Family Practice Grand Rounds

Vasectomy for the Single, Childless Man

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DR. RICHARD LIEBERMAN (*third year family practice resident*): This morning we would like to consider the questions that are raised when a young, childless man presents himself to a physician with a request for a vasectomy. Since we have included vasectomy as a regular part of our clinic service, we have had a number of requests for this procedure from such men. The decision to sterilize a patient who has never had children is a difficult one, laden with moral and legal considerations.[1-4] There has been mounting criticism of presumed excess sterilization of members of racial or economic subgroups, and much has appeared recently in medical and lay literature about improperly obtained informed consent.[5,6] Against this backdrop, we would like to address the nature of the physician's response to individuals who request this procedure. Participating in our discussion will be Drs. Leonard Cain and Karen Williams, who are family practice residents; Dr. Peter DiVasto, Assistant Professor, Department of Family Practice; Dr. Warren Heffron, Director of the Division of Family Practice; Drs. Arthur Kaufman and J. Dayton Voorhees, Assistant Professors, Department of Family Practice, and Mr. Lawrence Weiss, Research Associate, Division of Community Medicine. Mr. Weiss is a single, childless man who has had a vasectomy, and will offer a commentary on today's discussion. Before we hear today's case presentation, I will provide pertinent background.

The first outpatient vasectomy service in the United States was opened in 1969 at the Margaret Sanger Research Bureau, Inc. Their own Sterilization Subcommittee, which was composed of urologists, psychiatrists, and others, developed the following criteria for eligibility:

> The candidate must be at least 25 years old, married or in a stable relationship; he must have at least three children if less than 40 years old, two children if he is 40-45 years old, one child if 46-50 years old, and if over 50, he is eligible without any children.[7]

These are rather strict criteria and the Bureau soon realized that there were many circumstances in which a man could be eligible for vasectomy without falling into the above categories.

In 1975, Abel Leader, based upon his experience as well as that of others,[8] proposed a greatly modified eligibility scheme. He rejected the idea of a rigid cutoff according to age, number of years married, and even marriage itself. He believed that because vasectomy is a safe and very effective birth control modality, it should not be denied on the basis of irrelevant criteria. He argued that if a father reaches 40 years of age before the operation is performed, the risk of unwanted pregnancies is

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greatly increased. There is no reason for a 30-year-old father of two or three children, who desires sterilization, to have to wait ten years. In addition, Leader reminds us that five to ten percent of American men never get married, many rejecting marriage for fear of fatherhood. Thus, for some, vasectomy could facilitate entry into a marital relationship. In Leader's series of over 3,000 vasectomies, more than half the men did not meet the original Sanger criteria.

I would now like to present the case for this morning.

F.J. is a 28-year-old, single male who was referred to our Family Practice Clinic from a local family planning facility. He is a University graduate student who was born and raised in a rural Midwestern community where his parents ran a single family farm. He is the second oldest of five children and has two siblings who are married with children of their own. He appeared to achieve normal childhood and adolescent adjustment, and there is no evidence of traumatic psychosexual events. He describes his relationship with his parents and brothers and sisters as "good." He began "serious" dating in high school and sexual activity in college. He denies any homosexual activity.

He had lived with one woman for over three years, but is currently living alone and dating. He has long felt uncomfortable with the thought of fatherhood and for several years has entertained the idea of vasectomy. This seems not to have been influenced by any family or friends having had such a procedure. He did bring the subject up with his parents who were unsupportive of the idea; however, he remained interested in the procedure.

Review of systems and physical examination were essentially unremarkable and I considered the patient to be in good health. His presenting request seemed logical, but I was uncomfortable in agreeing to sterilize this man who had never had children. I expressed this personal discomfort and asked if he would mind returning for an interview with a psychologist so that we could obtain another opinion. Quite frankly, I felt that this would benefit me as well as the patient. He had no objection to the second opinion and, in fact, was interested in obtaining the opinion of a psychologist. Dr. DiVasto agreed to see this patient in consultation with me and a revisit was scheduled for the following week.

