Clinics in Mother and Child Health
ISSN: 2090-7214

Burrow, Clinics Mother Child Health 2016, 13:1
DOI: 10.4172/2090-7214.1000230

Short Communication Open Access

Labour, Birth and Autonomy

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Received date: January 28, 2016; **Accepted date:** February 25, 2016; **Published date:** March 17, 2016

Introduction

Several crucial bioethical concerns arise regarding physician approaches to caesarean sections in light of their increasingly high numbers. I have argued [1,2] that current obstetrical practices advocate active labour management and thus encourage or even demand the use of technology to manage labour and birth. Social pressures increase women's perceived need to use reproductive technologies and hence decrease risk tolerance, thereby encouraging dependence on technology for reassurance. Such pressures interfere with the ability to form and act on choices. Both social and physician pressures amount to a technological imperative that presses women to use technology to manage labour and birth. Below, I review my arguments showing that this technological imperative undermines women's capacity to choose an elective caesarean or to avoid an emergency caesarean and then point to my recommendations for health care providers.

Physician Preferences

Physician pressures are separate from physician intentions. While no one physician may intend to produce pressures on patients, I suggest that physician preferences for active labour management are linked to preferences for use of technology, even for low-risk birthing women, for two main reasons.

First, physicians are inclined to weigh interests in favour of the fetus greater than birthing women's interests. In cases of clinical uncertainty, physicians are inclined to regard duties to the fetus to outweigh duties to the birthing woman. In obstetrics, the interests of fetus are commonly regarded as separate from maternal interests. Viewing fetal interest separate from maternal interest is implicit to technology used to image, test, and treat the fetus. These forms of technology encourage a view of the pregnant woman as a "fetal container" or "uterine environment." These models devalue women and their interests, or at the very least place women's interests secondary to fetal interests. Confronted with clinical uncertainty, obstetricians are likely to favour caesarean delivery as a means of protecting fetal interests. Doing so devalues women's capacity to choose what is best for their own bodies and what is best for their own fetuses.

Second, "doing nothing" is a common obstetrical view of allowing women to birth naturally. On this view, failing to employ technological management of birth risks a failure to uphold a due standard of care. The concern is that the physician must prove that not pursuing medical options (epidural, episiotomy, caesarean, and so forth) shows no negligence. The possibility of failing to uphold a standard of due care may easily press physicians towards "defensive medicine." Defensive medicine in this case amounts to erring on the side of caution to avoid liability. In the case of birthing women, erring on the side of caution amounts to employing medical interventions as opposed to watching and waiting. It is well acknowledged in the literature that defensive medicine is a key cause of caesarean sections [3]. Physicians are at greater risk for complaint and litigation for failing to perform a caesarean than performing an unnecessary caesarean [4]. Physician preferences for defensive medicine are liable to pressure even low-risk birthing women towards caesareans or interventions commonly leading to caesareans. Such pressures interfere or undermine women's autonomy.

Social Pressures

Social and cultural pressures combine to exert patients to avail of any and all forms of medical technology that might seem to advance their health care. Labour and delivery is no different. In this context, patients may fear refusing use of technology or rely on technology for reassurance to promote the best health care for themselves and their fetuses. However, a technological imperative may interfere with best health care practices. Women's ability to avoid caesareans is instructive here. A caesarean is not necessarily the best health care option for delivery. These procedures come with severe risks to both women and their babies. Overall, caesareans are linked to maternal morbidity and mortality, increase in fetal morality rates, and increased numbers of babies admitted to intensive care units [5]. For women choosing an elective caesarean prior to trial of labour, the statistics show that they are twice as likely to die as women birthing vaginally [6]. Yet a technological imperative can make it difficult of women to refuse technology during labour and birth.

Women are in a vulnerable position during labour and birth. This vulnerability accentuates women's perceived risk of refusing technology. Women's perceived risk is compounded by health care providers' attitudes that use of technology provides patient reassurance. Prenatal screening is illustrative here. This screening typically consists of maternal serum screening to detect neural tube defects; chorionic villus sampling to identify genetic predispositions such as Trisomy 18; and nuchal translucency screening to identify Down's syndrome. These forms of prenatal screening were offered in the past only to high-risk birthing women. Now they are routinely offered as part of "prenatal care," at least on the Western model of obstetrical care. Such practices introduce early in pregnancy the notion that technology is needed to ensure a "healthy birth" or to "avoid disaster." A need for use of technology to provide reassurance is introduced early on and reinforced throughout pregnancy until birth. But the choice to birth vaginally is compromised during trial of labour because use of options such as continuous fetal monitoring, pitocin drips, and epidurals increase the likelihood of stalling during labour. Not to turn to technology to manage birth is seen as irresponsible or irrational, as an unnecessary risk for women and their fetuses. Yet once labour stalls, pressure to have an emergency caesarean mounts dramatically and may become unavoidable.

Best Practices Recommendations

Physicians lie at great risk of unknowingly pressuring women toward caesareans and thus not recognizing their contributory role in producing ever increasing number of caesareans. To counter physician reinforcement of social and cultural pressures, I close with the following recommendations.

First, before offering technological options, physicians must rely on the empirical evidence that use of technology during labour or birth is positively warranted in any particular case. It is not enough to suppose that common use justifies recommendation in any one case. Physician responsibility here includes counselling patients of empirically justified risks of declining use of technology in any one instance. Second, physicians are responsible to detect and counsel women whose reasons to pursue technology during labour and birth reveal unwarranted risk aversion. Fear of vaginal labour, for example, is not a reliable indicator that an elective cesarean meets the best interests of women and their fetuses. Third, physicians have an overarching obligation to recognize their own preferences for caesareans. Recognizing influences can be as simple as recognizing that higher malpractice premiums have been associated with increased primary caesareans and reduced VBAC; that planning "emergency" caesareans on Fridays reduces the likelihood of weekend calls; that many common uses of technology render caesareans more likely; or that relying on established practices may simply reflect outdated beliefs (such as the belief that vaginal birth following caesarean is unsafe). Fourth, physician obligations importantly include the recognition that one's actions are often a better indicator of one's preferences than one's own beliefs about one's preferences. Both physician and institutional percentages of cesareans performed are instructive here.

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