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Childfree by Choice: Stigma in Medical Consultations for Voluntary Sterilization

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ABSTRACT

Nearly one half of women between the ages of 40 and 44 who do not have children are voluntarily childless, or "childfree" (Pew Research Center, 2015). Many childfree women (and men) request sterilization from medical providers (Richie, 2013). Childfree women and men who request sterilization face questioning about their nulliparous status, risk of regretting the procedure, and age (ACOG, 2017). Narrative accounts of medical interactions from Reddit's /r/childfree were analyzed for evidence of experienced and anticipated stigma. Results indicated that clinicians' mention of a patient's age and the risk of regret during the sterilization counseling process were negatively predictive of procedural approval.

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The American College of Obstetrics and Gynecology (ACOG, 2017) recently updated ethical guidelines for obstetrician-gynecologists concerning the sterilization of women within a "reproductive justice framework" (p. 1). Recommendations outlined in the report are optional; they serve as the official stance of the ACOG and as a reference for providers when considering whether to grant a female patient a requested sterilization. Counseling recommendations aim to uphold standards of patient-centered care, emphasize the permanence of the procedure, offer reversible alternatives, and discuss male sterilization where appropriate. ACOG deemed the sterilization of nulliparous women (i.e., women who have never given birth) who do not wish to have children "ethically permissible" and cited a need to avoid bias and to balance paternalism with patient autonomy (p. 1). Furthermore, ACOG stated that a request for sterilization from a young, nulliparous woman "should not automatically trigger a mental health consultation" (p. 1).

Yet a large divide exists between the recommendations for the provision of sterilization and the lived experiences of those seeking it. Among married couples, female sterilization is the most common form of contraception, chosen twice as often as male sterilization (ACOG, 2017). However, the proportion of couples seeking sterilization who are voluntarily childless is unknown (Mosher, Martinez, Chandra, Abma, & Willson, 2004). Childfree women who seek sterilization face a multitude of challenges, including repeated denials, humiliation, procedural hoops, and questioning of the legitimacy of their request (Richie, 2013). This denial of preferred treatment occurs even in

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an era of patient-centered medicine, which aims to shift decision-making authority to the patient. In fact, the ACOG Committee on Ethics listed "respect for an individual woman's reproductive autonomy" as "the primary concern guiding sterilization provision and policy" (2017, p. 1). Women face unique challenges when they request sterilization; thus much of the following review focuses on childfree women, although childfree men will also be discussed (ACOG, 2017; Richie, 2013).

We examine the issue of voluntary childlessness through the use of a stigma framework. Goffman (1963) defined stigma as "an attribute that is deeply discrediting" (p. 13). Stigma is relationally situated, that is, what may be stigmatizing within one social group may be acceptable within another. Childfree individuals seek out others who do not ask them to justify the decision to be childfree. Therefore, it is unsurprising that online communities, such as Reddit's /r/childfree, exist to serve as detailed sources of information and records of both positive and negative medical interactions.

We used content analysis to examine factors that contribute to the likelihood that an individual will be rejected during a medical consultation for voluntary sterilization. By examining accounts of medical encounters written by childfree individuals seeking sterilization on /r/childfree, we sought to understand how stigma permeated those interactions. Our approach offers a novel method for examining narratives of interactions with medical professionals and attempting to capture the highly varied experience of being childfree in a culture that values reproduction.

Contemporary struggles

Since 1976, when guidelines were enacted to prevent coercive Medicaid-funded sterilizations of low-income, minority, mentally ill, and imprisoned women, any woman on Medicaid, of sound mind, and over the age of 21 in the U.S. has been eligible to be sterilized voluntarily. However, women with private insurance, to whom Medicaid regulations do not apply, interface with providers who may enact their own paternalistic criteria for determining whether to sterilize a patient (e.g., a physician may refuse to sterilize anyone under the age of 30; Richie, 2013). For individuals on Medicaid, other requirements for sterilization include that the patient must adhere to a 30-day waiting period and must sign a standardized consent form (Department of Health and Human Services [DHHS], 2012). However, these regulations had an unintended chilling effect on medical providers, who became reluctant to sterilize educated, White women (Richie, 2013).