DR. PETER DIVASTO (*Assistant Professor, Department of Family Practice*): We conducted the follow-up session with the patient's consent to videotape the interview. When I saw him, he was a tall, slender, soft-spoken man whose dress, speech, and self-presentation were appropriate and unremarkable. The body of the interview concerned his relationships and his concept of a person's changing needs. I was particularly interested in eliciting this patient's degree of impulsivity and spent considerable time on this issue. We also discussed his feelings about children. I suggested to him that it would be a good idea to spend some time around children and see how he felt. He said that he had already done that. There was no question in his own mind that he liked children, but that he was not interested in becoming a father. It was obvious to me that he had considered this question for a long time. He seemed self-aware, intelligent, and had an understanding of his own motives. I saw no contraindication to sterilization.

DR. ARTHUR KAUFMAN (*Assistant Professor, Department of Family Practice*): I wonder if there is any more information about why he did not want children. For instance, was there any sexual difficulty which he transposed into a concern about not wanting children?

DR. DIVASTO: None that we could elicit. His relationships seem to have been sound, as Dr. Lieberman mentioned, and we could not identify any untoward experiences that would have given him a phobia concerning fatherhood.

DR. LEONARD CAIN (*third year family practice resident*): Did the patient seem to have any reluctance to being videotaped?

DR. LIEBERMAN: None that we detected. In fact, he seemed interested in the taping.

DR. J. DAYTON VOORHEES (*Assistant Professor, Department of Family Practice*): Did he ask to see the tape afterwards?

DR. LIEBERMAN: Yes, and it turned out to be a pivotal event. After the interview, when I was rewinding the tape, he did ask if he could see it. I had no objections, and we sat down and watched the tape together. After seeing himself, he felt very unsettled and felt that the person whom he saw was not presenting a convincing argument. In fact, he told me that he was no longer sure he wanted a vasectomy and that he would like more time to think it over.

DR. CAIN: The first time I saw myself on vid-

eotape, I was also bothered. I felt I didn't look or sound like myself. I think it unfair to subject single men to a more rigorous interview than that given to married men requesting a vasectomy. Furthermore, I do not think that he should have seen the tape because it is not real life.

DR. KAUFMAN: Dr. Cain, do you think that if a person sees himself on tape and, as a result, decides against the procedure, that we have done him a disservice?

DR. CAIN: I can't make that decision. It is up to the patient. If he wants a vasectomy but does not want to be videotaped, I think that's all right.

DR. LIEBERMAN: This patient was not forced to have such an interview. We told him that we would like to do it, but that our decision would not be based upon it. I felt that he was very interested in talking with a psychologist and that he was also interested in the taping.

DR. WARREN HEFFRON (*Director, Division of Family Practice*): I think that the idea of utilizing videotape is a very good one. It has the obvious advantage of letting us all see the interview. In addition, it provides an excellent document of informed consent. There have been legal problems created by patients who felt that they were improperly counseled. Later, they changed their minds about having children and sued the physician who had performed the operation. By having the tape on file, we can easily demonstrate the care we took in informing a patient.

DR. DiVASTO: Perhaps we should have such interviews with all our vasectomy candidates and see what we come up with.

DR. KAUFMAN: I'm not so sure about that. Why should we have taken such extraordinary measures with this patient? It seems to me that he had more valid reasons for not having children than most people do for having them. It seems that it was important for him to have control over his life. Having a vasectomy symbolized a very important control over his body. You know, the women's movement has really taken the initiative in recognizing the importance of one's assuming responsibility for one's own health. Part of this responsibility involves the wresting away of many important health-related decisions from medical professionals. I feel this man may have reached a similar level of health consciousness. We should be more supportive of this emerging consumer demand.

DR. KAREN WILLIAMS (*second year family practice resident*): I agree. I think you were trying to be certain you were obtaining informed consent from this patient but, in reality, may have been badgering him unnecessarily in a psychological sense. To first be confronted with the necessity of going through a psychological evaluation, then be videotaped to "prove" that he gave informed consent must have left him feeling his request was in some sense "crazy" or deviant. Do you really think that a man who decides that he does not want to be a parent is deviant? This situation is analogous to that of a woman requesting sterilization. She is often confronted with a similar "formula" using her age and number of children which will determine her eligibility for a tubal ligation. A woman who totally rejects motherhood is thought by society to be truly deviant. I think it is presumptuous of us as health care professionals to determine who may or may not opt for control of reproductive potential, even if the control is by sterilization, when we are not the ones who must deal with the consequences of not having that control.

