Article

# High Risk Birth at Home – Why Don't Midwives Just Say No?

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## Introduction

I recently received a letter from an obstetrician who asked me what a midwife should do when faced with a woman who, despite significant obstetric risk factors, wants to birth at home against medical and midwifery advice. It was not a new question, but this obstetrician was unique in my experience, in that he would not automatically condemn the midwife as reckless if she opted to continue to provide care for that family. This was a welcome change from the usual obstetric demand in these rare cases, that midwives should abandon such women, in the hope that they will then be forced to come into hospital. This latter response always appears premised on two assumptions:

1. The midwife is acting irresponsibly or recklessly and endangering the life of the mother and baby by continuing to provide care at home and should not do so; and
2. The woman and her family are acting irrationally, irresponsibly and recklessly, endangering the woman and their baby by not going into hospital and submitting to the care of an obstetric team or specialist.

In my experience the situation is rarely that simple and such decisions are not made with reckless disregard for the wellbeing of either mother or baby. What does arise when a family acts against advice is an ethical dilemma for the midwife who, whilst understanding that significant risk factors are present, needs to determine what her ongoing involvement should be. In such a situation the midwife's options are either to withdraw from providing care for that family or continue in the midwifery partnership in the face of considerable disapproval and probable sanction should anything go wrong.

This article will consider the midwife as a maternal/foetal advocate, the wider context of such family decision making when there is a high risk pregnancy, and will attempt to determine if legal or ethical considerations are of assistance to practitioners who are faced with such scenarios.

## The Midwife as Maternal / Foetal Advocate

The changes in the New Zealand maternity system and the growing numbers of women choosing home birth and opting for midwifery caregivers, suggest that situations of maternal/medical/midwifery conflict will become more common. It is likely that there will be increasing debate on the morality of the decision making of women and their families who do not agree with medical or midwifery assessment of risk or who choose not to act on professional advice. The practitioners who opt to provide care for such families may find themselves in an ethical dilemma as they wrestle with their responsibilities to the woman, her family and their unborn child.

The midwifery profession works in partnership with women and accepts the woman's right to make informed decisions about her pregnancy, her birthing experience and her place of birth.[1] Increasing numbers of women and families chose to birth at home. Despite the very safe history of homebirth in New Zealand, it is not an option that is widely supported by either the obstetric or paediatric fraternities, who see women as unnecessarily removing themselves and their babies from the 'safety' sphere of the hospital. Midwives are seen as encouraging that move. The criticism of families choosing home birth ranges from mild unease to an outright moral condemnation and exclamations that such women are more interested in their own experience than their child's wellbeing.[2]

All midwives see themselves as advocates for the baby as well as the mother and they are trained to detect deviation from normal pregnancy. They also have a professional obligation to recommend and attempt to arrange referral to a specialist if significant risk factors develop or if pregnancy or birth becomes abnormal.[3] The midwife has legal and ethical obligations, as does any doctor involved, to conform to the doctrine of informed consent and to ensure that the family understands the ramifications of any risks and benefits associated with their choices. Midwives view an expectant mother as part of a family and recognise that decision making about pregnancy and birth is reflective of that family unit and not solely the view of the woman. Decision making is seen as a process which occurs within a cultural, social, religious, economic and psychological framework which might be quite different from that of the midwife. Despite these differences midwives trust parents as wanting the best outcomes for both themselves and their baby.

In the vast majority of cases women will heed the advice of their midwife and accept any consultation or intervention that the midwife considers to be warranted. Occasionally a woman may not agree with that recommendation and may instead stand on her legal rights and the principle of autonomy, or decide as a result of strongly and sincerely held values, experience or knowledge that she does not want to follow the midwife's or doctor's advice. Let us then first consider the legal position of a woman who, despite significant risk factors, refuses to accede to midwifery or medical referral, recommendations or intervention and consider whether the law provides any guidance to the practitioner.

