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## A Qualitative Study of Women's Decisions Not to Have a Hysterectomy

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### Abstract

In focusing on individual and physician demographics and system characteristics that lead to hysterectomy rate variations, researchers overlook the impact of culturally mediated meanings women assign to their bodies, hysterectomy, and other treatments. In this study I sought to provide a fuller description of this decision - making process by examining the role of meaning making in women’s decision not to have a hysterectomy. Using a descriptive qualitative approach, nine women diagnosed with menstrual disorders in Halifax, Nova Scotia, Canada each took part in a semi - structured interview. Factors deemed “irrational” in bio medical understandings of informed choice played a significant role in participants’ decisions not to have a hysterectomy. When these factors are hidden, they cannot be properly addressed during the treatment selection process. By shifting the approach to informed choice to incorporate a holistic view of the body and knowledge, requirements for informed choice may be more likely to be met.

### Keywords

Menstrual Disorders, Treatment Decision - Making, Women’s Health, Descriptive Qualitative Research

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Abnormal uterine bleeding (AUB) affects between nine and 30 percent of reproductive aged women in Canada (SOGC, 2001). The Society of Obstetricians and Gynaecologists of Canada (2001) defines a normal menstrual cycle as one that lasts 21-35 days, with a flow lasting two to six days, and blood loss between 20-60 millilitres. In accordance with this definition, a diagnosis of abnormal uterine bleeding can be applied to women experiencing menstrual cycles outside of this normal range. As this disorder is specific to menstruation and biological females, the experience of this illness is gendered. That is, it is related to what it means to be a "normal" or "abnormal" woman.

Seventy-five percent of hysterectomies worldwide are performed on women diagnosed with this disorder and/or uterine fibroids, which often cause AUB (SOGC, 2002). In 2002-2003, Nova Scotia, the site of this study, had a hysterectomy rate 1.4 times the national average (Nova Scotia Department of Health, 2006). Although the "right" level of utilization of hysterectomy is not known, the Canadian Institutes for Health Information (CIHI, 2005) states that a high rate may reflect a high degree of uncertainty about the appropriate use of the procedure.

Hysterectomy is one of the surgical procedures for which variation in rates have been most documented (Blais, 1994; Richter, Corwin, Rheaume, & McKeown, 2001). A strong focus on hysterectomy rates may also be attributed to its position as one of the most commonly performed surgical procedures in North America (Broder, Kanouse, Mittman, & Bernstein, 2000; Roos, 1984; Ontario Women's Health Council, 2002), and the discretionary nature by which the surgery is often recommended (Broder, Kanouse, Mittman, & Bernstein 2000; Kinnick & Leners, 1995). This variation is particularly noticeable in the rates of hysterectomy for benign conditions such as uterine fibroids and abnormal uterine bleeding (Broder, et al., 2000; Ontario Women's Health Council, 2002; Roos, 1984). The literature review I conducted indicates that one or more of three reasons for these variations is often cited: differential access to resources (Bickell, Earp, Garrett & Evans, 1994; Byles, Mishra &

Schofield, 2000; Hall & Cohen, 1994; Roos, 1984), physician characteristics (Bickell et al., 1994; Hall & Cohen, 1994; Roos, 1984), and/or patient characteristics (Byles et al., 2000; Roos, 2004).

This research project examined the decision-making process of individual women considering hysterectomy. The purpose of this research was to explore the ways information is used in decision-making regarding hysterectomy by interviewing women suffering from benign abnormal uterine bleeding who chose not to have a hysterectomy. Hysterectomies for benign conditions are often unnecessary (SOGC, 2002). Epidemiological studies have shown that indications for hysterectomy are more often benign conditions such as abnormal uterine bleeding, than cancer (Broder et al., 2000; Hall & Cohen, 1994). The availability of multiple treatments for these benign conditions requires physician and patient to make a decision about treatment (SOGC, 2002). In focusing on individual and physician demographics and system characteristics that lead to hysterectomy rate variations, researchers overlook the impact of culturally mediated meanings women assign to hysterectomy and other treatments. The results of this study provide a fuller description of this decision-making process by examining the role of meaning making in this process. These results contribute to research on hysterectomy variations and decision-making, and may also be useful to health care providers and patients as they collaborate to make informed treatment decisions.

