AIMS For a better birth...

Improving Our Thinking

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Elselijn Kingma shows us how to change maternity care by changing the way we think about it

Without doubt, our health care system should be geared up to support a wide variety of birth options, ranging from home births to maternal-choice caesareans, and should never restrict or oppose the birthing mother's free choice amongst these, except in the rarest of cases.

This conclusion is not a radical one, and what I am about to say should be neither new nor controversial as it is well-supported by both common sense and academic convention. However, somehow, in debates and decisions about birth options, it is consistently overlooked. It is vital for the health, safety and well-being of mothers and babies that we improve public and professional debates about birth options. We should focus less time debating the evidence, and more time considering the values that play a role in discussions about birth. Those values are at present disconcertedly lop sided, paying attention almost exclusively to the harms done to babies, but not to those done to women. Health care policy should expect to cater for variety, because different decisions are right for different people, even in the face of the very same evidence on safety. When all that is understood, it becomes obvious that the ultimate and only legitimate and authoritative decision maker in birth (except in the most exceptional circumstances) is always, and only, the pregnant woman.

Focus on values, not just on facts

It is a philosophical truism that although knowing facts is important, facts alone can never determine what is the right thing to do. This is because in order to decide upon a course of action, relevant facts need to be combined with and interpreted in the light of values. For example, you could know the survival statistics and side effects of different treatment options, but those facts alone don't tell you what to do. Only once you ask how you value those different benefits, side effects and survival chances, can you identify the right decision about what course of action or treatment, if any, to embark upon.

Despite this important role for values, they often remain hidden. Take the following two examples:

Research shows that home birth raises the risks for the baby therefore women cannot birth at home.

Maternal-choice caesareans are not medically necessary therefore we do not need to provide them.

Each of these claims jumps from a statement of fact to a statement about what to do – which can only be done if there is a hidden value-claim doing interpretative work. In the first claim this may be:*It is impermissible ever to put a baby at risk*. In the second claim it may be: *It is only ever permissible to provide medically necessary interventions.*

Bringing hidden value-claims out in the open is useful for two reasons. First, because it opens up the value-claim to scrutiny. In these examples it is immediately clear that neither simple value-claim can be defended. The claim that it is never permissible to put a baby at risk is untenable. Every action has risks, and the only way not to put a baby at any risk at all is never to create one. The claim that it is only permissible to provide medically necessary interventions is false. We provide nonmedically necessary interventions all the time, such as contraceptive services, and do so for good reasons.

Second, making hidden value-claims apparent improves our reasoning and arguments, and might often change our conclusions. This is not only because scrutiny often forces us to reflect on and revise our values; it is also because making value-claims explicit often reveals that we need further facts, and answers to further questions, before we can reach a conclusion. For example, in the above situation, we might decide that instead of endorsing the claim *it is impermissible ever to put a baby at risk*, we endorse the claim *it is impermissible to put a baby at excessive and unjustifiable risk.* That immediately reveals that we need more information to reach a conclusion about the permissibility of home birth: information on what are the extra risks that accrue to the baby during a home birth, their magnitude, and – most importantly – how they are to be traded off against all other risks and benefits associated with the different options.

In order to reach decent conclusions in the context of birth choices, then, we need explicitly to consider not just the facts that are relevant to our decisions and public debates, but also the values that should frame these.

Straighten out our values in the context of birth

What are the hidden value-claims involved in discussions about birth options? Take, for example, media reporting on the 2011 Place of Birth study.[1] This large and well-designed study compared outcomes for pregnancies classified as low-risk by planned place of birth in the UK. In brief, and focussing only on planned home compared with obstetric-unit births, the study found that planning a hospital rather than a home birth increases the risk of harm for all mothers, and decreases the risk of harm for first-born babies only. For second and subsequent babies, no differences in risk profiles of home and hospital birth were found.

If we take these findings at face value – and there is much to say about how exactly they should be interpreted and represented[2] – then what is striking is that nearly all news sources focussed the vast majority of their attention and emphasis on the increased risks that home poses for first babies. The message that for other babies, the options were equal, and that for mothers, hospitals universally posed a

much higher risk of harm, was much less prominently displayed in the articles, and sometimes not mentioned at all.