Women requesting tubal ligation surgery have reported a variety of reasons for their choice. Personal reasons often include freedom, a fundamental rejection of motherhood, the loss of identity associated with motherhood, and a rejection of the activities commonly associated with motherhood (Gillespie, 2000). There are also a range of medical conditions for which sterilization would benefit the health of the patient, or for which pregnancy would be harmful. Allergies or intolerances to traditional forms of birth control, for example, may prompt a woman to request sterilization to prevent an unwanted pregnancy (Richie, 2013).

The high satisfaction rates and reliability of this legal form of contraception make it a viable choice for thousands of women each year (ACOG, 2017). Although sterilization matters most when a woman is young and likely to become pregnant, age is among the

most commonly cited reasons for rejection in medical consultations, often because of the risk that a woman might regret having had the procedure (Richie, 2013). Sterilization regret can be quantified in terms of the percentage of patients who express a desire for procedural reversal. Eeckhaut, Sweeney, and Feng (2018) documented an increasing divide between women with less than a high school education (15% of sterilized women in this group expressed a desire for reversal) and those with bachelor's degrees or higher (only 3% of sterilized women in this group desired reversal). This may be because some women lack an understanding of what the procedure entails or its permanence (Shreffler, McQuillan, Greil, & Johnson, 2015) or because patient ethnicity and socioeconomic status affect the content of patient counseling and contraceptive recommendations (Borrero et al., 2011). For instance, a study of psychotherapists' attitudes revealed that the intersecting age and socioeconomic status of a childfree woman significantly affected therapists' ability to express empathy; younger low-SES patients received the most empathy, and older high-SES women received the least empathy (Ngoubene-Atioky, Williamson-Taylor, Inman, & Case, 2017).

However, childfree women who receive sterilization procedures do not report high rates of regret or frequently submit requests for reversals. In a longitudinal study of nearly 8,000 women who sought sterilization, 95.7% of women between the ages of 20 and 24 and 97.6% of women between the ages of 30 and 34 reported never having regretted their decision (Wilcox, Chu, Eaker, Zeger, & Peterson, 1991). Nor does age does appear to be a factor in regret among men who request vasectomies, although reversals occur 12.5 times more often among men who underwent sterilization in their 20s rather than later in life (Potts, Pasqualotto, Nelson, Thomas, & Agarwal, 1999). The number of children the patient has (for childfree individuals, zero) is another commonly cited reason for rejection. In the 1970s, obstetrician-gynecologists followed a guideline that recommended that a woman's age multiplied by the number of children she had must equal 120 or higher for sterilization to be considered (May, 1997). So, for example, a 30-year-old woman with four children would have been eligible to be sterilized according to this guideline. Today, there are no guidelines for the number of children an individual must have before sterilization is a viable option (ACOG, 2017). Therefore, the mention by the provider of the patient's age, the risk of regret, and number of children were used in the present study as predictor variables to determine which factors most influence the outcome of an appointment.

The /r/childfree subreddit

Today, one click can connect patients with tightly woven communities of likeminded people from around the world who are willing to offer guidance and support for specific health-related issues (Steuber & Solomon, 2008). One of these groups is Reddit's /r/childfree, who have defined themselves as "those who do not have and do not ever want children (whether biological, adopted, or otherwise)." Women and men on /r/childfree rant and rave, cover news, request advice, lead discussions, review social media posts, and share jokes (Reddit, n.d.). Resources on the subreddit include support groups, links to childfree literature, lists of "childfree-friendly" doctors, frequently asked question (FAQ) lists, and more (Reddit, n.d.). The /r/childfree subreddit was selected as the

data source for the present study because it is a large, well-known public forum for discussing issues that affect the childfree community; it is accessible to anyone with an Internet connection.

Whereas Reddit users in general are predominantly young, unmarried White men living in the United States (Reddit, 2016), users of /r/childfree are mostly White, college-educated, nonreligious, heterosexual women under the age of 30 living in North America (Reddit, 2017). One trend on /r/childfree is posting narrative accounts of both positive and negative experiences with medical providers. The medical narratives encompass a variety of appointment types, from seeking birth control to voluntary sterilization requests. The /r/childfree subreddit provides a record of the stigmatized experiences of individuals seeking voluntary sterilization. Although online communities provide opportunities for childfree individuals to share their experiences, few studies about voluntary sterilization have used these digital contexts.