In order to examine the role of culturally mediated meanings in women's decision-making regarding hysterectomy, the interview questions encouraged participants to describe their illness experiences and decision-making processes. Focusing on women who chose *not* to have a hysterectomy may help illuminate ways in which this decision-making process can be improved. The central research questions were: how do women experience abnormal uterine bleeding? What is the role of information in medical decision-making? And how can the process of deciding against hysterectomy be described and improved?

In considering hysterectomy for treatment of abnormal uterine bleeding, women are moved to examine and articulate the meaning of being a woman in relation to their physical body, within a social and historical context of medicalization. The meaning that a woman associates with her reproductive organs shapes her illness identity and the types of information she considers in her treatment decision. A woman considers, and is influenced by, many non-medical factors when making a treatment decisions for abnormal uterine bleeding. Without understanding the reasons behind this decision, one cannot ensure that informed choices are being made.

As a woman and a health researcher, my interactions with the health care system and research experience have led me to be increasingly interested in the ways in which gender shapes our experiences of health, illness and health care. At the time I was planning my Masters research, discussions about hysterectomy rate variations in Nova Scotia were quite common. It seemed ideal to take up my interest in gendered illness amidst this ongoing debate. Although I have no personal experience with the decision-making process described in this article, I discussed my proposal with family and friends and was surprised how many women I know have been diagnosed with a benign menstrual condition. I am sure that their stories have contributed to the analysis shared here.

## Methods

A qualitative approach was chosen in order to provide a detailed description of the decision-making process as the women themselves remembered it. A qualitative study in the field of surgical variation and illness construction may answer some of the "why" questions that have not been answered using quantitative studies (Blais, 1994; Grypdonck, 2006). As the experience of women choosing not to have a hysterectomy has not been previously

studied, a qualitative descriptive approach was selected. Sandelowski (2000) describes qualitative descriptive studies as those that “have as their goal a comprehensive summary of events in the everyday terms of those events” (p. 334). These studies are particularly useful in the field of applied health research, in which qualitative description can be used to challenge assumptions made in the predominantly quantitative evidence used to inform health care policy and practice (Thorne, 2011). In the case of this project, a qualitative descriptive approach provided a detailed description of each woman’s illness experiences, her reasons for choosing not to have a hysterectomy, and the decision-making process from her perspective.

This study was undertaken as my Masters’ project. The study protocol received institutional ethics board approval from the Dalhousie University Health Sciences Research Ethics Board. I conducted semi-structured interviews with nine English-speaking women who underwent medical treatment in Halifax Regional Municipality, Nova Scotia on the East coast of Canada. All participants were over the age of 20 and had considered having a hysterectomy for benign abnormal uterine bleeding since 2000. I chose an urban centre for the site of this research because the hysterectomy rates in urban areas are lower than those in rural areas. In 2004-2005 Capital District Health Authority reported a hysterectomy rate of 376 per 100,000 women over the age of 18, 20 percent below the provincial average (Nova Scotia Department of Health, 2006).

I used convenience sampling methods, including posters, advertisements on email listservs, newspaper advertisements and snowball sampling to recruit nine eligible interview participants. As patient characteristics, including age, race, education and socioeconomic status have been correlated with hysterectomy rates in previous studies, I attempted to recruit a diverse sample of women. This proved to be very difficult using the various recruitment methods in the time available. The nine women interviewed ranged in age from 23 to 57. Four of these women were identified as low socioeconomic status using Canadian Low Income Cut-offs (Statistics Canada, 2007). These four participants were currently university students; all nine participants had at least one university degree. Only one of the participants identified as non-Caucasian. All participants who self-identified as being in a relationship (N=seven) were involved in heterosexual relationships.

At the beginning of each interview, participants reviewed a consent form that outlined procedures for maintaining confidentiality and anonymity. After providing informed consent, each participant took part in one semi-structured, face-to-face interview that was approximately one hour in length. Interviews took place in various locations that were convenient for the participants, including a local women’s centre, the participants’ homes, and private rooms in public libraries. In the interview, I asked participants to describe the progression of their illness (symptoms and how these affected their lives), their diagnosis (how and why they decided to seek medical care, how they felt about being diagnosed), and their decision not to have a hysterectomy (what were the options, what they thought of each one, why they chose the option they decided upon). I also asked participants to comment on issues beyond their personal experience with questions such as: Why do you think hysterectomy is the most common treatment for benign menstrual conditions? Why do you think women choose hysterectomy? The answers to these questions provided insight into participants’ perceptions of the treatments offered to them. Immediately following each interview I completed brief field notes that described the context of the interview and initial thoughts I had about main themes arising from my discussion with the participant. Probing questions in the following interviews were developed in response to these initial themes. In this way, data analysis overlapped with data generation.