## Choices Against Advice and Resultant Dilemmas

### *a) The Law and Human Rights*

The various Accident Compensation statutes have hindered the development of New Zealand common law in the area of maternal and foetal rights. Statute law has been more definitive and Parliament has enacted two statutes in particular which evidence a strong intention to give effect to con-

sumer rights. These statutes provide a strong legal foundation upon which a person can refuse medical intervention or treatment. In the *Health and Disability Commissioner's Act 1994* and its *Code of Health and Disability Services Consumers Rights*, rights to privacy, freedom from discrimination, coercion, rights to services provided in a manner which minimises harm to *that* consumer, rights to services consistent with a person's needs, rights of informed choice and consent and the right to express a preference as to who provides health care, are all expressly provided for in the Code.

*The New Zealand Bill of Rights Act 1990* also has a human rights focus and it expressly affirms the right to refuse medical treatment, the right to freedom of thought, conscience, religion and belief, including the right to adopt and hold an opinion without interference.[4]

In Britain there is considerable statute and common law which suggests that any rights a foetus might have are subject to the rights of his or her mother.[5] This view was upheld in a recent English Court of Appeal decision *St George's Healthcare NHS Trust v S.*[6] where the Court emphasised that a competent pregnant woman has the right to refuse medical intervention even when her foetus needs medical assistance. The Royal College of Obstetricians and Gynaecologists also considered the legal and ethical position of women *vis à vis* their foetuses and concluded that:

> it is inappropriate and unlikely to be helpful or necessary to invoke judicial intervention to overrule an informed and competent woman's refusal of a proposed medical treatment, even though her refusal might place her life and that of her foetus at risk.[7]

In the American jurisdiction a review of the reported cases dealing with forced maternal treatment before the American Supreme Court decision of *In Re: AC*, reveals neither a consistent pattern of judicial decision making nor clear precedent.[8] In the appeal in *In Re: AC* the Court had had more time to give a considered, researched response to the issue of conflicting rights and although it did not formally address the question of how to decide cases where a competent woman refuses treatment for her foetus, it did say in dictum:

> We conclude that if a patient is competent and has made an informed decision regarding the course of her medical treatment, that decision will control in virtually all cases.[9]

The phrase 'in virtually all cases' leaves open the potential for an exceptional case to be decided in a different way.

We can see by the above statutes and case law that there is *prima facie* legal precedent and support for a woman to refuse treatment for herself or her foetus even in the face of risk factors, to make decisions against midwifery and medical advice and to refuse intervention. The existence of this legal support does not assist a midwife who might have a genuine concern about the woman's decision or who is trying to determine whether she should remain involved in providing midwifery care. The midwife simply knows that from the woman's viewpoint her decision can be justified in terms of law.

### *b) Autonomy Arguments*

Assertion of personal rights and invocation of the principle of autonomy can also be argued as support for a woman refusing intervention. The question for the practitioner is whether the recommended intervention will provide sufficient benefit or reduction of harm to warrant overriding the woman's fundamental rights. The answer to this question may be dependent on perspective, the adequacy of the data supporting the recommendation, the relationship between the woman, her family and involved practitioners and her personal experience and beliefs. Bassford felt the issue of human rights put a moral constraint upon the utilitarian principle of paternalism. He wrote:

> Even should his [the doctor in this example] paternalism best increase his patient's welfare, the physician is not justified unless in acting he is not abrogating any of his patient's fundamental moral rights.[10]

Warren also considered the effect of foetal rights on a woman's autonomy and wrote that:

> giving full legal rights to the foetus would give protection and authorise legal regulation of virtually every aspect of a woman's public and private life and is incompatible with even the most minimal right to autonomy.[11]

Draper felt that talk of competing rights obscured and distorted the wider obligations in play.[12] Reid and Gillett also rejected a rights focus, although in the context of abortion decisions. They considered that an emphasis on rights neglected the effects of the actions on and relationships with others and obscured '...the reasons and motivations behind the woman's decision'.[13] Chervenak and McCullough preferred the concept of a moral autonomy which acknowledged individual values and beliefs whilst recognising that such values although important in an individual case, 'were unstable, subjective and [could not] be generalised'.[14] Most midwives would not consider women to be a moral island and they would understand that many other relationships, connections, experiences and family values would impinge on or underpin the woman's decision making.

