

## COMMENTARY

# Tubal ligation on an unmarried girl: How and why?

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After going through the case report, it seems there can be two possible explanations for the tubal ligation performed without the consent of the patient: first, absolute malafide intent and second, a medical mix-up with tragic long-term consequences for the girl.

The doctors submitting the case offer the primary possibility of deliberate tubal ligation being performed as part of a nexus between the family and doctors to prevent the girl from having children, or with the more sinister motive of trafficking the girl. Alternatively, it could have been a case of medical negligence, with the wrong operation being performed on the wrong patient. We will look into both arguments.

### *Deliberate tubal ligation.*

This is unlikely for the following reasons:

The patient did mention that she had been suffering from abdominal pain, for which she was hospitalised and operated upon. Though she had no records or knowledge of that surgery, she had undergone only one surgery in the past and had a laparoscopy scar. Hence, she had not been forced into a surgery but had symptoms which might have required a diagnostic laparoscopy, maybe even an appendectomy.

The surgery was performed in a private hospital. Deliberate tubal ligation could have been possible in a government hospital, where doctors and family health workers have the Damocles' sword of the National Family Planning programme, with its incentives and numbers, hanging over their heads. Though subtle coercion is still used with women from the marginalised, poor and tribal communities, the days when young unmarried adults were made to undergo sterilisation operations vanished with the end of the Emergency, as well as the rise of local NGOs which will draw attention to any wrongdoing they may come across.

If the intent was to harm the girl's fertility, the surgeons would not have used Falope rings, which can be detected on X-ray as well as by laparoscopy. They would have damaged the Fallopian tubes surgically so that it would be considered a case of natural infertility.

The girl was married off and there was no intent or attempt to traffic her.

### *Medical negligence.*

In any hospital, most surgeries are listed in such a way that all laparoscopic surgeries are done one after the other in a particular operation theatre (OT) with the laparoscopic set up. Here, patients for diagnostic laparoscopy for infertility or diagnostic laparoscopy for pain or a lump in the abdomen would be in line with other patients who have been admitted for laparoscopic tubal ligation, sometimes also requiring surgical medical termination of pregnancy. The possibility of two patients with similar names, or confusion by the OT staff as well as operating surgeon, would cause the wrong operation to be performed on *two patients* who have been inadvertently interchanged, with tragic consequences for both.

To establish the cause, one would need to investigate details such as the day and the place where the woman underwent her first surgery, and a list of the other patients operated on that day. In all likelihood, another woman who was admitted for sterilisation may have ended up conceiving again, which would have been blamed on "failure of tubal ligation". She may also be missing an appendix. This would thus be a matter of medical negligence in two cases.

### **What can be done to prevent similar occurrences?**

Specific criteria should be applied and indications heeded before patients are taken up for **any** surgery. There seems to be an epidemic of laparoscopic surgeries for pain in the abdomen or ovarian cysts. These appendices and ovarian tissue have a normal morphology and histopathological examination reveals an absence of pathology. Could the surgeries be avoided by conservative management?

Stringent methods should be followed when pre-operatively handing over a patient to the OT staff. To prevent this sort of surgical mishap, checklists can be used for the patients' identity, pre-operative medications, pre-existing conditions, as well as the specific surgery to be conducted.

It is imperative to explain the details of the operation and required follow-up to the patients and their family members before as well as after the surgery. They are often distracted by post-operative pain, drowsiness, fatigue and the formalities of discharge from hospital. This results in poor compliance with post-operative instructions.

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I also believe that after the surgery, patients should be given a photocopy of the operation notes and not just a sanitised summary of the procedure.

Paediatricians and primary physicians must insist that parents maintain their children's medical records meticulously. The parents need to understand that childhood medical treatment may have an effect on the health of their progeny in later years.

Medical students, specifically interns and postgraduates, must undergo training in medical ethical practices and the latest jurisprudence on medical negligence. The importance of following protocols and checklists must be emphasised.

The following are a few cases that illustrate the points listed above.

**Case 1:** A 38-year-old woman presented with chronic pain in the abdomen. The X-ray of her abdomen, done for renal calculi, showed a Lippes Loop in the uterus. She gave a history of infertility and said she had undergone a D and C 20 years earlier. She had been diagnosed with Asherman's syndrome, for which the intrauterine synechiae had been broken and a Lippes Loop placed, to be removed after six weeks during follow-up. She did not return to the OPD but instead, resorted to many traditional methods in her village and was finally abandoned by her husband, who married again. She said that neither she, nor her family had been told about the insertion of the IUCD or the importance of coming back for follow-up.

**Case 2:** A 26-year-old woman, who had been married for four years, visited the OPD for primary infertility. She and

her husband had already undergone basic investigations in a private hospital, including semen analysis and HSG. As all the other tests were normal, she was posted for diagnostic laparoscopy. She was given the admission order and asked to come fasting since the previous night, directly for the surgery, after her period. Subsequently, the patient was admitted early one morning on a busy day on which many surgeries were lined up. She was prepared and sent to the OT. As she was made to lie down on the OT table, a resident realised that the date of her last period had been eight weeks earlier. On questioning, the patient said that her family had to go home to her village because of a sudden death and had returned only the previous week. When asked about her period, she admitted that it was strange but she did not want to delay further treatment for her infertility. Her pregnancy test was found to be positive. Luckily, the pre-operative medications had not yet been given and no harm was caused to the foetus.

**Case 3:** A young rural couple came for infertility assessment six months after marriage. On questioning, the 20-year-old groom's parents mentioned that he did not seem to be "performing well." The shy bride, unschooled and barely a teenager, was unable to utter a word as she sat with her head covered, chewing one end of her sari. Finally, after prolonged questioning, the parents proffered some medical records. The groom had undergone bilateral orchidectomy at the age of 12 years for a testicular tumour. The parents insisted that the doctors had never told them that their son would be infertile in the future, though I would give the operating doctors the benefit of the doubt!

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