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The choice is yours - or is it?

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How do current definitions of choice fit with women's ethics and ways of decision making? Nadine Edwards examines the current rhetoric of 'choice'

The relatively recent focus on choice has been seen on the whole as a positive feature of modern maternity services. There has been an increased emphasis on providing it since the 1990s policies[1,2] reinforced by a recent report.[3] But the assumption that choice has been overlooked in the past and can now be inserted is problematic and sweeps over some difficult issues. To examine some of these issues, I have drawn on various bodies of knowledge, including the women's accounts from my qualitative, prospective study on women's experiences of planning home births.[4] Talking to women who planned home births was an interesting place to examine choice and ethics, because home birth lies outside mainstream obstetric thinking.

At present, many practitioners are doing the best they can to offer information on which choices can be made, and women are doing the best they can to make good choices for themselves and their families. But choice as we know it does not provide an adequate framework for meaningful engagement between practitioners and women. However, if we were to think about choice in terms of ethics, we may find more appropriate ways of engaging.

The current rhetoric of choice fails us in a number of ways: it has been captured by a particular belief system, and it is based on assumptions about people that do not fit with women's accounts of making decisions.

A limited framework limits choice: Different beliefs impact on information, resources and skills

We know that there are, roughly speaking, two ideologies of birth-one based on obstetric ideology and the other rooted in a social/midwifery approach. While these are neither discrete nor mutually exclusive, it seems fair to say that Brigitte Jordan[5,6] and Robbie Davis-Floyd's[7,8] analyses still hold - namely, that the medical model remains dominant ('authoritative') and the social approach subordinate in industrialised countries.

The women in my study recognised that this was indeed the case and that even in the community, their decision-making was restricted both theoretically (in terms of information available) and materially (in

terms of birth practices).

Theoretical restrictions: Information

In terms of information, Jo Green and colleagues[9] suggested that:

"Information is in many ways a pre-requisite for 'external' control since having adequate information forms part of the basis upon which decisions can be made."

But, as Carolyn McLeod and Susan Sherwin[10] comment: "Patients' autonomy is generally reduced to the exercise of 'informed choice' in which the information provided is restricted to that deemed relevant by the healthcare provider (and by the healthcare system, which has determined what information is even available by pursuing certain sorts of research programmes and ignoring others). Even in 'ideal' cases in which patients have strong autonomy skills and full access to all available information, it is important to recognise the influence that oppression may have on the information base and, thereby, on the meaningful options available to patients."

Women experienced the reality of this observation: "I have to know everything about it. It feels that I can't just have the normal knowledge of a normal person to have a baby. I've got to have all the knowledge of all the midwives and all the obstetricians and all the rest of it because they won't advise me according to what they know I want. They will advise me according to their own set of rules and what they want. And that's not unbiased. They didn't give me unbiased information, and allow me to make my own decision. They specifically veered me towards their own outcome."

Material limitations: Practices

In terms of materiality, or having the means to make decisions, Joseph Raz suggests that:

"If having an autonomous life is an ultimate value, then having a sufficient range of acceptable options is of intrinsic value, for it is constitutive of an autonomous life that it is lived in circumstances where acceptable alternatives are present." [11]

But without defined alternatives, women in my study and others found they had little choice. The choice was often between shades of the same:

"I would just dearly love to see that at the point a General Practitioner is obliged, by health policy, to give women impartial, unbiased information on what is possible with childbirth and what options there are. I mean the full medical model, I'm sure, will always suit some women, but it's not easy to find any other choices at the moment."[12]

"You have no choice, you haven't really got any choice. The choice that I made was 'Let's get this finished and over with or do what I have been doing for the past four hours, for another couple of hours. So, okay, let's get this over with'."

Women frequently commented that to put decisions into practice requires both information and positive support:

"Well, to have a choice first of all, and the means to do it. Yeah, just being aware of all your options as well, so you know basically what's best for you."

Women's decision-making cannot easily be supported

Support was crucial, but they could see that midwives were in the difficult position of trying to support their decisions in the context of rule-bound policies and practices. They observed their midwives bending, stretching, even occasionally ignoring policies, but there was a continual tension around how far women's decisions could be supported:

"You know, when I've asked them about this and that, it's 'Oh well, this is how it is'. And I suppose it's that feeling of the midwives actually being very 'by the book' and not sort of free to make their own minds up about things. Although I must admit, most of them did seem quite relaxed, and they're in it because they want to be community midwives and they want to see home births, so I imagine they're going to be doing the best they can for you. I'm sure if I can stay at home, they'll make sure I do. But, on the other hand, I just hear so many people planning home births and going in [to hospital] for what seem like very small reasons and I wonder, you know, how can you sort of get round that"