### *c) Virtue and Moral Obligations*

McCullough and Chervenak believe that if a woman chooses to continue with a pregnancy then she becomes a moral fiduciary to the foetus. They considered the woman's moral responsibility means that she ought always to consent to intervention for the benefit of her foetus and if she refuses such intervention then her doctors are justified in seeking a Court order to enforce treatment. The writers do not limit the degree of risk to which a woman might be subject on behalf of her baby. This is a similar line of argument to that proposed by Judith Jarvis Thompson who considered also that women who opt to continue a pregnancy are effectively consenting to all involved in carrying a child to term.[15] Jarvis Thompson did, however, question whether a woman by law should be required to be a good Samaritan or merely a minimally decent Samaritan to her foetus, by virtue of the fact that she is the mother. This does not recognise that while a woman may assume a moral obligation to her foetus that does not give others a moral authority to enforce that obligation.

Most midwives would consider that the risk to the mother is a significant factor in determining whether any intervention should even be recommended let alone enforced. The idea of forcing intervention on non-consenting women tends to be abhorrent to many writers even in the face of a maternal moral obligation. In Strong's view the use of physical force should be avoided as such action is brutish and should be regarded as beyond the role of the physician.[16] This is a view that is deeply held by midwives and also by many obstetricians.

That is not to suggest that McCullough and Chervenak would resort to brutality. The entire thrust of their book is to disarm or avoid the possible conflict situation before it becomes an ethical crisis. They proposed that the physician has beneficence and autonomy-based obligations to the pregnant woman and beneficence-based obligations to the foetus – when a patient.[17] This latter gloss is very important as, although the foetus may be a patient of the midwife or doctor, if alienated, the woman can remove that patient status by withdrawing herself from the relationship. The midwife can only advise consultations, referral, tests of maternal and foetal wellbeing or intervention; she has not the power physically to enforce her advice and no social mandate to require the woman to remain against her will under the midwife's care.

The moral responsibility of motherhood which is something that midwives deeply respect, does seem to require the woman to consider her unborn child's best interests. Each mother and family will have a very different view of what morality requires them to do and this very individual moral responsibility does not guide the midwife in making hard decisions about whether to continue care.

### *d) The Midwife or Obstetrician's Values and the Dilemma of Care*

It seems that the midwife is not greatly helped by the law nor by a woman's assertion of rights. The moral imperatives of pregnancy are often individually defined and demonstrated and so they are not a basis for guiding difficult midwifery decisions. Perhaps there is assistance to be gained in identifying the factors that are important to the woman and her family and the values which are intrinsic to an individual midwife in opting to continue to provide care.

Johnson writes that in an obstetric dilemma the physician is subject to three competing ethical claims: the patient's right to autonomy, the maxim to do no harm and his or her responsibility as a professional and autonomous moral agent.[18] The same is true of the midwife. Obstetricians usually remonstrate with the midwife in situations where the woman persists in home birth against advice. The midwife is frequently accused of collusion with the woman against medical authority and is urged to abandon her care. In this vulnerable and increasingly litigious climate, some midwives will do just that. On the one side they consider their reputations; their reluctance to be the subject of a complaint by either the obstetrician or the woman; their desire to maintain their access (visiting rights) to the hospital – given that this is often controlled by the obstetrician and hospital staff; their lack of willingness to be seen as responsible for a potential poor outcome; the effect of adverse publicity should anything go wrong; and their desire to stay 'onside' with their medical colleagues or the wish to be seen as a 'safe' practitioner. These factors are then balanced against the informed choice of one family who have chosen to birth at home or who have refused referral or specialist care in the face of significant risk. Many midwives will consider the cost and risk to their professionalism too great and will withdraw from providing care and instead will try to assist the family to find an alternative provider. McCullough and Chervenak affirm such withdrawal, although from a medical perspective, and consider that it is part of the practitioner's right of autonomy that s/he has the right to refuse to practise non-consensual and 'unreasonable' medicine. They write:

> The doctor is free to withdraw from the relationship when s/he reliably concludes that continuing in the relationship entails a substantial risk of sundering the moral integrity or private convictions – what we shall term the private conscience of the doctor.[19]

This is undoubtably true also for the midwife but there is a small number of midwives who operate from a different ethical perspective and would not see themselves as free to withdraw from the midwifery partnership.[20] These few midwives recognise that place of birth decisions never occur in a vacuum but are a combination of the family's past experiences both good and bad, that the family may distrust the advice they have received or may have experienced a communication breakdown with the doctor or another midwife, that the woman may have a history of sexual abuse, rational or irrational fears, or have strongly held personal, religious and cultural values which reassure her that a choice to birth without medical input is the right one. All these factors will impact on the decision. In all the New Zealand 'cases' that I am aware of, the woman has also been totally supported by her partner and thus the place of birth is the couple's decision and not, as it is so often depicted, simply that of the woman.