Stigma and parenthood as a biological imperative

The act of choosing not to have children in a culture that expects couples to reproduce can be stigmatizing. In the U.S., there is a normative expectation that young heterosexual adults, at a certain age, will produce children. Thus conversations with others about being childfree often demand an accounting of one's non-normative choices. When reproduction is considered a biological imperative, childlessness is perceived as both unnatural and non-normative. The decision to abstain from reproduction requires a defense, whereas the decision to reproduce does not (Gillespie, 2000). Being childfree means shirking "pronatalist" social pressures that "favor gestational motherhood" and promote parenthood as a universal goal (Petropanagos, 2017, p. 119). Consequently, childfree status is often viewed as a perverse rebellion against nature (Gillespie, 2000). Thus childfree individuals elicit significantly higher moral outrage, (e.g., "feelings of anger, contempt, and disgust") than their parent counterparts, a consequence of "violating the prescribed social role of parenthood" and "harming the fabric of society" (Ashburn-Nardo, 2017, pp. 393–395).

Violations of normative expectations concerning parenthood can result in stigma (Park, 2002). Being childfree is a concealable stigmatized identity, that is, an identity "that can be hidden from others and that [is] socially devalued and negatively stereotyped" (Ikizer, Ramírez-Esparza, & Quinn, 2018, p. 1). Disclosing one's childfree status may elicit negative personal attributions (e.g., she is a bad person because she doesn't like children; he must have had a sad childhood) or unwanted empathy when it is assumed that one's childlessness is not voluntary. Durham (2008) discussed two social factors that largely determine whether a childfree choice is likely to be accepted. The first, *oughtness*, describes a social judgment about whether someone "should" have children. The second factor is the *perceived emptiness* of the lives of childfree people. Childfree women and men are perceived to be significantly less psychologically fulfilled than are parents (Ashburn-Nardo, 2017).

To compare the experiences of childfree women and men, it is necessary first to understand unique cultural expectations about motherhood as a biological imperative for women. As Gillespie (2000) suggested, powerful ideologies link motherhood with

womanhood: To be a woman is in tandem with being a mother, and, for many adult women, their social identity is linked to their status as a mother (Koropeckyj-Cox, Romano, & Moras, 2007; Park 2002). Childfree women are rated as being less warm (but more competent) than mothers, and they evoke passive harm behaviors, such as avoidance, envy, and disgust (Bays, 2017). Moreover, childfree individuals report feeling judged negatively by close others (Somers, 1993). Childfree men are rated as less stressed than fathers, although childfree couples are perceived as having more positive marital relationships than couples with children (Koropeckyj-Cox, Çopur, Romano, & Cody-Rudzewski, 2018).

Together, these factors may account for a portion of the rejection, stigma, and social scrutiny faced by the childfree. It has been suggested that "stigma may be the leading and least understood impediment to health promotion, treatment, and support" (Smith, 2011, p. 464). This stigma may lead physicians to make personal (rather than situational) attributions about an individual when judging their decision to be childfree (Lampman & Dowling-Guyer, 1995). These attributions manifest when, for example, a childfree individual is asked to undergo a psychiatric evaluation prior to receiving sterilization surgery. Stigma permeates the medical interaction, including preconceptions about what to expect at the appointment, the conversation with the medical provider, and the ultimate result of the consultation. Therefore, the use of a stigma framework to analyze content posted to digital communities is justified.

Experienced and anticipated stigma

Two types of stigma relevant to health care consultations are *experienced* stigma and *anticipated* stigma (Earnshaw & Quinn, 2012). In this context, experienced stigma refers to "experiences of actual discrimination" faced by childfree individuals in medical consultations that affect their ability to access health care services (van Brakel et al., 2006). Anticipated stigma refers to "the concern that [a person] will receive disparagement and poor treatment from others if the stigmatized identity becomes known" (Ikizer et al., 2018, p. 1). The decision to seek voluntary sterilization involves making the concealable, stigmatized childfree identity known to others, which can make a patient vulnerable to both experienced and anticipated stigma.