So women realised that inserting a rhetoric of choice where strongly held beliefs are in operation does not enable decision- making. They realised that they were being offered choices within a limited framework when they sometimes wanted to make decisions outside this framework. And, of course, ideology not only shapes information, but birth practices and structures of care. So it limits choices theoretically by the information it provides and witholds, and materially by the practices it develops and restricts. Decisions across ideologies were difficult to make:

"If there seems to be a problem, I don't want to hold out and have a bloody natural childbirth and a dead baby, or a really unhealthy baby. I'm just really anxious that they'll kind of panic and want to take charge really quickly. And, I don't know... yes, if the baby's in danger, then of course, do anything. But I suppose it's just if I don't know I'm coming from the same value basis as somebody, then I don't know if they're going to be making decisions on the same basis as I would."

When women's decisions challenged policies, often midwives could not engage with or support them proactively. They had to distance themselves and, at best, advise women of their rights-something women found divisive and problematic:

"I did think they stuck very much to their rules very rigidly. I think that's the problem. Do you know what I mean? Like she was, 'Well, unless you tell me to get lost.' But then I thought, well, that's fair enough, but why can't you make a judgement. Why can't you say, 'I think you're okay', you know? They could never do that. It had to be you that had to take the onus. And fair enough. To a certain extent, that's okay, that's

acceptable. I should take the onus. But they could at least sort of encourage you a bit more. I mean if something was wrong, it must be absolutely terrible and everybody must feel bad, but I don't think you're going to prevent that by not doing the best you can. Is that not what it's about, doing the best you can? If you know somebody's quite happy to stay there [at home], then go with it and support them and encourage them to make it as safe as possible."

In other words, the women's understanding about decision- making included a sense of sharing and mutuality that is not part of the current rhetoric of choice. So, while beliefs about birth impact on decision-making, there are other issues about how women make decisions that are rarely discussed in childbirth literature.

Women's accounts about decision-making

Assumptions about people

Typically, decision-making in healthcare and obstetrics is based on a series of assumptions about how people are and how they relate. It is based on narrow philosophical traditions that see people as equal, rational and self-contained, relating through rights.[13] But the women's accounts challenged this view.

Why rights are problematic

Most women were aware that they had rights, but felt uncomfortable about asserting these.

"I found out that I had a legal right [to a home birth], but I didn't really want to invoke that."

"I'm not really very pushy. I don't like to feel I make waves."

"The most important thing to me was to feel supported. From what I could gather, a home birth wasn't going to have much benefit if I wasn't with people who I felt were supportive. And so up till quite recently-what seven-and-a-half months!-I was still just trying to work out if I was going to feel supported enough by the midwives that were offering the service to actually want to go through it."

This is particularly interesting because women who plan home births are considered to be very assertive. But these women were extremely reluctant to appeal to rights if it meant jeopardising their relationships with their midwives. This accords with other findings that women do not usually pursue their desires if people around them are unenthusiastic or hostile.[14] It also ties in with patterns of women's decision-making and relating that other researchers have found. Carol Gilligan,[15] and Mary Belenky and colleagues,[16] for example, found that women's decision-making was located in an ethics of care and relationality, not rights and choices. While there is a great deal of debate about these issues (see references [17] and [18], for example), like choice, rights seem to miss the mark.

Equality has its problems, too

In terms of equality, debates about knowledge and power undermine the assumption that people are equal. But women highlighted the additional problem of maintaining autonomy in the context of the vulnerability of childbearing. The current rhetoric of choice does not acknowledge the coexistence of autonomy and vulnerability, and autonomy's dependency on trust between women and midwives. The observations below are from two women: one who knew and trusted her midwife; the other who booked with a team of midwives constrained by local obstetric policies.

"I worry a little about presuming you won't be compos mentis. I mean, I was myself. There were times when I was elsewhere, but that's another matter. I wasn't another person. I had my sense of humour, I had my faculties and I had my own wishes. I was in a state. But I wasn't in so much of a state that I did not know what I wanted.

"So it worries me a bit that people think that they're going to become some sort of gibbering heap who won't be able to say no."

"I got this worrying feeling that, even if I said beforehand that I didn't want [Syntometrine and vitamin K], at a vulnerable moment they might try to persuade me. And I didn't want to have to deal with that. I wanted my opinions to be respected."