This reporting is particularly interesting given the current state of the UK birth system where fewer than 3% of women give birth at home and there is a widespread perception that hospitals are both the safest and 'normal' option. In that context, surely the newsworthy message is that hospitals are in fact less safe than home (or midwifery units) for women, and only marginally safer for first-born babies, not for their younger siblings.

What does this way of reporting tell us about the hidden value-system within which research findings are reported? Crudely put, it reveals the hidden value-claim: *Harms to babies are of far greater concern than harms to mothers.* Or even more worryingly: *Only harms to babies matter – harms to mothers do not.*

That might seem an overstatement – but it is scarcely so. Only the value-claim *Harms to babies are of far greater concern than harms to mothers* allows one to think that increased risks to babies are worth reporting and emphasising in great detail, but that a no-difference in risk for babies in combination with an increased risk for mothers is not. Only the value-claim *Harms to mothers are irrelevant* allows one to think that one could ever say anything useful about birth services or a choice of place of birth on the basis of outcomes for babies alone, without needing to investigate or mention the risks to women.

As another example, take the Royal College of Obstetricians and Gynaecologists' (RCOG) official statement on the Brocklehurst study.[3] Risks for babies are reported in great detail, appropriately stratified to birth order, with mention of the absolute risks. Risks to mothers are severely underreported, and in a very unbalanced way; transfer-rates are elaborated in great detail, stratified to birth-order, whereas the only statement about interventions is: *lower intervention rates were reported in both types of midwifery units.*' No mention of home births with respect to interventions. The RCOG too, it seems, harbours the hidden value-claim *Harms to babies are far more important than harms to mothers.*

This impression is confirmed by the subsequent statement: *The RCOG has always supported appropriately selected home birth but this study has shown that first-time mothers wishing to deliver at home have an increased risk of poor outcomes for their babies thus raising questions about the right birth location for this group of women.* Harms to women do not seem to even enter into the RCOG's reasoning process. The hidden value-claim is quite clear : *Only outcomes to babies matter in decision-making.* The statement on mums having subsequent babies is even more telling: *The case is different for mothers with no complications in their subsequent pregnancies delivering at home or in a midwifery unit. There is therefore a need to expand these facilities with appropriate midwifery staffing to improve women's choices.* Now if harms to women were taken to matter, there would be a need to expand home birth and midwifery-led facilities to improve women's safety. It is only if baby safety is considered important, but mother safety is not, that one can arrive at the above combination of statements.

Though my analysis may sound damning, it should not make us think our newspapers and the RCOG actually endorse the idea that harms to women don't matter. The whole point of making hidden value-

claims explicit is to open them up to scrutiny and reflection, which often instantly reveals them to be either unsupportable or at least unsupported by us – prompting revision. Note that in this case we have no choice but to reject the value-claim that only harms to babies matter, but harms to mothers do not; not to do so would directly contravene equality under the law, and human rights legislation, which demands that we value all citizens and their well-being equally.

Revealing and revising the hidden value-claims in birth discussions completely changes the nature of the debate and the types of facts we should be taking into account: any pronouncement must not only focus on harms to babies, but also consider harms to mothers. If that is done, a completely different picture emerges from the one we have been fed so far. It becomes, for example, quite clear that the 'simple' – though revolutionary – message of the Place of Birth study is that home birth is the safest option for second to fourth-time low-risk births. Full stop. And that the 'difficult message' of this study is about safety in first-time births. In first-time births, safety pulls in different directions for the two people involved. Therefore what should be considered the overall 'safest' or 'recommended' option is a difficult question that depends on how exactly infrequent harms in babies, only some of which are very severe, are to be traded against much more frequent – but on the whole, less severe – harms to mothers.

This is quite a different message from the one the newspapers or the RCOG gave us – but one they have no choice but to endorse once they bring their hidden value-claims into the open and reflect on them.

Expect to cater for birth choice

Examining what the overall and on average safest birth option is, is one thing. Determining what options should be offered is quite another.