Each interview was taped and transcribed verbatim. In order to maintain confidentiality and anonymity, each participant was assigned a participant number, identifying comments were removed during transcription, the transcriptionist signed a

confidentiality agreement, and all documents containing participants' contact information were stored separately from the transcripts. I conducted thematic analysis (Boyatzis, 1998) to identify the major themes and subthemes present in the data. Guided by Mason (2002), I engaged in an interpretive reading of the transcripts, generating common themes. After a number of readings, these themes were narrowed into a hierarchical list of codes which I applied to sections of the transcripts using Microsoft Word. The major codes identified consisted of: Physician and the Health Care System, Symptoms/Condition, and Seeking, Choosing and Undergoing Treatment. Each of these further divided into 11 to 18 sub-codes. The sub-codes varied from simply describing participants' accounts, for example "experience of symptoms," to interpreting these accounts, for example "deciding what to believe." Field notes were not coded, but informed the development of the codes.

For practical reasons, I decided to code the data because it provided an organizational structure that made it easier to retrieve pieces of data relevant to each manuscript. In addition, the process of developing and applying the code list allowed me to view the data in different ways. Creating these pieces of data through coding did not complete the analysis process. Instead, these pieces are understood as "unfinished resources" (Mason, 2002, p. 157) that provide an opportunity for further analysis in response to the questions being asked for a particular paper or in relation to a body of literature. For the purposes of this article, multiple codes were pulled and then refined by further categorizing the pieces into the common themes discussed in the Findings section. My interpretation of the data continues to develop as I engage in the revisions process. Thus, data analysis is never complete and the coded data remains a resource that offers opportunities for new interpretations.

Many steps were taken to ensure the data for this study was generated and analysed using rigorous and trustworthy methods. First and foremost, supervision at all stages of the research process by my graduate supervisor provided opportunities to ensure congruence in the methods, engage in peer debriefing, and lend researcher credibility and confirmability to the results (Polit & Beck, 2004). I also sought to increase trustworthiness and rigor through the search for disconfirming evidence and kept a detailed research journal that described and engaged reflexively with each methodological decision (Polit & Beck, 2004). Most importantly, I sought to achieve "sensitivity" (Whittemore, Chase, & Mandle, 2001) by paying close attention to the effects of cultural contexts on participants' accounts. This attention to social structure informs all stages of the research process, including my efforts to contextualize participants' decision-making processes in this manuscript.

## **Findings**

### **From "Normal" to "Abnormal"**

Participants suffered from various symptoms, including pain and heavy bleeding for years before seeking a medical diagnosis and treatment. For some women, the pain was what they remembered the most from their illness experience: "The symptoms were just like a severe, severe lower abdominal pain. Like it felt like a labour contraction that was never ending. It was just continuous. And I said to my mom like I feel like my uterus is just going to explode in a million pieces on the floor."

For others, memories of heavy bleeding were the most significant: "I would know when my period started that I would get through about 10 hours when it was pretty regular, and then I would go into about a 12 to 15 hour say stretch, sometimes it would last as long as two days, but no usually, where I would virtually use a super-plus tampon pretty much every 30 minutes."

Over time, dealing with the pain and heavy bleeding associated with abnormal uterine bleeding took a toll on the emotions of most women. This resulted in bouts of depression, sadness and hopelessness: “I hated my life. I hated blood. Every month you are dealing with that.” The negative effects these symptoms had on other aspects of women’s lives also contributed to their emotional pain. The pain and bleeding disrupted their relationships, and limited their activities. The price of feminine hygiene products and over-the-counter pain medication caused financial difficulties for some.

Despite the negative impacts of the symptoms on participant’s lives, most waited years before seeking treatment for their conditions. Many described the pain, heavy bleeding, emotional effects, and negative impacts as something that had always been, or had gradually become, a part of their everyday lives: “I had endured the worst periods of pain when I was say 11, 12, 13, 14, 16. At the age of 20, 21 and 24 I don’t think the pain I was going through was worse than the pain I had endured in the past.” For this participant, then, the pain had become normal.