DR. HEFFRON: One might say that this patient should have the right to make a mistake. If, at a later time, his life-style should change so that he regrets his operation, the responsibility for this mistake remains his own. A case might be made to say the single man should have more of a right to make such a mistake than a physician has to make him remain fertile by refusing to perform a vasectomy. The latter, in my mind, is a far more grievous mistake.

DR. VOORHEES: I think there's something else we should consider in this case. Unlike a married man with children, the patient is under unusual stress during this kind of interview. He is almost on trial trying to convince a physician and a psychologist, under cross-examination, that his reasoning is sound. I am surprised that he was able to present his case so well. By the way, did you mention the possibility of reversal of vasectomy or the idea of using a sperm bank?

DR. LIEBERMAN: This is an important question. There are a few surgeons who are now reporting success rates over 90 percent with reanastomosis procedures.[9-10] While this might appear to be a comforting thought, reanastomosis is highly uncertain at this point and I strongly suggest to all patients who are considering the operation that

they should assume it is permanent. As for the sperm bank, Dr. DiVasto mentioned this in our interview, attempting to flush out any latent ambivalence. The patient told us it would not be necessary for us to store his sperm. I must admit I was relieved because, to my knowledge, sperm banking is not available in New Mexico.

DR. HEFFRON: That's correct. This is a relatively new technique which is developing and is only available in some parts of the country on a research basis. It is even being made available commercially through some private laboratories. The specimens must be frozen and shipped to the laboratory within 1 1/2 hours from the time of ejaculation. The closest site to us is in Los Angeles* and this practically precludes our use of it unless the patient travels there to produce a specimen in person. The methods of handling specimens vary among laboratories but, in general, the procedure involves collecting multiple ejaculates for multiple artificial insemination attempts at a later date. Some laboratories, for example, will collect enough specimens to provide insemination two times a month for a six-month period.

Cost is a significant factor. Commercial laboratories charge about $40 per specimen and an additional charge of $25 per year for storage. There is no guarantee of successful insemination, but recent reports are encouraging (personal communication, James D. Eisen, PhD, University of Nebraska Medical Center, January 1978).

DR. LIEBERMAN: Mr. Weiss, would you care to comment on the discussion?

MR. LAWRENCE WEISS (*Research Associate, Division of Community Medicine*): Yes, thank you. I would like to address three issues which struck me as I listened to the discussion. First, there is often the assumption that the subject desiring a vasectomy is a deviant. The mere attempt to have this simple surgical procedure performed may bring upon the patient a series of medical hearings, invasive interviews, and thinly veiled obstructionist tactics on the part of the medical profession. In my experience, such direct nonsupportive attention by physicians, psychologists, laboratory technicians, and nurses leads to a frustrating, tense, and anxious experience for the patient. Is the choice to have a vasectomy an indication of psychological pathology any more so than the choice to become the biological father of one or more children? No studies were quoted to substantiate this premise during today's discussion.

Secondly, there is a legal issue involved. I believe the medical profession has abrogated the legal responsibility of adults to consent to standard medical procedures. In flagrant disregard of equal legal protection expected by all patients, the profession has set up, in paternalistic fashion, obstacles to obtaining a vasectomy by many consenting, legally accountable adult men.

And last, there seems to be a confusion in both the medical and lay communities concerning the relationship between a vasectomy and parenthood. Though obtaining a vasectomy probably eliminates the male's option of becoming a biological father, it does not prevent him from becoming a parent if he so chooses. Such options as adoption or marriage into a family with children remain open to him. As a corollary to this, having a vasectomy does not impair in any way the ability of a man to interact with a woman and child as husband and parent.

DR. LIEBERMAN: Thank you. In summary, I think we are in a process of redefining our criteria for performing vasectomies on single, childless men. The need for this redefinition is hastened by changing societal mores, growing consumer demand for control of important, personal, medical decisions, and the advent of an ever-improving medical technology.

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