The basic point is very simple: people differ in their preferences. This means that very different things are good for different people. Suppose I love visual art and hate sitting still, whereas you love classical music. It seems obvious that when we both have an afternoon off, yours is best spent going to a classical concert and mine best spent going to an exhibition. It is not just preferences that are relevant; circumstances are too. If both of us equally like classical music, but you have time and money whereas I do not, then, again, different choices are the right ones for us.

Differences in preferences and circumstances materially affect whether choices are good or bad for people. Something that all else being equal would be the 'best' option, may in practice be good for some people and not for others, because in practice all else is never equal. This has important consequences for policy. Policies, particularly in medicine, should not just aim to provide what seems best all else being equal. Instead they should aim to provide what is the right thing in practice or actually the right thing for as many people as can be reasonably and feasibly accommodated. This invariably means providing for variety.

Does that point apply to birth choices? Without a doubt. Take preferences. Some people have a preference for pain relief which gives them a reason to birth in hospital that someone less keen on pain

relief lacks. What holds for preferences holds for circumstances. Whether you live five minutes from hospital or on a remote island without a hospital affects how bad an emergency transport would be; whether you expect to have five more children or swear this is your last; or whether you have a large support network or are a single parent with three dependent children, very much affects just how bad a caesarean section would be for you.

Also worth emphasising is that some people – in fact a very considerable percentage of people giving birth – have histories of abuse and violation. I cannot possibly pronounce on what things may be like for them – and undoubtedly they are all different – but I have no doubt that this materially affects how good or bad different options are for them.

Data on what is the case 'on average and all else being equal' is extremely useful and important. However, to determine what is right in individual cases requires that big and legitimate additional considerations are taken into account – and these will result in different decisions for different people.

This means that our birth system should expect to accommodate these different decisions. Even if home birth is safer all round for 'low-risk' pregnancies, we should expect there to be a subgroup of people for whom hospital may be the better option, for example, because they desire narcotic or epidural pain relief, have no safe home environment, or live very far from hospital. Our health-care system has to be able to accommodate these people. Similarly, in a group of women for whom hospital birth is, on average, safer all round, we should expect there to be individuals for whom home is the better option. Again, we need to be able to accommodate them.

Because our health-care services should aim to provide the best option for as many people as reasonable, feasible and worth the cost, they should provide more options and accommodate more choices than just those that are considered safest on average and all else being equal.

This means that we do not need more data to know what birth services to provide. Indeed we need far less than we already have. What we need instead is the realisation that people differ – and with that, what choices are right for them.

Always let the mother decide

It may be obvious, medically, what the 'best' option in a particular set of circumstances is. It is quite another question who, in the end, gets to decide what happens. That, except in the most exceptional cases, should always and only be the mother.

Here is why: the reason that we are entitled to decide about medical interventions to our own bodies is that they are our bodies. For someone else to decide what happens to our bodies, and enforce that decision against our consent, is to commit a grave violation that directly contravenes our basic human rights.

It is quite clear that in the case of birth almost all attempts to impose a health-care decision on a woman

against her will would involve such a violation. Forcing her to go to or stay in hospital restricts her freedom in a way that we ordinarily, and only reluctantly, reserve for criminals or the dangerously mentally ill. Practically any birth-related procedure – including something as basic as a vaginal exam or an episiotomy – effectively amounts to battery and/or indecent assault (or, in lay terms, rape) if done against the woman's consent.

Because of this, a pregnant woman's choices about her birth should always be respected. And – crucially – that does not just mean choices that are considered acceptable by those offering them. With the right to decide what we do with our body comes the right to make bad, stupid and even downright immoral decisions.

But, one may wonder, surely the mother's right to decide about who and what gets to interfere with her body is somehow limited – for example by the fetus's right to life or right not to be harmed. The simple answer is no, it is not. Suppose I need a donation of your bonemarrow, or even just a few drops of your blood, to survive. In our current legal and moral system, everyone recognises that it is within your right to deny me that lifesaving bone marrow or blood, and that no one can forcibly and physically interfere with you to obtain it. Even if your decision is immoral. Even if it costs me my life. That is how much we respect bodily autonomy.