Participants eventually reached a point where they decided their menstrual cycles were not normal. For most, this decision was triggered by an increase in the severity of their decisions or a life event that inspired them to take control of their health:

Probably I had been struggling with abnormally heavy periods for quite a while before I actually went to the doctor. I guess just because of things my mom had said growing up, I assumed that was just a normal part of being in the 40 area. And so I probably left it longer than I would have if I could re-do the experience. But I eventually decided that I should mention it to my family doctor.

Others visited their physicians without planning to discuss their menstrual cycles and were informed that their experiences were not normal after the physician elicited information about their menstrual cycles.

Once within the health care system, participants became patients who interacted with health care professionals and selected treatment for their disorders. Selecting a treatment alternative to hysterectomy was a transformative experience for participants who felt required to be good patients and good women:

Because I grew up in an era where you did assume your doctor was an expert. So it was a big deal to make the leap to [physician name] and to get the other procedure done. It was one of those re-defining moments in my life where I realized I have strength and I can tell a doctor no, and I can say I am not doing that, it’s my body. Probably up until then, I had been much more passive about my medical care. And so it was kind of a big turning point . . .

These medical decisions were rooted in participants’ values and identities. Following through on selecting an alternative treatment encouraged participants to more strongly state their identities as strong women.

### **Constructing a Female Illness Identity**

Following their diagnoses, participants were motivated to examine and articulate how their identities as women were connected to their physical bodies, particularly their reproductive organs. Participants approached this task in two different ways. The first group expressed the belief that their bodies and particularly their reproductive organs were an

important part of their identity as women. As one woman described: “I needed to keep all my organs intact to feel like a woman, to feel whole. I just felt something will be missing if I didn’t have all my organs in there.” The second group expressed the belief that their bodies and particularly their reproductive organs did not contribute significantly to their identity as women. One woman from this group described her relationship to her reproductive organs:

If it wound up being a partial hysterectomy where my uterus was removed, I was okay with that. I don’t identify myself as only a uterus. So I mean I know that that has bothered some women in the past. But my mom went through a hysterectomy when I was in grade 7, and it never bothered her. You know, it was never an issue that I am less of a woman because I don’t have my uterus. So I told them that right upfront too. Like you know, I am fine with that . . .

The development and expression of identity as a woman can be shaped by other statuses or roles a woman fulfills. Although there were no such associations expressed by women who saw no connection between their reproductive organs and identity as women, there were for some women who viewed their reproductive organs as important components of their identity as women. Several self-identified groups of women – African Nova Scotian, mothers and feminists – named connections between these statuses and/or roles and a strong connection between their reproductive organs and identity as women.

Although there was only one African Nova Scotian woman who took part in this study, she described a link between her race and her strength as a woman suffering from abnormal uterine bleeding. In comparing her strength to that of the Caucasian researcher, she said: “But I know that we [Black women] are stronger too. I can withstand more pain that you probably could. I don’t know you that well but trust you me, if you went through the fibroid episodes I went through, you would probably had the operation by now.” To this woman, her strength and identity as a woman were inextricably connected to her racial identity. Her strength enabled her to endure pain while searching for alternatives to hysterectomy.

For many participants, being a mother shaped their identities as women and decisions not to have a hysterectomy. For the mothers in this study, having a baby increased the value and meaning of their reproductive organs. Many used this as a reason not to have a hysterectomy. One woman described the difference in her decision-making after the birth of her daughter: “After my daughter was born, my anxieties basically increased for having my organs removed, for having the hysterectomy.”

Although few women who participated in this study identified as feminist, many expressed views regarding the oppression of women in the medical system, in comparison to men. They argued that men would not be encouraged to have their reproductive organs removed for a benign condition:

Because maybe they [women who chose not to have a hysterectomy] have some attachment to their uterus because it’s part of what makes you a woman, that you have a uterus. It’s something men don’t have. And you don’t want to give it up because why should you? Men would be very slow to give up their equivalent body part, I’m sure.

These participants felt that the option of hysterectomy was a reflection of inequality and searched for alternatives that would protect their reproductive organs and not contribute to this form of oppression: “And it also talked about the ridiculous rate of hysterectomies that were unnecessary. And I started to wonder if my issue was an issue that would fall under the category of unnecessary hysterectomy.”



