

# Hysterectomy: The Patient's Perspective

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**Objective:** Importance of information provision by the gynaecologist and its effects on women's decision making about hysterectomy. **Study Design:** Structured questionnaire and interview **Setting:** Department of Obstetrics & Gynaecology, Jinnah Hospital, Lahore. **Materials and Methods:** A questionnaire was given to 50 women who had undergone hysterectomy for benign menstrual problems and information was collected. **Main Outcome Measures:** Women's experience and satisfaction, with the communication and information provision by the doctor about her disease before hysterectomy. To assess the influence of that counseling on the decision-making process of hysterectomy. **Results:** Most of the women undergoing hysterectomy were between the age group of 40 – 45yrs (40%). Most common indication for hysterectomy was dysfunctional uterine bleeding (55%). 32% women reported optimal satisfaction with decision made. 57% highlighted sub-optimal aspects of decision-making process. 37% complained of deficiency in communication skills of doctors and 63% stated that information provided were incomplete ( $P < .001$ ). 11% had residual doubts about the appropriateness of hysterectomy. **Conclusion:** The efforts are required to ensure that women are adequately informed and involved in decision about gynecological treatment.

**Key Words:** Benign menstrual problems, hysterectomy, dysfunctional uterine bleeding

Hysterectomy is one of the most common major surgical procedure performed, having a rate of 6.1 – 8.6/1000 women of all ages<sup>1</sup>. Charles Clay performed first subtotal hysterectomy in Manchester, England (November 1843), while total abdominal hysterectomy was performed for the first time by Richardson in 1929<sup>2</sup>. In the early 20<sup>th</sup> century, hysterectomy attained popularity as definitive treatment for pelvic pathology including fibroids, abnormal and heavy bleeding, chronic pelvic pain, endometriosis, adenomyosis, uterine prolapse, PID, and cancer of the reproductive organs.

Although, this procedure is highly successful in curing the disease of concern, however it is a surgical alternative with the accompanying risks, morbidity and mortality. A patient may be hospitalized for 6 to 7 days and may require 10–12weeks of convalescence. Complications such as excessive bleeding, infection and injury to adjacent organs are real possibility. Though the appropriate decision making for the mode of treatment is the duty of a physician, Nonetheless involvement of the women is considered to be an important aspect of the surgical decisions.

Before seeking medical help women usually gather information from consulting other women with similar complaints. Most women desire information before hand about the physical effects of surgery and alteration in sexual activity. They express a strong desire to discuss and interact with their physicians for the treatment choices and to be involved in elective treatment decisions<sup>3</sup>. It is considered to be the legal obligation of the physician to enable women to make informed decision about the medical intervention<sup>4</sup>.

Male partners play an important role in decision-making of women. The patient want that their partners should know about the quality of sexual relation that follow after hysterectomy<sup>5</sup>. Women satisfaction with their

decision of surgery also affects the prevalence of post hysterectomy psychosis and depression<sup>6, 7</sup>. In pre and postoperative period, qualified discussion can be very helpful in women sexual behavior, body image and satisfaction with surgical outcome after hysterectomy<sup>8, 9, 10</sup>.

This study was conducted to emphasize the importance of communication and information provision to the patient about the diagnosis of her disease, the reasonable surgical and non-surgical alternatives and to assess the patient satisfaction with their decision of surgery. Mostly elective hysterectomies are decided when professional consensus and clear recommendation is usually not present. In these cases patient choice is particularly important.

## Material and Method

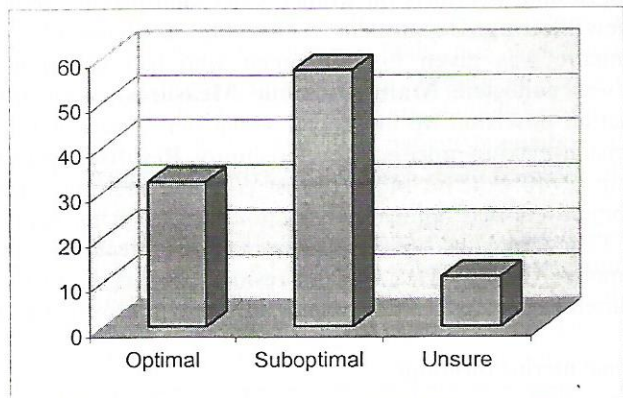
This was a Non-intervention, exploratory study. Sample consisted of 50 women, who underwent hysterectomy for benign menstrual conditions; selected at simple random bases. Data was collected on a pre-designed, structured questionnaire, by the residents and senior registrars. Information obtained were recorded and analyzed in a computer-based software (SPSS).

**Main Outcome Measures:** Women knowledge regarding the diagnosis of their disease and treatment options. Their satisfaction with the information provision and the way of communication of their doctors. Women experience of their decision-making process and satisfaction with the decision made.

## Result:

Hysterectomies accounted for 61% of major surgical procedures in year 2003(Gynae unit-I). In this study most of women undergoing hysterectomy were between the ages of 41 – 45 years (36%). 26% were between 46–50 Yrs and 21% were between 36–40 Yrs (Table I).

