, class, ability, and other identity factors can reveal how power and ideology are embedded in so-called objective medical materials.
3. Teach this persuasion brief to your students and discover what they think about this issue. Students in Abby's class have been surprised to learn about the barriers facing women who seek sterilization, which they have learned about from Sara. Likewise, students may be in the very early stages of learning about a variety of related issues, including government legislation about access to contraception, the science behind fertility, and other taboo topics that we often do not communicate about effectively, if at all. As the United States frequently legislates abstinence-only sex education, students often lack knowledge about human reproduction as well as contraception. If you teach this brief, please write to us to let us know how it went.

Appendix D

Search Terms and Dates Searched

May 8th
"#childfree", "childfree twitter", "reddit childfree stories"

May 10th
"Reproductive justice"

May 11th
"Feminist reproductive justice publications"

May 12th
"The cult of motherhood", "doctors discussing sterilization with female patients"

May 14th
"Federal law 1987 sterilization Medicaid"

May 16th
"Sterilization pamphlets", "voluntary childlessness"

May 27th
"Childlessness", "doctors reluctant sterilization"

May 28th
"Orem mother dies"

May 29th
"Average wait for tubal ligation", "discussing tubal ligation"

June 7th
"Vasectomy"

June 19th
"Sterilization pamphlet", "vasectomy pamphlet"

June 21st

“Benefits of childfree living”, “barriers to post-partum sterilization”

June 25th

“Facebook women getting sterilized”, “twitter women getting sterilized”, “sterilization childfree reddit”, “become childfree reddit”, “childfree reddit”, “doctors opinions about childfree”, “reddit female sterilization”, “twitter childfree”, “twitter female sterilization”, “twitter tubal ligation”