## **Deciding What to Believe and Who to Trust**

Having articulated how their identities as women related to their reproductive organs, participants developed two distinct representations of their reproductive organs and gender identity that shaped their roles as patients. These roles influenced their interactions with their physicians and their interpretation of medical information they read or were told. In this way, they decided what to believe and who to trust based on their embodied identity.

Participants who developed a strong connection between their identities as women and having female reproductive organs became protectors of their reproductive organs. As protectors of their reproductive organs, these participants were more inclined to strongly refuse invasive treatments and ignore information that supported the use of invasive treatments. They decided to believe information that supported their need to retain their reproductive organs, most often information produced by alternative practitioners. One participant described how she perceived her physicians' motivations after reading alternative information:

I am assuming that they work—they get paid, I'm sure, per procedure. And so a gynaecologist is bound to make—I don't know what they would make. I couldn't even give you a ballpark idea but I'm thinking they must make money per procedure. So why would they recommend that you go to a radiologist and have an [alternative] procedure done in [place] that they can do with a hysterectomy in [place] and get rich on my uterus?

Participants who wished to protect their reproductive organs selected physicians that supported this understanding of their bodies and identities. One participant described the reason she trusted her physician as: "I felt that I was not being regarded as stupid. That I wasn't being respected as an intelligent human being who had the right to have feelings about what procedures I want done to my body which I own."

Participants who believed that having female reproductive organs had little or no bearing on their identities as women, insisted that they were more than just their reproductive organs. These participants argued that their identities as women would be maintained no matter what happened to their bodies. In doing this, they became more open to invasive treatments and were less likely to trust information that described the importance of retaining organs. Overall, these women were more likely to trust their physicians and believe information produced from a biomedical perspective: "Well, yes, I guess if I knew there were more things [treatments] out there [I would have considered them]. I guess I am trusting that what I was told [by my physician] is what is out there but maybe there is something that I don't know about."

By selecting the medical information to believe and physicians that would support their decisions, participants played an important role in shaping the treatments that were suggested and selected for them. As will be shown in the following section, this role of the patient in shaping her treatment is not always recognized in medical practice.

## **Informed Treatment Choice: Biomedical**

Participants felt that their feelings and perspectives were often overlooked during their interactions with their physicians. One participant described this approach as overlooking her emotions: "But I really feel like there is some hesitation or just that they [physicians] are not supporting the whole person. That your emotions are not attached to your medical decisions." While another participant felt her life circumstances were overlooked: "So I feel like it's

been—The overall feeling I’ve had at least here is that there is no consideration of what your life situation is for undertaking a major decision like that. “

Biomedical approaches to informed choice may overlook the effects of forces deemed “irrational,” including beliefs, values, emotions and culturally-mediated meanings, on the medical decision-making process. Even if physicians and patients do not explicitly acknowledge the role of these factors in medical decisions, it is clear from this study that these factors have an effect. Whether or not this is recognized, the roles participants developed, as protectors of their reproductive organs or women with or without their reproductive organs, shaped their interactions with physicians and health information.

Participants were aware that expressing emotions to a physician was not an accepted form of interaction. In order to deal with this issue, many censored their interactions with physicians to ensure their preferred treatment choices were selected. They censored the reasons for their choices, but not the preferred choices themselves. One participant describes this process:

And then the second doctor, because he was getting a little closer to sort of wanting to book something, I pulled out the side effects [of hysterectomy] to sort of give him some reasons [not to have the surgery]. But I never really did go to that emotional [reasons] because I thought he would just scoff at that. Yes, I didn’t really feel that he would care.

By ignoring the context in which patient-physician interaction takes place and the actions that precede this interaction, for example patient selection of physicians and interpretation of popular health information, the real reasons behind a patient’s treatment choices may be hidden. This makes it difficult to ensure that requirements for informed choice have been met. Without being aware of the decision-making process of patients, physicians cannot be sure the patient is making a treatment decision that best meets their physical and emotional needs. While addressing the patient’s physical needs is the most important goal for the physician, an alternative treatment that can support this goal and better address the emotional needs of the patient may be the best informed choice.

### **Informed Choice: An Alternative Approach**

In order to ensure requirements for informed choice are being met, physicians must understand and consider the typical rational reasons for or against treatment and the “irrational” reasons that are important to the patient. In doing this, the health care system must incorporate a holistic view of the patient as someone whose body and mind are shaped by illness and treatment. In addition, this holistic view will require that “irrational” beliefs (often attributed to the mind of the patient) are considered in addition to expert physician understandings of the body. One participant expressed the need for knowledge sharing and respect of all knowledges within the patient-physician relationship:

The doctor doesn’t live inside me. I live inside my skin. Why should the doctor control the knowledge that pertains to me? I have to be the controller of that knowledge. While the doctor has the certificates and everything, guess what, he is also as human as I am. They make mistakes just like I do. They cry and bleed just like I do.