Relationality is too empty

In terms of rationality, the assumption is that ethical decisionmaking rests on our abilities to be rational and objective, and suppress other influences. But women were concerned with the holistic consequences of birth, which involved holistic decision-making:

"My responsibility is to form a relationship. I don't know, it's almost like the birth is a rite of passage in a way, and by the end of it, you've been through it together and you're in a relationship with the baby, you know? It's sort of, the baby is what comes at the end of the the process of giving birth, and I think the more connected I am with the birth, the more connected I am with the baby."

Unless the baby's life was directly under threat, women felt that the effects of childbearing are so profound and impact on so many areas of their lives, that social, emotional, bodily, spiritual, sexual considerations, among others, all have their place in decision-making. These are surely ethical issues that reach down into the very fibres of personhood-not skin-deep preferences. Yet, they are frequently dismissed as 'niceties' in a rhetoric of choice that acknowledges some concerns and mutes others.

Women's autonomy struggles to assert itself in the face of complex, hidden, and powerfully normative assumptions about birth and decision-making.19 It is not surprising then that choice is so problematic.

Of course, choice is not uniformly oppressive, and there are other ways of relating. But, in the main, these remain subordinate. 20 We thus need a robust ethical framework, away from oppressive general rules, absolutes, and pitting the woman's rights against those of her unborn baby: a framework for decision-making that understands that decisions are ethical journeys that join up a person's social context with

their experiential, embodied and intellectual knowledge. But to create an ethical framework in which these different concerns can be acknowledged, we face major challenges.

Redefining decision-making: What needs to be in place for ethical decision-making

Midwifery knowledge and skills

In terms of beliefs, the women identified again and again the need to develop an accepted theoretical alternative to medicalised birth practices with the skills to go with it. Ethical decision-making, choices, even rights cut little ice if the alternative is more of the same. I am not suggesting that midwifery knowledge and skills do not exist, but these are not widely recognised or practised enough to provide a real or consistently safe alternative.

Continuity

In terms of decision-making, women suggested that ethical practices arise from trusting relationships. Autonomy capacities (self-trust, self-esteem and the like) that enable decisionmaking do not develop between strangers, so as far as they were concerned, relationships are the main ingredient of appropriate maternity services rather than the optional extra often described[21]

Women's and midwives' autonomy

But even in the context of relationships, many women have not been encouraged to make decisions nor experienced situations in which their autonomy capacities have been fostered. While practitioners cannot wave a magic wand over women's lives that are affected by poverty, abuse and other difficulties, possibilities remain:

"Healthcare by itself cannot, of course, correct all the evils of oppression. It cannot even cure all of the health-related effects of oppression. If healthcare providers are to respond effectively to the problems, however, they must understand the impact of oppression on relational autonomy and make what efforts they can to increase the autonomy of their patients and clients."10

Work in Birth Centres[22] and other areas[23] confirms that this is possible and desirable. But, of course, midwives are in the same cultural plane as childbearing women. Just as women who challenge attract hostility, midwives who challenge often attract hostility[24,25,25] So, all too often, it is safer for women and midwives to refine their coping and manipulation strategies rather than develop their autonomy skills. Our blaming, rule-bound, risk culture systematically undermines autonomy.

Sensitivity to power differentials

In more general terms, a framework for decision-making needs to be sensitive to people's differences and vulnerabilities. Assumptions that women are equal and can just say 'no' erases the complex ways in which women decide. Women need to know that, whatever happens, their deeply felt concerns will be

protected. So choice does not mean disengaging and leaving decision-making entirely up to women. It is about listening to, engaging and travelling with the woman on her birthing journey.

Finally, in a system of care based on closed beliefs about birth, in the context of assumptions about individuals which de-emphasise relationships, limited choice is the best that can be achieved. If we want to provide real options and encourage decision-making and autonomy, we need to acknowledge diverse beliefs about birth. We need a system of care in which decision-making is acknowledged as an ongoing ethical process that happens through dialogue-between people.

The women in my study poignantly demonstrated the impact of being either unsupported or supported in their decision- making, its potential for lowered or raised self-esteem and its influence on wellbeing.

"I just want to forget about it [birth]. You know it's not a period of my life I look at gladly. I think it's left me with a feeling that I didn't handle the situation very well. I think it's left me with a feeling that I should have really handled the situation better. I should have been stronger. Sort of held out. And, I mean, I know why I didn't, but I just sort of feel I probably made the wrong decision. It was not a good choice I made."

"I find I still get great stuff out of it [home birth]. If I'm down about anything or I maybe have doubts about something I'm doing with [baby], you know? If I have a crisis of confidence, I think back to the birth and it's a very good anchor for me in that way. You know, it makes me believe in my ability to make good choices, and I think it's made a tremendous impact on how I make decisions."

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