It is deeply disconcerting that there are so many people who think nothing of curtailing or overriding a pregnant woman's right to decide what happens to her body, or of cutting her open in order to have a small chance of saving her fetus, but who would not dream of curtailing or overriding a potential bone-marrow donor's right to decide what happens to their body, or cut open a random patient in the hospital to have a large, let alone a small, chance of saving another one of their patients.

Pregnancy does not disqualify a person from citizenship. So as long as other UK citizens cannot legally be forced to donate life-saving organs or tissue after they have died, let alone during their life time, no pregnant citizen should be forced, legally or physically, to undergo interventions to save another – let alone to avert a small risk of harm to another. To treat only pregnant citizens' bodily autonomy and physical freedom as up for grabs, but not anyone else's, is a severe form of discrimination. Having said that, let me briefly reinsert a few complications. First, maybe our legal and moral frameworks are wrong, and people's bodily autonomy should be overridden in cases where the costs are low and the benefits high. Savulescu calls this the 'duty of easy rescue'.[4] That may well be right – but if so, we should not start by restricting birth choices. The cost of interventions incurred by women in birth is relatively high compared to the benefits they confer; tens if not hundreds of interventions to save one life. By contrast, bone marrow donation, blood donation, post-mortem organ donation and perhaps even participation in medical research will save far more lives for far fewer and less severe interventions. Thus even if bodily autonomy can be overridden in the interest of another person, birthing women's choices should be respected until we have started changing our laws in those other domains. Second, there are rare cases where pregnant women lack the ability to decide, for either physical or mental reasons. Like anywhere else in medicine, these should be handled carefully, sensitively, and with due concern for the interests of

the incapacitated person.

Third, we should not confuse the right to decide with the duty to do so. Of course a pregnant woman may prefer to let someone else make her decisions for her : a trusted health-care provider, a partner, or someone else. However, she retains the right to take that decision power back at any time.

Fourth, a right to decide about medical care is not limitless; it does not mean that one can excessively overask the health-care system. However, it does always involve the right to refuse interventions, and, I would be inclined to think, the right to choose freely amongst the full range of treatment options that are normally, reasonably and cost-effectively provided. The concept of over-asking is raised as an argument as to why people should not demand planned caesareans or the one-to-one care required for home births. I think that whilst in principle that is a fair argument, it does not actually hold up. Caesareans are not vastly more expensive than other forms of birth care, and home births are actually cheaper[1,5] so it becomes difficult to construe either as a case of over-asking.

Conclusion

It is vital that we should examine the hidden valueclaims that play a role in our arguments. These valueclaims are at present dangerously lopsided, valuing babies almost at the complete expense of their mothers. They need to be replaced by a value-system in which harms to mothers and babies are both given due consideration. In addition, health-care services should expect to provide a wide range of options, because people differ in preferences and circumstances, meaning that different options are right for individuals, even in the face of unified average safety data. The final decision on birth options is the mother's, and cannot be opposed except in the most exceptional circumstances.

What, in practice, does this mean for our birth system? It seems to me, first, that the UK should offer a range of birth options ranging all the way from obstetrician-led birth, including maternal-choice planned caesareans and pain relief – where costs allows – to midwifery-led, in hospital, out of hospital and home birth care, with a choice of who provides that care and with good obstetric back up and swift, integrated referral systems in place. Why? Because each of these options offers different risk, safety and benefit profiles, which are reasonable choices for at least a substantial subgroup of women. Women should – with only few exceptions – be entitled to choose freely between these services, even when their choice seems unreasonable or immoral to service providers. Of course birth providers are free to express concerns and lay out reasons when they fear a dangerous choice is being made. In fact, they probably should do so. But they cannot coerce, pressure, emotionally blackmail or misinform. Nor can they withhold basic forms of care that range within the normal. It serves everyone always to remember that each of us is fallible – not just pregnant mothers.

Is this radical? It really ought not to be, but it is by the standards and tone of current debates and practices. Those practices, and the value-systems and assumptions that underlie them, need urgent, critical and humble reflection and re-examination.

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