Three forms of experienced stigma that we explore here are (1) age discrimination (i.e., the mentioning of the patient's age by the provider as a factor in the decision in the medical interaction); (2) discrimination against nulliparous women (i.e., the patient's status as childfree cited as a factor in the decision); and (3) the stereotyping of childfree individuals as doubtful or likely to regret their decision (i.e., the discussion by the provider of the patient's risk of experiencing sterilization regret as a factor in the decision; Richie, 2013). These three factors may be discussed during the interaction for the purposes of patient counseling, and the mere mention of these items should not affect the outcome of the consultation. These factors represent experienced stigma, as they rely on paternalistic standards for the provision of sterilization that contradict current ethical recommendations concerning patient-centered care (ACOG, 2017). We explored anticipated stigma by examining (1) reported anticipated appointment outcomes (e.g., "I doubt they'll accept my request to be sterilized"); and (2) preparations made for the

defense of the patient's decision to be childfree prior to appointments with medical professionals.

To explore evidence of stigma in medical consultations for voluntary sterilization, we posed the following research questions and hypotheses.

RQ1: What disparities in treatment are reported between childfree men and women?

H1: Childfree women will report having been rejected more often than childfree men.

H2: Childfree women will report having been previously rejected more often than childfree men.

H3: Childfree women will report more rejection for age, risk of regret, and number of children than will childfree men.

H4: Childfree women will more frequently report anticipating an appointment outcome than childfree men.

RQ2: Does the mentioning of age, the risk of regret, and the number of children during the medical consultation affect the outcome of the consultation?

Method

Sampling procedures

A community on the website Reddit called /r/childfree was selected for this study. This community, called a subreddit, has approximately 261,000 members, and posts by members frequently include narrative accounts of interactions with physicians. Identifying information about post authors (e.g., names, contact information, demographic data, location) is not available within each post, as users are anonymous and have self-selected usernames that appear with each post they author. Our sampling unit was any post that described a medical encounter for voluntary sterilization, our recording unit was at the post level, and our context unit was /r/childfree. We searched the subreddit /r/childfree using the keywords "appointment" and "doctor," which had proven to be a useful way to find relevant posts. A total of 650 posts were identified. Posts were gathered as they appeared on the page after we sorted by relevance, and relevance sampling was employed to select posts that fit our criteria (Krippendorf's $\alpha = 0.91$). To be included in the final sample, the post had to be about an individual (woman or man) seeking voluntary sterilization and written before, during, or after the appointment. Posts merely sharing links ($n = 20$) or discussing childfree issues unrelated to the pursuit of voluntary sterilization ($n = 428$) were excluded from our final sample ($n = 202$).

Coding procedures

The content of each post was analyzed. Several codes we used were *a priori* codes, derived from existing literature (i.e., age, number of children, risk of regret), and the other codes were generated during the initial review of data. Each post was given a "1" to indicate the presence of a code or a "0" to indicate the absence of that code. Initially,

a sample of 40 posts was selected using a random number generator. Two coders then individually coded each post. Disputes were identified and discussed until agreement was reached on all codes. This process was repeated two additional times until reliabilities of 0.69 or greater (Krippendorf, 2012) were reached on all codes. Coders independently coded the remaining posts and met again to resolve any final disputes.

Codes

Patient sex. This code ($\alpha = .87$) distinguished between posts written by women seeking tubal ligation surgery ($n = 163$, 80.7%) and men seeking vasectomies ($n = 39$, 19.3%). For example, "I made an appointment to see about getting my tubes tied."

Preparation. This code ($\alpha = .77$) was an indicator of whether the author of the post mentioned any preparations they had made prior to the appointment, such as Internet research, talking to friends and family, or calling doctor's offices in advance ($n = 105$, 52.0%). For example, "I decided to find a clinic in the city after my GP told me no one in my rural area would sterilize me."

Anticipated outcome. This code ($\alpha = .82$) was used to determine whether childfree individuals had preconceptions or expectations about the outcome of the appointment ($n = 135$, 66.8%). For example, "I have waited until now to give [sterilization] a go for the first time because I knew this shit would be dumped on me."

Previous rejection. This code ($\alpha = .87$) was used to identify cases where individuals had had their request rejected at a previous appointment ($n = 30$, 14.9%). For example, "After many trips across Michigan, I finally found a doctor who would sterilize me."

