Choice, Autonomy, and Childbirth Education

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ABSTRACT

In this column, a reader challenges the idea that choice in childbirth is a myth. The ways in which women's choices in childbirth are undermined are explored. The relationship between choice, autonomy, and decision-making is discussed. Autonomy is considered as a foundation for decision-making and an important way to make birth safer for mothers and babies. Strategies for increasing autonomy within the framework of childbirth education are presented.

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READER'S QUESTION

I was disturbed to read your thoughts on women's choice in *Pushed: The Painful Truth About Childbirth and Modern Maternity Care* (Block, 2007). You are quoted as making the following claim:

"It's an illusion. No matter what anybody tells you in prenatal classes, or what your friends say, or what you read in books, the bottom line is, you will follow the rules of the hospital, and you will do what your doctor wants you to do. No matter what you think going into it. Sometimes I say choices are very limited, but in point of fact, I don't think women have any choices." (p. 166)

You suggest that childbirth education and birth planning are a façade and that we do women a disservice when we give women the impression that they have real choices. Is this what you really think? What can we do?

COLUMNIST'S REPLY

Block (2007) did indeed quote me accurately. It is a disturbing reality that our maternity care system offers little or no choice and, just as importantly, severely restricts women's autonomy. We have always touted the hallmark of informed decision-making as having full information, but the process of making decisions, even when choices are available, is more complex than that. Although childbirth educators and nurses have always understood that we play an important role in helping women sort out information and figure out what might work best for them, it is unclear what actually happens in that process. I had never thought about the essential role that autonomy plays in the process of informed decision-making. Nadine Pilley Edwards' (2005) research, *Birthing Autonomy: Women's Experiences of Planning Home Births*, forced me to think more deeply about these issues and about two more that are intimately intertwined with choice, autonomy, and decision-making: the influence of trusting relationships and safety concerns. Here is what I learned.

Choice

Informed choice is not a level playing field on which women can state their wishes and, if necessary, have recourse to rights to enforce these wishes (Edwards, 2000, 2005; Walsh, 2007). Choices are limited first and foremost by physicians and hospitals. Typical examples are restrictions on the number of people women may have with them during labor; restrictions on eating, drinking, and walking; and the unavailability of birth balls, showers, and tubs on labor units. Other constraints may restrict women's access to choices that are available. For instance, women's choice of care provider and place of birth are determined by insurance coverage, geographical distance from alternatives to the traditional hospital, and the availability of midwives, birthing centers, or home birth. Choice is further limited by the withholding of information or providing information to women that is consistent with restrictive hospital rules and obstetricians' protocols rather than with evidence-based information.

Levy's (1999) research describes how the framing of information shapes choice profoundly. She describes "gently steering" to capture the dynamic of how midwives coax women to choices that the midwife is comfortable with. Subtle blackmail is another strategy used to influence choice. In response to a woman's question, "What would you do?", the provider (or childbirth educator) answers, "If it were me (or if you were my wife), I would do. . . ." Women are coerced, steered, or manipulated to choose what others want and expect them to choose (DeVries, Benoit, van Teijlingen, & Wrede, 2001; Green, Coupland, & Kitzinger, 1998; Kirkham, 2004; Levy, 1999). Smythe's (1998) research identifies the following:

No choice is a free choice when others have feelings, beliefs and values about the choice that is made. The choice becomes much more than "will I do this or that?" It is about "will doing this bring other consequences with it, will it harm a relationship, will it offend, will it create barriers to ongoing help?" (p. 232)

The safety issue underlies and powerfully influences women's choices and decision-making. In the

current system, the experts hold the keys to safety and ultimately to choice. Obstetrics holds sway over and dictates "safety," both determining what it is and dictating how to insure it. Despite the lip service we pay to choice, there is still an assumption that obstetrics knows best and that, if women have the "right" information, they will make the "right" choices. If the right choices are explained well enough, women will listen to the experts' advice. It is extremely difficult—even for knowledgeable, assertive women—to resist obstetric coercion, as Edwards (2005) reports in her study of Scottish women who planned home birth.

In the current maternity care environment, choice is a myth. That being the case, our focus on choice just might be missing the more important point. Edwards (2005) believes that "the rhetoric of choice has been grafted onto the restrictions on autonomy" (p. 88). We need to step back, as Edwards' research findings suggest, and focus on autonomy and the relationships of autonomy and choice and decision-making. Without choice there is no autonomy, and without autonomy there can be no informed decision-making.

Autonomy

Autonomy is the major theme that emerged from Edwards' (2005) interviews with Scottish women planning home births. Edwards interviewed 30 women four times over the course of their pregnancy and 6–8 months after the birth of their baby. Their stories conveyed the struggle for choice, for control, and for autonomy. In order for each woman to be truly autonomous, she needed to be respected, valued, and honored for the authoritative knowledge that she possessed: knowledge of her body, her values and beliefs, what is important to her. Edwards (2005) describes this as "embodied knowledge," and it reflects what the Lamaze International (2007) Philosophy of Birth describes as women's "inner wisdom." Autonomy is necessary in order to tap into personal and authoritative knowledge, to develop confidence, and to make decisions. Otherwise, women are manipulated and swayed, and they give up control. Autonomy transfers power from the expert to the woman, but this does not happen if women are not respected, valued, and honored for their knowledge.