Participants saw changes in the interactions between patients and physicians as a necessary step in improving the health care system and truly reaching requirements of informed choice:

I don't know how our medical system is going to go forward if we are not going to be able to have those discussions. You know, if it's 5 minutes in and out you go. Because to me, there's a lot—People might feel better and actually get things done maybe in a little timelier manner. Like myself, I am not going to be talking about it and doing different things. I knew hysterectomy wasn't for me so I just put it off.

An alternative approach to informed choice would require physicians to engage with patients for a longer period of time, probing about the representations and roles that shape a patient's treatment preferences. This challenges current health care reforms in which physicians are spending less and less time with each patient. Although it is beyond the scope of this paper, the role of additional health care providers, for example nurse practitioners could be considered in supplementing the time requirements for a holistic approach to informed choice. One participant suggested that health care counsellors could support patients in their health care decision-making process:

The sort of thing that maybe you should talk to—I don't know if you would say counsellor or something but just talking to another person for a reason that you might not talk about with your doctor about why you would want something like that. You would get a bit more sort of real feedback. The sort of thing your doctor can't really provide you with.

Whether it is a physician, nurse or counsellor who engages with women selecting treatment for abnormal uterine bleeding, it is clear that physical, emotional and practical needs will affect this decision. When all of these needs are recognized, health care professionals will have a clear understanding of the reasons the patient has selected one treatment over another. This awareness may allow health care professionals to confirm that requirements for informed choice are being met.

### **Discussion and Implications**

Researchers have noted that women receive much of their information about menstruation from their mothers and other female relatives (Beausang & Razor, 2000; Stubbs, 2008; Uskul, 2004) and through advertisements for menstrual products (Simes & Berg, 2001). The information women receive often reflects gendered societal beliefs about menstruation and women's roles. Menstruation is often portrayed as a negative, secretive or shameful process that good women should silently endure (Cumming, Cumming, & Kieran, 1991; O'Flynn, 2006; Simes & Berg, 2001). For participants in this study, their understanding of normal menstruation was taken-for-granted until they were diagnosed with a benign menstrual condition.

Elson (2004) argues that most women do not consider the meaning of their reproductive organs in relation to their identity as women until they experience a related illness and must consider possible treatments, particularly hysterectomy. Having undergone a transition through diagnosis and now needing to interact with physicians and make treatment decisions about their reproductive organs, women are offered "a unique experience to contemplate the meaning of their sexual reproductive organs in the context of female identity"

(Elson, 2004, p. 2). For participants in this study, the embodied identities they developed during their decision-making processes connected in many ways to their other identities as mothers, Black women, or feminists.

Patients are increasingly understood as taking an active role in health care interactions as “consumers” who require access to information and support to make informed health care decisions (see for example, Hippard & Peters, 2003; Lupton, 1997). Discussions of how to support patients in making health care decisions tend to focus on how best to present health information (see for example, Hippard & Peters, 2003). This approach overlooks the role of emotions, values, beliefs and culturally-mediated meanings by describing these as “irrational” forces that must be controlled in order to make an informed choice.

Factors deemed “irrational” by this model are already playing an important role in women’s decisions not to have a hysterectomy for abnormal uterine bleeding. These include the representations and roles women have constructed to reflect their identity during a difficult transition to illness. When these factors are hidden by biomedical understandings of informed choice and the physician-patient relationship, they cannot be properly addressed during the treatment selection process. By shifting the approach to informed choice to incorporate a holistic view of the body and knowledge, requirements for informed choice may be more likely to be met.

It is important to note that this small qualitative study had significant limitations. The small, reasonably homogeneous sample size is not representative of or generalizable to the general population. While results of this study could only be used to speak to the importance of a holistic approach to informed choice for women considering hysterectomy in Nova Scotia, it can be presumed that a similar approach may be warranted in other situations of treatment decision-making for gendered illness. Further research in this area could examine this presumption and suggest changes to the informed choice process for women considering diverse treatments for many gendered conditions.

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