The most common indication was dysfunctional uterine bleeding (45%). Other indications for hysterectomy are shown in table II. 32% of the women reported optimal satisfaction with the decision of hysterectomy, 57% highlighted sub-optimal aspects in decision-making and 11% of women were unsure (Figure I)



Mainly the educated groups of the women were found capable of adequate counseling. 57% of educated women had adequate counseling, which dropped to 17% among uneducated group of women (P value <0.001). 83% of uneducated women were unable to discuss and understand their disease and treatment options. Only 17% were counseled adequately. Among the educated group, women with higher education counseling abilities were much better (57%). The counseling abilities among the women with primary, middle and matric education were 27%, 35% and 41% respectively (Figure II).

63% complained that the information provided was not complete regarding the diagnosis (11%), treatment options (23%) and risks of surgery (29%). 37% of the women were not satisfied with the way their doctor communicated with them (12%). They were not comfortable with the language of discussion (7%) and the concern of their doctors regarding the comprehension of the information given (18%)(P value <0.001).

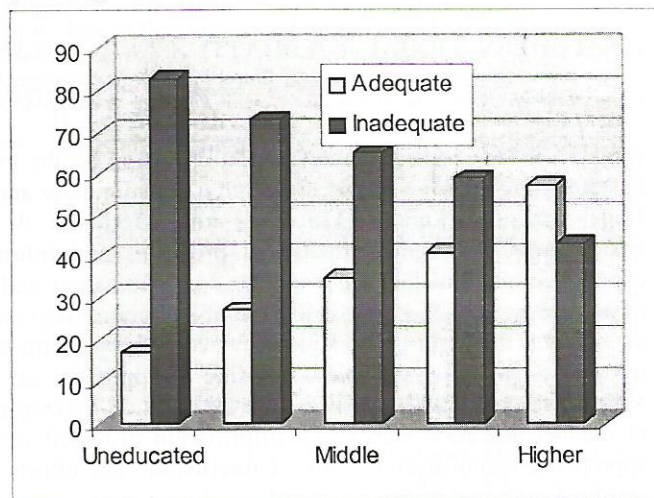
Table I: Different age groups undergoing hysterectomy:

Age of patients in years	%age
<30	0
31-35	1
36-40	21
41-45	36
46-50	26
50 and above	16

Table II Indications for Hysterectomy

Indication	%age
D U B	45
Fibroid	35
Adenomyosis	12
Others	08

Fig. II. Relationship of women education and adequacy of counseling



**Discussion**

Women think and discuss a lot before the decision of hysterectomy<sup>11</sup>. This study revealed that most of our women undergoing hysterectomy were not sufficiently informed when the consent for surgery was taken. This is consistent with a study conducted in Canada that their gynaecologist did not initiate a comprehensive discussion about other treatment options, their advantages and disadvantages<sup>12</sup>. In our study only 32% patients reported optimal satisfaction with the decision made. However, 97% of patients reported satisfaction in a study conducted in University of Aberdeen UK<sup>13</sup>. This showed that there were important shortcomings in our current pattern of information provision and communication leading to decision-making.

Although uterine leiomyomata are considered the leading indication of hysterectomy but our study showed dysfunctional uterine bleeding as the most common indication. This is consistent with the study in New-caster Australia<sup>14</sup>.

In this study it was concluded that the currently used methods for patients participation in health care decision-making were inappropriate, inadequate and invalid. Similar problems were identified in a study by health services research unit in UK<sup>15</sup>.

In our study there was a lack of collaboration and shared approach in patient physician interaction. We suggest that there should be an optimal patient physician interaction to provide useful information for hysterectomy decision. Similar suggestions were made in a study by the department of health promotion in Carolina<sup>16</sup>.

Most of our women did not have any specific opinion about the operation. 57% highlighted the sub-optimal aspect of decision-making. 11% had the residual doubts about the appropriateness of hysterectomy. This is inconsistent with the study of Helsinki University where most of the women had themselves wished hysterectomy<sup>17</sup>.

We suggest that patient should be offered the option of discussing diagnosis and alternative treatments for their disease. For all decisions of significant risk and uncertainty, shared decision-making and informed consent are important aspects of effective communication techniques. Information given to the patient should preferably in their primary language and patient comprehension of the information given is important because without it patient cannot achieve true autonomy in decisions making.

**Conclusion:**

There are important shortcomings in current pattern of information provision and communication relating to decision-making. The efforts are required to ensure that women are adequately informed and involved in decision about gynaecological treatment. There is an urgent need for patient education on physical, psychological and sexual aspect of hysterectomy.

Patient and physician must spent time to discuss all the details of operation. Satisfactory decision-making regarding hysterectomy mainly depends upon the way their doctor communicates with patient, provide information and recognized the capacity of each patient to deal with medical information.

Helping patients to reach a reasonable decision is an important part of the art of medicine

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