Autonomy has another essential aspect. Edwards (2005) explains weaving safety from autonomy and describes "women's embodied knowledge as an unacknowledged source of safety" (p. 140). Safety

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defined and managed by medicine is quite different from how women define and create safety in their own lives. Medicine defines safety in narrow clinical terms, deciding as experts what constitutes acceptable risk. Kirkham (2000) points out that “such decisions often involve the perceived safety-security of the health professional rather than that of the mother” (p. 242). The women in Edwards’ (2005) study drew on experiential, intuitive, and bodily knowledge, but they tended not to share it with professionals because they sensed that it would not be perceived as legitimate. The women wanted opportunities to share and discuss their knowledge rather than have it be discounted or ignored. Over and over, the women said they felt they would know best if something was wrong because they know their bodies best. The women also expressed the belief that being relaxed and comfortable, remaining confident and positive, and being able to trust those around them (not blindly, but trust that developed from getting to know and respect each other) would reduce risk and increase safety. Devaluing women’s knowledge was identified as a major obstacle to safe birth. Edwards’ (2005) research suggests that

women negotiate safety for themselves, their babies and their families through ethical decision-making that unfolds best in the context of trusting relationships with those who can engage with them and focus on what really matters to them. Enabling autonomy through the facelessness and technocratization of our maternity services is impossible. (p. 255)

Childbirth educator Kathy McGrath has always believed that the women in her childbirth classes develop confidence in themselves because of the trusting relationships that develop with her and the other women in her classes. I remember the early days of formal childbirth education: small, intimate groups, in the community with limited amount of “content” but plenty of time for sharing knowledge and concerns with each other. The trust that McGrath describes and I remember developed out of the respect childbirth educators and women had for each other. Women shared their concerns and knowledge of themselves, including their dreams and wishes, with the childbirth educator, not the obstetrician. Edwards (2000) discovered that, within the context of the trusting relationship (with the midwife), women are free to become the expert in their pregnancy and birth, which reduces

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risk and increases safety and becomes the foundation for decision-making.

Childbirth Education

Credible evidence demonstrates that choice is so limited that it is probably a myth. Additionally, increasing evidence suggests that autonomy plays an important role in maximizing safety and in decision-making, and that autonomy develops within the context of trusting relationships. What does this mean for childbirth education?

First, we need to value and respect in more straightforward ways women’s inherent ability to give birth and their authoritative knowledge (inner wisdom). The most important goal of childbirth education—indeed, of every encounter with women—is to inspire confidence. Not confidence in science or medicine, but confidence in women’s knowledge and ability. We need to trust women, not just birth. We need to have a deeper appreciation of the impossibility of making decisions when one has been stripped of all confidence in a maternity care system that insists it holds the key to safety for women and their babies.

Second, we need to applaud women’s knowledge and carefully “pull it out” by questioning them, listening to them, and creating learning environments where women share what they know and can learn from each other, not the experts. Our belief in a woman’s inherent ability to be her own and her baby’s expert should underpin all our interactions (Leap, 2000).

Third, we need to make sure that women know they hold the keys to safety for themselves and their babies. What they know, what they feel, and what they wish for are all important in reducing risk

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To view Lamaze International’s Philosophy of Birth, visit the Lamaze Web site (www.lamaze.org), click on the “About Lamaze” link, and choose “Mission and Vision.”

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In the Spring 2007 issue of the Journal of Perinatal Education (Vol. 16, No. 2), Kathy McGrath’s excellent guest editorial, “Finding the Path,” offers recommendations for assisting women to meet the challenges of labor and birth. McGrath’s editorial is available at the journal’s online site (<http://www.ingentaconnect.com/content/lamaze/jpe>). Lamaze International members can access the site and download a free copy of McGrath’s article (and all other journal articles) by logging in to the “Members Only” link on the Lamaze Web site (www.lamaze.org).

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and increasing safety. Their confidence, their knowledge of their bodies, and their feelings are vital.

Fourth, we need to focus on developing trusting relationships with the women in our classes. Our relationships are the context for women's autonomy, confidence, and trust. Could these elements be what ultimately changes the culture of maternity care?

How do we do this? Charlotte and Raymond De Vries (2007) present alternatives to the traditional childbirth classes. If our goal is to increase autonomy and confidence, there needs to be time to build relationships. Class should take place throughout pregnancy. Leap (2000) suggests forming "groups" instead of "classes." She describes a model in which groups meet weekly and women can attend regularly from the beginning of pregnancy. The childbirth educator facilitates the group and, instead of following a set agenda, asks questions and encourages women to share their knowledge and concerns. At every session, at least one woman returns to share her birth story. I see strong, trusting relationships developing over time and confidence being inspired by trusting the expertise of each woman.

We also need to advocate for more choice. To do that, we need to be more autonomous ourselves. What do we need to do to be more confident, more skilled, more independent, and more assertive? As childbirth educators and midwives become confident and able to inspire women to feel deep confidence in their knowledge and their ability to give birth and insure safety for themselves and their babies, is it possible that women and childbirth educators will raise a united and strong voice for real choice?

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Charlotte and Raymond De Vries' article, "Childbirth Education in the 21st Century: An Immodest Proposal," was published in the Fall 2007 issue of the *Journal of Perinatal Education* (Vol. 16, No. 4) and is available at the journal's online site (<http://www.ingentaconnect.com/content/lamaze/jpe>).