Outcome. This code ($\alpha = 1.00$) was used to determine whether the author of the post mentioned the outcome of the appointment ($n = 169$, 83.7%). The possible outcomes of the appointment were acceptance (i.e., a patient's request to be sterilized was approved by the provider; $\alpha = .78$; $n = 87$, 43.1%), referral (i.e., the patient was referred to another provider; $\alpha = 1.00$; $n = 24$, 11.9%), or rejection (i.e., the patient's request to be sterilized was rejected by the provider; $\alpha = .90$; $n = 57$, 28.2%). For example, "I received a referral to another physician."

Appointment Variables. The codes *age* ($\alpha = .76$; $n = 80$, 39.6%), *number of children* ($\alpha = .69$; $n = 59$, 29.2%), and *regret* ($\alpha = .87$; $n = 74$, 36.6%) were used to flag whether these issues were raised during the consultation with the medical provider. These three codes were selected because they appeared consistently and were supported by existing literature on the experiences of childfree individuals in medical interactions (see Richie, 2013). One example of the *age* code is "People of your age tend to regret this decision when they get older." An example of *number of children* is "You haven't had any children yet, and I only perform this procedure on people who have already had children…" One example of *regret* is "He said that I might end my 10 YEAR relationship with my husband and fall in love with someone else who wants kids."

Data analysis

To explore research question one and to test the four hypotheses about differences in the experiences of women and men, data were examined using chi-square tests of

independence. Significance was determined when $p < .05$. To address research question two, binary logistic regression was performed to examine the impact of the mentioning of the patient's age, number of children, or the risk of regret on the likelihood of acceptance, referral, and rejection.

Results

The results were mixed; they confirmed the roles of both age and regret in the likelihood of acceptance in a medical consultation but did not provide support for the gender differences described in existing literature about voluntary sterilization.

Research question 1

To explore sex differences in the experience of seeking voluntary sterilization, we examined rejection, previous rejection, the provider's mention of the patient's age, the risk of regret or the number of children they currently had, and whether the patient reported anticipating an appointment outcome. Although statistical analyses indicated significant disparities between childfree women ($n = 163$) and men ($n = 39$) in terms of the mention of regret, other hypotheses were not supported.

Hypothesis 1

In order to test the first hypothesis (i.e., childfree women would report having been rejected more often than would childfree men), a chi-square test of independence was conducted between patient sex and rejection. Women ($n = 46$; 28.2%) and men ($n = 11$; 28.2%) reported rejection equally often. Thus there was no statistically significant association between patient sex and rejection, $\chi^2(1) = 2.29$, $p = .13$, and no support for H1.

Hypothesis 2

The second hypothesis was that childfree women would have been previously rejected more often than would childfree men. A chi-square test of independence was conducted between patient sex and previous rejection. Fourteen percent of women ($n = 23$) and 18% of men ($n = 7$) reported previous rejections. There was no statistically significant association between patient sex and previous rejection, $\chi^2(1) = .37$, $p = .55$.

Hypothesis 3

The third hypothesis was that childfree women would report more rejection than childfree men for mentions during the consultation of age, the risk of regret, and the number of children. A chi-square test of independence was conducted between patient sex and each of the three variables in question.

Our first chi-square test examined the patient sex and whether the medical provider mentioned age during the appointment. Forty-one percent of women ($n = 67$) and 33%

Table 1. Logistic regression predicting the likelihood of acceptance based on mentions of the patient's age, number of children, and risk of regret.

	B	*SE*	Wald	*df*	*p*
Age	−1.306	.396	10.820	1	.001
NumbChildren	−.275	.423	.424	1	.52
Regret	−1.050	.472	6.191	1	.01
Constant	1.102	.248	19.803	1	.0001

of men ($n = 13$) reported that age had been mentioned during the consultation. The test revealed that there was no statistically significant association between patient sex and whether the medical provider mentioned the patient's age, $\chi^2(1) = .80$, $p = .37$.