In some of these situations a midwife who has provided continuity of care, will agree to continue to care for the family. Such a midwife is well placed to understand the utilitarian components of their decision. The midwife knows the family and their values well enough to recognise that if she withdraws the woman and her partner will birth at home regardless of a lack of professional support. In that situation, if the mother or baby gets into difficulty, there will be no one to provide emergency care or to initiate immediate treatment. The ethical imperative of such a midwife will require her to put aside the professional risks to herself and her reputation in order to try and maximise the assistance she can give to mother and baby. The midwife will also have the hope that if the labour and birth become abnormal she may be able to help the family to reconsider recommendations such as medical assistance or transfer to a hospital.

It seems clear that the most useful assistance to the midwife is not law or knowledge of human rights but knowing the family in an holistic way and exploring and understanding the rationales for their decision making. Once the midwife has that knowledge she can then determine what her response will be if they choose to birth at home against advice. The midwife must also be true to herself and her own values, experience and beliefs. If she is unwilling to assume the risks of such a birth then she must tell the woman in a timely and honest way why this is the case and assist her to find alternative care. If she is willing to continue in the relationship then it is important that the woman and family understand the reason for the midwife's decision and the professional vulnerability she is facing on their behalf.

## Preventing the Dilemma

It seems clear that ethical crises and conflict can, in most situations, be avoided by information sharing, identification of areas of concern and working towards mutually acceptable solutions before an urgent situation develops. A fundamental premise should be that the family in their decision making have the best interests of their baby

at heart and are genuinely attempting to make a decision which is coherent with their values and beliefs. Most women recognise that having decided to continue with a pregnancy, they are morally obliged to consider the effect of their actions on their foetuses. A refusal of intervention or a rejection of advised management of pregnancy is a serious matter and not one that a woman does lightly. Many families need more than the recommendation of intervention and the use of technological tools before they will agree to abandon a much considered birth plan. If the family remain unpersuaded about the medical necessity of an intervention, or are unconvinced by the rationales presented by the midwife or doctor, any resultant adversarial process will only 'encourage the adoption of polarised positions which substitute coercion for explanation, persuasion, negotiation and compromise.'[21]

The obstetric and midwifery professions in New Zealand have not really had to deal with Court-forced intervention situations. Most midwives would not support putting a pregnant woman in a position where she might physically resist any forced intervention and violation of her bodily integrity. The psychological effects on her relationship with the baby for whom she was overborne and restrained have never been considered but it would seem to follow that these could cause a significant harm. Midwives would also be concerned that such coercion would undermine women's trust in their caregivers and cause women who did have significant risk factors or strongly held beliefs, to go underground and not present for any care at all. This could cause a far greater community harm which could outweigh the rare individual benefit achieved through forced intervention. Miller writes:

> One cannot protect the fetus by laws that punish the mother, one can only strive to protect the interests of the fetus by protecting the interests of the mother. It is better to have a few tragic private wrongs than that state imposed coercion of pregnant women becomes part of the legal landscape.[22]

## Summary

It is inevitable that on rare occasions, practitioners will face the obstetric dilemma of an 'at risk' mother who exercises her legal right to make an informed decision which conflicts with midwifery and obstetric advice. Midwives understand that such decisions can never be isolated from a family context and are likely to a be a result of the family's sincerely held belief, that it is the best decision for both the woman and her baby. It is the nature of holistic practice that there is a myriad of social, religious, experiential and cultural values which form the contextual rationales for what may not seem at first to be a reasonable or rational decision. These rationales may hold the key to understanding why the choice is made and endeavouring to negotiate the best possible outcome for all concerned.