For the next variable (the risk of regret), a second chi-square test was performed to determine if there was a significant association between the two variables. There was a statistically significant association between patient sex and whether the medical provider mentioned the risk of regret, $\chi^2(1) = 7.27$, $p < .007$. Our frequency data show that 41% of women ($n = 67$) and only 18% of men ($n = 7$) reported that regret was discussed during their consultation.

A final chi-square test for independence was conducted between patient sex and number of children. Twenty-nine percent of women ($n = 47$) and 31% of men ($n = 12$) reported that the number of children they currently had was mentioned during the consultation. There was no statistically signification association between patient sex and a provider asking about the number of children, $\chi^2(1) = .06$, $p < .81$.

Hypothesis 4

The fourth hypothesis concerned whether childfree women would more frequently than childfree men report that they had anticipated an appointment outcome. A chi-square test of independence was conducted between patient sex and anticipation of appointment outcome. Thirty-five percent of women ($n = 57$) and 26% of men ($n = 10$) reported having anticipated an appointment outcome. There was no statistically significant association between patient sex and anticipation of appointment outcome, $\chi^2(1) = 1.24$, $p = .27$.

Research question 2

Binomial logistic regression was performed to determine the effects of the provider's mention of the patient's age, the number of children the patient had, and the patient's risk of regret on the likelihood that a request for voluntary sterilization was accepted (i.e., the request was not rejected or was referred to another physician). The total sample size was $n = 169$. The logistic regression model was statistically significant, $\chi^2(3) = 41.17$, $p < .0001$. The model explains 21.6% (Cox and Snell r^2) of the variance in the likelihood that a request for voluntary sterilization would be accepted by the provider. Of the three predictor variables (mention of age, number of children, and regret), two were significant, as shown in Table 1.

Discussion

Although several of our findings supported existing literature about the experience of childfree women in medical interactions, some of our results also challenge this dominant discourse.

Anticipated stigma

We hypothesized that women would report more anticipated stigma than would men, which was not supported by our data. Anticipated stigma was studied by examining preconceptions of the outcome of the appointment and making preparations (such as preparing for opposition to childfree views) prior to the medical consultation. A majority of our sample ($n = 135$, 66.8%) reported having had a preconceived idea about how their medical interaction would go. Thirty-five percent of the women and 26% of the men in our sample reported having anticipated an appointment outcome. Just over one half ($n = 105$, 52.0%) of our sample reported having made preparations or having conducted research prior to their appointment with a medical provider. Often, these preparations included patient self-education, where participants read about the experiences of others who had sought the same procedure and armed themselves with evidence and arguments in the event that they would be required to defend their choice during the consultation. In short, our results suggest that, although anticipated stigma exists when childfree individuals seek sterilization, it is not unique to one sex.

Experienced stigma

Experienced stigma was studied by examining the mention by the provider of the patient's age, the number of children they currently had, and the risk of regret as a factor in their decision during the medical consultation. The mention of age and number of children did not differ significantly according to the sex of the patient. In addition, women and men reported the same amount of rejection. Some may argue that the results of our study were a product of our sample. Our sample was, as expected, mostly young White women seeking voluntary sterilization. Our sample does not account for the experiences of older women, so we are unable to discuss how these experiences may have changed over time. Perhaps our sample might have been more motivated to post when appointments with providers went exceptionally well or exceptionally poorly or when their expectations were violated.

For example, many individuals wrote about having been surprised by the negative interactions they had experienced with doctors who had made it onto the "childfree friendly" list compiled by members of the subreddit. In addition, men's rejection, perceived as abnormal, might have been overrepresented in our sample. If women view rejections as routine and men view acceptances as routine and if they each had anticipated outcomes that correspond to those preconceptions, then they might not have felt motivated to post when the appointments went as expected. For example, some women wrote about having expected to be rejected, and they were surprised by how easily their requests were accepted. On the contrary, some male posters were surprised after having

been asked how old they were or how many children they had, as they did not seem to have anticipated encountering much difficulty during the interaction.

As the results do not show systematic differences in treatment between the women and men in this sample, it could indicate improvements prompted by relaxed moral and legal restrictions concerning contraception and birth control. As attitudes toward sex and sexuality have become more accepting, perhaps the acceptance of alternative childfree lifestyles has also become mainstream. Whereas decades ago being childfree may have made a couple social pariahs, voluntary childlessness appears to be a growing movement that is becoming more widely accepted, particularly among wealthier dual-income couples (Durham & Braithwaite, 2009).