In the home birth situation continued midwifery care of such women and their families does not reflect recklessness or unsafe practice on the part of the midwife, but instead may connote a different ethical beneficence or value. That value for a midwife is to be a good midwifery Samaritan, despite the risk of personal attack and criticism and even though many obstetricians advise abandonment of the family. We must recognise that some midwives travelling that road will not simply walk on but will instead stay and render what assistance they can to both mother and baby. Those midwives require understanding and support for the overall good that they are trying to achieve rather than condemnation because their ethical imperative requires that they act differently than most other practitioners faced with the same dilemma.

## Notes

1 New Zealand College of Midwives, *Handbook For Practice*. 1993 Christchurch. NZCOM.

2 Scully, Diana. *Men Who Control Women's Health*. 1994. New York: Teacher's College Press, 134.

3 Transitional Health Authority Maternity Project Team, *Guidelines for Referral to Obstetric and Related Specialist Medical Services*, July 1997.

4 This statute provided only for legal persons and did not extend these protections to the unborn.

5 *Congenital Disabilities (Civil Liability) Act 1976, Abortion Act 1967* as amended in 1991, *Paton v British Pregnancy Advisory Service Trustees [1979] Q.B. 276.*

6 *St George's Healthcare NHS Trust v S, R v Collins and Others, ex parte S. [1998] 3 All ER 673.* 'She is entitled not to be forced to submit to an invasion of her body against her will, whether her life or the life of her unborn child depends on it.' The judgement was however confusing as it also stated that it does not, without further analysis, entitle her to put at risk the healthy viable foetus she is carrying.

7 The Royal College of Obstetricians and Gynaecologists. *A Consideration of the Law and Ethics in Relation to Court Authorised Obstetric Intervention. Guidelines.* April 1994, 512.

8 Strong, C. Court Ordered Treatment in Obstetrics: The Ethical Views and Legal Framework. *Obstetrics and Gynaecology,* 78 (5) Part 1. November 1991, 861-3.

9 *In Re: AC 573 A2d 1235 (DC App 1990) : 1249.* See also *Re MB [1997] 8 Med Law Rev 217* where Butler Sloss L.J. held that a competent adult may '... for religious reasons, for rational and irrational or for no reasons at all choose not to have medical intervention'. 224.

10 Bassford, H. The Justification of Medical Paternalism. *Soc. Sci. Med.* 16. 1982, 731-9.

11 Warren, M.A. The Moral Significance of Birth. In Holmes, H. & Purdy, L. (eds) *Feminist Perspectives in Medical Ethics.*1992. Bloomington, Indiana University Press, 211.

12 Draper, H. Women, Forced Caesareans and Antenatal Responsibilities. *Journal of Medical Ethics,* 22. 1996, 327-33.

13 Reid & Gillett. *Journal of Medical Ethics.* 23. 1997, 19-25. Whilst not directly on point with this topic, the writers recognised that it is unlikely that a pregnant women would act with vicious motives towards her foetus and that it is far more plausible that any decision that she might make towards terminating a pregnancy arises out of a genuine moral conflict

14 McCullough, L. & Chervenak, F. *Ethics in Obstetrics and Gynaecology.* 1994. Oxford University Press, 51, 54

15 Jarvis Thompson, J. A Defence of Abortion, *Philosophy and Public Affairs,* 1 (1). 1971, 47-66.

16 Strong, C. *op cit.*

17 McCullough & Chervenak. *op cit.* 51.

18 Johnson *et al.* Obstetric Decision Making – Response to a Patient Who Requests Caesarean Section Delivery, *Ob & Gynae,* 67 (6), June 1986, 849. She writes that the physician cannot be morally required to act as an instrument of treatment of which he, in good conscience, does not approve, 850.

19 McCullough & Chervenak. *op cit.* 112.

20 For an excellent overview of what is meant by this term see the monograph by Guilliland, K. & Pairman, S. *The Midwifery Partnership – A Model for Practice,* Monograph Series 95/1. 1995, Victoria University, Wellington.

21 Stein, E. & Redman, C.W.G. Maternal-Fetal Conflict: A Definition, *Medico Legal Journal,* 58/4 : 230.

22 Miller, L. Two Patients or One – The Problem of Consent in Obstetrics. *Med Law Rev Inter.* 1. 1993, 97-9.