On the contrary, several of our findings do suggest that the women in our sample experienced more difficulty when seeking voluntary sterilization than did the men. First, mentions of age and the risk of regret during consultations were significantly associated with the likelihood of acceptance. Mention of regret was also significantly correlated with the patient's sex; approximately twice as many women as men reported that the possibility of regret was mentioned to them. Mention of regret during the appointment was often in the form of the female patient being told that she would regret the procedure, as opposed to asking a question about the possibility of regret or initiating a dialogue about the risk of regret. When a female patient's sterilization request was rejected, regret was also often cited as one of the main reasons for the rejection. Although we might expect the possibility of regret to be mentioned during the patient counseling process, current guidelines recommend against enacting a paternalistic model of patient care by assuming that sterilization regret will occur (ACOG, 2017).

We were unable to include codes for some ethically compliant reasons for rejecting a patient's request (i.e., procedural risk, procedural failure, the patient not understanding the permanence of the procedure, the patient not having carefully considered the decision) because they appeared too infrequently in our sample. Although these codes were included in our original codebook, most were coded once or never at all. Thus we are unable to provide reliability information for these codes. Our inability to include these items, as they appeared so infrequently within the sample data, does not allow for a full consideration of the ethical guidelines concerning the voluntary sterilization of childfree women. However, instead of rejecting patients for ethical reasons deemed necessary elements of the patient counseling process (e.g., does the patient understand that the procedure is permanent?), reasons for rejection retold by our sample speak to efforts to protect women from the predicted regret that providers believe the patient will subsequently experience (ACOG, 2017).

As childfree individuals reported having been told that they were too young to be sterilized or that they would regret the procedure, evidence exists to suggest childfree individuals would experience stigma in these medical interactions. The use of the patient's age and perceived risk of regret in our sample as the basis for determining whether a patient's request for sterilization should be accepted violates current recommendations concerning the ethical provision of sterilization and upholding of patient autonomy (ACOG, 2017). The lack of uniformity detailed in these accounts of providers' determination of patient competency during the sterilization counseling process

comes at the expense of the reproductive justice agenda that providers are recommended to promote.

Limitations and future directions

The present study has several limitations and suggests opportunities for future research. First, as our sample was small and limited to the material available on /r/childfree, our sample may not accurately characterize these medical interactions generally. Post authors might have felt compelled to tell their story only when their expectations were violated or when the appointment was exceptionally helpful or unhelpful. The high number of posts in our sample authored by women may not be indicative of a disparity in treatment, but merely a reflection of who is likely to participate in the discussion-oriented /r/childfree subreddit. Further research is warranted to determine whether these disparities in authorship are indicative of disparities in treatment. Coding for the sex of providers could provide additional insight. Second, users of /r/childfree represent a highly educated, largely White subset of the larger childfree community, which may have influenced the results of our study. Future researchers should seek to include samples from a more ethnically and socioeconomically diverse sample. Third, our participants' reports may not have accurately characterized their experiences with physicians. In other words, the posts may have skewed perceptions of the events of the consultation. Fourth, our analysis did not allow us to uncover underlying motivations for the behaviors by medical providers described in the posts. Future researchers should recruit a larger sample, explore the motivations underlying these communicative behaviors, and use a richer data source, such as interviews, observation, or surveys.

Conclusion

The results of the present study allow for a better understanding of which communicative factors may be present in medical consultations for voluntary sterilization. Findings indicated that the mention of a patient's age or risk of regret by the provider were negatively predictive of approval for voluntary sterilization surgery (i.e., a tubal ligation or vasectomy). Women were told about the risk of sterilization regret significantly more often than were men, yet the women and men in our sample reported rejection at the same rates. Although we do not know how accurately the experiences of this sample characterize the experiences of childfree individuals in general, the experiences of the childfree women and men in this sample could be improved in terms of adherence to the ethical guidelines outlined by the ACOG (2017). Furthermore, our findings challenge normative assumptions about the experiences of women seeking voluntary sterilization surgery.

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Disclosure statement

The authors declare that they have no conflicts of interest.

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